Parliamentary Briefing

Memorandum to the Public Bill Committee for the Health and Social Care Bill

The Nuffield Trust is an authoritative and independent source of evidence-based health service research and policy analysis. Our aims include promoting informed debate on healthcare policy in the UK. This submission highlights aspects of Parts 1 and 3 of the recommitted Health and Social Care Bill that we think merit closer examination. It can be read in conjunction with the longer Nuffield Trust policy briefing *The Health and Social Care Bill: Where next?*

Key Points

- The Government has an obligation to move quickly to fill the existing knowledge gaps surrounding the Bill, but any more substantial and unplanned delays to the legislation run the risk of distracting NHS organisations from the task of generating efficiencies and diluting the sense of enthusiasm that some clinicians feel at the prospect of taking on a stronger role in commissioning. We urge elected officials to avoid further protracted disagreements at this stage.

- Although the upward 'hard' accountability of clinical commissioning groups (CCGs) to the NHS 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 rather than acting as a brake on innovation and action. If progress is too slow, the centre may be tempted to exert more direction given the urgency of the financial challenge. The progress of commissioning groups should be carefully assessed particularly in the first two years, and the requirements upon them changed where necessary.

June 2011

- Some of the concern about the Government's reform plans in relation to GP commissioning was driven by uncertainty about the role that financial incentives might play in decision making by consortia and the potentially negative impact they might have on the doctor-patient relationship. The change of the language from 'performance' to 'quality' [Clause 23, p 42, line 11] attempts to speak to these concerns but it is difficult to appraise the legislation while much of the policy detail is still lacking.

- In respect of Part 3, we welcome the Government's commitment to promote and develop integrated care among providers, as evidenced by the new duties on Monitor, CCGs and the NHS Commissioning Board, their continued requirement that all NHS Trusts become Foundation Trusts (albeit to an extended timetable) thus encouraging more local freedom and innovation, and their extension of Monitor's compliance powers for Foundation Trusts to at least 2016 (thus establishing an important safeguard).

- However given that NHS exposure to UK and EU competition law is unchanged by these amendments, we are still not clear what impact the change of wording will have on Monitor's activities, particularly in relation to promoting integrated services. This is a crucial point as while the Bill strives to reform commissioning structures, ultimately it is fundamental reform on the provider side – possibly entailing the development of new models and networks that have implications for competition policy – which will unlock the fundamental efficiencies required to put the NHS on a more sustainable footing.

- The anti-privatisation clauses may be problematic. While they may go some way to assuaging the concerns of those worried about the expansion of the private sector, there is a risk that they could also be used to prevent change in other directions. If, for example, on the basis of pilots for integrated forms of care it was found that mutual (staff owned) enterprises were a successful ingredient of change, would these clauses make it impossible for any public body (local or national) to openly encourage the formation of this sort of organisation?

Introduction

Over time, clinically-led commissioning and the intelligent use of competition may help to reshape out-of-hospital (primary, community and social care) and hospital care so that providers are more ready to cope with future patterns of demand. However the main issue facing the NHS now and to at least 2014 is not the reform programme as set out in the Health and Social Care Bill, but the squeeze on funding. New commissioning models and the creation of a sector specific economic regulator are unlikely to impact quickly on productivity rates among the acute providers that are responsible for the largest proportion of NHS spending.

Thus the crucial question is whether it is possible to extract the needed efficiencies now, and in a way that lays the foundations for a more sustainable NHS in the medium term, and if so, will the revised Bill make that task easier, namely by giving provider organisations the space they need to innovate and experiment with new models that align incentives across traditional boundaries in order to deliver patient centred care, at an affordable cost?

This cannot be fully answered at Committee stage. In many areas of the Government's extensive reforms, the details of policy are yet be fully developed or published, making it difficult to evaluate fully some of the proposed revisions. It is also likely to be organisational behaviours, particularly in providers, and in an unpredictable political and economic climate that will have a greater effect than the primary legislation on how the Bill is enacted.

With this is mind this submission lists a few lines of inquiry, based on prior Nuffield Trust analyses that may assist Committee members to shed further light on the Government's intentions and expectations. However we would also urge elected officials to avoid protracted disagreements at this stage. While the Government has an obligation to move quickly to fill the existing knowledge gaps surrounding the Bill, any more substantial and unplanned delays to the legislation run the risk of distracting NHS organisations from the task of generating efficiencies and dissipating the enthusiasm that some clinicians feel at the prospect of taking on a stronger role in commissioning.

