

**HEALTH SELECT COMMITTEE INQUIRY  
IMPLEMENTATION OF THE HEALTH AND SOCIAL CARE ACT 2012  
EVIDENCE FROM THE KING'S FUND**

- 1) The King's Fund is an independent charity working to improve health and health care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

**Summary**

- 2) Commissioning has often been described as the weak link in the NHS since the purchaser-provider split was introduced in 1991. This Committee and its predecessors have highlighted its shortcomings on a number of occasions. Commissioning health services is a complex and difficult task and no other health system in the world that we are aware of places as much emphasis on it as a means of driving improvement. With the NHS facing huge challenges, the question is whether the latest incarnation of commissioning will be more effective than its predecessors.
- 3) Although it is too early to evaluate its impact, we welcome the Committee's inquiry as an opportunity to assess progress so far in implementing the new commissioning system and establish a baseline against which to measure future progress. During the parliamentary passage of the Health and Social Care Act, we made it clear that we supported greater involvement of clinicians in commissioning but raised a number of concerns about the design and implementation of the legislation including:
  - The risk to patient care as a result of the scale of structural change, particularly with the NHS facing the biggest financial challenge in its history.
  - The lack of strategic responsibility in the new system for leading large-scale reconfigurations of services.
  - The need for a nuanced approach to competition to allow commissioners to promote integrated care.
- 4) This submission comments on the majority, but not all of the terms of reference for the inquiry and concludes that:
  - Good progress has been made in establishing the new commissioning system and it is a considerable achievement that all clinical commissioning groups completed the authorisation process. However, there is significant variation in their readiness and competence to take on their new roles.
  - Although there is encouraging evidence of collaboration between CCGs, we remain concerned that the fragmentation of commissioning and lack of strategic responsibility in the new system for leading large-scale reconfigurations will make service changes more difficult to implement.
  - Guidance is needed to resolve confusion about the effect of competition on commissioning decisions. There is also significant uncertainty about the impact of increased involvement by the competition authorities in decisions about provider mergers and service reconfigurations.

- The fragmentation of commissioning responsibilities and sheer number of organisational changes risk confusing lines of accountability and creating an inconsistent approach to holding organisations to account across the NHS, public health and social care.
- Integrated care must now happen at scale and pace - a stronger commitment is needed from the Department of Health, NHS England and Monitor to ensure that policy and regulation supports rather than inhibits this.

### **The readiness of clinical commissioning groups and NHS England**

- 5) The King's Fund is taking a close interest in the development of clinical commissioning groups (CCGs). We are working closely with six CCGs to evaluate their work over a three-year period in a joint project with the Nuffield Trust, with the first report from this due to be published in the summer. We have also undertaken leadership development work with around a third of CCGs to help them prepare for authorisation - this has given us valuable anecdotal insight into the progress they are making to go alongside the findings from our research. Not surprisingly, our experience suggests significant variation in the state of readiness and competence of CCGs.
- 6) It is very positive that all CCGs successfully completed the authorisation process. However, four out of five CCGs had at least one condition attached to their authorisation. While some conditions were relatively minor, others highlight significant gaps in competence - two of the most common weaknesses were failing to produce a credible commissioning plan and not having a sufficiently detailed financial plan. There was substantial regional variation, with CCGs in the north receiving fewer and less severe conditions than other regions, while the south fared significantly worse. This variation is not linked to the size of CCGs - small CCGs performed just as well as larger ones - and there is no clear relationship with deprivation.
- 7) So far, there is considerable diversity in the approaches taken by CCGs, with commissioning priorities often appearing to be driven by key individuals within the group. Whether or not this continues or is constrained by pressure to conform to national priorities remains to be seen. In our experience, many CCG leaders are highly motivated, impressive and enthusiastic about their new roles. However, one of the most significant unknowns about the new system is whether there are enough enthusiasts to ensure success and whether these individuals feel they have sufficient freedom to lead and innovate.
- 8) Recent media coverage has highlighted large numbers of CCG board members with financial interests in provider organisations and the potential for conflicts of interest to arise in commissioning decisions.<sup>1</sup> It is vital to ensure that underlying principles of transparency, accountability and probity are seen to support all decision-making. Feedback suggests that many CCGs are putting in place robust arrangements to manage conflicts of interest by, for example, increasing lay representation on boards, co-opting additional members to help make decisions or obtaining outside clinical advice. However, it is important to strike a balance - over-emphasising conflicts of interest risks diluting clinical involvement in commissioning decisions and stifling innovation.

