The King's Fund

Ideas that change health care

Briefing

Health and Social Care Bill

Summary

The King's Fund supports the aims of the Health and Social Care Bill. Many of the changes it will introduce, such as involving GPs in commissioning, giving health care providers greater autonomy, and enhancing the role of local authorities in the health system have the potential to improve care for patients and enhance the performance of the NHS. While elements of the Bill are an evolution of previous reforms, the scale of the changes and the speed with which they will be implemented make this the biggest shake-up of the NHS since it was established.

The Bill will introduce a step change in the application of market-based principles in the health system, a radical reform of commissioning, and the biggest reorganisation of the NHS since it was established. While ministers are right to stress the need for service change if the NHS is to be truly world class, the means used must be proportionate to the problems to be addressed. Against a background of significant progress over the past decade and a need for the NHS to deliver unprecedented productivity gains over the next few years, the speed and scale of the reforms present risks that could affect performance during the transition.

This is a summary of The King's Fund's views on the Bill.

- While we support increased competition where this can be shown to benefit patients, the Bill appears to move towards promoting competition at the expense of collaboration and integration of services.

- The approach set out in the Bill places a heavy onus on Monitor as the economic regulator to oversee a step change in competition in the health care market. The outcome will depend on how Monitor interprets its duties and invokes its powers.

- The provider reforms set out in the Bill will be challenging to deliver in a difficult financial environment that will require significant changes to the configuration of services, including reductions in capacity and closures in some areas.

- We support GP-led commissioning as an opportunity to improve patient care, but GP consortia must include a wide range of health and social care professionals, and a flexible approach must be adopted to rolling out consortia across the country.

- While we welcome the enhanced role of local authorities in the health system, the powers granted to Health and Wellbeing Boards are weak and there is a risk that health and social care integration may be more difficult to achieve.

- The government's plans do not make clear who will be responsible for providing 'local system leadership' and planning services across GP consortia boundaries when strategic health authorities (SHAs) and primary care trusts (PCTs) are abolished.

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Market-based reforms

The Bill goes much further than previous reforms in applying market-based principles to the provision of health care. The aim is to increase diversity of supply, promote competition, and increase choice for patients. This will be achieved by establishing Monitor as an economic regulator, extending choice of provider to a wider range of services and allowing providers from all sectors to compete on an equal footing.

The economic regulator

From April 2012, Monitor will become an economic regulator for health and social care with three key functions: promoting competition, setting prices, and ensuring continuity of essential services. The Bill gives Monitor wide-ranging powers to impose licence conditions to prevent anti-competitive behaviour, apply sanctions to enforce competition law and refer malfunctioning markets to the Competition Commission. This mirrors the approach taken in the utility sector and will open up the NHS to challenge by the Office of Fair Trading and the Competition Commission. Such an approach places a heavy onus on Monitor to deliver an optimal configuration of services that balances access, quality, efficiency and cost.

The establishment of Monitor as a powerful economic regulator is very significant. It is being invested with wide-ranging powers and being relied on to oversee a step change in competition in the health care market. In practice, much will depend on how it interprets its duties and invokes its powers.

Choice

Patients are currently able to exercise a choice of provider when they are referred for elective care. Choice will be extended into other areas of care including community services, mental health and diagnostics, with the aim of implementing choice for most NHS-funded services by 2013/14. Patients will also be able to register with any GP practice, regardless of where they live. The expansion of choice will be accompanied by an 'information revolution' to provide patients with access to better information about the performance of providers.

Empowering patients to make choices about their care and treatment is likely to bring benefits. To support choice, information must be relevant, accessible and presented in a way that patients can understand. However, there is little evidence that choice drives improvements in performance, so we would warn against it being relied on as a mechanism for improving quality.

Competition

The Bill will create a level playing field in which 'any willing provider' will be able to provide NHS-funded services. Encouraging a greater diversity of supply will improve patient choice and help stimulate innovation. The risk, particularly in complex areas of care, is that services become more fragmented and co-ordinating care across a number of providers becomes more difficult. Research suggests that competition can work well in areas of care such as elective surgery where services are easily defined, outcomes can be clearly measured, and patients can make informed choices. In more complex areas of care, evidence suggests that the emphasis should be on collaboration and integration, both between primary and secondary care, and between health and social care. Although ministers have stressed the need for integration, there are no duties on Monitor to promote it.

The Bill signals a significant shift towards a more competitive market for health care. While we support increased competition in areas where it demonstrates

benefits to patients, the Bill appears to move towards promoting competition at the expense of collaboration and integration.

