

The Health and Social Care Bill: where next?

Policy response

May 2011

The NHS has entered a period of significant financial challenge. Four per cent in efficiency improvements each year to 2015 must be achieved without damaging care quality (this period can be called 'phase 1'). Structural reform aimed at ensuring sustainability – the provision of good quality care within the resources likely to be available in the medium to longer term – will also be necessary ('phase 2').

The Government's Health and Social Care Bill was conceived largely to address the phase 2 agenda. It will not make a major contribution to the immediate financial challenge. The job of managers and clinicians is therefore to get the service safely through the next four years whilst laying the foundations for longer-term system transformation. In this response to the NHS 'listening exercise', we build on our previous research and analysis (Nuffield Trust 2010a, 2010b; Smith and Charlesworth 2011) to outline a strategy in support of both objectives.

Key points

- Managing the transition

 - Spending on health care over the next four years is growing at a much slower rate than at any time since the NHS was founded. Combined with well-documented demographic pressures, the period from 2011 to 2015 is likely to prove the most challenging in the history of the health service. Strong system leadership and effective financial control is required over the next three to four years to ensure that quality of care and access to services do not deteriorate (phase 1). The test will be whether this approach can simultaneously accelerate rather than hinder the development of the phase 2 agenda, achieving better quality with the available funding in the medium to longer term through fundamental structural reform.
- Service reconfiguration

 - For many of the NHS trusts that are financially unsustainable, significant, clinically-led service reconfigurations will be needed to enhance quality of care and value for money. Service changes of the required magnitude are unlikely to be made without strategic leadership from either the centre (for example the NHS Commissioning Board) or from a regional commissioning entity (such as a primary care trust (PCT) cluster). One option to consider might be the example from Ontario in the 1990s when, in a financial downturn, a time-limited independent 'restructuring commission' was set up with a mandate to make binding decisions on reconfigurations according to agreed transparent criteria. Another might be to strengthen the mandate of the Independent Reconfiguration Panel.
- Preventing financial failure

 - The present system for managing trusts that fail financially is not as robust, coherent or open as it could be. If the Bill's proposals are enacted, Monitor's role in providing ongoing oversight of foundation trusts' performance would reduce. This leaves a gap that the Government proposes to fill with a banking function operating within the Department of Health (DH). A banking function is vital, but to be most effective it

should be fully independent and operate outside the DH. This could help to protect public assets by operating a finance regime that incentivises trusts to act early to prevent financial failure. There is also a strong case for extending Monitor's compliance regime (with its wide ranging powers of intervention) until such time as an effective banking function is developed.

- The role of competition
- Moves to increasing competition are right. The evidence suggests that the strengthening of choice and competition for clinical care (with fixed prices) in the NHS over the last few years has improved quality. On this basis it is an appropriate step to encourage more competition in the NHS (alongside other tools that help promote quality, efficiency and equity) but while also acknowledging that progress (given the past decade) may not be fast enough to deliver significant changes in efficiency in the NHS as a whole in the next three to four years.
- The need for an economic regulator
- Calls to scrap plans for an economic regulator for health care should be rejected. Health care is highly complex. Applying the principles and correct degree of competition alongside other tools that promote equity, access and efficiency within health care will require significant analysis, evaluation and experience. This is more likely to come from a health care-specific regulator than from general competition authorities such as the Office of Fair Trading. However we concur that the Government can and should do more to clarify the legal and policy framework through which Monitor will operate.
- The duties of Monitor
- In particular, it should be made clear in primary legislation that the overriding duty of Monitor should be to manage the health care system in the public interest by promoting competition *and collaboration* subject to an agreed public interest test. The Bill should include a requirement for the NHS Commissioning Board and Monitor to agree a set of principles and rules for competition and collaboration, and the public interest test.
- Consortia authorisation
- For new consortia, it is critical that the authorisation process and system for managing financial risk is robust and transparent. In their early years, GP-led consortia will be under-developed as commissioners, handling about £60bn of public funds, while subject to many of the same pressures as PCTs but with much less management resource. It would be particularly helpful to see the criteria proposed for authorisation (such as governance arrangements and accountability) alongside the Bill so there could be greater understanding about how this process would work and how it will complement the primary legislation.
- PCT clusters
- Previous history suggests that commissioning consortia will take years to develop effectively. There is a strong case for assuring that PCT clusters have a longer term future beyond 2013. This would allow them to develop consortia and integrated provider networks (see page 9); commission services not in the purview of specific consortia; and provide strategic leadership for service changes (see above). There is an argument that consortia should only take on responsibilities gradually, depending on the extent of their capacity as judged by the authorisation process.
- Provider networks
- Achieving more cost-effective care for the growing number of older patients and those with chronic conditions is an urgent priority. This will require the introduction of an intelligent set of coordinated initiatives (encompassing primary legislation, regulatory policy, financial reform and support for pilots) that anticipate clinically-led integration where this is appropriate, encourage further such initiatives that already exist, and enable new forms of experimentation.



