Briefing on the Health and Social Care Bill Second Reading Debate

31.01.11

The Health and Social Care Bill represents the biggest shake up of the NHS since its inception. It will fall to NHS managers to implement the proposed changes and ensure a smooth transition while maintaining current high service standards and delivering efficiency savings of up to £20billion by 2013/14.

Managers in Partnership (MiP) is the representative body for nearly 6,000 senior health service managers including over 200 chief executives working in all areas of healthcare.

MiP members are therefore at the forefront of current health service delivery and commissioning and are very well placed to inform the debate on the impact of the proposed NHS reforms as set out in the Health and Social Care Bill.

We have a number of specific concerns about the Bill – highlighted below - but one overriding message: effective management is part of the solution in the NHS not the problem. The Government needs to stop criticising managers because the ambitious reforms proposed will founder without talented and skilled management. It should instead prioritise keeping and building management capacity.

According to the Bill's Impact Assessment it is envisaged that up to 26,200 health service staff, will be lost at a potential total cost of £1.28 billion. These job losses, including at the more senior levels, have already begun in what is in danger of becoming a PCT "free for all." A more strategic approach to transition is essential to ensure that vital resources are not wasted on needless staff reorganisation.

The Bill sets up a number of radical new approaches to commissioning and providing health care including:

- Up to 500 new GP commissioning consortia to replace the 151 existing PCTs
- A market to develop in health care service provision
- National tariffs to be set in some instances as maximums
- Monitor's role to be first and foremost a promoter of competition.
- Changes to the provisions governing NHS foundation trusts

Taken together these raise some very serious issues. We would be grateful if

members could raise some of these issues at Second Reading and would be happy to provide further information if required.

Proposed new GP commissioning consortia: a Governance Gap?
The new GP commissioning consortia will be at the forefront of the new NHS structure, but there is a real lack of detail in the Bill about their governance and management arrangements. They will write their own constitution, to be approved solely by the National Commissioning Board (NCB). However, with up to 500 local commissioning consortia to oversee, the NCB will never be able to provide a suitable level of scrutiny.

Unlike almost all other corporate governance structures, the consortia are seemingly not required to have a board with externally appointed non executive directors or to hold meetings in public. There is one reference – in schedule 2 clause 4 – to the need to make provision in the constitution for dealing with conflicts of interest but this is clearly not sufficient in organisations responsible for hundreds of millions of public money.

The Government has argued that democratic accountability is created through the relationship between GP consortium and local health and wellbeing boards. However, according to the Bill, the consortia must only have "regard to" the local health and wellbeing strategy (clause 177) and it is only "a representative" rather than the accountable officer who must sit on each local authority Health and Well Being Board (which itself is not sufficiently democratically accountable as only one councillor must be on it). These conflicts might include the performance management of existing GP contracts, as well as commissioning new services.

All NHS staff, including managers and doctors, need to be held to account robustly but we have doubts whether Health and Wellbeing Boards will be sufficiently empowered and that the NCB will be sufficiently well resourced. If the only oversight is to be exercised by the NHS Commissioning Board then this represents a significant centralisation of powers.

Price competition: decisions based on cost not quality?
Clause 52 redefines the duties of Monitor, the first of which in future will be to "promote competition" within the NHS. But competition is not the answer to driving efficiency in every service area. Many services cannot be priced up neatly or specified in fine contractual detail but once tendered EU legislation will mean that the commercialisation of that service will continue.

Clause 104 provides for competition by price in the provision of health services. Some nationally set tariffs for specific health care services will be the maximum price rather than a fixed price – there is no indication of the percentage of services to which the maximum wil apply. However it is clear that private companies and Foundation Trusts will be incentivised to reduce costs risking quality of care or reduced terms and conditions for staff or both. NHS Chief Executive David Nicholson, said such a move was "extremely dangerous" when he gave evidence to the Public Accounts Committee.

MiP members are extremely worried that price competition will cut quality and standards. There is clearly a risk that GP commissioning consortia will be

tempted to accept lower cost above high quality - especially when working with tight financial constraints. Alternatively, competition on quality, which already exists in some services, could be extended more broadly although to do this requires experienced management expertise in procurement.