The tariff and price competition

The NHS currently operates a system of national tariffs, where providers are paid a fixed amount for providing a particular service and compete on quality. Evidence suggests that this has led to improvements in quality and better outcomes. In addition to setting fixed prices, the Bill will allow Monitor to specify a maximum tariff, thus enabling the introduction of competition on price as well as quality. Experience from the United States and from the internal market in the NHS in the early 1990s suggests that price competition may reduce quality as providers seek to lower costs. It will also increase transaction costs, with commissioners and providers spending significant amounts of time negotiating prices.

The use of fixed tariffs has helped drive improvements in quality and led to better outcomes. However, we would caution against the use of price competition, which is likely to reduce quality and increase transaction costs.

Provider reforms

The reforms to service providers set out in the Bill aim to encourage innovation by granting them more autonomy. This will be achieved by building on the process started by the last government and converting remaining NHS trusts into foundation trusts (FTs), relaxing a number of governance rules for FTs and allowing providers that are unable to compete to 'fail' and exit the market, with Monitor responsible for ensuring continuity of 'designated' essential services.

Foundation trusts

The government has stipulated that all NHS providers must become FTs by April 2014. A Provider Development Agency (PDA) has been established to support NHS trusts that will struggle to achieve FT status. The Bill also relaxes controls on mergers and acquisitions, increasing the options available where FTs are struggling. It is unlikely that all NHS trusts will be able to become FTs by April 2014 or that all existing FTs will remain financially viable as NHS finances tighten. In some cases, the PDA will need to implement a planned reduction in services or transfer services from current providers which may provoke local opposition.

The establishment of the PDA and streamlining of arrangements for mergers and acquisitions should kick start the FT process, which has stalled recently. However, the PDA will be working in a very challenging financial context and will need to act quickly and decisively, often in the face of local opposition.

Governance arrangements

The Bill transfers a number of governance responsibilities from Monitor to FT boards and lifts the cap on how much FTs can borrow from commercial sources. The provider reform agenda set out in the White Paper also included an emphasis on encouraging NHS organisations to adopt employee ownership models, which have been shown to increase staff engagement and innovation. Some progress is being made across the health sector in developing employee ownership models, although this has revealed a number of legal, accounting and employment issues which require government support if they are to be resolved.

The government is enthusiastic about encouraging employee ownership in the health sector. However, progress up to now has been slow and we hope more support will be provided to ensure this moves forward.

Designated services

Under the more market-based approach outlined in the Bill, providers unable to compete will be allowed to 'fail' and exit the market. Monitor will be responsible for protecting the public interest in these circumstances by guaranteeing the continuity of 'designated' services, for example, ensuring access to A&E and maternity services within safe travel times. The process must be flexible enough to challenge incumbent providers and allow new and innovative providers to enter the market.

In undertaking this role, Monitor will need to strike a careful balance between acting in the public interest to maintain access to essential services and avoiding subsidising inefficient or poor-quality providers.

Commissioning

Commissioning has been identified as a weakness under the current arrangements, with PCTs lacking the knowledge and skills to challenge providers about the quality and efficiency of their services. The government's proposals build on previous initiatives – GP fundholding in the 1990s and practice-based commissioning (PBC) in the last decade – which enabled groups of GPs to take on responsibility for commissioning some services on a voluntary basis. However, they go much further by making membership of GP consortia compulsory and giving them full budgetary responsibility for commissioning the majority of services.

GP consortia

GP consortia will take on statutory responsibility for their new functions in April 2013, at which point PCTs will be abolished. The Bill gives the NHS Commissioning Board powers to compel practices to join, or be removed from consortia. Ministers have not specified how many consortia there should be, although the fact that 141 groups of GPs, covering around half the population, have applied to join the government's pathfinder scheme provides some indication of likely numbers. The Department of Health should publish an evaluation of the pathfinders so that the findings can be acted on when GP consortia are rolled out nationally.

We support GP-led commissioning as an opportunity to improve patient care. The response to the pathfinder scheme is very encouraging and provides an important opportunity for lessons to be learned before GP consortia are rolled out nationally.

The authorisation process

While those who are ready and willing should be encouraged to move quickly, many consortia will lack the skills, experience and motivation to assume all their responsibilities in time to meet the April 2013 deadline specified in the White Paper. The authorisation process for consortia must be flexible enough to enable them to take on their commissioning responsibilities as and when they are ready to do so, and PCT 'clusters' should be left in place to guide the changes until consortia are ready to take up the reins. The Chief Executive of the NHS, David Nicholson, has recently indicated that there may be some flexibility in the process if consortia are unable to meet the deadline.

