Briefing

THE HEALTH AND SOCIAL CARE BILL
SECOND READING IN THE HOUSE OF LORDS
11 OCTOBER 2011

Summary

Throughout the debate on the Health and Social Care 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 amendments made following the NHS Future Forum's report have improved the Bill. We particularly welcome the new emphasis on integration, the more nuanced approach to competition and the stronger framework for commissioning now set out on the Bill.

Nevertheless, we remain concerned that the scale of the structural changes set out in the Bill and the challenges associated with implementing them present risks that could damage NHS performance and harm patient care. The uncertainty of the past few months has caused significant instability within the NHS. It is essential to move on from this so that the NHS can focus on its key priority – the need to find £20 billion in productivity improvements to maintain quality and avoid significant cuts to services.

There are a number of areas of the Bill where we believe further clarity is required and the government needs to set out its thinking more clearly.

- We strongly welcome the amendments made to promote integration. However, while the Bill now provides a useful starting point, wider changes to policy are needed to ensure integration is hard-wired throughout the NHS. Ministers should use the remaining debates on the Bill to outline further steps to promote integrated care.

- The sheer number of changes being made to the health system risk creating confusion and additional bureaucracy. The government must do more to clarify the roles of the various different bodies and how they will work together, especially the roles of clinical senates and networks, which are currently unclear. There is a risk of too much power being centralised in the NHS Commissioning Board and a need to balance national strategic leadership with local autonomy.

- While we welcome the changes made to promote a more nuanced approach to competition and the amendments to Monitor's duties, concerns remain about the extent of the role of competition in the future NHS. The government should use the remaining debates on the Bill to make its intentions about the role of competition absolutely clear and to explain how it will work alongside integration.

- Major reconfigurations of hospital services are urgently needed for clinical and financial reasons. We are concerned about the lack of clear responsibility for driving forward these reconfigurations under the Bill and that the changes it proposes will add to an already complex and bureaucratic decision-making process. As we made clear in a recent report, this process should be improved (The King's Fund 2011).

- High-quality leadership and management are essential to implementing the reforms and meeting the financial and operational challenges facing the NHS. Nevertheless, senior members of the government continue to denigrate NHS managers as 'bureaucrats'. This should stop, and the arbitrary target to cut the number of managers by 45 per cent should be re-visited.

- The reforms to service providers will be challenging to deliver in a difficult financial context. The revised failure regime for providers now set out in the Bill must strike a balance between maintaining access to essential services and avoiding subsidising inefficient or poor-quality providers – it is not yet clear whether the proposals achieve this, and further clarity is needed on a number of issues.

- The recent public health command paper failed to provide much needed clarity on a number of issues. This adds to the uncertainty created by the wider structural changes in the NHS and risks disconnecting public health from the NHS reforms. We welcome the announcement that the NHS Future Forum will undertake work on public health – the government must move quickly to clarify funding and other arrangements so that local authorities and health bodies can plan their work.

The rest of this briefing outlines the main provisions in the Bill and our views in more detail.

Market-based reforms

The Bill goes 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

The Bill gives Monitor, currently the licensing authority for foundation trusts, 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. The Bill was amended in the House of Commons to remove its proposed duty to promote competition and replace this with a primary duty to protect and promote patients' interests. It is also now under a duty to promote integration. As well as acting as a competition authority for the health sector, Monitor will be responsible for setting prices for NHS-funded services and ensuring continuity of essential services in the event of provider failure.

- The establishment of a sector-specific regulator for health care will provide the most effective safeguard against inappropriate application of competition law, so we agree that Monitor should assume responsibility for overseeing competition in the NHS.
- We welcome the changes to Monitor's main duties – it must strike the right balance between tackling anti-competitive behaviour and promoting integration.
- 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

Choice of provider will be extended beyond elective surgery to other areas of care under the 'any qualified provider' policy. Ministers recently announced that the policy will be initially implemented in eight types of mental health and community services from April 2012. Following the NHS Future Forum's report, a 'choice mandate' will now be included in the Secretary of State's mandate to the NHS Commissioning Board, and the duties on commissioners have been amended to better reflect the principle of 'no decision about me without me'. Ministers have promised an 'information revolution' to accompany the extension of choice, although the publication of the government's information strategy has been delayed.