- 9) As the Committee has pointed out, major reconfigurations of services are essential for quality and financial reasons. We remain concerned about the lack of strategic responsibility in the new system for leading large-scale reconfigurations. The fragmentation of commissioning risks making service changes more difficult to implement. In London and other large conurbations in particular, the risk is that a number of bodies are involved in commissioning services but none has responsibility for the population as a whole. The increased involvement of the competition authorities may also have an impact, with significant uncertainty about the application of competition law (see below).
- 10) Encouragingly, many neighbouring CCGs are collaborating to tackle issues across wider geographical areas and give them the financial clout to influence large providers. However, there is a risk that these arrangements are seen as a threat to local autonomy, with some finding it difficult to operate in this way while also retaining buy-in from their members. Reconciling this tension will be a key challenge for CCGs given the pressing need to reconfigure services. We also note recent comments suggesting that NHS England's local area teams may play a significant role in driving reconfigurations.<sup>2</sup> It remains to be seen whether they have the capacity to do this and how effectively they will work with CCGs - our research suggests that relationships between CCGs and local area teams are currently under-developed.
- 11) More generally, our work suggests widespread concern about the capacity of the local area teams more generally, particularly in relation to their role in managing the performance of general practice. Lack of capacity may mean that primary care commissioners struggle to develop close relationships with individual practices and are forced to rely on data only, with CCGs providing intelligence about performance. More positively, indications so far suggest that many CCGs are willing to engage in this role, with some CCG leaders pointing to examples where peer-to-peer influence is already having more impact than manager-to-practice relationships under PCTs. Nevertheless, there is a risk that responsibility for improving quality in general practice may be neglected where CCGs are reluctant to take on this role. This is a significant concern given the pressing need for improvement identified by our independent inquiry into quality in general practice.<sup>3</sup>

### **The effect on commissioning of requirements on competition and choice**

- 12) Throughout the parliamentary passage of the Health and Social Care Act, we argued for a nuanced approach to competition so that planned and collaborative approaches to commissioning services can be used where appropriate, as well as competitive processes. As the Committee stated in its 2011 report on commissioning, 'it is essential that NHS commissioners are able to choose the pattern of service delivery which reflects their clinical and financial priorities'.<sup>4</sup>
- 13) The debate about the regulations setting out how services should be procured under section 75 of the Act has highlighted the lack of clarity about the effect of competition law on commissioning decisions. Much will depend on how Monitor – which will adjudicate on alleged breaches – interprets its duties and, more broadly, how the courts interpret the application of EU competition law. The uncertainty has been exacerbated by a lack of clarity about the government's policy intentions and absence of guidance on how it expects the policy to be implemented.

- 14) In the past, commissioners - who often lack skills and experience in managing procurement - have tended to adopt a cautious approach, engaging in sometimes cumbersome and unnecessary tendering processes for fear of finding themselves in breach of competition law. This risk is that, faced with further confusion and uncertainty, they become even more risk-averse, potentially undermining efforts to deliver integrated care. It is therefore essential that Monitor and NHS England produce detailed guidance to clarify how the Section 75 regulations - and competition more generally - should be implemented by commissioners.
- 15) While the debate has raged about the impact of the regulations, less attention has been paid to the application to providers of the competition provisions in the Act and, in particular, the role of the Office of Fair Trading (OFT) in assessing mergers. In this regard, the outcome of the OFT's referral to the Competition Commission of the proposed merger between the Royal Bournemouth and Christchurch Hospitals and Poole Hospital foundation trusts could be significant. The evidence about the success of mergers is mixed. However, with many struggling trusts looking to them as a solution to financial problems and to pave the way to achieving foundation trust status, decisions about this and other proposed mergers could have significant implications for the foundation trust pipeline and, potentially, the use of the failure regime. This could be even more significant given the recent confirmation that the OFT will now have jurisdiction for mergers between foundation trusts and NHS trusts, as well as between foundation trusts.<sup>5</sup>
- 16) There is also a lack of clarity about the implications of the increased involvement of the competition authorities for provider-led initiatives to improve quality by centralising specialist services, such as the proposed reorganisation of cancer and cardiac services in North London. On the face of it, these types of arrangements could be deemed to be anti-competitive, so the outcome of the Cooperation and Competition Panel's investigation of plans to centralise some acute services in Bristol may be significant here.