Part 1

NHS Constitution

We welcome the insertion of a duty to promote the NHS Constitution with respect to commissioning consortia and the Commissioning Board [13BA] and [14JD]. The NHS Constitution contains important guarantees for patients, the public and staff, which we support. It should be noted however that some of these may have a significant impact on the way services are delivered locally (for example guarantees about waiting times and the access to NICE approved drugs) and potentially add to the centre's influence at the expense of local commissioning decisions. The NHS Constitution was designed to be a document in which the detail in relation to service guarantees would change over time.

Given the potential impact of the NHS Constitution on local NHS services and the importance of it remaining a living document, we encourage the committee to seek clarification from the government about the process for updating the Constitution. Which organisation will do this and what input should it have from the public, patients and professionals?

Governing bodies of commissioning consortia (and Foundation Trusts)

The first set of governance proposals for GP commissioning consortia were underdeveloped in the Bill, resulting in valid concerns about both their public accountability and their connection with other

parts of the NHS. We understand, however, that the original proposals were drafted with the aim of avoiding too much central prescription in the governance and structure of consortia, which is also a legitimate ambition if the consortia are to harness energy from local clinicians. A balance needs to be struck between specifying requirements that offer an appropriate level of accountability for public funds, and also foster genuine autonomy for local clinicians.

On the first point it is vital that local commissioning groups are accountable and conduct themselves according to the highest principles of public life. CCGs are legally responsible for the quality of their decision making processes (i.e. they need to be able to stand up to judicial review) and the individuals making those decisions should be required to adhere to the highest standards of conduct for public officials (e.g. the Nolan principles of standards in public life).

We welcome the Government's recognition of this fact and their revisions to the governance structures of CCGs, namely the inclusion of lay and other professional members on governing bodies, the requirement for compliance with principles of good governance and the pledges about public access to documents and meetings. It is also appropriate that the Bill does not over-prescribe and leaves the precise detail to guidance and secondary legislation. These are the suitable place for developing a sensible accountability framework for CCG, in terms of their governance, transparency, involvement of patients, the public and other stakeholders, as well as health outcomes and quality of services.

In advance of this work being done, it may be useful for the Committee to seek clarification about the methods for identifying and selecting lay and professional members of governing boards. There are established procedures and rules for recruiting PCT non-executive members and the costs are relatively modest. The existing system could be modified for CCG governance. Allowing CCGs complete autonomy over the selection of lay and professional governing members might undermine public confidence, particularly with respect to how CCGs will manage conflicts of interest.

The revisions to the Bill also state [14JA (5) that "a commissioning consortium may pay members of the governing body such remuneration and allowances as it considers appropriate". Full autonomy may not be appropriate, as it might undermine public confidence in the ability of members of CCGs' governing bodies to act in the public interest. Some degree of national guidance about fee scales might be valuable here.

We would encourage the committee to seek clarification about how lay and professional members of CCG governing bodies are to be selected and remunerated, specifically whether the Government intends to draft national guidelines for CCGs in relation to this.

However it is also important to note that the existence of boards and established governance rules/guidance does not guarantee a focus on quality, an issue that is of particular interest to the current public inquiry into events in Mid-Staffordshire. Guidance for board members has been developed by a range of bodies within the NHS and in wider public life, which aim to clarify roles, standards and processes for board members.

We would urge the Committee to press the government for detail on what training and support will be available for members of CCG governing bodies and how their performance will be assessed on a continuous basis.

The inclusion of a provision to oblige CCG governing bodies to open their meetings to the public [Schedule 2, 5B (4)] is an important step towards enhanced accountability. The subsequent right of CCGs to exclude the public from a meeting or part of a meeting 'where the consortium considers

that it would not be in the public interest' may be used for reasonable purposes (for example to protect patient confidentiality) but might also be used for unreasonable ends.

We would urge the Committee to request some clarification of the circumstances under which the public can be excluded (this would also apply to the new proposals for FT governing bodies also).

Clinical Commissioning Groups' relations with other local bodies

In responding to the NHS Future Forum report, the government has decided to broaden the scope of clinical commissioning, by including other professionals on the governing body (as discussed above) by entrenching the position of specialist clinical networks and through the creation of 'senates'. These do not require legislation. It is not clear to us how these bodies will interact with commissioning groups, in particular what weight their decisions will have on CCGs. Wider clinical engagement has the potential to improve the quality of commissioning decisions in a local area, but if mishandled, it could also entangle CCG's in a web of competing priorities and accountabilities that slows down the decision making process.

The recommitted bill also strengthens the voice of other local stakeholders. CCGs will now be obliged [22 14YB] to consult health and wellbeing boards (HWBs) in the drawing up of their commissioning plans and explain in writing how they have taken account of the HWBs' views in their final commissioning plans. HWBs 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 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 whether the original assumptions for administrative spending for CCGs are still valid and whether CCGs will be adequately resourced to discharge these activities.