To ensure that GP commissioning is implemented successfully and that public money is well spent, it is important that GP consortia do not take on their

responsibilities before they are ready. We therefore welcome indications that there will be some flexibility in the authorisation process.

Governance and performance

The Bill includes few requirements on the governance of consortia. As the Health Select Committee pointed out recently, it is essential that consortia include a wide range of health professionals and involve the public in their work. While the Bill includes a limited duty on consortia to involve the public, it is silent on the need for them to include other health professionals, suggesting a potential area of weakness.

The government should set out clear expectations that GP consortia will include hospital specialists, other clinicians and health and social care professionals, and involve the public closely in their work.

Primary care services

To avoid a conflict of interest for GP consortia, the NHS Commissioning Board will commission primary care services. Experience shows that quality improvement in primary care is best undertaken locally so we welcome recent statements indicating that the Board will work closely with consortia in undertaking this function. Experience also suggests that innovation often comes from GPs delivering community-based services. This creates a potential conflict of interest for GPs as commissioners and providers of services. The Bill requires that consortia constitutions set out how conflicts of interest will be managed – it will be important for this to be done in a proportionate way that provides transparency without deterring GPs from delivering services themselves when this brings benefits to patients.

The NHS Commissioning Board and Monitor must develop a proportionate approach that allows GPs to develop and deliver innovative services, while providing reassurance that conflicts of interest will be managed effectively and transparently.

Public health and the role of local authorities

The Bill extends the role of local authorities in the health system by creating Health and Wellbeing Boards (HWBs) and giving them responsibility for public health. The aim is to strengthen democratic legitimacy and ensure that commissioning is joined up across the NHS, social care and public health. The interface between GP consortia and local authorities will be critical in ensuring that services meet the full range of local population health needs.

Health and Wellbeing Boards

HWBs will be responsible for producing joint strategic needs assessments and developing a joint health and well-being strategy for their local area. The core members of HWBs will be GP consortia, the Director of Adult Social Services, Director of Children's Services, Director of Public Heath, and the local HealthWatch. However, HWBs have not been granted sufficient powers to meet the expectation that they will join up commissioning between the NHS and local authorities. For example, while consortia must consult HWBs in drawing up their commissioning plans, there is no requirement for them to have regard to their views.

While we welcome the establishment of HWBs, the Bill appears to grant them insufficient powers to join up commissioning effectively between the NHS and local authorities.

Health and social care integration

The Bill includes duties on the NHS Commissioning Board and HWBs to promote integration between health and social care and includes provisions to enable the Board or consortia to establish pooled funds. These provisions are welcome and should encourage joint working across health and social care, although we are concerned that there is no equivalent duty on GP consortia to promote integration. Under the current arrangements, PCTs and local authorities have developed numerous ways of working in partnership, resulting in better co-ordination of services. The loss of the co-terminosity achieved between many authorities and PCTs may create practical barriers to joint working, so it will be important that this good practice is carried forward.

We welcome the inclusion of duties to promote health and social care integration. However, without an equivalent duty on GP consortia, in the context of the weak powers given to HWBs and with the loss of co-terminosity between local authorities and PCTs, we fear that progress to date in improving integration may be reversed.

Public health

The Bill abolishes the Health Protection Agency, places a duty on the Secretary of State to promote public health, and transfers responsibility for public health to local authorities. This provides an opportunity to improve the co-ordination of public health with other local services with a role to play such as housing, planning and leisure. However, it is vital that public health does not become separated from the work of the NHS. While HWBs provide a forum for maintaining this link, we are concerned that the Bill does not appear to place a duty on GP consortia to promote the health of their local health population.

While we welcome the transfer of responsibility for public health to local authorities, we are concerned that the lack of clarity about the role of GP consortia in promoting population-wide health could result in the NHS not giving it sufficient priority.

Health inequalities

The Bill includes new duties on the Secretary of State, NHS Commissioning Board and GP consortia to have regard to the need to reduce health inequalities. While these duties are welcome, they are narrowly drawn, only applying to the role of the NHS in providing services to patients. The duties do not reflect the broader role of the NHS in promoting public health as a provider, commissioner and major employer. There are also no equivalent duties on the Secretary of State or local authorities in respect of their roles in promoting public health.

