Parliamentary briefing

Health and Social Care Bill: Commons' consideration of Lords amendments

This briefing focuses on several major amendments agreed during the Lords' report stage relating to ministerial responsibility for the NHS, economic regulation and CCG conflicts of interest. Looking ahead to the Bill becoming law, it restricts itself to questions of implementation. As the briefing was written shortly before Lords' Third Reading it excludes any amendments that may have been tabled following the Liberal Democrats' Spring Conference.

Key Points

- The original Bill aimed to limit the ability of the Secretary of State to interfere in the running of the NHS. Giving local NHS bodies more autonomy is an important goal but should not be at the expense of accountability, particularly of ministers to Parliament. We therefore welcome the amendments to Clauses 1 and 4 which clarify Ministerial accountability and responsibility, but we would emphasise that the challenge of reducing Whitehall's attempts to control the NHS in the future is as much cultural as legal.
- Lord Hennessy's amendments tethering the Constitution to the work of national and local bodies are logical insofar as the Constitutional principles command widespread support. But it should be noted some of the pledges have the potential to affect local commissioning activity in a very direct way, such as the guarantees around maximum waiting times and access to NICE-approved treatments.
- Given the enhanced role of the Constitution in the future, it is important that it remains a living document and that patients, carers and professionals have a voice in shaping it. The forthcoming review of the Constitution will need to strike the right balance between providing a robust national

framework of service assurances and respecting local commissioners' freedom to act.

- Amendments to Monitor's role to enable integration through its licensing functions (clause 87) are a useful clarification of the regulator's powers to encourage better coordination of services. However, much of the behaviour of providers will in practice be shaped by detailed guidance and the work on pricing conducted by both Monitor and the NHS Commissioning Board. The two organisations have a major task ahead of them to ensure there is the necessary information, data exchange, contracting and payment tools to support patient choice, integrated care, efficiency and quality.
- The amendments to clause 111, which extend Monitor's scrutiny powers over Foundation Trusts, must not stifle local NHS providers in their efforts to innovate. The amendments to clause 111 have the potential to reinforce the tendency in the NHS for boards to look 'upwards' continually to their regulators, at the expense of thinking creatively about how to best meet the needs of their communities. Monitor will need to adopt a sufficiently nuanced approach to discourage this.
- The success of the failure regime will in no small part depend on how the Department of Health manages the new operationally independent banking function. The intention is for the bank to take responsibility for all new public lending to FTs, imbuing the process with greater transparency and commercial rigour. Loans would only be made where there is an expectation of repayment in line with the agreed terms.
- A more independent financing facility potentially encourages FTs to tackle problems at an early stage. However the lack of detail from the Government on their plans to date, particularly in relation to the scrutiny and accountability of this function, would seem to represent a serious omission.
- GPs face inherent conflicts of interest when deciding whether to "make or buy" local health services that can be provided by general practice, in which they may have a personal financial interest. Baroness Barker's amendments are the latest in a now long line of amendments designed to strengthen the governance of Clinical Commissioning Groups. We support them in principle, but an emphasis on robust governance must not generate unintended consequences such as an unwarranted use of tendering, which could be costly and time consuming. Commissioners need to be properly supported by clear, official guidance on how to manage procurement in a proportionate way.

Introduction

While it did not appeal to all stakeholders across the NHS, the original Bill contained 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. 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.

The Bill that returns to the Commons is quite different. Building on the considerable changes voted in by MPs at Report Stage, the Lords amendments offer an alternative vision of public sector reform. There is now a stronger emphasis on statutory structures to deliver accountability for public funds and an emphasis on collaboration and integration alongside competition.

Such amendments have not fully assuaged all critics, and some still argue that the legislation ought to be scrapped. Our view is that while the case for such a comprehensive Bill was weak given the financial challenges facing the NHS it is preferable that there be a resolution in the interests of providing the system with stability. The challenge for the NHS going forward is to develop a shared vision for how to drive improvement, efficiency and innovation, within the framework of the new Act.

Secretary of State's duties

Government amendments to clause 1 and 4: stipulate that the Secretary of State retains ministerial responsibility to Parliament for the provision of the health service in England

Reducing ministerial 'micromanagement' was a key aim of the White Paper.[i] Understandably this led to questions about whether clause 1 would weaken the link between the country's largest single public service and democratic politics.[ii]

In an earlier briefing we argued that Whitehall and Westminster's often decisive influence over local NHS decision making is more a cultural than legal phenomenon, reflecting the political and social significance of the health service.[iii] Politicians' desire to control and 'interfere' with the NHS derives from public expectations, particularly when service failures become apparent.

As such we interpret the amendment as ensuring that the law better reflects the sharing of responsibilities in practice.[iv] Ministers will account to parliamentary colleagues and voters for the provision and performance of NHS services whilst legal responsibility will rest with the organisations tasked with commissioning and providing health care services.

