October 2011

Health and Social Care Bill

Lords' Second Reading Parliamentary Briefing

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 at the forefront of current health service commissioning and delivery and are very well placed to inform the debate on the future of the NHS.

Executive Summary

The NHS reorganisation proposed by the Health and Social Care Bill will be the biggest shake up of the NHS since its inception. The "pause" has in fact made the new structural architecture – from clinical commissioning groups to clinical senates, from health and wellbeing boards to the national commissioning board – even more complex.

There are significant risks with this upheaval:

- The risk that the reforms will not succeed – the Government's own risk assessment identifies five potential pitfalls all, in MiPs considered view, highly likely;
- The risk that the reforms will distract from the "Nicholson challenge" – the savings that are currently required – or even make those savings more difficult to achieve (as NHS Confederation[1] and others have also raised);
- The risk that introducing change and making savings at the same time as also massively cutting management – by an "arbitrary" 45% - is a recipe for potentially longer waiting times and worse clinical outcomes.

In addition there are a number of erroneous features of the Bill which remain in place, contrary to the concerns expressed by the Future Forum and other organisations:

- Lack of accountability of the Secretary of State for provision of a comprehensive NHS;
- The wholesale introduction of competition into every aspect of the NHS;
- Probity and public sector ethos issues as well as privatisation concerns.

Managers in Partnership have concluded – along with many other organisations such as the BMA and RCGP – that the goals of a more clinical led and patient focused NHS could be achieved – along with significant costs savings – through the reform, and clustering, of PCTs and SHAs and without new unsettling legislation.

The Bill should therefore be withdrawn. If it is not we support its proper and full consideration through a Lords Bill Committee, rather than on the floor of the House of Lords, and significant further amendment.

[1] See NHS Confederation Briefing for Report Stage and Third Reading

A. THE RISKS INHERENT IN THE HEALTH AND SOCIAL CARE BILL

A1. By the Government's own admission

According to the recently released DH risk assessment[2], the key risks of the Health and Social Care Bill are:

- Clinical Commissioning Groups (CCG) not having the capacity and capability to engage with and deliver clinical commissioning;
- Potential conflicts of interest between CCG members as providers and commissioners of patient care;
- Potential higher transaction costs as we change the number of organisations commissioning services;
- The ability of CCGs to manage risk;
- The ability of GPs to deliver the potential financial savings outlined above.

In relation to the first of these it is worth quoting in full paragraph A78 titled **Capacity and Capability.**

> **"**The greatest risk in terms of policy delivery is the capacity and capability of CCGs to deliver effective clinical commissioning given the reduction in the resources available. This is increased by the fact that the scale of the policy change is both large, i.e. all GP practices must conform, and it is mandatory. *Linked to this are the risks associated with the loss of corporate memory as the transition from the current 151 commissioning organisations to a larger number of CCGs." (Our italics)*

Paragraph A84 spells out "**Shorter term risks** of joined-up working (i.e. with local authorities, other practices, other health and social care professionals) including inefficiencies and lack of communication resulting from organisational and working practice differences, and the potential reduced emphasis on the QIPP by GPs as they realign themselves. Additionally, there may be a risk related to allocating budgets to CCGs in the transition period given until membership and functions have settled down."

Managers in Partnership do not believe that there are processes in place to mitigate these – correctly identified – risks, not least because the experience and expertise of senior managers is being lost often in a haphazard way. As the Kings Fund have said "the sheer number of changes being made to the health system risk creating confusion[3]."

MiP urges Peers to draw attention to each of the five risks the Government have identified and the inadequacy of the mitigation (if any) proposed.

A2. The risk the reforms will distract from the "Nicholson challenge"

The NHS Confederation have stated that "the biggest immediate challenge facing the NHS over the next four years is the requirement to save £20billion of efficiencies" but "in large part the Government's reforms do not directly address the Nicholson challenge."

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[2] See Department for Health Impact Assessment

[3] Kings Fund Report and Third Reading Briefing

Meanwhile the Nuffield Trust have stated that "the Government's revised plans increase the number and complexity of "soft" accountability arrangements locally" whilst the Kings Fund states that "we remain concerned about the lack of clear responsibility for driving forward hospital reconfigurations under the Bill and that the changes it proposes will add to an already complex and bureaucratic decision making process."

