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The Health and Social Care Bill

Lords Second Reading brief

Royal College of General Practitioners

Health and Social Care Bill Second Reading Briefing – House of Lords

During its passage through the House of Commons there have been a number of amendments to the Health and Social Care Bill which have addressed some of the Royal College of General Practitioners' initial concerns.

We continue to welcome and support putting clinicians at the centre of designing and commissioning services for patients. The increased emphasis on integration is particularly welcomed, as is the strengthened voice of patients.

However, we continue to have a number of serious concerns about the impact that the changes may have on patients and the NHS.

The College is concerned that the continuing emphasis on choice and competition runs a real risk of restraining any real progress in the integration of services to best serve patients.

Along with this, the added tiers of bureaucracy that have been proposed since the 'listening exercise' are likely to further increase the power of the NHS Commissioning Board – and constrain the ability of clinical commissioning groups (CCGs) to lead in the new NHS – unless arrangements are put in place to limit this bureaucracy and define responsibilities and accountabilities.

There are also ongoing issues that have not fully been addressed, including the duty of the Secretary of State which, if not properly resolved, will have far-reaching impacts on the universality of the NHS.

This briefing outlines the College's concerns in detail and calls on Peers to seek clarification on key issues (with a view to seeking possible amendment at a later stage if appropriate). In summary they are:

- **The Secretary of State must remain accountable for a universal National Health Service**

- **Commissioning Groups must be geographically- and population-based and be able to select Board members without the interference of additional bureaucracy**

- **Competition must add value to existing services and an impact assessment on Any Qualified Provider must be carried out before any contract of service is awarded**

- **Commissioning groups must be of sufficient size to allow for re-configuration and strategic planning**

- **An assurance must be given that the formal training of the workforce for the NHS will be strengthened, with the long term future of deaneries secured**

- **The public health function of Local Authorities must be defined**

- **An examination of how health inequalities will be affected, and how duties aimed at reducing them can be strengthened**

Secretary of State's Duty to Provide Health Services

The duty to 'provide or secure provision of medical services' has been placed on the Government since the establishment of the National Health Service in 1948. This duty is underpinned by structures, systems and mechanisms that promote fairness and efficiency in resource allocation. It facilitates planning of services according to geographical healthcare needs through risk pooling and service integration. This duty is repeated in the NHS Acts of 1977 and 2006.

As the Bill currently stands, this duty is replaced with a duty to exercise functions "so as to secure that services are provided in accordance with this Act". As well as this, the duty of the Secretary of State to provide particular services such as hospital accommodation, medical, dental, ophthalmic, nursing and ambulances are all transferred to Clinical Commissioning Groups.

Furthermore, the Explanatory Notes to the Bill state that the amendment to section 1 (2) "reflects the fact that the commissioning and provision of services will no longer be delegated by the Secretary of State, but will be directly conferred on the organisations responsible".

Although the new organisations of the NHS will need operational independence, the Secretary of State must retain the duty to provide these services as part of providing a comprehensive health service so that that ministerial responsibility and legal accountability are maintained.

The College supports amendments that:

- Reinstate the Secretary of State's duty to provide a comprehensive service

Commissioning Structures and Bureaucracy

The Health White Paper outlined the creation of the NHS Commissioning Board as "a lean and expert organisation, free from day-to-day political interference, with a commissioning model that draws from best international practice".

Although not part of the Bill, the proposed introduction of Clinical Senates and Clinical Networks after the 'listening exercise' will further increase the bureaucratic power of the NHS Commissioning Board, and the complexity of the NHS.

In particular, Clinical Senates will be hosted by the NHS Commissioning Board and will have a "formal role" in the authorisation of clinical commissioning groups[1]. There is very little detail about the function and constitution of Clinical Networks and their relationship with commissioning.

