Subject: **Health and Social Care Bill**

To: Rt Hon Andy Burnham MP
From: Thomas Powel, Social Policy Section
Reference: 2011/12/118-SPS
Date: 14 December 2011

The July 2010 White Paper *Equity and excellence: Liberating the NHS* set out the Government's aims to reduce central control of the NHS, to engage doctors in the commissioning of health services, and to give patients greater choice. The *Health and Social Care Bill* would give effect to those reforms requiring primary legislation. Measures include giving groups of General Practitioners responsibility for commissioning the majority of health services, the creation of an independent NHS Commissioning Board, and the abolition of Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs).[1]

You asked for a briefing on what might happen if the *Health and Social Care Bill* was withdrawn, and the implications for the emerging structure for commissioning health services in particular.

The following briefing provides some background to the arguments for introducing reform through existing PCT structures, a summary of what has happened so far with the implementation of the Government's health service reforms, and what might happen if the current Bill is withdrawn. Given the short time I have had to prepare this note I would stress that this is not a comprehensive briefing, on what is obviously a very complex policy question. However, I hope it helps identify some of the key issues; in particular, it looks at:

1. The clustering of PCTs and SHAs, and the emergence of CCGs
2. NHS Commissioning Board, Clinical Senates and Clinical Networks
3. Health and Wellbeing Boards
4. Integration

It also briefly covers some related areas, including patient advocacy, public health, and education and training.

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[1] The *Health and Social Care Bill* and giving local authorities responsibilities for coordinating local NHS services, social care and health improvement. The Bill would also establish Monitor as an economic regulator for the health sector. The most recent Library Research Paper on the *Health and Social Care Bill* (RP11/63, 30 August 2011) can be found here: http://www.parliament.uk/briefing-papers/RP11-63**.** Section 1 of this paper provides an overview of the NHS Future Forum's listening exercise and the Government's response. Sections 2, 3 and 4 provide information about the re-committal motion and the Committee stage, including a summary of the key debates and amendments to the Bill agreed in the Committee. There are two earlier Library research papers on the Bill: the first, prepared for the Commons Second Reading debate, provides more detail on the Bill, and the background to the Government's proposals for reform (RP 11/11, 27 January 2011); the second paper provides a summary of the Commons Second Reading debate on the Bill, on 31 January 2011, and the changes made during the Public Bill Committee's first consideration of the Bill, between 8 February and 31 March 2011 (RP 11/31, 6 April 2011).

Arguments for reforming existing PCT structures

On 30 March 2010 the House of Commons Health Committee published a report on *Commissioning*.[2] The Committee criticised PCTs for failing to commission effectively, accusing them of being too passive and lacking the clinical knowledge and other skills to challenge hospitals over the provision of services. It found that constant reorganisations and high turnover of staff had made a bad situation worse. The Committee looked at five options for the way forward:

- The abolition of PCTs
- Keeping PCTs but doing more to integrate care
- Retain PCTs, but introduce "local clinical partnerships"
- The Department of Health commissioning services from hospitals
- Retaining and strengthening PCTs

As noted above, the *Health and Social Care Bill* would give groups of General Practitioners known as Clinical Commissioning Groups (CCGs) responsibility for commissioning the majority of health services, establish an independent NHS Commissioning Board, and abolish PCTs and SHAs. Critics of the Bill, including the BMA, have argued that many of the improvements to the NHS that the Government says it wants – for example, shifting decision-making powers to clinicians and streamlining patient pathways – do not require legislation, and can be achieved without wholesale structural change.[3]

During the two Commons Committee stages Labour and Liberal Democrat Members argued that a slimmed down version of existing PCT structures, with greater involvement of clinicians, would avoid the cost of "organisation disruption":

