

# Health and Social Care Bill

## Second reading

The Government's Health and Social Care Bill makes provisions for major changes to the NHS in England. The plans build on previous NHS reforms to devolve more responsibility to the front line and, we believe, are broadly in the right direction. However, they will be judged on the extent to which they deliver sustained improvements to patient care during a period of major financial challenge for the NHS. Implementation therefore needs to be managed very carefully. This briefing by the Nuffield Trust, an independent health think tank, highlights aspects of the legislation that we believe merit greater scrutiny.

### GP-led commissioning consortia (Clauses 1, 5–6, 9–10, 13, 16, 22, 24)

Under the proposals, groups of GPs will be given real budgets to buy care on behalf of their local communities. They will be responsible for handling about £70 to 80bn of the NHS budget. GP practices will continue to offer community-based services as independent businesses contracted into the NHS, but will also form new, legally separate organisations – commissioning consortia – that will be statutory NHS organisations. All GP practices will have to be part of a commissioning consortium, although they will have a degree of choice over which one they join.

- **The principle of giving doctors more responsibility for how services are planned is a logical one, since they are in effect responsible for most NHS spending through prescribing, patient referrals to hospital, and other clinical decisions.** However, evidence from similar but less radical policies in the past – GP fundholding, total purchasing, primary care groups and practice-based commissioning – shows they will take several years to develop properly. GP practices are used to acting as small businesses, not large conglomerates, handling millions of pounds.
- **In their early years, GP commissioning consortia will be underdeveloped as commissioners and subject to the same pressures as primary care trusts (PCTs) but with significantly reduced management resources.** The Government needs to consider carefully how GP consortia can be provided with high-calibre management and analytical support, and how to address both the risks of loss of financial control by GP consortia in the early years and the handling of financial risk. In addition, the systems for assessing independently whether GP consortia are sufficiently prepared to assume budget responsibility and achieve value for money are as yet unclear. With the large sums of money involved, it is crucial that these arrangements are robust.
- **Substantial investment in leadership, management and IT will be vital if GP consortia are going to be able to manage public funds on such a large scale effectively, to reduce inappropriate hospital admissions and succeed in moving care into the community.** There are clear risks of introducing GP commissioning in England when the Government has placed such a strong emphasis on reducing management costs.
- **GP consortia should have an explicit authorisation regime similar to the one NHS hospital and mental health trusts undergo before achieving autonomous foundation trust status.** This would enable them to demonstrate that they can commission good-quality care across a wide range of services, as well as handle increasing amounts of NHS funds effectively before assuming full responsibility. It would also allow the 'first wave' (the enthusiasts) to demonstrate success and encourage subsequent development.
- **If the high level of public trust in general practice is to be maintained it will be important that patients do not perceive a conflict of interest over their GP's role as both a commissioner and provider of services.** A particularly sensitive issue will be the extent to which the personal remuneration of GPs is affected by commissioning decisions.
- **If they are to succeed, GP consortia will need to work with hospital consultants, patients and social care organisations to expand their own and other community based services, to ensure that patients can access a range of care in hospitals and in their local communities.** The US experience of doctor-led commissioning shows that integration of primary and secondary care is vital to the delivery of efficient high-quality care.

## The NHS Commissioning Board (Clauses 1, 5, 11, 13, 16, 19, 21, 23, 38, 41)

Although *Equity and Excellence: Liberating the NHS* stated clearly that the NHS Commissioning Board is not meant to be the 'headquarters' of the NHS, the Board will play a pivotal role as the overall funder of NHS commissioners by undertaking resource allocation, designing service standards, and holding GP consortia to account against the NHS Outcomes Framework.

- **In a tense financial climate, the role of the centre will need to be thought through carefully.** The Bill gives considerable powers to the Board to intervene in the activities of GP consortia. While this might arguably be necessary to guard against management failures that seriously affect patients' access to services, such provisions are in tension with the localism that the legislation is seeking to embed.
- **A key challenge will be to make sure there is clarity about how hard choices will be made, and who will be held responsible for them.** A forthcoming Nuffield Trust report on the experiences of the new national health board in New Zealand suggests there is a need for formal restrictions on the Government's ability to intervene in the work of the Board, and equally limits on the ability of the Board to interfere in the activities of GP consortia. One major test will be if the Secretary of State can stand aside from contentious political decisions, such as about local hospital closures.
- **Notably, the Board will also hold all individual general practice contracts on behalf of the NHS. This poses the question of as to whether and how these two principal areas of general practice activity (commissioning and provision) can be jointly and effectively overseen at the national level.** Under the present system PCTs have made significant progress modifying the contracts they held with GPs locally in order to develop extended and improved general practice services in the community to meet complex patient needs. Thought needs to be given as to how this progress can be sustained and built upon with the new national focus given to general practice contracts.

