RCGP Briefing Paper

6th February 2012

The Health and Social Care Bill
House of Lords Report Stage Briefing

Royal College of General Practitioners

INTRODUCTION

The RCGP wrote last week to the Prime Minister calling for the wholesale withdrawal of the Health and Social Care Bill. This decision has been made following careful consideration of the amendments to the Bill published by the Government on 1st February 2012, and subsequent responses we have now received from Ministers following our requests for clarification on our concerns.

The College has consistently said that we support the principle of greater involvement of clinicians in designing and shaping services to meet the needs of their local population. However, this does not necessitate the sweeping structural changes in England that would be introduced by the Health and Social Care Bill.

The following briefing sets out why the RCGP believes the Bill should be withdrawn and the alternative approach that we believe must be taken. Whilst it is the College's firm view that the best outcome for patients would be the complete withdrawal of the Bill, we have outlined below those areas where amendments would best mitigate the potential harmful effects of the Bill should it complete its passage through Parliament.

1. RCGP POSITION ON THE HEALTH AND SOCIAL CARE BILL

1.1 Background

The Royal College of GPs believes that the founding principles of a universal, national health service, free for all and based on need will be put at serious risk if the Health and Social Care Bill is passed.

While much effort on the part of a number of individuals and organisations has succeeded in securing some concessions regarding the Bill, these have failed to satisfy the concerns that the College has consistently raised. The numerous amendments have actually made the Bill more complex, contradictory, and more confusing for professionals and patients alike.

Thousands of GPs across the country have repeatedly made their views clear on the Bill in response to our consultations, formal Council debates, and membership surveys. The views of members indicate very consistent support for GP leadership but scepticism about the overall impacts of the Bill. The most recent survey found that 90% of respondents said they would support or strongly support the College if it called for full withdrawal of the Bill.

Furthermore, the tension between the NHS trying to implement large-scale efficiency savings and at the same time trying to implement sweeping structural reforms is producing a significant fault line in the NHS and impacting on quality, access, cohesion of services and morale amongst staff. This has been echoed in the recent report by the House of Commons Health Select Committee that concluded that the reorganisation is creating disruption and distraction and is complicating the push for efficiency gains[1].

We have identified three key areas in which the Bill will have a harmful impact on patient care - the changes contained in the Bill in relation to the responsibilities of the Secretary of State to provide a comprehensive health service; the role of competition in the NHS and the impact on achieving more integrated services; and the sweeping changes proposed to medical education and training.

1.2 The Secretary of State's accountability for the NHS

The College has called on the Government to retain the existing duty of the Secretary of State to provide, or secure the provision of, a comprehensive health service throughout England. The Government's proposals – including the latest tabled amendments – do not deliver this.

Clause 1 of the Bill proposes to change section 1(2) of the 2006 National Health Service Act, meaning that the Secretary of State would no longer have a duty to provide or to secure provision of services in accordance with the Act. The College has continually expressed concerns that this risks undermining the universality of the NHS and increasing inequalities of provision. The House of Lords Constitution Committee echoed these concerns in a report published in September 2011.

The Government has responded to this by supporting an amendment to Clause 1 to make it clear that the Secretary of State retains ministerial responsibility to Parliament. However, although the College agrees that this ministerial responsibility should be maintained, neither the Constitution Committee nor the Government's amendments adequately retain the legal duty to provide a comprehensive health service.

Furthermore, the Government has not set out a convincing case as to why it is necessary to change the existing duty at all, which would already appear to allow the Secretary of State to use the National Commissioning Board to secure the provision of a comprehensive health service, while retaining the alternate duty of provision. Overall, the Secretary of State's duty to promote a comprehensive health service will be substantially weakened, mediated through a Mandate to the National Commissioning Board, detailed information regarding which has not yet been published.

As well as this, Clause 12 removes the duty of the Secretary of State to provide certain listed services throughout England and replaces it with a duty on Clinical Commissioning Groups (CCGs) to arrange the provision of services that are 'considered necessary' for each group's registered population. Although a new amendment by the Government states that a CCG must 'act consistently' with the discharge by the Secretary of State and the NHS Commissioning Board of their duty to 'promote' a comprehensive health service, this is not a 'duty' and only relates to the duty to 'promote' a comprehensive health service.

