Briefing

**THE HEALTH AND SOCIAL CARE BILL:
RECOMMITAL TO PUBLIC BILL COMMITTEE**

Summary

We welcome the report of the NHS Future Forum and the government's response to its recommendations. The amendments proposed by the government respond to many of the concerns that we and others have raised and will significantly improve the Bill. It now offers a more promising approach to addressing the challenges of the future and a more compelling vision of a health system based on stronger collaboration between professionals and better co-ordination of services.

The key priority facing the NHS remains the need to find £20 billion in productivity improvements to maintain quality and avoid significant cuts in services. It is essential to move on from the uncertainty of recent months so that the NHS can focus on the financial and operational challenges this presents. We remain concerned that the scale of the reforms and the challenges associated with implementing them present risks that could affect NHS performance during this critical phase. Strong leadership and management will be essential to overcome these risks, so we welcome the emphasis on this in the government's response to the Future Forum.

Our key points in response to the changes to the Bill are set out below.

- We strongly welcome the new emphasis on integration – this offers the most promising approach to addressing demographic change and supporting the increasing number of people with long-term conditions.
- We also welcome the changes to widen clinical involvement in commissioning, strengthen governance arrangements for local commissioning groups and adopt a more flexible approach to implementing clinical commissioning.
- While competition can bring benefits to patients, the Bill previously went too far in moving towards a market-based health system – we therefore welcome changes to promote a more nuanced approach to competition.
- The provider reforms will be challenging to deliver in the current financial context and we remain concerned about the lack of clear responsibility for driving forward major reconfigurations of hospital services.
- The sheer number of changes being made to the structure of the health system risk creating confusion and additional bureaucracy – the government will need to set out clearly how the various bodies will operate and work together.
- While we welcome the changes made to improve accountability, the emphasis in the Bill has shifted from a permissive to a more prescriptive approach – a careful balance will be needed to avoid over-centralisation and to encourage locally led innovation.
- The focus on the NHS Constitution is welcome, although the pledge to keep waiting times low will be difficult to meet and it is not clear how it will be measured and enforced.
- The uncertainty of the past few months has caused instability within the NHS – the government must now provide the direction and stability the NHS desperately needs to navigate the challenging times ahead.

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Market-based reforms

The previous version of the Bill signalled a significant shift towards a more market-based health system, with a strong onus on the economic regulator, Monitor, to promote a step change in competition. We support moves to extend patient choice, increase diversity of supply and increase competition where this brings benefits to patients. However, the previous version of the Bill went too far in promoting competition as an end in itself, so we welcome amendments designed to ensure a more nuanced approach to competition.

The economic regulator

Monitor will retain its role as economic regulator for the NHS, although a number of changes have been made to its remit and powers. We agree that a sector-specific regulator with expertise in health care is the most effective safeguard against inappropriate application of competition law and that Monitor should therefore assume responsibility for overseeing competition in the NHS and for setting prices (in association with the NHS Commissioning Board). We have consistently argued that competition should not be an end in itself, so welcome the amendments to remove the duty on Monitor to promote competition and focus its primary duty on protecting and promoting patients' interests. It will be essential that it strikes the right balance between tackling anti-competitive behaviour and promoting integration.

- Monitor's powers are now focused on preventing anti-competitive behaviour – it must use these powers to prevent providers from using dominant market positions to the detriment of quality or value for money, while working closely with the NHS Commissioning Board and commissioners to promote integration.
- A number of changes are proposed to the statutory framework for the tariff – in setting prices it will be important to balance national specification of prices with the need for local flexibility to innovate.
- In light of the problems experienced by Southern Cross, there is a case for extending Monitor's role to include prudential oversight of the financial viability of health and social care providers with a significant market share of publicly funded services.

Choice

Extending choice of provider beyond elective surgery to other areas of care including community services, mental health and diagnostics is likely to bring benefits to patients. We welcome the commitment to include a 'choice mandate' in the Secretary of State's mandate to the NHS Commissioning Board and the aim of embedding the 'no decision about me without me' principle throughout the NHS. While patients currently have a right to choice of provider at the point of referral, in practice primary care trusts (PCTs) have often limited the range of providers and GPs do not routinely offer this choice to their patients, so it will be important to monitor how this is implemented.