- Under the current arrangements for choice at the point of referral, PCTs often limit the range of providers and GPs do not routinely offer choice to their patients, so it will be important to monitor how any qualified provider is implemented.
- As our recent report on shared decision-making argued, '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 (Coulter and Collins 2011).

- To support choice, information must be relevant, accessible and presented in a way that patients can understand – the government's information strategy should set out how this will be achieved, alongside meeting the data requirements of providers, commissioners and regulators.

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. Following the recommendations made by the NHS Future Forum, the Bill now adopts a more nuanced approach to competition than originally proposed, and competition on price has been ruled out. The Secretary of State recently assured the Health Select Committee that 'it is absolutely clear that integration around the needs of the patient will trump other issues, including the application of competition'.

- While we welcome the amendments made to promote a more nuanced approach to competition, concerns remain about the extent of competition in the future NHS – the government should use the debates on the Bill to make its intentions about the role of competition absolutely clear and explain how it will work alongside integration.
- We welcome the move to rule out competition on price – evidence suggests that price competition reduces quality and increases transaction costs.
- Although the new arrangements could provide opportunities for social enterprises and the voluntary sector, our work suggests they may struggle to compete in the new environment – this risks reducing diversity of supply.

Commissioning

The Bill significantly reforms the arrangements for commissioning health services. It builds on previous initiatives – GP fundholding in the 1990s and practice-based commissioning in the last decade – which enabled groups of GPs to take responsibility for commissioning some services on a voluntary basis. However, it goes much further by making membership of clinical commissioning groups compulsory and giving them full budgetary responsibility for commissioning the majority of services. A number of changes were made to this part of the Bill following the NHS Future Forum's report – the framework it now sets out is much more prescriptive than originally proposed.

Clinical commissioning

Following the recommendations made by the NHS Future Forum, clinical commissioning groups will be required to obtain a wider 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, although little detail has been published about their role. Clinical commissioning groups will also now be required to include a nurse and a hospital specialist on their governing body. The Bill makes it clear that they will be responsible for commissioning services for unregistered people in their area, not just for registered patients, although there is no duty to promote population-wide health.

- Although we welcome the emphasis on wider clinical involvement in commissioning, the number of bodies that local commissioners will need to consult and take advice from risks creating confusion and additional bureaucracy.
- The role of clinical senates is unclear – the government should move quickly to clarify this.
- We welcome clarification that commissioners will be responsible for unregistered patients but remain concerned that the absence of a clear duty to promote population-wide health could result in GPs giving insufficient priority to public health.

Governance and authorisation

Following the recommendations made by the NHS Future Forum, clinical commissioning groups will now be required to have governing bodies, which 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, meet in public and publish the minutes of meetings. The April 2013 deadline for establishing clinical commissioning groups has been relaxed – they must be established either in full or in shadow form by this date, but will take on their new responsibilities only when they are ready to do so. The government's response to the Future Forum made 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.

- 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, and for the NHS Commissioning Board to play a strong role in supporting this.
- The response to the government's pathfinder scheme 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.
- Aligning 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 the quality of care in general practice revealed widespread variations in performance and highlighted the opportunity to use the development of clinical commissioning to create a much stronger focus on quality improvement (The King's Fund 2011). However, very little attention has so far been paid to this issue during the debates on the Bill. With experience suggesting that innovation in service delivery often comes from GPs delivering services, there is a potential conflict of interest for GPs as providers and commissioners of services. In response to concerns raised about the 'quality premium,' which will be paid to high-performing clinical commissioning groups, it will focus on quality and outcomes, rather than financial performance, and may take account of progress in reducing health inequalities.

- The NHS Commissioning Board and clinical commissioning groups should work together to improve quality in general practice as a priority – this will be best achieved by supporting locally led initiatives rather than 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 clarification that the quality premium will not be based on financial performance 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 service providers aim to encourage innovation by granting them more autonomy. This will be achieved by building on the process started by the last government requiring all remaining NHS trusts to become foundation trusts, changing some of the rules governing foundation trusts and revising the failure regime for providers that are financially unsustainable.

Foundation trusts

The government has relaxed its April 2014 deadline for remaining NHS trusts to become foundation trusts, although the majority will still be expected to meet it. An NHS Trust Development Agency has been established to support NHS trusts in achieving foundation trust status. A number of governance responsibilities will be transferred from Monitor to foundation trust governing bodies, and board meetings will now be held in public. However, in recognition that many governing bodies have struggled to hold their boards to account, Monitor's oversight role has been extended to 2016 to enable governors to develop their capabilities.