1.3 Competition, collaboration and choice

The RCGP believes that competition, when applied appropriately, can bring many benefits to the health service and there are many examples of voluntary and third sector organisations delivering excellent care. However, the proposed introduction of 'any qualified provider' and the functions of Monitor in relation to competition risk opening the health service to increasing fragmentation at a time when providing more integrated services should be prioritised.

[1] House of Commons Select Committee 13th Report of Session 2010-12, Public Expenditure
http://www.publications.parliament.uk/pa/cm201012/cmselect/cmhealth/1499/1499.pdf

The College has called on the Government to clarify on the face of the Bill that commissioners will not be required to open up services to competition unless it can be demonstrated that this would be in patients' best interests.

In addition, we have expressed concerns that the application of competition rules will inhibit the integration of care, by deterring collaboration between providers.

While the Government has tabled amendments to the provisions of the Bill relating to competition, these fall substantially short of addressing the College's concerns:

- Clause 73 of the Bill provides the power to make regulations imposing requirements on the NHS Commissioning Board and commissioners regarding good practice in procurement, promoting patient choice, and preventing anti-competitive conduct. Responsibility for enforcing these regulations will rest with Monitor. The Government has stated that its intention is that regulations made under Clause 73 will give commissioners a full spectrum of options, and will not set a presumption either way that services should be open to competition or not. Critically, however, these regulations have yet to be laid, and could be subject to future change. Furthermore, decisions taken by commissioners not to apply competition could be subject to challenge by Monitor on the grounds that they are not in patients' best interests.

- The Government has welcomed the NHS Future Forum's recommendation that Monitor and the NHS Commissioning Board should urgently support commissioners and providers to understand how competition, choice and integration can work together, but to date no such clarification has been given. It is vital this is done ahead of the Bill being enacted.

- In Clause 97 of the Bill, the Government has tabled amendments to give Monitor the power to set and enforce license conditions for the purposes of enabling integration and enabling cooperation. This is welcome, and addresses the concern previously voiced by the College that the new duty on Monitor to promote integration, introduced following the "pause" had no regulations or powers to back it up. Despite this, it remains open to Monitor to rule that the integration of services raises competition concerns.

- Monitor also retains sweeping pro-competition powers, including concurrent powers with the Office of Fair Trade under the Competition Act 1998 and Enterprise 2002.

The Dutch system provides a useful practical example of how the imposition of a competition regulator such as Monitor affects health care provision. The Dutch GP association, a national body, has been recently fined 7.7 million Euros (£6.4 million) for a "bad case of anti-competitive behaviour" for working to ensure that all areas of the country were adequately provided with GP services.[2]

As well as these problems of enforcing competition, the College is concerned that CCGs will be able to outsource the majority of their commissioning functions to private providers and that this risks undermining them, rather than empowering them. We understand that across the country this outsourcing is already beginning to happen.

The College is also concerned that the proposed increase in income from private patients that Foundation Trusts will be able to generate, from around 2% now to 49% if the Bill is enacted, will lead to soaring waiting lists for NHS patients.

[2] Sheldon T. Dutch GP association is fined 7.7m for anticompetitive behaviour. BMJ 2012;344:e439 http://www.bmj.com/content/344/bmj.e439?view=long&pmid=22250223

1.4 Education and training

Professional leadership in medical education, based on co-operation between the medical Royal Colleges and deaneries, is currently very strong and cohesive, and devolving responsibilities to 'provider skills networks', risks seriously weakening this.

The College has argued that in the long-term this new system will not have the appropriate incentives for service providers – especially under the policy of Any Qualified Provider – to provide the appropriate number and mix of training placements. In addition, with the proposed dissolution of deaneries, future arrangements for ensuring the consistency and quality assurance of post graduate training provision and retaining the ability to address needs and issues on a nationwide basis remain ambiguous.

