Parliamentary briefing

Health and Social Care Bill: Second reading, House of Lords

This briefing incorporates our response to the latest Government amendments of the Health and Social Care Bill published in September 2011, ahead of a second reading in the House of Lords. It does not aim to be a comprehensive summary of the Bill, but instead provides some evidence-based analysis of those sections (namely parts 1 and 3) that we believe might usefully be the subject of further debate and clarification by the House of Lords.

Key Points

- Many changes are already underway in the NHS in anticipation of the Health and Social Care Bill. There now needs to be a resolution to the Bill in the interests of providing the system with some much-needed strategic certainty. Further protracted negotiations run the risk of alienating the many clinicians and other stakeholders across the NHS whose enthusiasm and energy will be vital to the effective implementation of what is still a complex reform programme.
- There remain many areas of the Bill that lack policy and implementation detail. Although it sets up the outlines and broad expectations of the new organisations, for example Monitor, clinical commissioning groups and the NHS Commissioning Board, much will depend on the culture and modus operandi of these bodies as they carry out their functions. We would encourage the House of Lords to use the time it has available to push for as much contextual detail about implementation as possible.

- We are not yet convinced that the clauses relating to the Secretary of State's duties will allow reasonable autonomy for NHS organisations from both ministers and the new arm's length bodies, while at the same time ensuring that the Secretary of State remains politically accountable for the performance of the NHS to Parliament.
- The governance and accountability arrangements for clinical commissioning groups have been much improved but questions still remain about the impact of the authorisation process, ensuring the competency of their boards and the impact of financial incentives.
- The government has proposed an improved failure regime, but details about access to funds, including the NHS Bank, are still lacking. These are crucial for ensuring increased transparency and supporting the drive towards greater efficiency.
- There is a strong possibility of a new wave of hospital mergers, in response to the financial challenges among a number of NHS trusts who have yet to attain Foundation Trust status. It is important that reconfiguration decisions for the current NHS Trusts are subject to the same rigorous assessment of their impact on both competition and patient and public interest as they would under the new framework. Given the complexity of these issues in health care there is a case for Monitor, rather than the Office of Fair Trading, to lead the appraisal of mergers.

Overview

Although their genesis predates the current financial crisis, the proposed reforms to the English NHS set out in the Bill have been viewed – inevitably – through the lens of the immediate financial challenge facing the NHS over the next four years. As we have described previously (Smith and Charlesworth, 2011) the NHS has only once (in the 1950s – albeit over a shorter time frame) experienced a slowdown in spending growth of a similar magnitude. This, along with growing demand as well as rising cost pressures, means the NHS will have to generate productivity gains roughly to the value of £20bn between now and 2015 if it is to preserve access and quality levels.

Efficiencies on this scale will require sustained high-quality leadership in the NHS to foster innovation, improve hospital productivity, enable collaboration across organisational boundaries and – where necessary – the reconfiguration of local health services (Dixon, 2010). While the Government has argued that the measures contained in the Bill –- particularly clinical commissioning and competition – are essential to meet the financial challenge, numerous stakeholders across the NHS have, over the past 12 months, called into question the wisdom of the reorganisation required by the reforms, in particular the threat it poses to the search for efficiencies (Health Committee, 2011a and 2011b).

The amendments tabled following the unprecedented halt to the legislative process earlier this year have not fully assuaged all critics, and some still argue that the legislation ought to be scrapped in favour of organisational stability (BMA, 2011). Our view is that many changes are already underway in NHS in anticipation of legislation. The mergers of primary care trusts (PCTs) into 'clusters', the merger of strategic health authorities (SHAs) into clusters prior to abolition in 2013, the creation of pathfinder clinical commissioning groups and the creation of a shadow Commissioning Board are just some examples. There now needs to be a resolution to the Bill in the interests of providing the system with some much-needed strategic certainty. Further protracted negotiations run the risk of alienating the many clinicians and other stakeholders across the NHS whose commitment and enthusiasm will be vital to the effective implementation of these reforms.