As well as this, structures based on PCT clusters will remain in place as "local arms of the NHS Commissioning Board" – even where Clinical Commissioning Groups are ready to take the majority of the budget. Guidance stipulates that PCT clusters should have already "begun ensuring that a clear percentage of budgets are delegated to CCG pathfinders". This rushed implementation is taking place before the Bill has been given assent and risks destabilising CCGs before they are even fully functional.

Under current proposals, Health and Wellbeing Boards, where disputes cannot be settled locally, must refer a commissioning decision to the NHS Commissioning Board. This is a decision that should be referred directly to the Secretary of State, not an additional tier of bureaucracy.

It is therefore hard to see how the NHS Commissioning Board will be "a lean and expert organisation". Furthermore, these changes push the number of statutory bodies to over 500 – before the publication of the White Paper, there were 163.

Commissioning Groups must be given the autonomy and freedom to make the decisions for their population. They must not be left hamstrung by ever-increasing levels of complex bureaucracy which impede decision making without adding clarity and sound evidence for good decisions. This is especially important considering the fact that £20bn must be found in efficiency savings. It is also crucial that they are provided with sufficient resources to enable them to fulfil their functions.

Commissioning Consortia will, by nature, be inexperienced users of external support for commissioning and can learn from PCTs about the challenges that are faced. Although commissioning bodies will not be able to delegate their responsibility for commissioning decisions to private companies, arrangements will need to be put in place so that the management and delivery of these decisions cannot be completely delegated.

The proposed abolition of practice boundaries, at the same time as these CCGs are taking on their duties, will inhibit their ability to commission for their populations. These

[1] Government response to the NHS Future Forum report. June 20 2011
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127719.pdf

boundaries balance national demand and their removal will lead to instabilities for practice and consortia populations.

- Although not directly within the scope of the Bill, the College calls for Clinical Senates to be hosted by CCGs and not the NHS Commissioning Board, to ensure that the former is not merely an extension of the latter. Further clarification is also required on the funding of Clinical Networks.

The College supports amendments that:

- Recognise the autonomy of CCGs in making commissioning decisions for their population
- Enable Health and Wellbeing Boards to refer disputes directly to the Secretary of State
- Prevent the complete delegation of commissioning to private sector organisations

Incompatibility of Integration with Choice and Competition

Integration has been on the NHS agenda for over 50 years and across the UK there are many excellent examples of integrated services. In the context of a universal nationally-funded health service, integration must be about shared working, where different professionals work across professional boundaries whilst maintaining professional independence, pooling resources and ideally with shared, GP held, electronic records.

Although amendments to the Bill after the 'listening exercise' place a new duty on Monitor to exercise its functions with a view to enabling services to be provided in an integrated way, there is a continuing emphasis on choice and competition that runs a risk of inhibiting this. Furthermore, this new duty to promote integration has no definition, regulations or powers to back it up.

Evidence from other countries shows that competition results in fragmentation of services. The organisation and delivery of health care in a nation state is not suited to competitive market mechanisms, as health care is a natural monopoly that requires strategic, regional and local planning. The use of health care is unpredictable and a pooling of risks is necessary to mitigate against this.

Whilst the duty of Monitor to promote competition has been removed, it has been replaced with a new duty of "preventing anti-competitive behaviour" – this may not substantially affect how Monitor carries out its duties. Although this duty is to prevent anti-competitive behaviour where it is not in the interests of patients, neutrality demands that there needs to be a duty to prevent anti-collaborative behaviour which could similarly be against the interests of patients.

Without this, Monitor would remain focused on preventing anti-competitive behaviour where this harms patients but not be concerned with anti-collaborative behaviour. Monitor also retains sweeping pro-competition powers, including concurrent powers with the Office of Fair Trade under the Competition Act 1998 and Enterprise 2002.

Any Qualified Provider will now be implemented in a phased way, but before a contract of service is issued by a Clinical Commissioning Group, an impact assessment must be carried out on the provider's ability to deliver integrated care as well as the impacts on education and training, patient safety, cost and governance. Competition must add value to existing services and should not be pursued as an end in itself.