To address this, the College has said that the NHS Commissioning Board must have a duty in respect of education and training, and that as part of this it should be required to consult Health Education England. In addition, we have proposed that Health Education England, as part of its responsibility to ensure oversight of workforce planning, education and training in the NHS, should be given the power to specify minimum numbers of training placements that providers of care must adhere to.

Although the Government has tabled amendments to place a duty on the NHS Commissioning Board and CCGs to have 'regard to the need' to promote education, there still remains a fundamental lack of levers to ensure that employers provide an adequate volume of training placements of appropriate nature and consistent quality, particularly on the part of Health Education England.

The Government's response to the Future Forum's workstream on education and training stated that HEE is expected to need to intervene directly in the decision-making of Local Education and Training Boards only in exceptional circumstances, specifically where there is evidence that local plans and delivery look likely to lead to a shortfall in an important part of the professional workforce. There are however, no provisions within the Bill for this and this intervention would apply only to LETBs and not to providers. Furthermore, even if such interventions are now added to the Bill they would be retrospective in impact and so would not prevent short-term problems.

2. THE RCGP's PROPOSED ALTERNATIVE

Rather than pressing ahead with a failed Bill, the RCGP believes an alternative way forward is needed that promotes clinicians' involvement in shaping and designing services to meet the needs of patients and communities within a financial envelope whilst protecting the foundations of the NHS. The following recommendations would ensure stability within the NHS whilst implementing reforms to meet the major challenges it faces. This approach is based on acknowledging the positive role that clinicians can play in commissioning, whilst ensuring that the NHS is in a position to deliver efficiency savings in a way that safeguards patients' safety, quality and the relationship between doctors and patients.

2.1 Area Based Commissioning

The RCGP recommends that PCT clusters should be maintained, with a lay chair and a majority of clinicians on the board. This would enable strategic commissioning on the basis of large, geographically aligned, contiguous populations, and would ensure that organisational memory is retained. To ensure that local geography is reflected and to achieve local sensitivity, sub-committees can be formed as necessary with PCTs incorporating CCGs where appropriate.

Choosing this route, rather than pursuing the roll-out of largely unviable CCGs, which will not have the financial muscle to do the job as well as the NHS deserves, is the best way of ensuring managerial stability whilst allowing GP clinical leadership and patient empowerment.

2.2 Co-operation between providers over competition

We want the NHS to innovate and deliver the services patients want and need. Competition has a role to play at the margins where it can be proven to enhance care for patients, but it is not a solution to many of the challenges that face the NHS. We would see a role for competition primarily where existing services are poorly performing, expensive, or do not meet patients' needs, or where there are credible alternative providers that can offer better value for money.

However, key to improving the quality of services is the ability of clinicians and healthcare providers to collaborate across organisational boundaries. Evidence shows that collaboration between clinicians can improve coordination and quality of care and reduce costs and error. The most cost-effective approaches are those which use good data to identify the patients most at risk of deterioration, which actively reach out to help these patients, and effectively coordinate the right type of care and self-care services.

GPs must be allowed to continue to have close working relationships with their local hospitals so that repeat investigations and unnecessary referrals are reduced.

2.3 Reforming payment incentives

The system of payment by results currently used within NHS for the reimbursement of secondary providers creates perverse incentives, discouraging attempts to transfer more care into the community and undermining integration.

An urgent review of the payment by results system in England is required, to identify ways of tackling this problem. Financial mechanisms must be found to encourage acute providers to provide specialist support to GPs and to work alongside them to move more services out of the hospital and into the community.

2.4 Integrating care

We believe that the best way forward is to develop integrated working for patients with complex co-morbidities or chronic long term conditions, who are often the most vulnerable. Integrated working

should be primary care led, based on shared working, across professional boundaries, including health and social care, but maintaining professional autonomy.

2.5 Investment in Primary Care

General practitioners are central to finding innovative solutions to their patients' needs. Many of the advances in NHS practice have been driven by GPs - for example the use of IT in practice and the development of shared care services.