That being said, there remain many areas in the Bill that lack policy and implementation detail. Although it sets up the outlines and broad expectations of the new organisations, for example Monitor, clinical commissioning groups and the NHS Commissioning Board, much will depend on the culture and modus operandi of these bodies as they are implemented. We would encourage the House of Lords to use the time it has available to push for as much contextual detail about implementation as possible.

Part 1 analysis (establishment of the NHS Commissioning Board and clinical commissioning groups)

Secretary of State's duties: responsibility and autonomy

The proposed revision of section (1) 2 of the 2006 Act (removing the Secretary of State's duty "to provide" health services, and inserting a more indirect responsibility, that he or she "must exercise the functions conferred by this Act so as to secure that services are provided") has attracted a great deal of comment and ongoing debate (RCGP 2011; PBC Deb 15 February 2011 c204–c247; PBC Deb 30 June 2011 c138–c144). Behind criticism of this change are a number of different concerns, ranging from the plausible – weakened accountability to Parliament – to the more improbable, a Trojan horse for dismantling the state's role in the NHS.

The Government argues that it is merely updating the law to reflect long-established reality, namely that the Secretary of State does not directly provide services and has historically delegated these powers (most recently to PCTs and in the future to the national NHS Commissioning Board). It also argues that the change is needed to avoid parallel powers residing with both the Secretary of State and the Commissioning Board, which could be confusing and tempt the Government into "political micromanagement".

Freeing the NHS from ministerial 'interference' and excessive central control has been a central aim of the Government's reform programme and, with that in mind, the Government has also introduced specific clauses (1C) that require the Secretary of State to permit the relevant bodies latitude to exercise those functions or provide those services in the manner that they consider most appropriate. Amendments 80 to 83, the new clause 8, and amendments 200 to 203 further reinforce the concept of distance between the Department of Health and both the NHS Commissioning Board and Monitor.

We support the ambition to create more autonomy amongst commissioners (and providers) of NHS services. But it is questionable whether new legislation was in fact required to free the NHS from central interference. PCTs already exercised delegated power under the terms of the 2006 Act to PCTs. Whitehall's dominance over the affairs of PCTs (whether originating from the Department of Health officials or ministers) has been a cultural rather than a legal phenomenon and creating a genuinely 'local' NHS is likely to require a sustained change in behaviour at many levels in the system. It is not entirely clear that the insertion of clauses 1C and 8 will do enough to protect the NHS from central interference. This is because the Bill creates two new organisations with potentially far-reaching powers, namely the NHS Commissioning Board and Monitor, both of which could also exert excessive central control on the NHS. In other words there are relatively fewer clauses promoting autonomy that are directed *downwards* into the system.

While there is evidence in favour of tilting responsibility for commissioning and providing NHS services away from the centre to local areas, it is important, from a public accountability standpoint, that the Secretary of State retains responsibility for the NHS; this is because of the tax-funded nature of the health service. This inevitably becomes more challenging if the landscape of provision grows more diverse: as ensuring public accountability over independent and privately-owned providers is not straightforward (Thorlby and others, forthcoming).

The Government asserts that the Bill leaves the Secretary of State fully responsible for providing a comprehensive NHS, both answerable to Parliament for the performance of the NHS and legally liable – it would, for example, still be theoretically possible for the Secretary of State to be the subject of a judicial review claim from a member of the public (Department of Health, 2011a). However, there are still legitimate concerns about the extent to which the Secretary of State will be politically answerable for the performance of the NHS.

We are led to conclude that in order to be successful, the clauses relating to the Secretary of State's duties need to allow reasonable autonomy for NHS organisations from both Ministers and the new arm's-length bodies, but at the same time ensure that he or she remains politically answerable for the performance of the NHS to Parliament. These aims will not be easy to achieve: the desire to control and interfere derives from the pressure of assuming political responsibility, for instance the political consequences of local or national failures in quality or financial health. This will require courageous political leadership and it is not clear that the wording of the Bill can be refined with enough precision to guarantee this.