## Abolition of strategic health authorities and primary care trusts (Clauses 28–29)

The NHS, in particular commissioners, have been subject to numerous reorganisations over the past two decades. Despite pledges not to subject the NHS to a further structural reorganisation, the Government is planning radical changes that will see all 150 PCTs in England abolished from 2013, together with all ten strategic health authorities (SHAs).

- **This is a huge undertaking and will distract management attention at a period when the NHS needs to make rapid and extensive efficiency savings.** Research evidence on restructuring and mergers suggests that there are inevitable costs to organisations of such change, including the loss of organisational memory, time and resources taken up by the process of implementing change, and distraction of organisations from their core activity. Furthermore, evidence on high-performing health organisations points to the importance of long-term, sustained clinical and general managerial leadership with senior teams among whom there is trust and expertise developed over many years.
- **Reinforcing the recommendation by the House of Commons' Health Committee, we have suggested that the formation of the PCT 'clusters' (which will help manage the transition) needs to be speeded up** to ensure there is appropriate oversight during the challenging interim period before GP consortia take up their new powers.
- **Assurances about the longer-term existence of clusters should also be given so that they can attract and retain the best managerial and analytical talent.** If allowed to, such clusters could perform a valuable long-term role by helping to: manage financial risk, assure the quality of patient services during a time of transition, provide commissioning support to GP consortia and oversee the contracts for local primary care providers on behalf of the Board.

## The proposed role of Monitor as an economic regulator, price based competition and the universal creation of FTs (Clauses 51–59, 103–112, 164–165)

Under the Bill, all NHS trusts will become foundation trusts within three years. The foundation trust regulator Monitor will also be developed into an economic regulator of ‘providers of NHS care’. Its main functions will be to promote competition between providers where appropriate, set maximum prices and help the Board ensure that all populations have access to care should a hospital fail in their local area. The legislation makes it clear that in performing its role around competition, Monitor will be required to do so in accordance with the Secretary of State’s wider duties to deliver a comprehensive health service, improve the quality of services, reduce inequalities and promote autonomy.

- **The Nuffield Trust supports the aim of using competition and choice to help improve quality and efficiency. However, if patient care is to improve and taxpayers are to get better value for money, Monitor will need to decide on the most appropriate units of competition.** Promoting competition simply between the GP practices or hospitals may prevent GPs and hospital consultants from cooperating to provide new forms of care, despite this approach holding more promise for achieving efficiency and quality gains through, for example, reducing inappropriate emergency hospital admissions. Vertically integrated providers – practices and hospitals – may be the more appropriate unit of competition.
- **We support the proposal for Monitor to focus on economic regulation, leaving the Care Quality Commission (CQC) to regulate quality, for these require different and specialist skills. However both organisations will need to work together effectively.** Concerns that the Bill allows for Monitor to pursue untrammelled competition at the expense of other considerations may be unfounded under the legislation as presently phrased. However, practice will to a large extent depend on the wider political consensus and policy framework. A key consideration will be the extent to which it is understood that the Competition Commission, in its seven yearly review of Monitor’s performance does so with due regard to the specific context of health care and Monitor’s wider obligation to support the Secretary of State’s duties (as laid out above).
- **The economic literature on competition between hospitals suggests that competition with fixed prices increases quality of care, provided that the price is above the marginal cost of providing it. Competition on price is however associated with decreases in quality, since quality is less measurable and observable than price.** The evidence does not support moving to a maximum tariff (something that is allowed under this Bill).
- **The creation of foundation trust status (which brought greater independence) for high-performing hospitals was a key reform of the previous Labour Government. There are now 160 foundation trusts (over half of all NHS trusts). We are concerned that the fixed deadline for making all NHS Trusts foundation trusts will, within three years, either require Monitor to lower the bar for attaining foundation status, or mean that some individual hospitals will concentrate on achieving and maintaining this status at the expense of other priorities, as the case of Mid Staffordshire NHS Foundation Trust appears to demonstrate.**

## Public involvement and local government (Clauses 166–184)

It has proved very difficult in the past to achieve local legitimacy and accountability in the NHS as strong lines of accountability reach upwards to the Secretary of State and to Parliament. The further development of community services, the expansion of foundation trusts and the increased use of independent sector providers all underline the need to have an impartial body to ‘hold the ring’ of local involvement and represent the views and concerns of patients and the public.