Under the Bill as it stands, the boundaries of local commissioning consortia should not normally cross those of local authorities, with any departure needing to be clearly justified. However, if there is to be true integration over health and social care, there should be no justification for this departure.

There is a concern that even with a greater emphasis on integration, other mechanisms of the Bill will no longer make it possible to deliver integrated services in practice, especially where there is a reliance on close collaboration between different NHS providers and commissioners, and could be seen as anti-competitive.

The continuing emphasis on choice has a risk of diverting focus away from improving quality, tackling lack of fair access, tackling inequality of outcomes, promoting the application of the fruits of research and enabling integration and coordination.

- The outcomes frameworks for the NHS, public health and social care should be revised to reflect the new emphasis on integration.

The College supports amendments that:

- Classify when collaboration between providers - in the interests of integration – is permissible.
- Place a duty on Monitor to prevent anti-collaborative behaviour
- Specify that CCG boundaries should not cross those of local authorities under any circumstances
- Require an impact assessment to be carried out under Any Qualified Provider before any contract of service is issued by a Clinical Commissioning Group

Failure Regime and Reconfiguration

The new failure regime distinguishes between whether or not the failing provider provides a 'designated service'. Those services that are deemed designated will be afforded protection, whilst those that are not will be treated in the same way as other failing providers. Commissioners will be effectively able to decide which services are designated by applying to Monitor for this definition.

In making these decisions it is important that clinical commissioning groups are not hampered by clinical senates. If CCGs are to follow the advice of clinical senates, it is imperative that these bodies are not dominated by secondary care clinicians. The reconfiguration of secondary care services must not be affected by conflicts of interest and there must be safeguards put in place to ensure that this does not occur.

Similarly, clarity will need to be provided on where the ultimate decision lies for the reconfiguration of services. GPs are likely to come into conflict with their secondary care colleagues in making these decisions but ultimately should not have their hands tied by 'provider capture'.

Commissioning consortia must cover a sufficiently large population to be able to undertake effective strategic planning and re-configuration. While CCGs will not commission the rarest diseases there will still be others which commissioning groups would struggle to provide services for if they are too small.

As well as this, a sufficiently large population would mitigate against the risk of the sudden appearance of patients with conditions requiring expensive treatment and the adverse impact on budgets that this would bring.

GPs are ideally placed to plan health care for their populations and CCGs need to be given the autonomy and power to lead on the reconfiguration of services. The increased bureaucracy created after the listening exercise, risks undermining this ability to lead and to truly innovate services to better meet patients' needs.

The College supports amendments that:

- Define the accountability and authorisation process for the reconfiguration of services
- Require commissioning consortia to cover a minimum level of population

Public Health

Among the amendments announced to the Health Bill regarding public health, Public Health England will become an executive agency, operationally independent from the Department of Health. It is important that in making this distinction, that any risks that public health becomes more distant from mainstream health are mitigated against.

As the majority of public health functions will be moved into local authorities with ring fenced funding, the Bill should clearly state exactly what should be covered by this funding and how much is to be allocated so that Local Authorities devote it all to public health. Well-intended funding has been siphoned off for other purposes on too many occasions in the past.

In previous responses to consultations relating to the Bill, the College has stressed that Consortia will need to be equipped to take on responsibilities for population health through sharing of best practice; and called for a more sophisticated usage of population health data.

To further this, there will need to be a more specific clarification on the working relationship between NHS and public health staff. A definition of the terms of cooperation between these staff will be required along with assurances that commissioners will have access to the public health skills they need. Public health professionals should continue to be appointed via a statutory advisory appointments committee and registered – regardless of background.

- The public health capacity must be enhanced with regards to the training of specialty registrars, particularly in general practice. The extension of GP training will compliment this.