- 'No decision about me without me' must mean going beyond offering choice of provider to actively involving patients in decisions about their treatment – this needs to be systematically embedded in clinical practice.
- To support choice, information must be relevant, accessible and presented in a way that patients can understand – we hope the information strategy due to be published later this year will make the 'information revolution' a reality.
- The government's response to the Future Forum also includes a new pledge to extend personal health budgets – more detail is needed about how this will be

implemented and pilots must be fully evaluated before decisions are made about extending personal budgets beyond a limited range of conditions.

Competition

A number of changes have been made to Part 3 of the Bill to reduce the emphasis on competition. Competition can bring benefits to patients – research suggests it can work well in areas of care such as elective surgery where services are easily defined and outcomes can be clearly measured. However, in more complex areas of care, evidence suggests that the emphasis should be on collaboration and integration. We therefore welcome the more nuanced approach to competition signalled by the amendments to the Bill. We also welcome the move to rule out competition on price – evidence suggests that price competition reduces quality and increases transaction costs. The commitment to phase in 'any qualified provider' from April 2012 should reduce the risk of fragmentation of services.

- While it is right that competition is based on quality, with fixed prices for services, commissioners must ensure they extract value for money from providers.
- The commitment to phase in the move to 'any qualified provider' is welcome, although it is not yet clear how this will work and it will be important to ensure that commissioners can commission whole pathways of care.
- By creating a level playing field, the Bill potentially provides opportunities for voluntary sector organisations – these organisations play a crucial role in the NHS and must not be crowded out in a more competitive environment.

Commissioning

Significant changes have been made to the arrangements for establishing clinical commissioning, with the permissive approach previously set out in the Bill replaced by more prescription. The King's Fund continues to support clinical commissioning as an opportunity to improve patient care by linking clinical and financial decisions. We welcome the changes made to widen clinical involvement in commissioning, strengthen governance arrangements and adopt a more flexible approach to implementation. However, it will be important to maintain momentum and ensure that the changes do not discourage enthusiastic GPs from leading change at a local level.

Clinical commissioning

A number of welcome changes have been made to strengthen clinical involvement in commissioning. GP consortia will be re-named clinical commissioning groups and will be required to obtain a wide range of clinical advice and consult a number of bodies in developing their commissioning plans. Existing clinical networks (groups of experts working in specialist areas such as cancer) will be strengthened and new clinical senates established to bring together a wide range of health and social care professionals. The government's response to the Future Forum describes clinical senates as 'local' bodies, but early indications suggest that there will be fewer than 20 of them across the country and that they could play a role in advising the NHS Commissioning Board and clinical commissioning groups on major service reconfigurations. Clinical commissioning groups will also be required to include a nurse and a hospital specialist on their governing body.

- Although we welcome the emphasis on wider clinical involvement in commissioning, the number of bodies local commissioners will need to consult and take advice from risks creating confusion and additional bureaucracy.
- The government should move quickly to clarify the role of clinical senates – their main function should be to provide support to clinical commissioning groups and

health and wellbeing boards and they should not be part of the NHS Commissioning Board's performance management regime, even if they are hosted by it.

- Although we agree that clinical senates could have an important role to play, we remain concerned about the lack of clear responsibility for driving forward major reconfigurations of hospital services.

Governance and authorisation

We also welcome the changes made to the governance of clinical commissioning groups and the more flexible approach to authorising them. They will now be required to have governing bodies that must include two lay members (one to champion patient and public involvement and one to lead on governance). Governing bodies must adhere to Nolan principles and will be required to meet in public and publish the minutes of meetings. The April 2013 deadline for establishing GP consortia has been relaxed – clinical commissioning groups will be established either in full or in shadow form by this date, but take on their new responsibilities only when they are ready and willing to do so. The government's response to the Future Forum made it clear that their boundaries must not now cross those of local authorities unless this can be justified in terms of benefits to patients and integration of health and social care services.