Introduction

A new financial year in the NHS has begun, during which PCT commissioners face an average reduction of 2.3 per cent in recurrent, real resources, and acute providers an overall efficiency challenge of between 4.7 and 6.5 per cent (Smith and Charlesworth 2011; Monitor 2011a). Managing this while maintaining quality and access to care will be a major challenge, not least when it has been reported that just over half of foundation trusts have lagged behind on delivery of their cost improvement plans, calling into serious question the ability of many hospitals to face these harder economic times (Monitor 2011a).

“ The amount of recurrent real-terms resources available to PCTs to spend this year is on average 2.3 per cent less

Dealing with these more pressured circumstances in a way which lays the foundations of a more sustainable NHS in the medium term will require considerable political and managerial skills. Namely, by putting into place measures that accelerate reorientation of the system so that providers become focused on quality as well as good financial management, and on supporting individuals to stay well and reduce their dependence on hospital care wherever possible (Dixon 2010).

This is a complex task which the Health and Social Care Bill, in speaking largely to the medium-term imperatives, only partly helps to address. Therefore, while disagreements over the Bill (Figure 1) are important to resolve, they need to be settled soon so that political and managerial effort can be redirected towards the immediate task. With this priority in mind, we outline in this briefing a series of measures, some short term, some with an eye to the medium term, that the Government could adopt to address many of the concerns that its reform plans have attracted.

Figure 1: An overview of the main concerns outlined since the publication of the White Paper

Concerns about timing and transition	The fast pace of reforms carries significant risks, especially in the context of a pressured financial climate and clear evidence that organisations distracted by reform can experience major financial and service failure.
Concerns about accountability and a lack of inclusion	The transfer of commissioning responsibilities to GP consortia creates serious conflicts of interest and potentially locks out important professional groups. Accountability arrangements in the proposed new set up are poorly developed and undemocratic.
Concerns about competition and the risk of fragmentation	Exposing the NHS more fully to the full extent of competition law will open the service to privatisation ‘by the back door’ and make it more difficult to develop integrated services that better meet the needs of patients with chronic diseases.

Addressing concerns about the next four years (phase 1)

Despite the relatively favourable settlement for the NHS compared to the rest of the public sector, budget and demographic pressures combined will make the period from 2011 to 2015 extremely challenging (Health Committee 2011a). The 2010 Spending Review budget settlement for the NHS was 0.4 per cent real terms growth between 2011/12 and 2014/15. Since then, the forecasts of general inflation have increased. As a result, NHS spending in 2014/15 is likely to be almost one per cent lower in real terms than during 2010/11. Furthermore, because of health care-specific inflation, earmarking of £1bn for social care, and 'top-slicing' by strategic health authorities (SHAs), the amount available to PCTs to spend in real terms this year is on average at least 2.3 per cent less (Smith and Charlesworth, 2011).¹

**almost 1
per cent**
likely real-terms reduction
in health spending

Implementing a large-scale reform programme as proposed in the Bill in this climate is a high-risk strategy. If managed poorly, organisational failure in parts of the system is likely. This failure could take several forms including a lack of expenditure control, rushed service changes or, more fundamentally, a decline in the quality of care (Marks 1997; Tetenbaum 1999; Audit Commission 2006; Dickinson and others 2006). The next two years of transition to the new structures will be particularly critical and, on balance, we believe that calls to abandon the Bill wholesale are misguided. Much of the NHS is already being reorganised along the lines set out in the White Paper

and it would be less disruptive at this stage to pass the legislation (in a modified form) than withdraw it completely. Further uncertainty about the commissioning framework at national, regional and local levels would make service change more difficult to achieve.