> **Grahame Morris:** ...take the existing PCT structures; slim down their management costs by 30%—I believe the chief executive of the NHS indicated in his evidence that that was the intention—bring in clinicians, and perhaps not just from primary care, to take note of the evidence that we have received as a Committee; and bring in more clinical expertise, including from the secondary sector, and clinicians from other areas, such as nursing in particular, and let those people dominate the board. We might also want to bolt on additional democratic accountability and some outcome measures, although I am aware that the Conservative party does not like targets, but that was what was outlined by the hon. Member for Southport. If we followed that path instead of abolition, we could keep the institutional memory—there is a risk that that will be lost—of the PCTs, the acquired skills that they have been built up, and their coterminosity with their local authority boundaries. That would have the advantage of producing less upheaval and risk, and we would save money while creating very few new organisations. We still do not know exactly how many new organisations will be created by the new commissioning arrangements, but that option seems to make eminently good sense.[4]

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2 Health Committee, *Commissioning*, 30 March 2010, HC 268–I 2009–10

3 See BMA briefing on the Bill (December 2011); and blog post by Paul Corrigan blog post (7 November 2011): http://www.pauldcorrigan.com/Blog/pcts/remind-me-again-why-is-the-secretary-of-state-abolishing-pcts/

4 PBC Deb 15 February 2011 c201, see also Lord Warner's contribution to the Lords Committee on the Bill (HL Deb 5 Dec 2011 c546)

As early as July 2010 the think-tank CIVITAS had commented that "instead of effectively eradicating PCTs, the coalition government should focus attention on developing PCT's commissioning skills and getting behind them as vigorous, impartial, purchasers of care, able to exert pressure on providers to improve, or to switch services where necessary to new innovative ones (NHS or non-NHS) without fear of backlash. The goal of increasing clinical involvement in commissioning is vital to this, but would be better achieved working through existing structures."[5]

1 The clustering of PCTs and SHAs and the emergence of CCGs

What has happened so far?

The clustering of the 151 PCTs into 50 clusters, with each cluster led by a single executive team, has gone ahead without the need for legislation. Some PCTs are already delegating the responsibility for a majority of commissioning decisions to the emergent, GP led, Clinical Commissioning Groups (CCGs). In October the NHS moved from ten management teams at SHA level to four SHA clusters. There are now more than 253 groups of GP practices across the country which have come forward to directly commission services. Once authorised as CCGs, and subject to the passage of the Bill, they will take on responsibility for health care budgets from April 2013.

A measure of the percentage of PCT commissioning spend delegated to GP practices is being used to monitor how emerging CCGs are progressing supported by the PCT clusters. Based on the most recent returns almost half of the total estimated commissioning funds have been applied for by emerging CCGs – and of the funds applied for, over 97% has been delegated.[6]

Regarding issues to do with the size and configuration of CCGs the Government has already accepted the NHS Future Forum's recommendation that the boundaries of local CCGs should not normally cross those of upper tier local, following concerns that CCGs should be coterminous with local authority boundaries in order to ensure integration between health and social care.

A Department of Health press release on 30 September 2011 provided an update on its reform of commissioning arrangements and announced the publication of guidance on the development of CCGs.[7] The Clinical Commissioning Coalition, set up by the NHS Alliance and the National Association of Primary Care, has this week published a discussion paper on CCG size and configuration issues.[8]

What might happen if the Bill was withdrawn?

Although CCGs would not be established as statutory bodies, the developing arrangement where PCT clusters delegate commissioning decisions to shadow CCGs could be continued indefinitely. This would be analogous to what happened under Practice-based Commissioning (PBC), where GP practices volunteered to control indicative budgets for purchasing some kinds of care for their patients while PCTs still had formal responsibility for budgets.

In 2009 the DH described how PBC "put clinicians at the heart of PCT commissioning":

> Practice-based commissioning (PBC) continues to play a vital role in health reform. It puts clinicians at the heart of PCT commissioning and allows groups

5 http://www.civitas.org.uk/press/prcs_nhswhitepaper2010.php
6 DH CCG Pathfinder bulletin, November 2011
7 DH Press notice 30 September 2011 and *Developing CCGs: Towards authorisation*
8 http://healthandcare.dh.gov.uk/napc-alliance-paper/