There also needs to be clarification of the roles and responsibilities of various agencies and bodies during public health emergencies. At a local level, it is not clear who will lead on responding to outbreak and emergency situations.

Health and Wellbeing Boards should be able to engage clinical commissioning groups in public health issues but much depends on the willingness and ability of these boards' members to cooperate and coordinate activities. Questions remain over how success in this can be guaranteed.

The College supports amendments that:

- Define which services and budgets lie under public health provision by Local Authorities.
- Specify the terms of cooperation between public health staff, members of Health and Wellbeing Boards and consortia members
- Retain the appointment process for public health professionals via a statutory advisory appointments committee and compulsory registration
- Clarify the roles and responsibilities of various agencies and bodies during public health emergencies

Education and Training

The consultation, *Developing the Healthcare Workforce*, proposed that, rather than deaneries, workforce planning and management functions would be better undertaken by local provider skills networks, taking on deanery functions. Although recognising that the Royal Colleges have an important role to play in devising and delivering education in their specialties, it proposed greater freedom for local education commissioning.

There was also to be a shift from the current training and development funding to a levy-based system with all providers funding the education of their healthcare professionals. A newly formed Health Education England (HEE) would take a strategic overview of the funding priorities.

Following concerns raised during the 'listening exercise' the Department of Health has now promised that it will ensure a "safe and robust" transition for the education and training system. In the interim, deaneries will continue to oversee the training of junior doctors and will be given a "clear home" within the NHS family.

Professional leadership in medical education, based on co-operation between the medical Royal Colleges and deaneries, is currently very strong – devolving responsibilities to networks of providers, funded by levies, would appear to threaten to weaken this.

Local schemes within regional frameworks currently allow flexibility and tailoring to populations and context. It is not clear how the proposed new system will accomplish these functions more effectively. It does not seem to us that the proposed system of 'provider skills networks' funded by levy will be nearly as effective, fair or efficient, nor that the proposed Health Education England will have sufficient capacity to carry out all these functions effectively nationwide.

Also, Deaneries are engaged in a variety of programmes to improve education (and thus workforce) quality not only for the present workforce but for the next generation of professionals. It is doubtful whether provider skills networks will have the same regard to long-term quality improvement rather than short-term service requirements.

They too have central roles in continuing professional development and supporting the quality agenda in clinical commissioning. They can provide essential support for the appraisal process and ensuring standards –a crucial role if the revalidation agenda is to be successfully delivered.

The College supports amendments that seek to clarify:

- Giving the NCB oversight and responsibility for delivering a nationwide system of education and training.
- If representation on Local Education and Training Boards is proportionate to the balance of primary and secondary care workforce, and how will it ensure a coordinated approach to workforce planning across England
- Whether functions of universities and deaneries in the formal training of the workforce for the NHS will be strengthened

Health Inequalities

Although the new post-pause duties on Monitor, the NHS Commissioning Board and clinical commissioning groups to promote integration of health services emphasise reducing health inequalities, the College remains concerned that this hoped-for progress will be threatened by the emphasis on patient choice, which often sees those with the greatest health needs often possessing the least availability to exercise choice.

We urge that all outcome measures are piloted before nationwide implementation to achieve these goals. As we argued in our response to the Government's consultation paper 'Liberating the NHS: Transparency in Outcomes' we continue to believe the outcomes framework should highlight the reduction of health inequalities as a priority, and that it should even warrant a domain of its own.

It is also vital that in the transitional period while this change is managed that tackling health inequalities does not slip down the Department's agenda.

Questions remain over whether the duties to reduce health inequalities are strong enough to ensure that the consequences are those intended i.e. that they will provide cost-effective care and improve health outcomes, and we urge members of the Lords to further examine this in more detail.

The College supports amendments that:

- Strengthen the duties on the Secretary of State, Monitor, the NHS Commissioning Board and Clinical Commissioning Groups to improve health inequalities