### **The preparedness of health and well being boards**

- 17) In April 2012, we published the results of a survey of 50 shadow health and well being boards (HWBs),<sup>6</sup> an exercise we will repeat this year with all 152 HWBs now that they are fully up and running. This found that HWBs had made good progress in establishing themselves, with strong engagement from CCGs, social care and public health in particular. It reported widespread optimism about the prospects for success, tinged with some nervousness about whether top down national imperatives might override locally agreed priorities. One potential cause for concern was that acute providers were only represented on a quarter of the boards we surveyed.
- 18) HWBs face daunting challenges and heavy expectations that they will act as the crucible for developing integrated care, particularly at a time of unprecedented financial pressure on local government and complex organisational change in the NHS. Nevertheless, based on our work supporting a number of boards and other feedback, we remain optimistic about the prospects for success. Our experience suggests that many HWBs are developing genuine partnerships with CCGs, engaging effectively with local stakeholders and demonstrating real ambition by producing health and well being strategies focused on delivering key high impact changes rather than shopping lists of aspirations. The biggest single challenge

facing the new boards is delivering strong, shared leadership that engages people in transforming local services.

- 19) More broadly, there is a pressing need to develop integrated care at scale and pace. Despite the legislative commitments in the Act and high level political commitment, progress in developing integrated care locally has been patchy. We agree with the Committee that HWBs should provide the local forum for driving the development of integrated care. A stronger commitment is needed from the Department of Health, NHS England and Monitor to ensure that policy and regulation supports rather than inhibits this. We look forward to forthcoming ministerial announcements on this.

### **The effect on patient care of the transition and the financial health of local health economies**

- 20) It is too early to assess the impact of the transition on patient care and difficult to isolate its effect from the impact of measures designed to meet the financial challenge. Despite a very difficult financial environment, our assessment is that the NHS is continuing to hold up well nationally, with a significant surplus forecasted for 2012/13. However, the financial squeeze is beginning to bite as it becomes more difficult to deliver efficiency savings, and a small but significant number of trusts are in real difficulty.
- 21) As part of our work tracking and analysing NHS performance, The King's Fund publishes a quarterly monitoring report based on the views of a panel of NHS finance directors and analysis of performance data. We have recently added a survey of directors of adult social services to enable us to look across the health and social care system as a whole. These surveys suggest growing pessimism among health and social care leaders as they respond to mounting financial pressures.
- 22) Our most recent report, published in February, found that, while most NHS finance directors were upbeat about the financial position in their own organisation, they were pessimistic about the prospects for their local health and care economies.<sup>7</sup> More than three-quarters (39 of 48 respondents) expected their organisation to end the financial year in surplus, with only 3 anticipating a deficit. In contrast, when asked about the financial state of their local health economy over the next 12 months, around two-thirds (32) were pessimistic.
- 23) With local authorities grappling with the second year of a budget squeeze that will see an overall cut of 27 per cent in central government funding by 2015, directors of adult social services were more pessimistic about the financial outlook. Nearly a third (18 of 58 respondents) predicted an over-spend on their budgets, with a similar number (17) expecting an under-spend and 23 expecting to break even. Nearly three-quarters (43) said that they are pessimistic about the overall state of the local health and care economy over the next 12 months, with only 3 reporting any optimism.