Key questions

- **In what circumstances will Departmental ministers be obliged (or not) to answer detailed questions in Parliament on the performance of NHS commissioners and providers?**
- **What will be the nature of any direct lines of accountability between Parliament, the NHS Commissioning Board and Monitor?**
- **Can this Bill be properly described as a localising force, or do many of the clauses merely shift power sideways rather than downwards?**

Commissioning groups

Although there have been substantial revisions to the original commissioning proposals, the core idea behind clinical commissioning remains intact, namely that clinicians are best placed to make decisions about spending NHS resources. We support the principle of clinically-led commissioning. It is logical to give doctors and other clinicians more responsibility for planning and purchasing services, as they have a pivotal role in decisions on how to spend finite public resources and an enhanced level of knowledge about the health care needs of their individual patients compared to their managerial counterparts in PCTs. The research evidence particularly supports the potential of clinically-led commissioning in reducing costs and improving some aspects of quality, especially inpatient and intermediate care (Mays and others, 2001; Smith and others, 2004; Smith and Curry, 2011).

Our most recent research into priority setting (one of the more complex and contested aspects of commissioning) found that clinicians' involvement in rationing decisions was seen to be crucial, particularly in building support amongst the public and other local clinicians (Robinson and others, 2011). But it also pointed to how difficult this will be for clinical commissioning groups (CCGs), especially in making decisions about core spending in hard times. For clinically-led groups to be successful, the research literature highlights the importance of groups being locally owned, having high quality leadership and management support, clear incentives to work together to improve care and a degree of autonomy within which to develop, albeit within a clear transparent framework (Thorlby and others, 2011; Smith and others, 2010).

The original Bill (and accompanying policy documents) set out a vision for commissioning groups that were formed organically, led and owned by GPs, with lines of accountability that led primarily upwards to the national Commissioning Board. These proposals were met with criticism in three related domains:

- that their governance structures were underdeveloped, leading to poor accountability for public funds
- that the groups were inadequately linked into the local health community and other local stakeholders
- that any financial incentives payable to the group for delivering efficient care might create a fundamental conflict of interest between GPs and their patients.

In our view, the amendments successfully strengthen the governance and oversight arrangements, but they also make it complex, potentially bureaucratic and unattractive to clinicians, undermining the innovation that CCGs are designed to unleash.

The importance of governance

Evidence suggests that much of the innovation that might be expected from CCGs will come from new ideas about provision and it is important that clinicians working within CCGs be free to design new such models. It is equally important that the relationships between the providers and commissioners are transparent and do not compromise patient choice.

The Government's amendments to the Bill, specifically requirements to publish constitutions (96, 97) and to set out arrangements to ensure transparency in the decisions of the CCG (102) will help, alongside measures to broaden the membership of CCG governing bodies to include lay persons (98) and meet in public (104). Much will now hinge on the quality of the oversight exercised by governing boards, which as commissioners will have an extensive set of responsibilities to be discharged within limited management budgets. There is ample evidence that the presence of a pluralistic governing body does not guarantee high quality (Jha and Epstein, 2010). While we do not think the proposed Bill needs to be adapted at this point, we would urge the House of Lords to seek some clarification around the following points, in order to assess the proposed amendments:

- **How will lay and other members of CCG boards be recruited and remunerated, as well trained, supported and performance assessed?**
- **Are there (as recommended by the Future Forum) guarantees in the Bill that CCG contract agreements with providers will be placed in the public domain?**

Relations with other clinicians and local government

In response to the NHS Future Forum report, the government broadened the scope of clinical commissioning, by including other professionals on the governing body (as discussed above) but also by the creation of clinical networks and 'senates' (these initiatives do not require legislation). Wider clinical engagement has the potential to improve the quality of commissioning decisions in a local area, but if mishandled, it could also entangle CCGs in a web of competing priorities and accountabilities that slows down the decision making process.