To win over sceptics, the Government needs to explain more fully how its plans to handle phase 1 (pre-empting financial and care quality crises in those parts of the system that are likely to be at highest risk), without at the same time disillusioning the enthusiasts of greater devolution whose energy and support will be instrumental to turning the phase 2 reforms into reality. There are several aspects to this balancing act that require further elaboration from ministers.

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Reconfiguration

In the past it has been difficult to secure political agreement over the big service changes, and much needed reform has been blocked for a range of reasons. There is a major opportunity cost for the quality and efficiency of care as a result. These are complex decisions for which securing a mandate requires significant political skills, in particular full engagement with the local communities involved, good communication with the staff affected, clinical support, the provision of rigorous, publicly available information and analysis upon which to base decisions, and clear pre-agreed criteria for taking them.

1. 2.3 per cent estimate based on forecast GDP deflator of 2.5 per cent at 22 December 2010. Forecast GDP deflator for 2011/12 as at 23 May 2011 is 2.9 per cent.

Despite the original intention of the White Paper to remove day-to-day political interference in the management of the health service, under the current Bill the Secretary of State remains theoretically the ultimate arbitrator of dispute in this area. Given the pressing need for change, the Government should carefully consider how these decisions can be made more swiftly than in the past, perhaps by decoupling national politicians from the decision-making process. In particular, thought could be given to the setting up of a time-limited independent national ‘restructuring commission’ which could have a clear mandate to make decisions on the basis of predetermined and agreed criteria (such as full public and staff engagement) and publicly-reported analysis. A similar non-partisan body was set up for three years in Ontario during the 1990s, given a mandate by politicians to make decisions with ‘no sacred cows’ and was effective in making difficult decisions about reconfigurations (Health Services Restructuring Commission (HSRC) 2000). Such a move would no doubt be highly contentious but – aside from cutting access levels and staff numbers – the biggest short-term savings are most likely to come from thoughtful reconfiguration. The model is worth further scrutiny and the wider question (of what changes to the structure of local health economies would be necessary) deserves a fuller public debate than has been the case up to now. Another option would be to strengthen the powers of the current Independent Reconfiguration Panel, for instance by making it the final stop in the decision-making chain.



It has been difficult to secure political agreement over the big service changes required. There is major opportunity cost for the quality and efficiency of care as a result

Making NHS finances more transparent

In a more challenging financial climate, tight and explicit financial controls, with transparency mechanisms for reporting progress, will be critical. However, the present system for managing trusts that fail financially is not as robust, coherent or open as it should be. The flows of money throughout the NHS are often opaque, with hidden subsidies; this both undermines the drive for a more efficient health service and raises issues of fairness. Not infrequently, money is moved between communities on the basis of (poor) financial performance rather than need. To encourage commissioners and providers to face the economic challenge effectively, and pre-empt a situation arising (as has been the case in the past) in which excessive funds have to be pooled centrally as a contingency for commissioner or provider failure, greater transparency around financial flows will be required. This is particularly important as such funds would have to be diverted from front-line patient care; a questionable use of resources in austere financial climate.

This necessitates an effective and robust system to deal with financial failure that:

- protects patient’s interests in safe, high-quality care across the NHS
- provides clear incentives for boards, governors and investors to avoid failure
- secures the interests of investors (including the taxpayer) in the event of failure.

These objectives are most likely to be met with the establishment of set rules within a clear framework that is itself managed by politically independent bodies (but with appropriate public accountability).

NHS banking function

Further measures will also be required to address the weaknesses in the current financial system. If the Bill's proposals are enacted, Monitor's role in providing ongoing oversight of foundation trusts' performance would be reduced so that it can take on the system management role envisaged for it. However, this leaves a gap. The Government recognises this and has proposed the establishment of an operationally independent banking function within the DH. An effective banking function is vital, but it is unlikely to be fulfilled by the Government's proposals to establish such a function within the DH. This should be replaced with a fully independent 'NHS Bank', outside of the DH.