### **The lines of accountability in the new system**

- 24) The fragmentation of responsibilities for commissioning and sheer number of organisational changes has left considerable space for ambiguity about divisions of responsibilities and accountabilities. For example, the Act states that NHS England

is responsible for assuring continuous improvement in the quality of primary care services but that CCGs must assist and support it in this duty. Emerging findings from our research with CCGs (see above) indicate that CCG board members are not clear about how this responsibility should be divided between themselves and NHS England's local area teams. Not surprisingly, GP member practices also have different understandings about who they are accountable to in this context.

- 25) It is not clear whether or to whom NHS England is accountable for its own, considerable commissioning functions. It is accountable to the Department of Health for the performance of the system as a whole against the priorities set out in the Mandate and the NHS Outcomes Framework. However, while it holds CCGs to account for their commissioning work, its own commissioning of primary care and specialist services appears to be unchecked. In addition, while Commissioning Support Units (CSUs) will continue to be hosted by NHS England for the next three years, there is a lack of transparency about their ownership, management and contractual arrangements. This is a concern given the significant role CSUs will play in commissioning, with CCGs spending on average more than a third of their management allowance on their services.
- 26) We have consistently argued that having three separate outcomes frameworks for the NHS, public health and social care risks undermining the ambition to deliver integrated care. Despite efforts by the Department of Health to align them, the contrasting arrangements for holding different parts of the system to account against the various frameworks risk exacerbating this. NHS England has the power, resources and, arguably, intention to manage the performance of local commissioners against the Commissioning Outcomes Framework (which supports the NHS Outcomes Framework). In contrast, Public Health England will rely on a mixture of transparency of reporting and sector-led improvement (via local authority peer review) to monitor performance against the Public Health Outcomes Framework. This imbalance risks causing confusion locally where performance fails to improve or disputes arise. The Communities and Local Government Committee recently raised concerns about this and also called for clarification about the accountability arrangements for health and well being boards.<sup>8</sup>

### **The preparedness of local authorities and Public Health England**

- 27) Although it received comparatively little attention, the shift in responsibility for public health to local authorities and establishment of Public Health England (PHE) is a very significant change. Feedback suggests that local authorities have made good progress in preparing to take on their new responsibilities, with the LGA reporting in December that 95 per cent localities expect the transition to be completed successfully, although there was some concern about difficulties in recruiting enough Directors of Public Health, particularly in London.<sup>9</sup> Although it is more than a year out of date now, our survey of shadow health and well being boards indicated a very high level of engagement by Directors of Public Health, which is another encouraging sign.
- 28) The financial allocations to local authorities also give reason for encouragement - the 5.5 per cent increase in 2013/14 (compared to estimated baseline PCT spending), to be followed by a further 5 per cent increase in 2014/15, exceeded most expectations. However, it is too early to tell whether this will be sufficient or whether, given financial pressures on local authorities, resources will be diverted for other purposes. This also needs to be seen in the context of fragmenting

resource allocation between CCGs, NHS England and local authorities - although logical given the design of the reforms, it risks fragmenting commissioning and accountability for outcomes.

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<sup>1</sup> *More than a third of GPs on CCG boards have conflicts of interest*; British Medical Journal, 16 March 2013

<sup>2</sup> *NHS England to lead 'radical' service change*; Health Service Journal, 19 April 2013

<sup>3</sup> The King's Fund (2011). *Improving the quality of care in general practice: Report of an independent inquiry commissioned by The King's Fund*. London: The King's Fund

<sup>4</sup> Health Committee (2011). *Commissioning; third report of Session 2010/11*. London: House of Commons

<sup>5</sup> Office of Fair Trading press release, 22 March 2013

<sup>6</sup> The King's Fund (2012). *Health and wellbeing boards: System leaders or talking shops?* London: The King's Fund

<sup>7</sup> The King's Fund (2013). *How is the health and social care system performing? Quarterly monitoring report*; London: The King's Fund

<sup>8</sup> Communities and Local Government Committee (2013). *The role of local government in health issues; eight report of 2012/13*. London: House of Commons

<sup>9</sup> Local Government Association (2012). *Public health transition at local level: LGA survey of national progress; December 2012*