The recommitted Bill also substantially strengthens the voice of other local stakeholders. CCGs will now be obliged [22 14YB] to consult health and wellbeing boards in the drawing up of their commissioning plans and explain in writing how they have taken account of the boards' views in their final commissioning plans. Health and wellbeing boards do not have the power to veto a CCG's commissioning plans, although they are able to refer upwards to the Commissioning Board [14YC] their opinion on whether a CCG took proper account of their views, and this information is taken into account in the NHS Commissioning Board's assessment of performance of the CCG.

Although the upward 'hard' accountability of CCGs to the Commissioning Board remains unchanged, the Government's plans increase the number and complexity of 'soft' accountability arrangements locally. If CCGs are to be able to act quickly and redesign services to meet local needs, it is important that local accountability and consulting arrangements support this process rather than acting as a brake on innovation and action.

The clinical networks, senates and new arrangements for health and wellbeing boards represent a potentially significant additional layer of administrative activity for CCGs. We would question

if the original assumptions for administrative spending for CCGs are still valid and whether CCGs will be adequately resourced to discharge these activities.

Key questions

- **How will the roles of clinical senates, clinical networks and health and wellbeing boards complement each other?**
- **To what extent will CCGs be bound by the decisions of networks or senates, when compared to the views of health and wellbeing boards?**
- **Harnessing the power of clinicians into effective clinical commissioning groups is a process that will take considerable time and resources. How will the extra administrative activity represented by these amendments be resourced?**

Financial incentives and the potential for conflicted interests

The financial incentives that CCGs could receive for good performance represent a potentially important source of conflict of interest. There are three broad levels of incentives to consider: incentives to the group for performing well (for example the extent to which they can keep any budgetary surpluses, or are made to bear overspends against the budget); incentives to practices; and incentives to individual GPs or other clinicians for improved performance.

The evidence suggests that financial incentives have an important role to play in motivating physician led groups and that these incentives can create potential conflicts of interest with respect to individual clinician behaviour, which have to be carefully managed (Curry and others, 2008; Thorlby and others, 2011). For example incentives based on a group's efficient use of resources might influence a GPs decision whether or not to refer an individual patient or prescribe treatment. The government has therefore amended the Bill [143 and 146] to state that any financial rewards to the clinical commissioning group will depend on quality (clinical outcomes) not efficiency. A group's efficient use of resources will instead be part of a group's authorisation criteria and ongoing performance assessment by the Commissioning Board.

While we recognise that the government has taken steps to address legitimate concerns about creating conflicts of interests through the incentives scheme at the level of the clinical commissioning group, it is not clear whether the groups themselves will be free to instigate incentive schemes to individual practices or individual GPs, and whether these incentives would also be subject to the same restrictions outlined in the Bill. It also remains unclear as to whether quality-based incentives also apply to the generation of financial surpluses.

Key questions

- **How much freedom will CCGs be given to design incentive schemes that reward member practices?**
- **What, if any, weight will the NHS Commissioning Board give to a CCG's ability to generate a financial surplus, when assessing its performance on quality?**

Timing and relations with the NHS Commissioning Board

We have previously suggested (Nuffield Trust, 2010) that CCGs will take at least two years to develop, and that having a rigid deadline for all clinical commissioning groups to form would be unrealistic. In its response to the Future Forum, where similar points were raised, the Government has relaxed the deadline. We welcome the relaxed timetable, but would urge the Government to maintain the momentum for the transition to clinical commissioning groups. The revisions to the Bill make clear that if there are areas that have not been authorised by April 2013, local commissioning will be handled by the national Commissioning Board. This runs the risk of diminished local stakeholder and patient input into the residual commissioning done by the Commissioning Board, and of increased centralisation of decision-making by commissioners.