- Although the provider reforms have so far received little attention during the debate on the Bill, they are nonetheless very important and will be challenging to deliver in a difficult financial context.
- It is clear that a number of NHS trusts are not financially sustainable and will struggle to achieve foundation trust status – the NHS Trust Development Agency will need to work closely with these trusts to find solutions, including mergers and, in some cases, planned closures of services.
- We welcome the extension of Monitor's oversight of foundation trusts – governors should be provided with support to develop their capabilities in the period up to 2016.

The failure regime for providers and continuity of services

The government tabled a series of amendments at Report stage in the House of Commons to revise the failure regime for providers that are financially unsustainable. The aim is to establish a clearer framework that avoids subsidising inefficient or poor-quality providers, but ensures continuity of essential services. The current failure regime for foundation trusts will be strengthened, and new arrangements will be applied to independent providers. Under the revised arrangements now set out in the Bill, Monitor will be responsible for intervening to support providers before they reach crisis point and commissioners will be involved in identifying services that should be protected once it becomes clear that a provider is unsustainable. Monitor will also be given powers to levy a charge on providers and commissioners to create a standing fund to cover the costs of administration and maintaining access to essential services when providers fail.

- The failure regime must strike a balance between maintaining access to essential services and avoiding subsidising inefficient or poor-quality providers – these proposals arrived late in the parliamentary process and it is not yet clear whether they achieve this.
- These measures are a last resort – wherever possible, commissioners and providers should work together to plan service reconfigurations and avoid the need for intervention.
- Clinical and financial failures are often closely linked, so it will be essential for Monitor and the Care Quality Commission to work closely together to identify and resolve problems before they reach crisis point.

Social enterprises

The provider reform agenda also includes an emphasis on encouraging NHS organisations to become social enterprises and adopt employee ownership models. Our recent report on social enterprise in the health sector found that social enterprises can deliver benefits by reducing bureaucracy, allowing the reinvestment of surpluses and increasing staff engagement (Addicott 2011). However, despite the government's commitment to creating 'the largest social enterprise sector in the world', progress in developing employee ownership models has so far been limited.

- The government should facilitate the provision of more legal, financial and other support to develop and grow the social enterprise sector.
- Some start-ups need to develop more robust business models and NHS commissioners should offer longer-term contracts to enable social enterprise providers to establish themselves in a more competitive environment.
- Simply moving to a new operating model is not enough to deliver the benefits of greater staff engagement – senior managers needed to make specific efforts to engage staff from the outset.

Local authorities and the NHS

The Bill extends the role of local authorities in the health system by creating health and wellbeing boards 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 clinical commissioning consortia and local authorities will be critical in ensuring that services meet the full range of local population health needs.

Health and wellbeing boards

Health and wellbeing boards will be responsible for producing joint strategic needs assessments and developing a joint health and wellbeing strategy for their local area. This provides an opportunity to strengthen democratic legitimacy and join up commissioning across the NHS, social care and public health. Following the recommendations made by the NHS Future Forum, their role has been strengthened in a number of ways. They will now 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 the plans take proper account of the local health and wellbeing strategy. A flexible approach will be adopted towards the membership of boards, which will be left to local authority discretion.

- The government's original proposals failed to give health and wellbeing boards sufficient powers to fulfil their remit in joining up local commissioning, so we welcome the enhanced role for them now set out in the Bill.
- Stronger duties to promote health and social care integration are welcome but are only a starting point – 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 therefore not be strong enough.

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. However, the government's public health command paper, published in July, deferred many key decisions, including funding levels, to the autumn. Some changes have been made following the NHS Future Forum's report. Public Health England (PHE), the new national public health service, will now be established as an executive agency of the Department of Health, as a response to concerns that locating it in the Department could have undermined the independence of its advice. 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 deferral of key decisions about public health adds to the uncertainty created by the wider structural changes in the NHS – the government must move quickly to clarify funding and other arrangements for public health so that local authorities and health bodies can plan their work.
- 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.
- We are concerned that making PHE an executive agency may weaken the voice of public health within government – ministers must set out clear arrangements for ensuring that public health is given priority across government.