Ideally the independent bank would have responsibility for ensuring that the taxpayer receives value for money from the £24bn of public dividend capital invested in trusts by operating a finance regime that incentivises trusts to act early to prevent financial failure, as well as to provide trusts with access to capital. The latter function is particularly important, not just for foundation trusts wishing to innovate and invest, but also for removing some of the barriers standing in the way of developing the voluntary sector's role in health. The independent NHS Bank could develop links with the new 'Big Society' Bank to tackle some of the barriers to innovation facing small and medium-size voluntary sector providers. Given the importance of this function, this body needs to be politically independent, open to scrutiny and accountable to the public.

Foundation trust oversight

Current proposals dictate that Monitor will apply a compliance regime (with wide-ranging powers of intervention) for performance of new foundation trusts for two years after authorisation, and for existing financially challenged foundation trusts to 2014. It is not clear after that point to whom foundation trusts will be accountable for financial performance. There is a case for the quality compliance and governance work by Monitor to continue after foundation trust status is granted to NHS trusts, at least through the phase 1 transition period, and until an independent banking function is fully operational. Thought should also be given to extending the deadline by which all trusts must attain foundation status, with, in the interim, structured support programmes put into place for financially distressed NHS trusts, some of which (it should be acknowledged) will never achieve foundation status as currently configured.

Primary care commissioning

Historically, PCTs have struggled to control expenditure on hospital care and achieve the reinvestment in community services long advocated in policy (Audit Commission 2009). The decision to give zero payment to providers for readmissions within 30 days of discharge after an elective procedure, and implement a new marginal tariff for emergency admissions above agreed baseline levels, is likely to place greater pressure on hospitals to try to reduce unnecessary emergency admissions, and work with commissioners to develop new forms of urgent care, community support and reablement.

Nevertheless, initially, GP-led consortia will still be under-developed as commissioners, handling about £60bn of public funds, while subject to many of the same pressures as PCTs but with much less management resources. The Government needs to consider carefully how they can be supported and the risks of a loss of financial control in the early years addressed. Consideration should be given to assuring a future for PCT clusters beyond April 2013, possibly as outposts of the NHS Commissioning Board and using

them, for example, as strategic commissioners of services not commissioned by consortia; as strategic leaders in the system regarding service reconfigurations; and as the developers of commissioning consortia (Smith and Charlesworth 2011).

Consortia authorisation

It would be particularly helpful to see the criteria proposed for authorisation alongside the Bill so there could be greater understanding about how this process would work and how it will complement the primary legislation. Authorisation is meant to determine whether a consortium is competent and able to commission care on behalf of the population covered. There is an argument that consortia should only take on responsibilities gradually, depending on the extent of their capacity as judged by the authorisation process (for example for elective care only, or excluding mental health). Under this model, the aim of authorisation would be to enable consortia to develop their skills and commissioning responsibilities over time. Some consortia might not be able to assume the full risk for their populations in the early stages and indeed, the immediate future may consist of a small number of authorised fully functioning consortia, with others subject to partial authorisation (authorised to commission for a subset of services negotiated between the NHS Commissioning Board and the consortia) and the balance being picked up by the PCT clusters. A few may not be in a position to be authorised at all and would require ongoing support.



Some consortia might not be able to assume full risk in the early stages

Membership of consortia

We note that there has been considerable debate about whether the requirement that all practices join consortia should be diluted, allowing for optional or staged membership. On balance, however, we believe that membership by a practice of a consortium should be mandatory rather than voluntary. If they are voluntary then some general practices inevitably will not join and commissioning the hospital care for the populations registered with these practices by the PCT clusters is likely to be far more difficult and fragmented if the populations are not integrated with a local consortium. Furthermore, the potential benefits of peer review and oversight by consortia of the quality of primary care provision and referrals to secondary care will not be realised (Dixon, in evidence to the Public Bill Committee, 2011). It is therefore still preferable for those practices with no interest in taking on commissioning responsibility to be formally linked to the new system.