MiP echoes these concerns. The dismantling from April 2013 of any intermediate level of overview of the whole NHS as was previously provided by SHAs and now by SHA clusters will also hinder rather than help strategic decision making. Given that the some significant decisions will need to be taken in the next 18 months this loss of strong system management is a retrograde step.

Managers should be free to manage once fully democratically accountable strategic decisions are made. Without clear instruction there is a risk of organisational delay and inefficiency. After a spate of examples of anti manager rhetoric in the media[4] – which would seem to suggest that any problem in the NHS can now be blamed on managers – we would be fearful that managers will again be in the "firing line" of any future organisational failure.

MiP urges Peers to seek clarification of the powers, responsibilities, roles and relationships of different organisations in the new structure.

A3. The additional risk of also cutting management by "arbitrary" 45%

At the same time as undertaking a major reorganisation, the NHS is facing strict government targets to reduce management costs by 45% (an overall administration cost reduction of 33%). This represents 12,900 redundancies.

In a recent report on NHS management[5], the King's Fund warned that the numbers used in these targets are "*simply arbitrary*" and "backed *by no published analysis whatsoever*". (It is interesting to note that in Scotland the devolved administration's target is to reduce management by 25%.)

In fact the King's Fund Commission found that the NHS may actually be "*under-managed*". The report therefore urged the Department of Health to "*re-think*" the planned reductions in the face of other pressures facing the NHS through reforms and budget reductions.

In its briefing at Report Stage in the Commons the Kings Fund repeated its concerns:

> "High-quality leadership and management are essential to implementing the reforms and meeting the financial and operational challenges facing the NHS. Nevertheless senior members of the government continue to denigrate NHS managers as 'bureaucrats.' This should stop, and the arbitrary target to cut the number of managers by 45% should be re-visited."

Of course MiP recognises the need to make efficiency savings within the NHS, and understands that part of these savings will be made through managerial job cuts.

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[4] See http://www.bbc.co.uk/news/health-14337427 and also the Telegraph report on 8th September which claimed that NHS Managers were "restricting access to crucial scans and tests." Both stories failed to acknowledge that mangers are working within national and local guidelines set by others

[5] The Future of Leadership and Management in the NHS report from Kings Fund Commission 15/05/11

However the pace of job reductions should be slowed and the process should be far better planned to ensure a smooth transition to the new structures.

Moreover it is time that the rhetoric surrounding the Health Bill changed from a simplistic "clinical = good, manager = bad" to a more sophisticated language that recognises reality: that clinicians and managers will need to work in partnership if the new commissioning arrangements are to have any likelihood of bedding down and delivering for patients.[6]

MiP therefore urges Peers to raise the issue of the "arbitrary" 45% figure as well as the importance of good management to the future success of the NHS.

B. KEY SPECIFIC CRITICISMS OF THE BILL

B1. Lack of accountability of the Secretary of State for provision of a comprehensive NHS

Many professional as well as trade union organisations remain fearful of changes to clauses that appear to mean that the Secretary of State will no longer have a duty to provide a heath service to all.

This concern was most recently echoed by the House of Lords own Constitution Committee which concluded: "We are concerned that the Bill, if enacted in its current form, may risk diluting the Government's constitutional responsibilities with regard to the NHS."

MiP share those concerns not least because of the Government's other changes which include a new duty (clause 4) on the Secretary of State to promote the autonomy of "any other person exercising functions in relation to the health service or providing services for its purposes".

This is not a point of technicality but a crucial new feature in the NHS if the Bill is passed – the NHS will be made up of numerous autonomous organisations. This was made clear when Andrew Lansley spoke forthrightly to the National Association of Primary Care and NHS Alliance Conference on 18/9/11:

> "I want Clinical Commissioning Groups to cover the whole of England and I want them to be fully authorised. I know some of you are concerned that authorisation is a way for the NHS Commissioning Board to have constant control, that you will never be able to be fully autonomous.
>
> "But I can tell you that authorisation is a one-off process. A single test. And when you pass, that's it done. You will have all the freedom of a statutory body. I'm confident that you will thrive on that freedom, that responsibility to commissioning healthcare safely. There's no-one better placed to take control of most of the NHS budget with a clear clinical focus and added clinical value."

