

Health and Social Care Bill

Main points

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The Bill is a very big document. The main text is [available here](#). There are 367 pages and it is divided into two volumes with a total of 281 sections and 22 schedules. The second volume contains the Schedules to the Bill.

Interpretation of each of the sections will take the forensic attention of experts. This document is an overview.

We hope to compile a Wiki comments document comprised of insights from readers. If you look at the Bill and spot something that you think is important and should be brought to the attention of colleagues and other readers, [mail it to us here](#). Please reference the section and paragraph and give your interpretation or comment. The more the merrier and we will publish them all. Thank you!

Fundamentally, the Bill creates a regulated market in healthcare, open to NHS, third and private sector organisations to provide and compete for the provision of health services.

The Secretary of State plays no hands-on role and the 'ring' is held by a powerful NHS Commissioning Board with powers to appoint Consortia of GPs, who will purchase healthcare for their populations.

All Trusts must become Foundation Trusts and Monitor is appointed as an 'Off-Sick' style regulator to encourage fair competition between providers and ensure the financial stability of participants.

Secretary of State

- A duty to promote 'autonomy' and the protection of Public Health
- To 'mandate' the Commissioning Board, annually with objectives, requirements, proposals and a resource allocation.
- No power to exercise any requirement over any individual consortia.
- Power to impose public health functions on local authorities, the commissioning board or consortia.

Day-to-day control goes to the commissioning Board. Strong emphasis on Public Health

SoS has the power to step in if it is considered the Board is, or has, failed in the discharge of its functions'

The Commissioning Board

- Consisting of a chair, at least five other members and a chief executive plus non-executives (remunerated) who must, in number, be more than executive members.
- May appoint committees or sub-committees.

This may be a way to establish 'regional' Commissioning Board outposts

- Must secure continuous improvement, outcomes, effectiveness, integrated working, public involvement and quality of the patient experience
- Must produce an Annual Business plan and an Annual Report to which the Sec of State must reply, in a letter.
- The Board has a duty not to overspend, reduce inequalities and innovation. There can be 'prizes' for innovation.
- Performance manage consortia.
- Award performance payments to consortia who may distribute them to members as it 'considers appropriate'.

Does this cash go to Consortia, practices or GPs? Surely, not more money to GPs?

If there are a big number of small Consortia, compliance and transactions costs are going to be high. DH impact analysis says 100k populations, like PCTs (without sharing functions) may cost as much as 17% more. Many thought PCTs were too small to leverage change. Optimal might be 80 consortia but there are already some, in formation with 2 practices. The Commissioning Board will have the final say-so and may insist on reconfigurations.

Consortia

May be of any size from two or more practices.

- They must apply to the Board for establishment and they may, thereafter merge or dissolve.
- The application must include a constitution, including procedures of operating, a named 'accountable officer' (who may be an employee of the consortia and not a member and must be appointed/approved by the Commissioning Board) area covered, ensure effective participation by each member and a way of dealing with conflicts of interest, plus anything else the Board may want to add.
- The constitution must include a provision for dealing with conflicts of interests of members or employees of the commissioning consortium.
- The Board has the right to add or remove any member of a consortium.
- Consortia may merge and may work together exercise functions on behalf of others and create pooled funding.
- Property and staff may be transferred to a consortium.
- Consortia have a duty to improve quality of services, promote effectiveness and efficiency.
- Publish a commissioning plan, consult with health and well being boards, publish an annual report and come to financial balance year on year. They must reduce inequalities and promote patient involvement.
- If consortia wish, they can pass their functions to committees which can include "persons other than members or employees of the commissioning consortium" – for example lay members or non-GP clinicians.

Doc's buying services from themselves. Conflicts will occur and will patients have the choice to go elsewhere?

There is still no answer to; 'what happens to the NHS estate' question?

NICE are giving out 'business as usual' messages

NICE

- Becomes a 'body corporate' and must have regard to the balance of benefits between the costs of the provision of health services and social care, the degree of need for health and social care and the desirability of promoting innovation.
- Prepare quality standards and keep them under review.
- Publish a NICE Charter – how it intends to discharge its functions.

Costs and risks

- Total cost is *questimated* by the DH as £1.2bn in the next two years.
- The DH estimates, the future cost of commissioning will be £1.3bn less than existing costs.
- The expected savings mean that the benefits will outweigh the costs of transition by 2012-13.
- The reforms will lead to 15,800 redundancies across PCTs, strategic health authorities, arm's length bodies and jobs in the DH. The total cost of the redundancies is estimated at £772m.
- The assessment predicts that there will be an average of £1.06bn of annual savings made over 10 years due to the reduction in the cost of commissioning.
- Around £600,000 will be spent on the transition in each of the next two financial years.
- The DH estimates existing costs for primary care trusts commissioning arms as £1.93bn for staff costs and £2.01bn for non-staff costs. While it expects that the annual "commissioning budget running costs" will fall to £2.63bn by 2014.
- Non-staff costs for the transition to commissioning consortia are estimated at £323m, or £2.1m per primary care trust. This includes £950,000 per PCT for the transition of IT and £650,000 on double running costs during the changeover.

Health and Wellbeing Boards

Comprised:

- at least one local authority councillor,
- the director of adult social services for the local authority,
- the director of children's services for the local authority,
- the director of public health for the local authority,
- a representative of the local HealthWatch organisation for the area of the local authority,
- a representative of each relevant commissioning consortium,
- a representative of the commissioning Board, when the group is drawing up strategic needs assessments
- and such other persons, or representatives of such other persons, as the local authority thinks appropriate.

Their role seems to be to 'encourage' and does not appear to have powers to direct

Monitor

- Chair appointed by Sec of State
- The main duty of Monitor in exercising its functions is to protect and promote the interests of people who use health care services
- Promote fair competition where appropriate, and through regulation where necessary.

SoS has powers to 'direct' Monitor to sort out a failing FT

- Monitor must have regard in particular to the likely future demand for health care services. Duty to review regulatory burdens
- Adhere to good practice in relation to procurement,
- protect and promote the right of patients to make choices with respect to treatment or other health care services provided for the purposes of the NHS,
- Promote competition in the provision of health care services for those purposes.
- Will be able to de-authorise a failing FT – consultation this summer on the how, what and where
- May require providers and commissioners to contribute to a ‘bail-out’ fund for providers who go broke.
- It may fine the Commissioning Board if it fails to provide ‘necessary and expedient’ information for the purposes of any of its regulatory functions.
- May designate a service ‘protected’ – a Tribunal will adjudicate disputes.

This appears to apply to all providers, ‘public’ that is to say FTs and private

FTs

- Mergers to be made easier
- Cap on private income goes
- No assurance that private income is used for the benefit of patients
- All Trusts abolished and have to become FTs or subsumed – or a stay of execution if the Trusts is to become privately managed a-la Hinchinbrook

If private income is used to subsidise NHS activity, this might be thought ‘unfair’ and be open to challenge by disgruntled private competitor.

The aim must be to get FTs off the Treasury balance sheet and reduce debt – and get them away from DH spending limits. Tricky as EU rules apply