The Committee may wish to press the government for an explanation of how the roles of clinical senates, clinical networks and health and wellbeing boards will work and to what extent CCGs will be bound by the decisions of networks or senates compared to the views of health and wellbeing boards. The Committee may also wish to explore whether the extra administrative activity that this represents is adequately reflected in government funding assumptions.

Clinical Commissioning group's quality premium

Some of the concern about the Government's reform plans in relation to GP commissioning was driven by uncertainty about the role that financial incentives might play in consortia decision making and the potentially negative impact they might have on the doctor-patient relationship. The change of the language from 'performance' to 'quality' [Clause 23, p 42, line 11] and the additional subsections attempts to speak to these concerns but it is difficult to appraise the legislation while the policy detail is lacking.

As we have explored elsewhere[i], to succeed, some of the motivation for commissioning consortia may indeed be driven by the ability to keep surpluses and/or access to performance related funds (the absence of meaningful incentives was certainly a factor in the limited impact of practice based commissioning). This use of financial incentives does however require appropriate governance and transparency, both to assure patients and the public, and to protect clinical commissioners from judicial and other challenge about processes of decision making.

We would urge the Committee to seek reassurances that such guidance will be developed.

At the same time we realise that there are hazards arising from incentivising efficiencies at a clinical level, particularly in relation to under-referral and avoidance of sicker patients or patients who are otherwise difficult to treat. We recognise that this requires skilled local and national leadership by clinicians if the incentives are not to undermine patient confidence. The detail of how any surpluses or quality-related incentives needs to be developed in a consensual way between the Board and the local commissioning groups, as well as other stakeholders, and published.

It should also be noted that neither the Government's response to the Future Forum nor the revisions to the Bill refer to the question of surpluses by the local commissioning groups. It is not necessarily the role of legislation to specify the disposition of surpluses, but it would be advisable to press the government for the detail of their policy in relation to this. In previous policies the ability of GP fund holding practices to keep surpluses from the budget for hospital care and transfer surpluses into primary care (general medical services) was contentious but a key incentive for fund-holding practices.

We would encourage the Committee to explore the Government's plans (a) for commissioning groups to keep surpluses for use in other budgets, and (b) monitoring the potential downsides of financial incentives for commissioning, including under treatment, particularly of sicker patients, where the impact on overall outcomes might not be visible.

Part 3

The role of Monitor as an economic regulator

The original reform proposal to create an economic regulator to 'promote' competition in the NHS where appropriate attracted a great deal of opposition. In response, the Government has now revised the objectives of Monitor to include the promotion of integrated services alongside functions to prevent anti-competitive behaviour in the NHS. [Clause 65 (2A, 2B)]. We note that the original proposals to give Monitor concurrent powers with the OFT to implement competition law remain apparently unchanged. The Government's Response to the NHS Future Forum Report also undertook to incorporate the existing Co-operation and Competition Panel into Monitor, giving them a 'statutory underpinning' in the process. It should be noted that this commitment is not immediately apparent in the re-committed Bill.

As we have argued elsewhere[ii] research suggests a potentially beneficial role for some choice based competition in the NHS, alongside other tools that help promote quality, efficiency and equity. We believe that an economic regulator specific to the NHS is important, because of the unique characteristics of healthcare, notably the complexities associated with the measurement of quality, cost and value of healthcare from both a consumer and purchaser perspective.

We therefore welcome the direct reference in the Government's response to the Future Forum to three major issues. The first is promoting and developing integrated care among providers – primary

community secondary and social care providers – for example in the new duties of Monitor and the clinical commissioning groups, and in the role of the NHS Commissioning Board in setting the structure of payments for clinical care. The second is to require all NHS Trusts to become Foundation Trusts (albeit to an extended timetable) thus encouraging more local freedom and innovation. The third is to extend Monitor's compliance powers for Foundation Trusts to at least 2016.

However given that NHS exposure to UK and EU competition law is unchanged by these amendments, we are still not clear what impact the change of wording will have on Monitor's activities, particularly in relation to promoting integrated services. This is a crucial point as while the Bill strives to reform commissioning structures, ultimately it is fundamental reform on the provider side – possibly entailing the development of new models and networks with implications for competition policy – that will unlock the fundamental efficiencies required to put the NHS on a more sustainable footing.

Understanding whether the NHS would be subject to EU competition law is therefore still key. We would again urge the Government to make public the legal advice it has been given in relation to EU competition law and the NHS. If NHS services are opened to EU competition law it potentially undermines the Government's intent to contain competition and encourage collaboration, and it would add complexity to the duty to promote integration. In other sectors, integration of services is regarded by regulators as a potential loss of competitive pressure.