Concerns about accountability and a lack of inclusion

Under current proposals many GPs will potentially occupy three roles (commissioner, primary care provider, and provider of extended specialist and community-based services). The need to consider how patients will respond to their GP when they are known to be responsible for local funding decisions has previously been noted (Royal College of General Practitioners 2011). It will be particularly important that patients do not perceive a conflict of interest in their GP acting as both commissioner and provider if public trust in general practice is to be maintained. Sensitive issues in this respect include the extent to which the personal remuneration of GPs is affected by commissioning decisions through, for example, the quality premium (Thorlby and others 2011). Conversely, previous research also suggests that prescriptive arrangements discourage a

sense of clinician ownership, a vital component of the reform programme (Ham and Smith 2010). The Bill is relatively silent on this dilemma and the Government needs to clarify what it thinks constitutes effective distributed governance frameworks of the kind which would permit the successful evolution of a wide range of clinician-led organisations while protecting the interests of taxpayers, and the reputation of general practice.

Laying the ground for system transformation (phase 2)

Primary–specialist collaboration

It is widely accepted that the biggest challenge now and into the future will come from meeting the demand for health care from the growing numbers of older people and those with long-term conditions (Health Committee 2011a; Department of Health 2010). Achieving more cost-effective care for this growing group of people will require an intelligent set of coordinated initiatives (Dixon 2010) and there is a strong argument that the Bill could be amended to more clearly encourage what is needed. In particular, providers must be incentivised towards supporting people at home so that costly avoidable hospitalisation is reduced.

As recent reviews have shown (Smith and others 2010; Health Committee 2010), commissioning in the NHS has largely failed to achieve this goal. This has mostly been because of a lack of influence over the activities of hospitals in which expenditure occurs. The research evidence suggests that to have more effect on expenditure and quality, GPs will need to work together with specialists, patients and indeed local authority social services to reorientate care in models that encompass both commissioning and provision (Ham, Smith and Eastmure forthcoming). For instance, those GPs who commission are likely to need to expand their own and other community services and work with hospital clinicians in the provision of care (Lewis and others 2010).

In a previous report we described how GP-led commissioning could be used as a means for federations of practices to achieve this ‘local clinical partnership’ (Ham and Smith 2010). The rationale for this model is that in allocating defined (ideally capitated) budgets to practices, policy-makers would overlay responsibility for commissioning with incentives to develop stronger primary care provision. Other models are also possible however, for example multi-professional integrated care teams working to shared goals but employed by different organisations; networks of provider organisations operating under a single integrated budget; or single organisations consisting of merged providers (Rosen and others forthcoming). There are numerous examples of NHS providers and commissioners who have been working to develop more integrated services. A set of more radical demonstration sites based on these initiatives would enable the testing out of how such models of care could be developed, as explored in Nuffield Trust and King’s Fund analyses (Lewis and others 2010; Ham and Smith 2010).

It would be advisable to allow some degree of gain-sharing (a share of the savings between commissioner and providers, and among providers) in cases where the network demonstrated improvements in quality and had in place systems to guard against conflicts of interest and/or gaming. The NHS may also be able to learn from overseas in this respect. The arrangements now being set up by the Centers for Medicaid and Medicare for developing accountable care organisations in the US, and the lessons from the Medicare Group Physician projects begun in 2005 are one possible source (Iglehart 2010). Another is the emerging integrated health networks and alliances in New Zealand. The important point is that all these models have the potential to align incentives across different institutions, professional groups, and budgets, and across the

commissioner/provider divide to help a population stay well, and reduce the costs of care. To be effective they would have to work to explicit and demonstrable goals around efficiency and quality, have clear financial incentives to help prompt innovation, and be independently evaluated centrally to improve understanding of how they develop.

Competition in health care

Empirical research supports a continued role for some choice-based competition within the NHS, alongside other tools that help promote quality, efficiency and equity. Competition is not an end in itself but a mechanism for achieving further improvements in the provision of health care. Balancing the right types of competition for different services and ensuring that health care providers can collaborate where this is in the interest of patients and taxpayers will be the key task, particularly when it is not known how much of either is needed to encourage providers towards better performance. It will therefore require significant analysis, evaluation and experience, which is more likely to come from a health care-specific regulator than from general competition authorities. On that basis, the calls to scrap plans for such a regulator should be rejected. However, we concur that the Government can and should do more to clarify the framework through which Monitor will operate.