While the new duties in the Bill are welcome, they are unlikely to be sufficient to ensure that tackling health inequalities is prioritised in the health system.

Structural reform

The Bill will implement a radical reorganisation of the NHS which aims to devolve responsibility to clinicians, cut management costs, and reduce political involvement in the health system. A new NHS Commissioning Board will be responsible for the operational management of the NHS, services will be commissioned by GP consortia, and PCTs and SHAs will be abolished. These changes will be implemented alongside a reduction in management costs of 45 per cent. The reforms will be implemented at the same time as the NHS grapples with the need to find productivity improvements of £20 billion by 2015

if it is to cope with rising demand while maintaining quality and avoiding significant cuts to services.

The NHS Commissioning Board

The objective behind the establishment of the NHS Commissioning Board is to place operational management of the NHS at arm's length from ministers. However, the Secretary of State will still account to parliament for the performance of the NHS and the Bill includes wide-ranging powers for him/her to intervene in the system, so the test will be whether ministers are able to resist intervening in politically sensitive issues. The Board will need to strike a balance between operating as the 'lean and expert body' described in the White Paper, and having capacity to fulfil its extensive responsibilities, which include commissioning a range of services not commissioned by GP consortia.[1] It is likely to need a regional presence to provide leadership across consortia.

The creation of the NHS Commissioning Board could reduce political involvement in the operation of the NHS and help devolve power through the system. However, it remains to be seen whether this will be the case in practice – much will depend on whether ministers can step back in the face of performance failure.

Local system leadership

Under the current system, SHAs and PCTs play an important strategic role in planning services across geographical boundaries. For example, cancer, stroke and trauma services are best delivered by concentrating some specialist services in centres of excellence serving large geographical areas. In some areas, there is also a need to reduce hospital capacity and move services from hospitals to the community to improve quality and reduce costs. London faces particular challenges in this regard. The government's proposals fail to make clear who will be responsible for this type of 'local system leadership' across consortia boundaries when SHAs and PCTs are abolished.

The government should clarify responsibility for local system leadership under the new arrangements. GP consortia may agree to collaborate to fill this gap but allowing this to happen organically is insufficient, especially as decisions on some service reconfigurations are needed quickly.

Managing the transition

The abolition of SHAs and PCTs, alongside the reduction in management costs, is already resulting in many experienced staff leaving the NHS and absorbing the time and energy of managers when they need to be focusing on delivering productivity improvements. The loss of experienced managers could have serious implications in terms of financial stability and performance, for example, on waiting times. There is already evidence that the funding squeeze is being felt, with some PCTs delaying treatment and restricting services. The government has responded to these risks by reorganising primary care trusts into 'clusters' to provide local leadership during the transition period, providing continuity of employment for experienced managers and appointing the NHS Chief Executive, David Nicholson, to head up the NHS Commissioning Board.

[1] Specialised services – which require particular expertise and are best commissioned across a wide population base – will be commissioned by the NHS Commissioning Board. The Board will also be responsible for commissioning pharmaceutical, dental, and ophthalmic services. The government has announced that GP consortia will be responsible for commissioning maternity services, reversing the position set out in the White Paper, which indicated they would be commissioned by the Board.

Finding the £20 billion in productivity improvements needed to maintain quality and avoid significant cuts to services must be the NHS's overriding priority over the next few years. Despite the welcome arrangements established by the government to manage the transition, there remains a risk that implementing the reforms will make this much more difficult.

Conclusion

The government is right to stress the need for service change if the NHS is to be truly world class. The reforms set out in the Bill have the potential to improve care for patients and enhance NHS performance if they are implemented well, but also pose a number of risks. The complexity of the reforms makes it difficult to predict their impact. As we argued in our response to the White Paper, a number of outcomes are possible depending on how the various elements of the reforms interact with each other and how successfully the proposals are implemented including:

- **stasis** as the new structures replicate the form and behaviour of the previous one and the reforms fail to make an impact
- **a more market-orientated system** as choice and competition are significantly expanded
- **an integrated system,** with GP consortia working closely with other clinicians and stronger links made between health and social care
- **disintegration** as a lack of collaboration within the system and the impact of the financial squeeze push it into meltdown.

The real choice is therefore not between stability and change but between reforms that are executed well and deliver results for patients and those that are poorly planned and undermine the performance of the NHS. The debate on the Bill provides an opportunity to address the questions we have raised and enable the NHS to build on the progress made in the last decade.