The King's Fund

Ideas that change health care

Parliamentary Briefing
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Health Bill
Second reading briefing, House of Commons

The King's Fund welcomes the measures outlined in the new Health Bill to introduce a Constitution for the NHS; pilot direct payments for patients; require providers of NHS-funded care to produce annual quality accounts; and make further provisions on tobacco control. Ahead of the Health Bill's second reading in the House of Commons on Monday 8 June, we have some specific issues relating to the Health Bill that we would like to raise with you and encourage you to seek clarification on these during its passage.

The NHS Constitution (clauses 1-7)

The Constitution defines the guiding principles of the NHS; it codifies existing legal rights of patients and staff and adds some pledges; it proposes a list of NHS values; and it is accompanied by a statement of accountability that will outline the roles of the various NHS and non-NHS bodies that deliver health care in England. It is also important to note that the Constitution encompasses the recommendations of Professor Mike Richard's review, *Improving access to medicines for NHS patients*, which ensures that NHS care is not withdrawn from patients who choose to purchase additional private drugs.

Key points

Process for review – although its content is largely uncontroversial as it is based on existing legislation, the Constitution is ambitious in its scope and is a potentially useful way of clarifying the NHS' purpose. Its original status was as a 'declaratory document' but following amendment in the House of Lords, reviews of the guiding principles of the NHS Constitution are required to be formally legitimised by parliament through regulations laid down by the Secretary of State. The King's Fund welcomes the Department of Health's decision to set a minimum of every three years for revising the Handbook that accompanies the Constitution to take into account developments in policy.

Staff rights – the Constitution applies to all providers of NHS-funded care. At present the rights of staff may vary according to who they are employed by. Both NHS and non-NHS organisations employing clinical and non-clinical staff will be obliged to demonstrate that they have taken the Constitution into account in any decision they make regarding their staff. Effective monitoring will be required in order to assess whether the rights enshrined in the Constitution are upheld for staff and patients in non-NHS organisations.

Key points cont

The right to treatment in the EU – the Constitution enshrines the right in 'certain circumstances' for patients to seek treatment in other EU countries. This right is based on rulings by the European Courts of Justice that patients have the right to go abroad for treatment if they face an 'undue delay' in receiving that treatment at home. This right may expand with subsequent interpretations of European legislation and with the implementation of the proposed European Commission Directive on patients' rights to cross border care.

Quality accounts (clauses 8-10)

Lord Darzi first introduced quality accounts in the final report of the NHS Next Stage Review, *High Quality Care for All*, and the Health Bill contains provisions to require all organisations providing services funded by the NHS to publish annual quality accounts alongside the financial accounts they publish. The quality accounts are expected to detail performance in relation to safety, patient experience and clinical outcomes. The intended aims of quality accounts are that they will increase NHS leaders' focus on quality improvement and increase public accountability on quality. The majority of detail about the required form and content of quality accounts will be given in regulations and is not on the face of the Bill. A pilot exercise of quality reporting to inform these regulations and associated guidance is currently underway in the NHS East of England region.

Key points

Role of NHS trust boards – quality accounts could strengthen NHS trust boards' focus on quality and ensure that they are held to account equally for robust clinical quality as for financial governance. Greater transparency on clinical quality will flag up variations in performance and should put pressure on organisations to improve.

Public accountability – the publication of quality accounts will be a relatively passive and limited method of increasing public accountability on quality. For quality accounts to give an account to the public on quality more actively and meaningfully, the information in them will need to be presented and disseminated in a variety of forms appropriate to different groups' needs. The government has said that the NHS Choices website will be one place the public will be able to find information published in a quality account.

Data collection – collecting and publishing data on the quality of care, on patient outcomes and experience has the potential to drive up standards. But the measures must be appropriate and clinically relevant, and must enable comparison with other organisations locally or nationally to put the performance of any one organisation in context. It is also important to minimise the administrative burden of data collection. Therefore, the indicators and measures in the quality accounts should be consistent with those that are collected and reported for other purposes.

Audit and scrutiny – as initially proposed, quality accounts were not expected to be subject to any prescribed validation or audit, although local organisations were encouraged to consider some form of audit as good practice. However, in response to the Colin-Thomé Report on Mid Staffordshire NHS Foundation Trust, the government has announced its intention to introduce a legal requirement for commissioners to validate NHS providers' quality accounts prior to publication.

Role of the regulators – an area requiring further clarity is how quality accounts will be used in practice by regulators. Will they be used by the Care Quality Commission (as the main regulator of quality and safety) or will Monitor (the regulator of foundation trusts) consider quality accounts when authorising foundation trusts?

Direct payments (clauses 11-13)

The Health Bill contains provisions to allow the piloting of direct payments for the health care of particular patients in certain circumstances. Direct payments are currently used in social care – they are cash payments made to individuals who have been assessed as needing services, in lieu of

social service provisions. Linked to this, personal budgets will also be piloted in the NHS but do not require primary legislation. A personal health budget could work in many ways, including a notional budget held by the commissioner or a budget managed on the patient's behalf by a third party, such as their GP.