- We welcome the more flexible approach to authorising clinical commissioning groups but it will be important to continue to encourage those that are ready and willing to move quickly in taking on their responsibilities.
- The response to the government's pathfinder scheme for GP consortia has been very encouraging – it will be important to sustain the momentum this has generated and evaluate the lessons learned to inform the roll-out of clinical commissioning groups.
- The move to align clinical commissioning group and local authority boundaries will help to promote health and social care integration, although local authority boundaries do not always reflect patterns of need, so some flexibility should be retained.

Primary care services

Our independent inquiry into quality in general practice highlighted widespread variations in performance and the need to improve quality in general practice. The NHS Commissioning Board and clinical commissioning groups should work together to address this as a priority. Experience suggests that innovation in service delivery often comes from GPs delivering services. This creates a potential conflict of interest for GPs as providers and commissioners of services – a transparent but proportionate framework is needed to manage this. The quality premium paid to high-performing clinical commissioning groups has been revised to focus on quality and outcomes, rather than financial performance, and may take account of progress in reducing health inequalities.

- Evidence shows that quality improvement in primary care is best undertaken locally – the NHS Commissioning Board should work with clinical commissioning groups to support locally led initiatives rather than adopting a top-down management approach.
- Clarity is needed about the arrangements for managing potential conflicts of interest for GPs – while these arrangements must provide transparency, they should not act as a barrier to GPs delivering services that benefit patients.

- We welcome the changes to the quality premium and the requirement for clinical commissioning groups to account for how the additional money awarded to them has been spent.

Provider reforms

The reforms to providers have received relatively little attention so far during the debate on the Health and Social Care Bill but are nonetheless very important, particularly in the context of the need to deliver £20 billion in productivity improvements by 2015. We support the aim of completing the process of converting NHS trusts into foundation trusts. However, these reforms will be very challenging to deliver in a difficult financial context.

Foundation trusts

The government has relaxed the April 2014 deadline for the remaining NHS trusts to become foundation trusts, although it stresses that the majority will still be expected to meet this deadline. The provisions in the Bill to streamline the process for mergers and acquisitions of struggling trusts should help kick start the foundation trust process, which has stalled recently. However, it has become clear that a number of NHS trusts are not financially sustainable and would not be able to meet the April 2014 deadline. The NHS Trust Development Agency, established to support NHS trusts struggling to achieve foundation trust status, will need to work with these and other trusts with financial and clinical challenges to deliver planned reductions in services and, in some cases, closures.

- Major reconfigurations of hospital services are needed for financial and clinical reasons – this issue has been ducked for too long and must be confronted urgently if the NHS is to respond to the financial challenge it is facing.

The failure regime

The government's response to the Future Forum indicates that it will withdraw the proposals set out in the previous version of the Bill to 'designate' essential services. Amendments will be tabled at a later stage to establish 'an effective failure regime that ends the culture and practice of hidden bailouts and gets the right incentives into the NHS, whilst protecting essential services'. Given the importance of this issue and the concerns raised about the government's original proposal, we hope that stakeholders will be consulted and that the amendments will receive proper parliamentary scrutiny.

- The failure regime must strike a careful balance between acting in the public interest to maintain access to essential services and avoiding subsidising inefficient or poor-quality providers.

Governance

In recognition of the fact that many governing bodies have struggled to hold their boards to account, Monitor's oversight of foundation trusts has been extended to 2016 to enable governors to develop their capabilities. Foundation trusts will now be required to hold their board meetings in public.

- We welcome the extension of Monitor's oversight of foundation trusts – governors should be provided with support to develop their capabilities and progress should be reviewed in 2016 before Monitor surrenders this role.

Local authorities and public health

The establishment of health and wellbeing boards, the emphasis placed on public health and the priority given to reducing health inequalities have been widely welcomed. A number of changes are being made to the Bill to reflect the recommendations made by the Future Forum on these issues.