Some of the concerns about accountability and governance outlined above are likely to be addressed through the details of the authorisation process. Earlier in the summer the Department of Health released its preliminary thinking in relation to the development of the Commissioning Board (Department of Health, 2011b). The document hinted at an authorisation process that could be intensive but potentially burdensome, perhaps not dissimilar to the World Class Commissioning and PCT Fitness for Purpose initiatives pursued by the Department of Health under the previous government.

The major responsibilities these groups will bear means that it is critical that the process of CCG authorisation is thorough. However it also needs to avoid being excessively time-consuming or bureaucratic and instead be about encouraging best practice. For instance CCGs should be required to demonstrate effective clinical engagement with their constituent practices, searching peer review of clinicians delivering primary care (and other services), backed up by robust IT and management systems. An updated version of the authorisation guidelines has just been released (Department of Health, 2011c). We urge peers to examine for themselves whether the latest proposals satisfy such criteria.

Public health

The Government's emphasis on the value of public health is welcome. The transfer of public health to local government certainly has the potential to improve action on the determinants of poor health. However, we remain concerned that the pool of public health expertise that CCGs and providers will need to draw upon to develop high-value health care will be severely weakened by the reforms.

Of the three main functions of public health: to manage communicable disease and major health incidents; health promotion and reducing inequalities in health; and increasing the effectiveness and cost effectiveness of health care. On this last point, the Bill is almost silent. Substantial expertise in evaluating health care has built up in public health in the NHS over the last twenty years following the Acheson report in 1991 (first within health authorities and later PCTs), and is in danger of withering at a time when it is most needed by commissioners. We suggest that the Bill should be more explicit about the need for CCGs to demonstrate they have access to skills in this area and that this expertise is actively incorporated into commissioning health services and evaluating their effectiveness.

Part 3 analysis (regulation, competition and integration)

The most contentious part of the proposed Bill related to the role of competition in the provision of NHS services. The empirical evidence supports the use of competition and choice amongst other mechanisms to improve the quality of NHS services, particularly in areas where units of care can be clearly defined and priced. This evidence derives from two studies of the impact of choice-based competition for elective care in the NHS since 2006, which found that hospital death rates after admission for heart attacks fell faster in areas with more competition between NHS providers (Gaynor and others, 2010; Cooper and others, 2010). However, the evidence base is limited, particularly in relation to competition in mental health or community services as activity, prices and outcome measures are less developed in these areas. Extending competition beyond elective care, for example to community-based services, as recently announced by the Department of Health (2011d), may offer further potential benefits in terms of quality and efficiency, but it will need to be carefully evaluated.

Many feared an uncontrolled expansion of market forces within the NHS provoked by the original wording of the Bill – which required Monitor to promote competition where appropriate – which they claimed opened up the NHS to the full force of EU competition law. The Government's subsequent clarification and reworking of the Bill aims to defuse the concern about the primacy of competition between providers to improve their performance. Monitor will now (Amendment 149) have a duty to prevent anti-competitive behaviour rather than promote competition. In addition, it will have to enable the integration of services where this improves quality, patient access and outcomes. It will also have a general duty to promote services that are economic, efficient, effective and maintain or improve the quality of care.

However, it is still not clear what impact this change in wording has on the applicability of EU competition law. The Department of Health has stated that the Bill has no impact in the applicability of EU law and that there is still legal uncertainty about how much of the NHS might be subject to competition because of an absence of relevant case law (DH 2011e). It appears that full clarity will have to await developments through the courts. In the meantime, it seems likely that the pace of change in relation to competition will be heavily dependent on the policies and behaviour of Monitor as the sector regulator. As we have pointed out elsewhere, depending on what definition of competition is used, many areas in England have low levels of competition, raising the probability that many mergers and other organisational changes could be seen to be anti-competitive (Lewis and Thorlby, 2011).