> of family doctors and community clinicians to develop better services for their local communities.
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> Primary care trusts (PCTs) are the budget holders and have overall accountability for healthcare commissioning, however practice-based commissioning is crucial at all stages of the commissioning process.
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> In particular, practice based commissioners, working closely with PCTs and secondary care clinicians, will lead the work on deciding clinical outcomes. They also play a key supporting role to PCTs by providing valuable feedback on provider performance.
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> PBC is about engaging practices and other primary care professionals in the commissioning of services. Through PBC, front line clinicians are being provided with the resources and support to become more involved in commissioning decisions.
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> Practice based commissioning will lead to high quality services for patients in local and convenient settings. GPs, nurses and other primary care professionals are in the prime position to translate patient needs into redesigned services that best deliver what local people want.[9]

While the DH achieved its goal of "universal coverage" (meaning that the vast majority of GPs voluntarily signed up to PBC in principle), this was not necessarily a sign of widespread enthusiasm for PBC among GPs. It did not go unnoticed that GPs had been able to claim incentive payments of at least £1.90 per patient for signing up to PBC – and, in practice, there has been very little commissioning involving PBC.

In October 2009 Dr David Colin-Thomé, the National Clinical Director for Primary Care at the DH, was quoted as saying that PBC "isn't really taking off, in any systematic way ... it's certainly not seen as a major vehicle for change". He reportedly added that efforts by the DH to revive the policy did not seem to be working, concluding: "I think the corpse is not for resuscitation. There doesn't seem to be much traction."[10] However, Dr Colin-Thomé subsequently claimed that he had been somewhat misquoted and indicated that he thought the policy could be made to work.[11]

Another approach would be for PCTs to be retained to commission services in those areas where CCGs were not ready or did not want to commission (in effect two different commissioning systems – in those areas where CCGs were keen and had passed the assurance regime, then they would get the money to commission. In those areas where GPs did not want to commission the PCTs would receive the money and continue to commission. This would be more similar to the GP fund-holding arrangements that existed in the 1990s, although this led to concerns about was a two tier system.

Information on how the current system of health service commissioning, and previous attempts at involving GPs (GP fundholding and Practice Based Commissioning), can be found in this Library standard note: http://intranet.parliament.uk/briefing-papers/SN05607

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9 http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Practice-basedcommissioning/DH_4138698

10 "GP commissioning shows little sign of life - David Colin-Thomé", *Health Service Journal* website, 14 October 2009

11 Health Committee, *Commissioning*, 30 March 2010, HC 268–I 2009–10, para 103

2 NHS Commissioning Board Clinical Senates and Clinical Networks

What has happened so far?

The Government proposed establishing an Independent NHS Commissioning Board whose role would include supporting, developing and holding to account an effective and comprehensive system of clinical commissioning groups. The Board would also take responsibility for services that can only be provided efficiently and effectively at national or regional level.

The Board has been established as a Special Health Authority in "shadow form". Subject to the passage of the *Health and Social Care Bill*, by October 2012 the Board would be established as an independent statutory body and take on some formal statutory accountabilities from this date such as the authorisation of clinical commissioning groups and the planning for 2013/14. The Board would take on its full formal statutory accountabilities from April 2013.

The Board would have powers and functions, many of which are set out in the proposed legislation, including:

- To agree and deliver improved outcomes and account to Ministers and Parliament for progress. There will be a clear mandate, setting out expectations for the Board and the broader commissioning system;
- To oversee the commissioning budget, ensuring financial control and value for money;
- To develop and oversee a comprehensive system of clinical commissioning groups with responsibility for commissioning the majority of healthcare services;
- To commission directly around £20bn of services including specialised services and primary care services (including holding around 35,000 contracts for primary care services).[12]

What might happen if the Bill was withdrawn?

The Board could remain as a Special Health Authority although this might raise questions about its functional powers, and its operational independence from the Department of Health.

In response to the Future Forum's calls for multi-professional involvement in commissioning, the Government suggested a number of non-legislative ways in which it would introduce a wider range of clinical advice for commissioners such as extending clinical networks and establishing clinical senates.[13]

The NHS Commissioning Board would host clinical networks, to advise on distinct areas of care, such as cancer or maternity services. The Board would also host new clinical senates to provide multi-disciplinary input to strategic clinical decision making to support commissioners, and embed clinical expertise at the heart of the Board. However, there have also been concerns that the development of these structures could lead to greater complexity and costs (see evidence to the Public Bill Committee on the re-committed Bill from the NHS Confederation and Royal College of GPs). For its part the Government's have stated

12 DH, *Developing the NHS Commissioning Board*, July 2011

13 *Ibid*. c234

that clinical networks and senates would not be new organisations or new forms of bureaucracy and would be hosted by the National Commissioning Board.[14]

3 Integration of services

What has happened so far?