Health and wellbeing boards

The role of health and wellbeing boards will be strengthened in a number of ways. They will be given a stronger role in the development of local commissioning plans, more responsibility for promoting joint commissioning and health and social care integration, and a lead role in local public involvement. They will also be able to refer commissioning plans back to clinical commissioning groups or the NHS Commissioning Board if they are not satisfied it takes proper account of the local health and wellbeing strategy. A flexible approach will be adopted towards the membership of health and wellbeing boards which will be left to local authority discretion.

- The previous version of the Bill gave health and wellbeing boards insufficient powers to fulfil their remit in joining up local commissioning, so we welcome the enhanced role for them now set out in the Bill.
- Amendments strengthening duties to promote health and social care integration are welcome, but the key to achieving this will be strong leadership and cultural change to develop joint working at a local level.
- Legal powers for joint commissioning and pooled budgets have existed for some time but few local authorities have used them – the approach set out in the Bill may not therefore be strong enough.

Public health

Public Health England, the new national public health service, will now be established as an executive agency of the Department of Health. This reflects concerns that locating it in the Department could have undermined the independence of its advice. While we agree that some public health functions should be independent, we are concerned that making Public Health England an executive agency may weaken the voice of public health within government. Duties on the NHS Commissioning Board and clinical commissioning groups to secure advice from public health professionals have been strengthened and they will also have a role in the new clinical senates. The amendments make clear that clinical commissioning groups will be responsible for commissioning services for unregistered people in their area, not just for registered patients.

- It is essential that public health has a strong voice within government – the government must set out clearly how this will be achieved in its forthcoming response to the public health White Paper.
- We welcome clarification that clinical commissioning groups will be responsible for unregistered patients but remain concerned that the absence of a clear duty on them to promote population-wide health could result in GPs giving insufficient priority to public health.
- While the amendments to strengthen the involvement of public health professionals in commissioning are welcome, there is a risk that there will not be sufficient public health capacity to fulfil its various responsibilities.

Health inequalities

We have previously welcomed the new duties on the Secretary of State, NHS Commissioning Board and clinical commissioning groups to have regard to the need to reduce health inequalities, although we noted that these are narrowly drawn, only apply to the role of the NHS in providing services to patients and do not extend to local authorities. The amendments setting out the new duties on the NHS Commissioning Board, Monitor and clinical commissioning groups to promote integrated care also place a welcome emphasis on reducing inequalities. However, while the Future Forum report called for these duties to be 'translated into practical action' through the NHS Commissioning Board's mandate, the outcomes frameworks, commissioning plans and other system levers and incentives, the government's response is largely silent on how this will be achieved.

- While the new duties in the Bill are welcome, they should be widened to reflect the broader role of the NHS as a significant contributor to the economy and a major employer.
- The failure to place equivalent duties on local authorities is an omission, especially given their responsibilities for public health and the role of health and wellbeing boards.
- The government should set out how it intends to use non-legislative levers and incentives to translate the duties in the Bill into practical action and how the NHS will be accountable for reducing health inequalities.

System reform

The previous version of the Bill outlined a radical reorganisation of the health system, including the abolition of strategic health authorities (SHAs) and primary care trusts (PCTs), the establishment of the NHS Commissioning Board and other new bodies, and a number of changes to the responsibilities of existing organisations. Following the recommendations made by the Future Forum, a number of changes have been made to the original proposals and to the timetable for implementing them. There is a much stronger emphasis on integration, the accountability of the NHS through the Secretary of State has been clarified and there is now a strong emphasis on the NHS Constitution. It will take some time before the full implications of these changes and their impact on the various bodies in the health system become clear.

Integration

Throughout the debate on the reforms we have argued that integrated care, based on stronger collaboration among professionals and better co-ordination between services, offers the most promising approach to improving patient care and meeting the key future challenge facing the NHS – demographic change and supporting the increasing number of people with long-term conditions. We therefore strongly welcome the Prime Minister's pledge to put integration at the heart of the reforms and the new duties being placed on the NHS Commissioning Board, Monitor and clinical commissioning groups to promote it. There are also stronger duties on clinical commissioning groups and health and wellbeing boards to promote integration between health, social care and 'health related' services such as public health. This will also be helped by the move to align clinical commissioning group and local authority boundaries.