Key question

- **How proactively will Monitor pursue its duty in relation to seeking out and suppressing anti-competitive behaviour?**

Developing prices

Fundamental to any drive to extend competition and more integrated patient care is the availability of timely, accurate information on cost, clinical quality and patient experience. The models of contracting and payment needed to underpin an effective framework of competition and integration are underdeveloped in the NHS. The NHS Commissioning Board and Monitor need to work together to ensure the necessary information, data exchange, contracting and payment tools to deliver patient choice, integrated care, efficiency and quality. At present this work is fragmented. Critically, accurate information on provider costs is needed to develop national tariffs appropriately, and

current evidence shows that the costing by providers of services not yet subject to a national tariff is particularly weak (Audit Commission, 2011).

The Nuffield Trust has previously argued that, to deliver a health care system that effectively combines integrated care with choice and competition, Monitor and the NHS Commissioning Board should be required to develop a joint pricing strategy. Innovative models of care will be harder to deliver without clarity about how providers will be paid. However, pricing is only one of the system incentives and tools needed to support innovative commissioning and provision. Clear contractual models, accurate prices, improved patient information and data exchange are all needed to help develop appropriate integrated care, choice and competition.

Key question

- **Is the Government willing to impose a joint requirement on Monitor and the NHS Commissioning Board to publish a set of 'system rules' that would include pricing, contractual models, improved patient information and data exchange to support integrated care?**

Mergers

The Department of Health has identified that a number of NHS trusts (around 20) which, based on their current performance (on financial and quality measures), are unlikely to attain Foundation Trust status. In the past the policy response to under-performing hospitals has been to merge them with other hospitals. Research evidence from the NHS suggests that merging a challenged hospital with another provider has not been an effective response to tackling financial problems in the short to medium term (Propper, 2011).

It is also important to be able to explicitly diagnose the underlying problem, whether it is poor-quality management or more intractable issues relating to excess capacity and changing patterns of patient demand. The failure regime referred to below, if implemented correctly, should deliver some consistency and transparency in understanding the drivers of reconfigurations. However, it will take time for these to be developed. It is important that pressing reconfiguration decisions for the current NHS trusts are subject to the same rigorous assessment of their causes, the impact on competition and patient choice in order to gain a full understanding of patient and public interest, as they would under the new framework. Given the complexity of these issues within health care there is a case for Monitor, rather than the competition authorities, leading the appraisal of mergers.

Key question

- **Given the complexity of health care is there a case for Monitor to assess potential mergers for their effect on patient choice and access, on behalf of the general competition authorities?**

Failure regime

A critical element in any publicly-funded health service – particularly one that aspires to inject more market mechanisms into the system – are the effectiveness of the procedures in place to deal with providers whose operations are unsustainable for financial and/or quality reasons. The original Bill's proposals for a 'failure regime' for NHS trusts, foundation trusts and other publicly-funded providers

were revised following the NHS Future Forum's report (NHS Future Forum, 2011). The amendments to this part of the Bill were published in September, within a very short time of the Bill being passed by the House of Commons.

The amendments (100, 104) concern Monitor's duty to ensure continuity of services in the event of financial failure. Instead of designating services in advance for protection in the event of financial distress within providers, Monitor will keep the financial health and performance of all NHS-funded providers under surveillance and will intervene proactively to identify and protect essential services. Where needed, Monitor will have the power to set special licence conditions to protect services, which could include replacing managerial teams. Monitor will also have the power to increase the tariff (price) payable by commissioners to protect services that are uneconomic but deemed essential by local commissioners.

In the case of a foundation trust becoming unsustainable, the amended Bill stipulates how a special administrator would work with commissioners, local government and patient representatives to craft solutions that could include reconfiguration. The Bill allows Monitor access to funds, generated from a risk pool levied on providers and commissioners (it should be noted that this potentially important detail has not yet been finalised). The amendments also set up a special administration regime for non-NHS owned companies.

One of the biggest drawbacks of the existing approaches to financial failure in the NHS has been the absence of transparency in financial flows, where trusts have often been 'bailed out' in a process that has been thoroughly opaque. In our view many of the details contained in these amendments represent a reasonable upgrading of the existing policy, particularly with respect to ensuring more transparency in managing failure. The proposed amendments put greater emphasis on intervening early to prevent organisations failing. This is welcome. The goal of a failure regime must be to develop a clear understanding of failure, reduce the number of organisations who fail and manage the consequences of any failures to minimise the impact on patients, communities and the taxpayer.