Health inequalities

Our review of NHS performance from 1997 to 2010, published in April last year, identified the lack of progress in reducing health inequalities as the most significant health policy failure of the last decade. We therefore welcome the 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 note that these are narrowly drawn and do not extend to local authorities. New duties on the NHS Commissioning Board, Monitor and clinical commissioning groups to promote integrated care also place an emphasis on reducing inequalities. However, while the NHS Future Forum's report called for these duties to be 'translated into practical action', the government has not yet set out how this will be achieved. Meanwhile, the

weighting given to health inequalities in the formula for allocating NHS funding has been reduced from 15 per cent to 10 per cent.

- While the new duties to reduce health inequalities are welcome, they should be widened to reflect the broader role the NHS plays as a major employer and contributor to the economy, and equivalent duties should be placed on local authorities.
- 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 progress in reducing health inequalities.
- While the reduction in the weighting for health inequalities in the allocation of NHS funding will be implemented gradually, reducing the impact on local budgets, we are concerned about the signal this sends about NHS priorities.

System 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. The NHS Commissioning Board will be responsible for the operational management of the NHS, while primary care trusts (PCTs) and strategic health authorities (SHAs) are being 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.

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 placed on the NHS Commissioning Board, Monitor and clinical commissioning groups to promote it, although it is not clear why the duties are qualified and differ between the different bodies. 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.

- While the Bill provides a useful starting point, changes are needed to wider health policy to ensure that integration is hard-wired throughout the NHS – ministers should outline further steps to promote integrated care.
- Although changes to widen clinical involvement in commissioning will help, a culture change is needed among health professionals who must work more closely together – leading this process must be a top priority for the NHS Commissioning Board.
- We have previously argued for a single outcomes framework for the NHS, public health and social care – given the new emphasis on promoting integration, the current outcomes frameworks should be reviewed and more closely aligned.

Structural changes

Following the NHS Future Forum's report, a number of changes have been made to the timetable for the structural reforms. The abolition of SHAs will now 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 four '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 environment, 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.

- 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 original White Paper – it will need to ensure that it avoids over-centralisation and encourages locally led innovation.
- The dismantling of PCTs and move to PCT clusters risks breaking up established arrangements for integrating health and social care in some local areas – more flexibility is needed in the arrangements for managing the transition to avoid this.

The Nicholson challenge

Although its budget was protected in the Spending Review, the NHS faces the tightest financial settlement in its history. This will be implemented alongside significant cuts in local government funding, with the risk that the strain on social care services will add to the pressure on the NHS. The key priority therefore 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 period. High-quality leadership and management are essential to implementing the reforms and meeting the financial and operational challenges facing the NHS.

- Delivering on the 'Nicholson challenge' must be the NHS's top priority – it is essential to move on from the uncertainty of the last few months so that it can focus on the financial and operational challenges this presents.
- Major reconfigurations of hospital services are essential to meeting the Nicholson challenge – we remain concerned about the lack of strategic responsibility for driving forward hospital reconfigurations across geographical areas, while there is a pressing need to improve the decision-making process, which is complex and bureaucratic.
- While we welcome the government's recognition of the importance of leadership and management, ministers should stop denigrating NHS managers as 'bureaucrats' and the target to cut the number of managers by 45 per cent should be re-visited.

Conclusion

Despite the headlines generated by the reforms, the key priority for 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 last few months has caused instability at a time when the NHS faces significant financial and operational difficulties. While the changes made following the NHS Future Forum's report have improved the Bill, a number of areas need further clarification – the Bill's passage through the House of Lords provides an opportunity to address these issues and provide the direction the NHS needs to navigate the challenging times ahead.

References

Addicott (2011). *Social Enterprise in Health Care: Promoting organisational autonomy and staff engagement*, London: The King's Fund. Available at: www.kingsfund.org.uk/publications/social_enterprise_in.html

Coulter A, Collins A (2011). *Making Shared Decision-making a Reality: No decision about me, without me*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/nhs_decisionmaking.html

Imison C (2011). *Reconfiguring Hospital Services*. Briefing [online] The King's Fund website. Available at: www.kingsfund.org.uk/publications/articles/nhs_reconfiguration.html

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. Available at: www.kingsfund.org.uk/publications/gp_inquiry_report.html

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