The duties of Monitor

Much has been made about the possible intentions of the new economic regulator and the implications this might have for the behaviour of commissioners. The debates about competition in health care, and the approach that the regulator should take to its promotion have been well rehearsed elsewhere (Nuffield Trust 2010b; Ham and others 2011). A clear consensus is emerging that Monitor will need to consider how it can use its powers to achieve improvements in unplanned care and for those with long-term conditions as well as elective and community services drawing on international evidence. One of the principal questions that arises is around the unit of competition. Although individual hospitals are an obvious entity for competition purposes, as reflected in the White Paper, they have many different ‘product lines’. Moreover, as the system evolves and new clinically-led commissioner–provider networks emerge in places (Lewis and others 2010; Ham, Smith and Eastmure forthcoming), a further layer of complexity will be added.

“ Monitor should have a duty to: *‘Promote choice and competition where in the public interest; to improve the quality and accessibility of care for patients and value for money for the NHS.’* ”

In anticipation of this, and to reflect that it is far less certain how competition would impact on emergency care, care for frail older people, or those with long-term conditions who will be receiving a variety of services, we recommend that the Bill be modified so that Monitor should have a duty to: *‘Promote choice and competition where in the public interest; to improve the quality and accessibility of care for patients and value for money for the NHS.’* Consideration should also be given to putting into place a parallel duty to consider the overall care for the patient (that is, both their health and social care), rather than individual components, when considering quality, accessibility and value for money, and the appropriateness of competition and collaboration.

The relationship between the Care Quality Commission (CQC) and Monitor will be critical. Moreover it will be important to ensure congruence between the activities of the NHS Commissioning Board with regard to quality, particularly within its outcomes framework, and the duties of the economic and quality regulators. Whilst CQC will have a role in basic authorisation/registration for care providers, in order to avoid the sort of problems highlighted in previous Commission for Health Improvement and Healthcare Commission investigations, they must also be alive to serious lapses in quality of care. The ability to undertake such surveillance will be a key concern and any actions must dovetail with those of the economic regulator.

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Competition on the basis of the price of health care

The evidence on competition shows that competition with fixed prices above marginal costs can improve quality for at least some services, but that the experience of competition where organisations compete on prices is that quality suffers. The Nuffield Trust has argued that prices for care should be situated within a fixed, national tariff. We welcome the Government’s decision to remove the right of Monitor to set maximum prices, as well as the more restrictive approach to price competition set out in the Payment by Results Guidance (DH 2011) under which SHAs must now approve any proposals to set prices below the mandatory tariff following agreement by commissioners and providers. However, if local flexibility in prices (from the national tariff) is to be allowed even in these limited circumstances, studying the extent of these practices and the quality of services in the places where prices are lower, should be made a priority. This could be a key duty for Monitor.

Clarifying the implications of competition law

Most of the concerns about Monitor (and Part 3 of the Bill as a whole) flow from the debate about whether the Bill would extend EU Competition Law to the NHS. Monitor’s Memorandum to the Health and Social Care Public Bill Committee clarified its reading of the position:

“The Health and Social Care Bill does not change the way in which UK competition law (and, therefore EU competition law, since this is reflected in UK law) applies to healthcare providers. What it does is to give Monitor the same powers as the OFT already has in relation to publicly and privately funded health care (Monitor 2011b).”

Our understanding from the proceedings at the Bill’s committee stage is that EU competition rules apply where the bodies involved are ‘undertakings’ (these can be individuals, partnerships, charities, social enterprises and government departments or agencies – the key to determining whether a body is an undertaking is whether the body is engaged in ‘economic’ activity although it is not clear whether the degree of economic activity plays a role, for example public hospitals which also cater to privately-funded patients). Organisations that fulfil a social function do not fall within this definition and

the Government's view is that this applies to "90 per cent of the healthcare provision [which] has been delivered by public providers fulfilling a largely social function" (Burns 2011, c718). This explanation is however only partly satisfactory and there is a strong argument to be made that the DH should make more public the legal advice it has received on what the implications are following the overall changes to the NHS envisaged in the Bill. In particular the Government accepts that UK and EU competition will become increasingly applicable as trusts and other providers (including GP practices) begin to compete actively with private and third sector providers for contracts (c718). Greater clarity around what this means for tendering in cases where a consortium (which as purchasers of health care for the public good will be deemed not to be acting as undertakings) hopes to develop extended services through its constituent member practices (which will be so deemed), may be needed.