The Bill would introduce a duty for the NHS Commissioning Board and CCGs to promote integration between health services and between health and social care services and part of the rationale for introducing Health and Wellbeing Boards is to promote joint working. 138 out of 152 top-tier local authorities have joined the early implementer network for Health and Wellbeing Boards. The shadow boards have been urged to examine issues such as: governance; services for key groups; health inequalities and public engagement.

What might happen if the Bill was withdrawn?

Although legislation would be required to put shadow HWBs on a statutory footing arrangements for closer working between local government and the NHS already exist (such as Care Trusts and other joint commissioning arrangements under section 75 of the *National Health Service Act 2006*). In Torbay, for example, a Care Trust has been established, with the development of single locality health and social care teams – aligned with GP practices, using a single assessment process and pooled budgets. The King's Fund has found that this is having a demonstrable impact on the use of hospitals, and enabling older people to receive care outside of hospital. Attempts could be made to roll out existing models of integrated working more widely without the need for legislation.[15]

A report from the King's Fund in July 2011 outlined a number of key changes that it said could facilitate integrated working without the need for legislative change, including the following:

- Alternatives to the tariff for non-elective, long-term and complex care. These alternatives may include bundled payments, pooled or delegated budgets and capitated budgets. Any payment mechanism adopted needs to ensure that financial rewards are linked to the quality and outcomes of care.

- System leadership at a regional level, provided by multi-professional clinically led groups or clinical cabinets.

- Facilitating joint working between health and social care needs. GP commissioning boundaries should, as far as possible, be aligned to local authority boundaries to support this.

- At a local level, multi-professional health and social care teams that support the needs of high-risk patients such as frail older people should be a core element of service provision, as is already the case for patients with chronic mental health problems and learning disabilities.

The *Health Service Journal* has published a number of articles on different aspects of "integrated care"; including an article which mentions a number of UK examples seen as models of integrated care:

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[14] *Ibid.* c237

[15] Thistlethwaite P (2011). *Integrating Health and Social Care in Torbay: Improving care for Mrs Smith*. London: The King's Fund.

> ....Weston Area Health Trust, which was declared not clinically or financially viable in its current form, has begun talks with North Somerset Council, NHS Somerset, primary care provider North Somerset Community Partnership and clinical commissioning groups about creating an integrated care organisation to provide all health and social care in the area.
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> (...)
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> Wye Valley Trust, formed under the transforming community services programme earlier this year, provides acute, community and social care for a population of 180,000 and is due to submit its foundation trust application to the Department of Health next year.
>
> (...)
>
> Torbay, one of the pioneers of integrated care, provides community healthcare and social care for a population of about 140,000. ....[16]

Any Qualified Provider

The extension of Any Qualified Provider to new areas does not require legislation. Guidance has been published on the phased roll-out of AQP to areas such as community services and mental health from April 2012.

Education and training

It is proposed that Health Education England will be created in "shadow" form during 2012/13 before taking full responsibility for education and training from April 2013. SHA clusters are expected to work with local employers to develop commissioning plans for this area for 2012/13.

Public involvement and patient advocacy

Legislation is required to establish HealthWatch England and local HealthWatch from October 2012, and for local authorities to assume responsibility for NHS advocacy from April 2013. However, it is expected that local authorities will work in partnership with their existing LINk, voluntary groups and community organisations when designing their approach to commissioning patient advocacy, and changes could be made to these existing networks without legislation.

Public Health

It is intended that Public Health England will be established as an executive agency within the DH from April 2013, although this does not require legislation it would be necessary in order to abolish the Health Protection Agency and in order to transfer PCT responsibilities for public health from the NHS to local authorities.

[16] "European integrated care models weighed up by struggling hospital", HSJ, 26 October 2011