With the rise in long-term and complex conditions, increased flexible working patterns (linked to the increased number of GPs working part-time) and the shift to the provision of more care in the community, we need more GPs with the ability to spend more time with their patients. This would have the additional benefit of realising cost savings by facilitating earlier interventions, reducing referrals and the number of patients receiving on-going secondary care and addressing long-term conditions and multiple-morbidity more efficiently.

The College is currently putting forward the case to extend and enhance GP training to ensure that new GPs have the skills and confidence they need to deliver the health service of the future.

2.6 Federations

As well as appropriate numbers of GPs, new models of working must be developed to enable GP practices to join together to design, plan and deliver primary care.

The College has consistently promoted the Federation model of working as one of the best ways of achieving this. Federations allow groups of GP practices to work together to design, plan and deliver primary care and to offer patients access to a broader range of services outside the hospital setting. Further information:
http://www.rcgp.org.uk/pdf/Primary%20Care%20Federations%20document.pdf

2.7 Preserving practice boundaries

Practice boundaries are a vital tool to allow GPs to see their patients in their homes, keep track of vulnerable patients, control demand and work with other local services.

A geographically defined GP practice area also underpins joint working with other specialised health services such as mental health, midwifery, health visiting and district nursing, as well as with local authorities to coordinate social care and public health.

If GPs are to continue providing high quality care at the heart of communities, with accessible primary care services close to home and through health and social care working together, then practice boundaries must be preserved.

2.8 The future

- The College remains convinced that there must be a move towards community-based, integrated solutions to the major challenges facing the health service.

- Over the longer term, it is also important that we work with politicians and the public to determine what the NHS should be providing, how it should be funded and how, over the next decade, we address the big health issues facing our population. In order to create an NHS that is fit for the future, this must include more GPs spending more time with their patients.

3. RCGP VIEW ON AMENDMENTS TO THE BILL

The RCGP is clear in its view that we believe the best way forward for patients lies in withdrawing the Bill and focusing on the measures outlined in Section 2 above.

However, should the Bill complete its passage we believe that amendments in the following areas would help mitigate the impact of the Bill.

3.1 The responsibilities of the Secretary of State

The RCGP believes that for the avoidance of any doubt regarding the responsibility of the Secretary of State to provide or secure a comprehensive health service, Clause 1 of the Bill should return to the original wording in the 2006 National Health Service Act. An amendment to this effect has been tabled by Baroness Thornton.

3.2 Competition, collaboration and choice

The RCGP believes that Chapter 2, Clauses 70-76 of the Bill – which deal with the functions of Monitor in relation to competition – should be dropped in their entirety. This would ensure that Monitor is not given powers to take action against providers for taking part in so-called anti-competitive behaviour – a measure which, in the College's view, would have a potentially very damaging impact on the integration of services. Removing these Clauses would also ensure that Monitor cannot impose requirements for competitive tendering, which we believe would lead to significant fragmentation without any guarantee that such competition would benefit patients.

In addition, the College supports the amendment proposed by Lord Clement-Jones, Lord Marks of Henley-on-Thames and Baroness Barker, which would introduce a duty of cooperation on CCGs. This would ensure that integration is placed at the heart of commissioning and would have a positive impact on patient care.

3.3 Education and Training

The College supports amendments to strengthen the role of Health Education England (HEE) to ensure that providers of health services in England have due regard to any minimum numbers of training placements that HEE may specify and that there is consistency in quality of training.

The Bill proposes that healthcare providers work together in provider-led networks to manage the planning and commissioning of education and training. However, without strong national oversight of the system, including specification of the minimum number of placements that should be provided in each sector, providers – especially profit-making private providers with shareholders to answer to and an increasing range of competitors – will have little impetus to provide an adequate number of training opportunities in the long-term.

FURTHER INFORMATION

- Further briefing materials on the Health and Social Care Bill from the Royal College of General Practitioners are available on the College's website here: http://www.rcgp.org.uk/policy/health_bill.aspx.

For further information – or for any questions or queries – please contact:

Mark Thomas
Head of Policy and Public Affairs
Tel: 0203 188 7570
Email: mark.thomas@rcgp.org.uk