Key points

Agreeing how direct payments are spent – NHS funds could be spent on non-traditional, non-health, or even ineffective treatments. In health care there is a stronger evidence base for the effectiveness of treatments and care models than in social care, where services are mainly designed to meet personal needs. If patients are free to spend their direct payment at their own discretion (within broadly set parameters), resources could be spent on care that does not improve their health as effectively as if the money had been spent in another way. Patients might even buy treatments that are wholly ineffective or potentially harmful to their condition.

What happens if a patient's budget is under-spent? – the issue here is whether patients would be able to carry over unspent money to the following year. In the United States, where many employers have introduced health savings accounts, there appears to be a strong incentive for employees to resist spending on treatments that could benefit them now in order to save cash to cover possible greater expenses they fear they might encounter in the future.

Setting the initial payment level – getting this right will be important. The need for medical care is uncertain even for people with stable illnesses and this makes allocating appropriate resources to individuals complex. Even where needs are clear, the accurate costing of services, or components of services, will be highly complex. Constant review will be required. Given the potential for patients to negotiate a higher budget where there is a perceived shortfall, it is essential that all patients' needs are accurately and objectively assessed to ensure that those with equal needs receive equal budgets and that the more articulate do not benefit disproportionately.

Potential to 'top up' health care – although top ups to direct payments will not be allowed, there is potential for confusion about what constitutes a 'top up' and thus still a possibility of better-off patients purchasing an enhanced service.

Providing support and advocacy – in order for a patient to derive maximum benefit from their personal budget or direct payment, their 'care manager' will be required to provide quite a considerable level of support and advocacy. It is not clear who will take on that role - will it be a person's GP or a community matron or is a new NHS role to be created?

Evaluating the pilot schemes – the evaluation of personal budget pilots is welcomed and will provide vital indications of the feasibility of direct payments. It is critical that sufficient time is allowed for these schemes to 'bed in' and for evaluation data to be examined before pilots of direct payments are begun.

Tobacco controls (clauses 20–24)

The Department of Health's 2008 consultation on the future of tobacco control resulted in 90,000 responses and considered how to reduce smoking rates and health inequalities caused by smoking; protect children and young people from smoking; and support smokers in quitting. Yet the suggestions in the Health Bill fall short of dealing with any of these issues.

Key points

Targeting those who most need help – to address health inequalities, structural polices and health prevention programmes need to target those in most need. The current strategies do not

Key points cont

do this. For example, an opportunity to introduce better regulations on smuggling would have had an impact on health inequalities, but this option is not included in this Bill.

The government needs to do more to support other programmes that motivate people to change their behaviour, such as financial incentives schemes. For example, NHS Tayside's 'Give it Up for Baby' scheme gives pregnant women supermarket vouchers for passing a weekly breath test proving they have stayed off cigarettes in addition to other more conventional support like information, advice and nicotine replacement therapy. In its first nine months 50 out of 55 pregnant women registered with this scheme managed to stop smoking, making it more cost effective than the previous more traditional smoking cessation service offered. (Kicking Bad Habits, The King's Fund 2008).

Advertising at point of sale – The King's Fund supports the greater regulation of tobacco products, including banning advertising at the point of sale and covering up or removing displays of tobacco products. There is evidence that point of sale displays influence levels of smoking – for instance, a survey in California concluded that displays are estimated to increase tobacco sales in the US by between 12 and 28 per cent. (Feighery EC et al, 2001)

Sales from vending machines – the proposals to impose requirements on vending machines are vague. Twenty-two countries in Europe, such as France, Belgium and Norway, have banned vending machines as they sell a disproportionate number of cigarettes to young people. In the United Kingdom, 17 per cent of regular smokers under 16 usually bought cigarettes from vending machines (National Centre for Social Research, 2007). As sales from vending machines comprise only 1 per cent of overall sales, it is unclear why banning these outright has not been taken up.

Possible questions for debate

Direct payments

- What controls are in place to discourage a patient from choosing to spend their budget on clinically ineffective treatments that could result in either harm or a deterioration in their condition with associated costs to the NHS?
- How will the complexities around budget-setting be addressed, particularly given the potential for patients to renegotiate their budget?
- How will the ambiguity around what constitutes a 'top up' be tackled?
- Who will provide the advice and advocacy required to ensure patients derive maximum benefit from their budget?
- Will extra funding be available for either creating a new role of care manager or extending the role of existing clinicians to take on the work?

Quality accounts

- What measures will be taken to ensure data for quality accounts is in line with that collected for other purposes, especially the information collected by the CQC and Monitor?
- What role will quality accounts play in reality? Will they affect how boards manage quality? Will patients, commissioners and regulators use them?
- How can we ensure that quality accounts are accurate, fair and honest assessments of performance? How will validation by commissioners work in practice?

Tobacco controls

- As vending machines sell a disproportionate number of cigarettes to young people but constitute only 1 percent of sales to adults why does the government not go further and ban them altogether?