Any Willing Provider and new provider models

Extending the model of joint accountability between Monitor and the NHS Commissioning Board further, to determine where different models of competition and collaboration are used and encouraged, might help to address some of the issues such as those raised above. The Bill should include a requirement for the NHS Commissioning Board and Monitor to agree a set of principles and rules for competition and collaboration. Crucially these principles and rules should set out the planned scope of Any Willing Provider and competitive tendering assessed against the public interest test that Monitor should arguably be obliged to meet (see above). These rules, especially if made more specific than the 2009 statement on competition and collaboration, should provide greater clarity and certainty for commissioners and providers.

To remain current, the rules should be subject to formal review at least every three or five years and there should be a requirement for widespread consultation. Ideally they should build on the Vertical Agreements Block Exemption provisions in EU competition law within Article 101 (which covers restrictive agreements) that applies to agreements entered into by two or more organisations operating at different levels along the production chain. Almost all such agreements are exempted provided that the market share of the parties is less than 30 per cent. The rules should also build on the experience of US regulators in proactively establishing examples of permitted models of competition and collaboration in so-called 'safe harbours,' especially if the market share was greater than 30 per cent.

Setting the price that the NHS pays for care

Given the acute financial pressures on the NHS, and the policy to move over time to paying increasingly specific prices for separate elements of care (the 'unbundling of tariffs'), the task to ensure that the regulated price is at an appropriate level will become far more complex and politically fraught. It will also require a great deal of accurate information on costs. Developing the policy on regulated prices in the NHS will require close collaboration between Monitor, which will set prices, and the NHS Commissioning Board, which will design the structure of pricing (that is, decide the type of services for which the national tariff would apply) and then enforce them through contracts. There is a strong argument for Monitor and the NHS Commissioning Board to agree and publish a pricing strategy for NHS-funded care – alongside the rules and principles to show how pricing will support these new models. This would give organisations some clarity about the financial operating environment and reduce the risk to organisations seeking to build new pathways from and into primary care. It would also have the added benefit of helping

to clarify how the tariff would be extended to some more specialised complex acute work and also to community and other services that are not currently covered.

Conclusion

There is a considerable logic to many parts of the Government's NHS reform programme. Clinicians are already in effect responsible for most NHS expenditure through their referral decisions and it makes sense that they be given the chance to more actively shape the patterns of care. Similarly, there is an encouraging (although far from complete) evidence base behind the emphasis on competition, patient choice, better contracting and public reporting of outcomes.

However, many of the proposals in the Bill had their genesis during a period of major funding growth for the NHS (Conservative Party 2007, 2008a, 2008b). The financial picture as outlined here and in previous Nuffield Trust reports is now very different and this appears to have had a major bearing on recent debates. Whether it be in relation to the question of placing £60bn into the hands of under-developed consortia, abolishing SHAs and PCTs, the lack of clarity around how financially distressed trusts will be dealt with, or the supposedly looming threat of 'privatisation', the common thread to most substantive criticisms is that the public's investment in the service is being put at risk.



Structural reform of the NHS as proposed in the Bill – however well designed – will not make a major contribution to this immediate financial challenge

On the Bill, our calculation is that it would be less risky to move ahead, in a broad sense, with the changes to the commissioning landscape than to halt progress now that the reorganisation has begun. Further uncertainty would likely have a demoralising effect on clinical and managerial staff and make it more difficult for providers to get on with the urgent business of moving their patterns and structures of care onto a more sustainable footing, while meeting the expectations around finance, service quality and outcomes set out in the 2011/12 NHS Operating Framework (Smith and Charlesworth 2011).

But simultaneously, the Government needs to craft a much more compelling and credible narrative for how it plans to help keep the service on the rails (in terms of quality of care for patients and financial control) during what we are calling phase 1. Structural reform of the NHS as proposed in the Bill – however well designed – will not make a major contribution to this immediate financial challenge and this needs to be acknowledged. A modified plan must involve adjustments to the reform timetable (on both the commissioner and provider sides) to a more sustainable pace and establishing effective interim safety mechanisms. The overall approach needed may be a transition period (phase 1) when there is much greater managerial grip in the system to create stability, which at the same time encourages (in part through amendments to the Bill) what we are calling a phase 2 reform agenda that includes greater levels of competition where this can be shown to improve the quality and efficiency of care, and new commissioner–provider models that better suit local population needs.