However, the proposals set out will not be able to achieve this unless they are backed up by a coherent set of financial rules and flows of money around the NHS. The Nuffield Trust has previously argued that a transparent and rules-based system to manage the financial flows around the NHS is necessary, to provide the right incentives for providers and commissioners to improve their performance, and for transparency and public accountability. We have argued that the banking function that the Government intends to establish within the Department of Health should be independent. This has not been adopted in the revised Bill, and peers should press as to why not. The case for a transparent, rules-based system remains and the Nuffield Trust would encourage the Department of Health to set out its proposals for the banking function. The Department should also set out a financial framework for commissioners and providers that includes clear rules for the management of risk, the retention, repayment and draw-down of surpluses and deficits, and the use and criteria for top-slicing and levies.

To summarise, we would argue that picture is not complete without details of the proposed NHS Bank and the terms under which it will function. We would also welcome more detail about the risk pool to be operated by Monitor. The commitment for Monitor to establish transparent and objective tests to establish whether intervention and any subsequent action to protect essential services is necessary and welcome, but the complexity of this task should not be underestimated. It may for instance require Monitor to develop some normative standards of service (possibly set out in the NHS Constitution). This has been an elusive and politically sensitive endeavour in the past, for example in respect to the provision of maternity or emergency services per head of population.

Key questions

- **Can the Government give an indication of when it will publish full details of the proposed NHS banking function?**
- **Why is the Bill not proposing a banking function that is independent of the Department of Health?**
- **Given the risk that higher than average prices might have to be paid for essential services if organisations fail, can the Government give an indication of the timelines that will apply to implementing failure regimes?**

Monitor's duty to promote integration

A strong message that emerged from the NHS Future Forum was the need to for the NHS to work harder to integrate services for patients, particularly those with chronic diseases. As a result, the Government has amended the Bill to include a "duty to act with a view to securing that health services are provided in an integrated way". This duty applies to clinical commissioning groups and the NHS Commissioning Board as well as Monitor. We welcome this emphasis on integration and would encourage all NHS bodies to take opportunities to explore innovations in provision, supported by new forms of pricing and IT systems.

The inclusion of integration as an organisational focus for Monitor increases the complexity of its role, which will now include: the authorisation of new foundation trusts, considerations of mergers and policing of anti-competitive behaviour, setting prices for NHS providers, monitoring the financial health of providers and implementing the failure regimes described above, as well as promoting integration across the NHS. Some of these tasks imply significant surveillance capacity, for instance the monitoring of the financial health of all foundation trusts, NHS trusts and other private and voluntary sector providers (assuming that the data for private and voluntary sector providers are made available).

A related point concerns the intensity of Monitor's supervisory activity in relation to FTs and NHS trusts. From the standpoint of public accountability, Monitor's scrutiny powers need to be extensive. But from the perspective of freeing local NHS providers to innovate, Monitor's role (and equally the NHS Commissioning Board's role in relation to CCGs) should not dominate the agendas of managers and governing bodies to the extent that it stifles and distorts local priorities. These concerns are not matters for legislation but apply to the implementation of the new organisations that are established by the Bill and underscore the potentially powerful influence that Monitor will have on shaping the culture and behaviour of local NHS organisations. We would seek reassurances about how Monitor will handle some of the conflicts of interest now inherent in its role: for example, how to encourage innovation in integration without expanding monopolies, or how to balance the benefits of potential mergers from a financial sustainability perspective with the costs of less competitive, more concentrated provider environments that may result. A further question concerns the relationship between Monitor, the NHS Commissioning Board and the Care Quality Commission, all of whom will now have potentially overlapping spheres of influence on NHS organisations in relation to quality regulation and performance management. To avoid duplication or gaps in responsibility, there needs to be clarity about what each of these bodies should be doing; regulatory confusion may have been an important contextual factor in the case of the failures in care at Mid-Staffordshire NHS Trust.