- **The proposals to create health and well-being boards go some way towards creating a representative local body to help shape local commissioning decisions.** However, while the Bill is clear about the importance of needs assessment, the power these boards may have to challenge or intervene in commissioning decisions seem less certain.
- **Governance arrangements for GP consortia, with respect to the accountability to the enrolled population served, are weak and need to be developed.** The Government has chosen not to mandate public involvement in the governance of GP consortia, so the Board will need to develop an understanding of what effective public engagement should look like and ensure that local GP consortia do not neglect this aspect of their work. It is particularly relevant in relation to decisions about scarce resources, which will appear to be illegitimate if GP consortia have not adequately involved and consulted with local people, directly and in conjunction with local government.

## Possible questions to raise in the debate

### Reform of commissioning

1. What methods will be used to assess the readiness of GP consortia to take on and manage NHS budgets?
2. How will it be established that GP consortia are delivering value for money for taxpayers?
3. How will the remuneration of GPs for commissioning performance be kept separate from their clinical decisions about individual patient care, in a transparent manner?
4. How will the Board manage the performance of consortia that appear to be failing, and what will it do if they are unable to improve?
5. Will the Board's control of general practice contracts undermine local commissioners' ability to improve local primary care services in a timely and flexible manner?
6. What will be the longer-term function of PCT clusters in relation to GP consortia and the Board?
7. How exactly will GP consortia be accountable for commissioning to the population enrolled in their constituent practices?
8. How will the Board be able to manage 8,200 practice contracts?

### Reform of providers

1. How will the quality of patient care and experience be measured and assured, during the process of organisational change and beyond?
2. What will happen to NHS trusts that genuinely cannot achieve the standard demanded by Monitor for becoming a foundation trust?

### Economic regulation

1. On what basis will Monitor measure the extent of competition in local health services?
2. How will the well-known risks of price competition within health services be mitigated?
3. Through what process will Monitor and the CQC (and indeed the Board) resolve conflicts when their objectives clash?

### Public involvement

1. How will Healthwatch relate to the Care Quality Commission at a national level?
2. What assurances will be put into place to ensure that local Healthwatch organisations are representative?
3. How will the Board ensure that GP consortia involve and consult local people in relation to commissioning decisions?
4. How will Health and Well Being Boards hold commissioners to account?

### About the Nuffield Trust

The Nuffield Trust is charitable trust carrying out research and policy analysis on health services. Our focus is on the reform of health services to improve the efficiency, equity and responsiveness of care. We have recently published a number of briefings and reports dealing with several of the key themes underpinning the Bill:

1. *GP Commissioning: Insights from medical groups in the United States*
2. *NHS Resources and Reform: Response to the White Paper Equity and Excellence: Liberating the NHS, and the 2010 Spending Review*
3. *The Coalition Government's NHS Reforms: An assessment of the White Paper*

4. *Giving GPs Budgets for Commissioning: What needs to be done?*
5. *Making Progress on Efficiency in the NHS in England: Options for system reform*
6. *Trends in Emergency Admissions 2004–2009: Is greater efficiency breeding inefficiency?*

To download free copies of these publications visit [www.nuffieldtrust.org.uk/publications](http://www.nuffieldtrust.org.uk/publications)

For more information on any of the points raised in this briefing, or to speak to one of our policy leads, please contact Frank Soodeen on 020 7462 0555 or write to [frank.soodeen@nuffieldtrust.org.uk](mailto:frank.soodeen@nuffieldtrust.org.uk)

To sign up to receive our regular e-newsletter, visit [www.nuffieldtrust.org.uk/newsletter/login.aspx](http://www.nuffieldtrust.org.uk/newsletter/login.aspx)