Government amendment to clause 4: clarifies that in the event of a conflict between the Secretary of State's duties with regard to the promotion of autonomy and the promotion of the health service, the latter takes precedence.

This should be read alongside Lord Marks of Henley-on-Thames' amendment to clause 22 which clarifies the Secretary of State's powers of intervention over the NHS Commissioning Board if it were to fail to discharge its duties. Details on the types of failure that would trigger ministerial interventions are sketchy, but collectively the amendments emphasise that the new bodies created by the Bill will have a degree of democratic oversight. We welcome this clarification.

The NHS Commissioning Board will play a pivotal role in allocating resources, designing service standards, and holding clinical commissioning groups to account against the NHS Outcomes Framework and the rolling re-authorisation process. Monitor, as the economic regulator, will likewise wield considerable powers of oversight and compulsion.

We have pointed out that earlier versions of the Bill seemed to merely shift power sideways from the Secretary of State to national arms length bodies, rather than sufficiently downwards to the new CCGs which, particularly following the Future Forum amendments, could be said to sit within a comparatively robust framework of professional and public accountabilities. These new amendments may help to address concerns about the potential accountability gap of these national bodies.

What is still less clear however is whether the Bill will do much to practically minimise the political tension that can build up when local decisions conflict with a national consensus about what the NHS should be providing (see below).

Lord Hennessy of Nympsfield's amendment introducing a new clause: imposes a duty on the Secretary of State to have regard to the NHS Constitution when exercising his functions.

Currently decisions about what services the NHS should pay for (what could be called the 'NHS benefits package') are arrived at implicitly, as a result of decisions made by national, regional and local decision makers, working within a context of laws, duties, policies, budgets and financial incentives that change over time.

Embedding the NHS Constitution within the final Act is meant to reassure those who worry that the legislation undermines the NHS' commitment to provide a comprehensive, universal service, particularly in the context of squeezed budgets and the introduction of a more robust failure regime that could (in cases of profound financial distress) designate only some services as essential.[v]

The consequent amendments tethering the Constitution to the work of national and local bodies are logical insofar as the principles on which the Constitution is based command widespread support. However several of the pledges, such as the guarantees around maximum waiting times and access to NICE-approved treatments, have the potential to affect local commissioning decisions. The document is also less precise on the question of how *local* decisions should be made so as to command public legitimacy.[vi]

We note that a review is underway to measure the effect of the Constitution during its first three years of operation, as a foreword to a planned consultation on how the document can be strengthened.[vii] We welcome this. Given its potential importance it is appropriate that the Constitution remain a living document that is regularly shaped by patients, carers and professionals. It will be important to find a balance between providing a robust national framework of access and quality of services and respecting commissioners' freedom to act.

Monitor's regulatory powers

Government amendments to clause 87: create new powers for Monitor to set license conditions to enable the integration of services

Clause 61 already requires Monitor to exercise its functions with a view to enabling integration. Amendments to Monitor's role to enable integration through its licensing functions (clause 87) are a useful clarification of the regulator's powers to set and enforce licence conditions for the purposes of enabling integration and co-operation between healthcare providers. Consultation documents issued

by Monitor imply strongly that they will build on the obligations providers already face through the Principles and Rules of Cooperation and Competition.[viii]

However, much of the behaviour of providers will in practice be shaped by detailed guidance rather than the content of license conditions. In addition, the detail of pricing structures being developed by both Monitor and the NHS Commissioning Board will also be an important tool to enable new ways of working across organizations. Both Monitor and the NCB have a major task ahead of them to ensure there are the necessary information, data exchange, contracting and payment tools to support patient choice, integrated care, efficiency and quality. At present this work is fragmented (we have previously recommend that they develop a joint pricing strategy) whilst providers of services not yet subject to a national tariff have made insufficient progress establishing the actual costs of their services.[ix]

Government amendments to clause 111: clarify Monitor's enduring powers to require a foundation trust to remove directors or governors in cases of serious license condition breaches, and enable Monitor to retain its transitional powers to suspend directors and governors directly, unless instructed to relinquish the powers by the Secretary of State.

From the standpoint of public accountability, it is important that Monitor's scrutiny and surveillance powers over Foundation Trusts are extensive and durable. But to free local NHS providers to innovate, Monitor's role (and equally the NHS Commissioning Board's role in relation to CCGs) must avoid dominating the agendas of managers and governing bodies. The new amendments have the potential to reinforce the tendency in the NHS for boards to look 'upwards' continually to their regulators, at the expense of thinking creatively about how to best meet the requirements of their communities. Monitor will need to adopt a sufficiently nuanced approach to regulation in order to discourage this.