We would encourage the committee to seek clarification about the application of competition law to the NHS and the interaction between Monitor's duty to reduce anti-competitive behaviour and promote the integration of services.

Choice

The Government's response to the NHS Future Forum report attempts to reframe the debate about the role of competition by emphasizing the role of patients' choices as the underlying driver of change. It states [para 5.20] that the NHS Commissioning Board will draw up guidance in relation to choice, following a 'choice mandate' [5.34]. While the details of this choice mandate do not fall within the scope of primary legislation, we would nevertheless encourage the Committee to explore the Government's plans for setting this 'choice mandate'. The scope of choice will have major implications for how commissioners deploy their resources, including which additional services may need to be procured to offer choice where currently none exists (which applies to many services currently) and how information on quality will be made available to patients.

Given the Government's intent to allow more autonomy for local commissioners, it will be important to understand the likely scope of this centrally determined 'choice mandate' and the degree to which local clinicians, patients and other stakeholders are involved in its construction.

A financial failure regime

In the past, financially distressed NHS trusts (some persistently in deficit) have received subsidies in a way which is not transparent.[iii] This has undermined the incentives to tackle poor quality management and reconfigure local services where necessary. In the next four years a transparent system for dealing with financial distress and failure among providers will be crucial. Although the real terms budget increase for the NHS for 2011/12 is roughly flat, once the £1bn ring fenced for social care and the 'top slice' by strategic health authorities has been taken for contingencies, many PCTs and providers face real terms reductions in their incomes for 2011/12. For example the

average 'increase' in budget available to PCTs in 2011/12 is actually -2.3% and some areas are already showing signs of financial distress.[iv] The Government's response to the NHS Future Forum report acknowledged that there needed to be further development of a financial failure regime and promised to amend the Bill by withdrawing proposals to designate essential services for additional regulation by Monitor. These promised amendments are not contained in the re-committed Bill.

We would recommend that the Committee request that the government explain its current policy on distress and financial failure and, specifically, the status of its proposals with respect to designated services.

Anti-privatisation clause

In response to the concerns encountered by the NHS Future Forum about the future scope of private sector activity within the NHS, the Government has introduced an amendment to the Bill which prevents either the Commissioning Board or Monitor from pursuing a policy which favours one sector (public or private) at the expense of the other [Clause 19 13KA and Clause 56]. While these amendments may go some way to assuaging the concerns of those worried about the expansion of the private sector, there is a risk that they could also be used to prevent change in other directions. If, for example, on the basis of pilots for integrated forms of care it was found that mutual (staff owned) enterprises were a successful ingredient of change, would this clause would make it impossible for any public body (local or national) to openly encourage the formation of this sort of organisation? Similarly, if a commissioning body locally wished to encourage more voluntary sector engagement in the provision of mental health services or health promotion, would this be illegal under the amendments?

The Committee might seek clarification from the Government about the circumstances under which this amendment would be applied (and by whom) and explore how it would fit with other government objectives to expand use of the voluntary sector and staff owned enterprise.

References

[i] Casalino L *GP Commissioning in the NHS in England: ten suggestions from the United States,* Nuffield Trust 2011; Thorlby R, Rosen R and Smith J *GP commissioning in the NHS: insights from medical groups in the US*, Nuffield Trust 2011, Smith J and Thorlby R *Giving GPs budgets for commissioning: what needs to be done?* Nuffield Trust 2010

[ii] *The Health and Social Care Bill: where next?* Nuffield Trust 2011

[iii] *Audit Commission review of the NHS financial management and accounting regime*, Audit Commission 2006

[iv] *Health Service Journal* 3/2/2011 Dowler C, PCT overspending sparks fresh efficiency fears PCT overspending sparks fresh efficiency fears http://www.hsj.co.uk/news/finance/pct-overspending-sparks-fresh-efficiency-fears/5024987.article

evidence for
better health care

nuffieldtrust

For more information about Nuffield Trust,
including details of our latest research and analysis,
please visit www.nuffieldtrust.org.uk

Download further copies of this parliamentary briefing from www.nuffieldtrust.org.uk/publications

Subscribe to our newsletter:
www.nuffieldtrust.org.uk/newsletter

Follow us on Twitter: Twitter.com/NuffieldTrust

Nuffield Trust is an authoritative and independent source of evidence-based research and policy analysis for improving health care in the UK

59 New Cavendish Street
London W1G 7LP
Telephone: 020 7631 8450
Facsimile: 020 7631 8451
Email: info@nuffieldtrust.org.uk

Published by the Nuffield Trust.
© Nuffield Trust 2011. Not to be reproduced without permission.