Whilst MiP support local discretion the language of 'freedom' and 'autonomy' jars with that of a comprehensive NHS in which "postcode lottery" has become anathema to patients and politicians alike. Despite this, the Government have

[6] The NHS Confederation and Kings Fund have commissioned research - already underway - to measure the impact of good management on clinical outcomes.

decided not only to introduce the new system without any piloting at all but also that the Secretary of State will not need to be held responsible for the provision – merely the promotion – of a comprehensive NHS.

Furthermore it is equally important that the Secretary of State retains the means to ensure that this provision can be delivered: there are widespread concerns that he or she will also lack the "levers" to ensure a comprehensive NHS in the future as well as the specific responsibility or mandate.

MiP urges that Peers call for the publication of a transparent - readily understandable - accountability structure including the specific remits of the Secretary of State and the National Commissioning Board.

B2. The introduction of competition into every aspect of the NHS

MiP are not against all competition. However its introduction must be tightly managed to ensure that it is having the desired effect – improved outcomes for patients.

Moreover, despite the concerns raised up to and within the Future Forum report, the current Bill still places an over emphasis on competition to improve performance. Our view is that there is a greater need to promote collaboration and integration to ensure we can meet health needs of the population and to achieve necessary reconfiguration of acute services.

This point was also made in a new book from The King's Fund – Understanding New Labour's market reforms of the English NHS – which warns that competition alone will be insufficient to meet the challenges the NHS faces and must be used alongside and in combination with increased integration within healthcare, and between health and social care.

Monitor as primarily an economic regulator must be transformed into one that puts the interests of patients – and not the market – first. The fact that competition is a subordinate priority - to promoting integration, reducing health inequalities, increasing patient outcomes - must be specifically written into the Bill itself not left to Ministerial reassurances in public.

MiP urges Peers to press for the greater prioritisation that needs to be given to integration rather than competition to be reflected in the legislation itself.[7]

B3. Probity and public sector ethos issues as well as privatisation concerns

There remain a number of other issues – all raised by many other organisations – which MiP believe deserve the urgent and considered attention of Peers. First, MiP adds its voices to those, most notably the BMA, who are very concerned about 'premium payments' which would give bonus payments to CCGs that hit financial and performance targets.

MiP have raised from the very start of the Bill's passage a range of issues relating to probity – or rather the potential for impropriety – and echoes Lawrence

[7] It is not sufficient for the Secretary of State to assert publicly – as he did at the Health Select Committee– that "it is absolutely clear that integration around the needs of the patient will trump other issues, including the application of competition." It will only be clear if this higher prioritisation is on the face of the Bill.

Buckman's statement that quality premiums are "ethically dubious" and "utterly immoral".

Second – and following from the point above – MiP are very concerned that in a future NHS of autonomous institutions, all with statutory freedom and operating within a competitive environment, the public sector ethos will be lost. As Unison and others have remarked the NHS is in danger of becoming a brand with any sense of collective endeavour for the common good vanishing for ever.

Third – and again this follows on from the foregoing two points – MiP share the concerns of those alarmed at the complete lifting of the private patient income cap on Foundation Trusts.

Whilst there is a case for reform of the cap – in order to make it applicable to all hospitals and to differentiate between different types of income – lifting it entirely seems to signal the fulfilment of an ideological position by the administration: that is, it doesn't matter if NHS treatment is provided by NHS or private hospitals, and it doesn't matter if private treatment is provided by private or NHS hospitals.

MiP urges Peers to remove the premium payment provisions from the Bill, speak up for the public sector ethos of the NHS and call for a consultative review of the patient income cap rather than its complete lifting.

Further information

MiP would be pleased to provide further information in relation to any of the issues above and to work with you – and others – on amendments during Committee Stage.

We would also be pleased to meet with you to explain our concerns in greater detail.

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