References

- Audit Commission (2006) *Learning Lessons from Financial Failure in the NHS*.
- Audit Commission (2009) *More For Less: Are Productivity and Efficiency Improving in the NHS?*
- Bennett D (2011) in Timmins N 'PM vows to stop 'cherry picking' of the NHS', *Financial Times*, May 16.
- Burns S (2011) *Public Bill Committee Debate*. PBC Deb 15 March 2011 cc718–766.
- Conservative Party (2007) *NHS Autonomy and Accountability: Proposals for legislation*.
- Conservative Party (2008a) *Renewal: Plan for a better NHS*.
- Conservative Party (2008b) *Delivering some of the best health in Europe: Outcomes not targets*.
- Department of Health (2010) *Liberating the NHS: Legislative Framework and next steps*.
- Department of Health (2011) *Payment by Results Guidance for 2011–2*.
- Dickinson H, Peck E and Smith JS (2006) *Leadership in Organisational Transition: What can we learn from the evidence?* Health Services Management Centre and NHS Institute for Innovation and Improvement.
- Dixon J (2010) *Making progress on efficiency in the NHS in England: Options for system reform*. London: Nuffield Trust.
- Dixon J (2011) *Evidence to Public Bill Committee*. PBC Deb 08 Feb 2011 c 21.
- Ham C and Smith JA (2010) *Removing the Policy Barriers to Integrated Care*. London: Nuffield Trust.
- Ham C, Imison C, Goodwin N, Dixon A and South P (2011) *Where Next for the NHS reforms: The case for integrated care*. London: The King's Fund.
- Ham C, Smith JA and Eastmure E (forthcoming) *Commissioning Integrated Care in a Liberated NHS*. London: Nuffield Trust.
- Health Committee (2010) *Commissioning. Fourth report of session 2009–10*. London: House of Commons.
- Health Committee (2011a) *Commissioning: Third report of session 2010–2011*. London: House of Commons.
- Health Committee (2011b) *Commissioning: further issues. Fifth report of session 2010–11*. London: House of Commons.
- Health Services Restructuring Commission (2000) *Looking Back, Looking Forward: The Ontario Health Services Restructuring Commission (1996-2000); a legacy report*.
- Iglehart JK (2010) 'Assessing an ACO Prototype – Medicare's Physician Group Practice Demonstration', *Perspective*. New England Journal of Medicine Online, December.
- Lewis RQ, Rosen R, Goodwin N and Dixon J (2010) *Where Next for Integrated Care Organisations in the English NHS?* London: Nuffield Trust.
- Marks ML (1997) 'Consulting in mergers and acquisitions: interventions spawned by recent trends', *Journal of Organisational Change* 10, 267–279.
- Monitor (2011a) *NHS Foundation Trusts: Review of nine months to 31 December 2010*.
- Monitor (2011b) *Memorandum submitted by Monitor*.
- Nuffield Trust (2010a) *NHS Resources and Reform: Response to the White Paper Equity and Excellence: Liberating the NHS, and the 2010 Spending Review*.
- Nuffield Trust (2010b) *The Coalition Government's NHS reforms: an assessment of the White Paper*.
- Rosen R, Mountford J, Lewis G, Lewis R, Shand J and Shaw S (forthcoming) *Integration in Action: Four international case studies*. London: Nuffield Trust.
- Royal College of General Practitioners (2011) *The Government's Health Reforms: An analysis of the need for clarification and change*.
- Smith JA, Curry N, Mays N and Dixon J (2010) *Where Next for Commissioning in the English NHS?* London: Nuffield Trust and The King's Fund.
- Smith JA and Charlesworth A (2011) *NHS Reforms in England: Managing the transition*. London: Nuffield Trust.
- Tetenbaum TJ (1999) 'Beating the odds of merger and acquisition failure: seven key practices that improve the chance for expected integration synergies', *Organisational Dynamics*, Autumn, 22–36.
- Thorlby R, Rosen R and Smith JA (2011) *GP Commissioning: Insights from medical groups in the United States*. London: Nuffield Trust.

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