Lord Warner's insertion of new clauses: provide for Monitor to notify commissioners if it considers that the continuation of health services is imperiled by the way services are configured, and permits Monitor to assess whether applications to secure price adjustments is driven by sub-optimal service configuration that needs addressing.

It has often proved difficult to secure political agreement over major changes to local services. Reforms are often blocked for a range of reasons, which has an opportunity cost in terms of the quality and efficiency of services. Local service changes are complex decisions for which securing a mandate requires significant political skills, in particular full engagement with local communities, good communication with staff, clinical support, the provision of rigorous, publicly available information and analysis upon which to base decisions, and clear pre-agreed criteria for taking them.

Lord Warner's amendments, developed with the King's Fund, aim to facilitate this process by a) essentially giving Monitor a specific role supporting commissioners to build the case for reconfiguration where appropriate and b) making cross subsidies between correctly and incorrectly configured health economies less automatic.[x] We strongly support the aims of both amendments. However, given the scale of the challenges relating to local service changes, the impact of these amendments should be kept under active review.

We also note that a standard policy response to under-performing hospitals is 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.[xi] Commissioners and the regulator need to accurately diagnose the underlying problem, whether it is poor-quality management or more intractable issues relating to excess capacity and changing patterns of patient demand before settling on a way forward.

The strengthened failure regime, if implemented correctly, should encourage local bodies to investigate more deeply the sources of financial distress. However it will take time for this regime to develop, with success in no small part depending on how the Department of Health manages the new operationally independent banking function. The intention is for the bank to take responsibility for all new public lending to FTs, imbuing the process with greater transparency and commercial rigour.[xii] Loans would only be made where there is an expectation of repayment in line with the agreed terms.

We support the principle of a more independent financing facility as it potentially encourages FTs to tackle problems at an early stage. However the lack of detail from the Government on their plans to date, particularly in relation to the scrutiny and accountability of this function, would seem to represent a serious omission.

Clinical Commissioning Groups' conflict of interests

Baroness Barker's amendments to clause 24: require a register of interests for members of the CCG, its governing body, its sub-committees and its employees.

Reviews of GP-led commissioning reveal that while GP commissioners start with a strong desire to form nimble clinically focused organisations, they are usually rushed by policy makers into becoming larger statutory bodies with wide ranging responsibilities that are then deemed bureaucratic and distant from local professionals.[xiii]

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. This implies a mixture of commissioning and provision with GPs who commission likely needing to expand their own and other community services.[xiv]

However GPs face inherent conflicts of interest when deciding whether to "make or buy" local health services that can be provided by general practice services in which they have personal financial interests. Baroness Barker's amendments are the latest in a now long line of amendments designed to strengthen the governance of the CCGs. We support them in principle but it is crucial to craft a set of rules that allow GPs to innovate at the same time as delivering accountability. Otherwise the NHS risks losing out on systemic efficiency gains.

Commissioners need to be properly supported by clear, official guidance on how to manage procurement. Recent proposals from the 'Commission on Competition' (such as requiring commissioners to publish their justifications for not introducing competition for some services) could be useful in this respect.[xv]

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[i] DH (2010) *Equity and Excellence: Liberating the NHS*. London

[ii] Official Report, Health and Social Care Public Bill Committee, 15th February 2011, c225

[iii] Nuffield Trust (2011) *Memorandum to the Public Bill Committee for the Health and Social Care Bill.* London

[iv] Official Report, HL Deb 8 February 2012, c307

[v] At the urging of the NHS Future Forum, the Government also introduced new duties for commissioners to promote the rights of patients as set out in the NHS Constitution during the Bill's recommital.

[vi] Rumbold et al (2012) *Rationing health care: Is it time to set out more clearly what is funded by the NHS*. London: Nuffield Trust

[vii] Department of Health (2012). *Press Release March 08: Government announces independent group to look at impact of NHS Constitution*. London

[viii] Monitor (2012) *Developing the Competition Oversight and Integrated Care license conditions: stakeholder engagement document (tranche 2)*. London

[ix] Audit Commission (2011) *Improving Coding, Costing and Commissioning*. London

[x] Nuffield Trust (2011) *The Health and Social Care Bill: Where next?* London

[xi] Gaynor M, Laudicella M and Propper C *Can governments do it better? Merger mania and hospital outcomes in the English NHS* CMP Working Paper No. 12/281 January 2012

[xii] DH (2011) *Liberating the NHS: Legislative framework and next steps*. London

[xiii] Smith, JA and Mays N (2012) GP led commissioning: time for a cool appraisal. BMJ 2012;344:e980

[xiv] Lewis RQ, Rosen R, Goodwin N, Dixon J (2010) Where Next for Integrated Care Organisations in the English NHS? Nuffield Trust.

[xv] OHE (2012) *Report of the OHE Commission on Competition in the NHS*. London