- While the amendments to the Bill provide a useful starting point, changes are also needed to wider health policy (eg, NHS payment systems) to ensure that integration is hard-wired throughout the NHS – leading this process must be a top priority for the NHS Commissioning Board.

- Delivering integrated care depends on overcoming historic divisions within the medical profession – changes to widen clinical involvement in commissioning will help to encourage this but a culture change is needed among health professionals who must work much more closely together.
- We have previously argued for a single outcomes framework for the NHS, public health and social care – given the emphasis on integrating care, the current outcomes frameworks should be reviewed and more closely aligned.

Structural changes

A number of changes have been made to the timetable for the structural reforms. The abolition of SHAs will be delayed until April 2013 and the NHS Commissioning Board will now be established in shadow form in October 2011, before taking on its full responsibilities from April 2013. In the meantime, SHAs will retain responsibility for NHS finances and will be slimmed down to a small number of 'clusters'. The PCT clusters currently being formed from the consolidation of PCTs will become local arms of the NHS Commissioning Board and will oversee clinical commissioning groups after April 2013. This leaves a very crowded health landscape, with clinical commissioning groups, health and wellbeing boards, SHA clusters (until April 2013), PCT clusters and clinical senates and networks operating at a regional, sub-regional and local level. There is a new emphasis on the NHS Constitution, with amendments requiring the NHS Commissioning Board and clinical commissioning groups to promote it. This was reflected in the Prime Minister's pledge to keep waiting times low, which will be based on the 18-week maximum wait from referral to hospital treatment enshrined in the Constitution.

- The sheer number of changes being made to the structure of the health system risks creating confusion and additional bureaucracy – the government must set out very clearly how these bodies will operate and work together.
- The NHS Commissioning Board will be very powerful and seems unlikely to be the 'lean and expert' body described in the NHS White Paper. It will need to ensure that it avoids over-centralisation and encourages locally led innovation.
- The focus on the NHS Constitution is welcome, although the pledge to keep waiting times low will be difficult to meet and it is not clear how it will be measured and enforced.

The transition

The key priority facing the NHS remains the need to find up to £20 billion in productivity improvements by 2015 – the so-called 'Nicholson challenge'. Implementing the reforms while maintaining the focus needed to achieve this will be very challenging and there remains a real risk that NHS performance could be undermined during this crucial phase. As the government's response to the Future Forum recognises, high-quality leadership and management will be needed throughout the NHS to manage this risk.

- It is now essential to move on from the uncertainty of recent months to focus on the financial and operational challenges presented by the 'Nicholson challenge'.
- We welcome the new emphasis on the importance of leadership and management and hope it will be accompanied by a shift in political rhetoric to support, rather than denigrate, NHS managers.
- Many experienced managers have already left the NHS, so we welcome moves to retain and develop the best remaining talent – this will be essential if the NHS is to meet the financial and operational challenges ahead.

Conclusion

The aims of the Health and Social Care Bill – putting patients first, improving health outcomes and empowering health professionals – were never in dispute. Throughout the debate on the Bill, The King's Fund has argued that the real choice is not between stability and change, but between reforms that are well-designed and deliver benefits to patients and those that are poorly planned and undermine NHS performance.

The 'pause' in the passage of the Health and Social Care Bill has served the NHS, its staff and patients well by allowing time to reflect on how to deliver the reforms that the health system needs. The amendments proposed by the government will significantly improve the Bill and it now offers a more promising approach to addressing the challenges of the future.

Despite the headlines generated by the reforms, the key priority facing the NHS remains the need to find £20 billion in productivity improvements to maintain quality and avoid significant cuts to services. The uncertainty of the past few months has caused instability within the NHS at a time when it faces significant financial and operational difficulties. The government must now provide the direction and stability the NHS desperately needs to navigate the challenging times ahead.

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