Key question

- **Will Monitor require more resources to discharge its expanded functions under the amended Bill?**

Conclusion

While it did not appeal to all stakeholders across the NHS, the original Bill could be said to contain a coherent (if somewhat radical) logic within it. It envisaged a fully bottom-up, clinically-owned network of GP commissioning groups, with an apparently light-touch regime of regulation, and sparse accountability structures. These bodies, formed within a tight timescale, would be free to engage in a series of 'make or buy' decisions in a relatively autonomous environment, in sharp contrast to PCTs with their more cumbersome, bureaucratic processes. The quality of commissioning would be overseen by a national NHS Commissioning Board, independent of the Department of Health and Secretary of State.

Meanwhile, the landscape of health care provision was to be galvanised by a dose of competitively driven innovation, with an expectation of easier entry and exit to the market. Crucially, competition would be on price as well as quality, allowing efficiencies to be generated over the short term. Patient choice would drive this competition, assisted by the new economic regulator and more published information about the quality of care. Most importantly, the freedom of local clinicians to compete and innovate was to be strengthened by formally limiting the Secretary of State's powers to intervene and enshrining autonomy as a guiding principle for relations between the NHS and the centre. Choice rather than voice was the dominant mechanism for patients and the public to shape services. Even though new vehicles for enhanced local accountability were envisaged – health and wellbeing boards, local Healthwatch – their powers to intervene in the decision-making processes of commissioners were circumscribed.

The revisions to the Bill prompted by the NHS Future Forum's report (2011) represent the reassertion of a different approach to public sector reform, with a stronger emphasis on statutory structures to deliver accountability for public funds such as more specific requirements for CCG governance, duties to involve the public, and an emphasis on collaboration and integration rather than competition. What is now clear, as a result of the changes suggested by government in the wake of the Future Forum report, is a potential downgrading of competition and market forces as a possible motor of improvement within the NHS, in favour of a more managerially-driven approach. For example, the modification of Monitor's duties with respect to promoting competition, while it does not change the applicability of EU competition law to the NHS, signals a damping down of competition, while the procedures associated with the failure regime will mean that market exit is likely to be a lengthy process (which is not unreasonable given the publicly-owned nature of NHS organisations).

Given the Government's repudiation of targets and central control as a mechanism for improving quality, this leaves the role of local commissioners, the national Commissioning Board and quality regulation as the main agents for quality improvement in the NHS. While the Bill sets up new structures, what is now lacking is a convincing narrative of what will drive improvement in the absence of competitive pressures. There is a danger that these new central bodies will revert to a centralised model of command and control over the NHS, this time (perhaps) without obvious ministerial interference, but likely to be just as strong nonetheless. The financial challenge over the next three to four years (and perhaps beyond) will increase this likelihood. Given the modifications to

the Bill made as a result of the Future Forum listening exercise, it is now vitally important that the Government articulates a new vision of what will drive improvement, efficiency and innovation in the NHS in the absence of the more market-inspired original plan. This model must allow for genuine local autonomy for clinicians to innovate, delivering public accountability without a reversion to central control. If there is organic growth and innovation within the structures outlined by the Bill, it will be more vital than ever that the Commissioning Board puts in place new mechanisms to spot what works to improve value in health care. The mechanism to do this at present is extraordinarily weak and lacks a robust empirical basis. Without such knowledge, future development will lack justification and progress towards higher value and more sustainable financing will be significantly impeded.

Finally, we are led to conclude that there may be value in having either the Health or Public Administration Committee carry out a review of the policy-making process since July 2010. This would focus on the extent to which legislation was needed to make changes envisaged in the White Paper, whether the time between publishing the White Paper and obtaining Royal Assent could have been used differently, with more effort devoted to building greater consensus, and the appropriateness of reforms being implemented before legislation has been agreed and passed.

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