

“Navigating the New Health Order”

The Health and Social Care Bill: Where are we now?

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The structure of the NHS is changing and has already changed. It is still the intention that The Department of Health (DH) and Secretary of State will have ultimate responsibility for providing a national health service. However, there is no doubt that the operational organisations – particularly the NHS Commissioning Board – will wield considerable power and the interaction between these bodies remains unclear, with many yet to be established in even shadow form. In this article, we take a slightly quirky look at the emerging structures and relationships.

So what will be the most important bodies in the new health system?

A helpful way of envisaging the new health order is to think of it as a “temple to health”, with each of the organisations represented by a piece of the temple. The position of each body in the temple structure conveys its importance and position within the health order.

The pediment

The pediment is the triangular structure that sits atop of the temple. It is held in place by everything beneath it, but is also the focal point for those approaching the temple. In the new health order, this pediment represents both the Secretary of State and the DH. Andrew Lansley MP was accused of attempting to remove the long-standing responsibility of the Secretary of State for the NHS. However, as a result of the amendments to the Bill in response to the Future Forum report, the power and responsibility of the Secretary and, through him, the DH, is preserved (at the time of writing this has been challenged by legal opinion commissioned by activist organisation 38 Degrees). For those who use the NHS it is often not the detailed structure of the health system that they see, but those at the top.

The four pillars

The pillars of the temple are key structures; they hold up the pediment, keeping it away from the pillar base and temple steps, but also bear the weight of the pediment. The health reforms have created four clear, key operational bodies that will be responsible for much of the running of the health service, but which are accountable to DH and Secretary of State.

- 1. The NHS Commissioning Board (NHSCB)** is one of the new creations coming out of the Bill. Its primary purpose will be to support Clinical Commissioning Groups (CCGs), but it will also be directly responsible for commissioning around £20bn of services directly, including primary care and specialist services.

In the new health order it seems possible that the NHSCB could wield much greater power than is currently obvious. It will be supported by the more established non-department public body, the National Institute for Health and Clinical Excellence (NICE), in drafting commissioning guidelines for CCGs and will have the power to interfere in CCGs' decisions if it is able to demonstrate “reasonable grounds” for doing so. Referring to the NHSCB, the Health Service Journal mischievously headlined its 21 July issue “One Quango to Rule Them All”. With a total staff of 3,500, this is not pure hyperbole. The NHSCB will not come into its full power until April 2013 and it will take several months, possibly years, to see how its role fits in with the other organisations, but it certainly seems that there is the potential for this new body to be very powerful indeed.

- 2. Historically, Monitor** was responsible for regulating Foundation Trusts, a role it will continue, but its powers are considerably increased by the Bill. Monitor's main duty now will be to “protect and promote the interests of patients”. This was after the proposals for Monitor to promote competition within the NHS attracted fierce criticism. The controversy around this proposal was based on the idea that Monitor would be promoting competition as an end in itself and this prompted fears of “privatisation by the back door” for many opponents of the reforms.

In response to the Future Forum's recommendations, the Government peddled backwards, emphasising that the interest of the patient came above all else. The Co-operation and Competition Panel will now be absorbed into Monitor. Although promoting competition as an end in itself will not be its purpose, Monitor will still be involved in regulating competition as well as ensuring that the system gives patients choice and works in their interest.

- 3. The National Institute for Health and Clinical Excellence** is being put on a statutory footing by the Bill and also taking on responsibility for social care. To reflect this, the Institute's name is being changed to the National Institute for Health and Care Excellence. This is a sensible decision in principle which

allows for greater integration between health and social care (something that was called for by both this and the previous administration). There are, however, some practical concerns. Can NICE's cost-effectiveness methodology be successfully applied to an area as complex as social care? NICE will also work with the NHS Commissioning Board to draft commissioning guidelines. This raises a potential concern about the expanding influence of NICE. If NICE is helping to draft commissioning guidelines based on their evidence base, is there a possibility that NICE guidance, through the NHSCB, will no longer be secondary to the clinicians' judgement? Could a situation arise where a clinician is pressured to prescribe treatment contrary to their clinical judgement because of NICE-influenced commissioning guidelines from the NHSCB?

- 4. The Care Quality Commission (CQC)** is the final of the four pillars. Its present role - that of inspector of quality for all providers to the NHS - appears to be staying the same despite the health reforms. However, how strong is this pillar? This year CQC has come under fire for perceived failures in its role, the most high profile being the Panorama investigation into an elderly care home. The organisation does have its problems, particularly its inability to fill all the inspector vacancies. Rumours have circulated that it may be merged with Monitor, although this seems unlikely as this would muddy the waters between care quality and cost; an accusation the Coalition will be very keen to avoid.

Pillar bases

The base is where the pillars meet the steps that lead into the temple; the base adds strength and stability to the temple. The health reforms have created three bodies that are intended to give such strength to the health system with its new focus on localism.

- 1. Public Health England (PHE)** is perhaps the most high profile of these bases. Public Health is now the starting point for solving many of the challenges facing healthcare. A renewed focus on the public's health ranging from obesity and smoking to vaccination will be driven by this body. PHE will be a key interface between the bureaucracy of the NHS and local organisations responsible for delivering public health initiatives and programmes, such as Local Authorities. PHE will have considerable power, having absorbed the Health Protection Agency (HPA) by the time it launches. It was intended that the HPA would be abolished in 2012 but this was postponed due to fears it would distract staff from concentrating on potential public health threats during the Olympics. PHE will be responsible for overseeing the public health work of Local Authorities and will co-appoint Directors of Public Health. It has now been decided that Directors of Public Health will be accountable solely to Local Authorities, and not the NHS, but PHE will influence who is appointed to the role.
- 2. Health Watch England.** This base sits underneath the CQC pillar. Health Watch will be established from October 2012 and will be a statutory distinctive part of CQC. It will provide advice to Monitor, the NHSCB and the Secretary of State, as well as have the power to propose investigations to CQC about poor service. Through its network of Local Health Boards it will be the voice for those concerned about local health services. The body is still under design by CQC with DH therefore its role and position may well change as time goes on.
- 3. Health Education England (HEE)** is intended to bring together the interests of healthcare providers, the professions, the commissioners and patients to provide national oversight and support on strategic workforce issues. Clare Chapman, Director General of Workforce at the DH, claimed in February 2011 that HEE would work in a "similar way to the NHS Commissioning Board which will support GP consortia in commissioning services"; this is far from certain. The Government, in its response to the Future Forum, said it would work to put the body in place quickly, but it seems unlikely its strength will be equal to the NHSCB as its powers are not as far-reaching.

The priests

Clinical Senates and **Clinical Networks** sit below the pillars of the PHE, NHSCB, CQC and Monitor and are

intended to provide support and guidance to CCGs and Local Authorities. This position within the structure makes them akin to priests greeting and guiding visitors to the temple at the walk up the temple steps, through the pillar bases and looking up at the pillars.

Clinical Networks are likely to cover three main areas; very specialist services (e.g. neonatal), specialist but generic services (e.g. cancer) and higher level generic services (e.g. acute care). Clinical Senates will advise the CCGs on commissioning and were to have a role in authorising CCGs, although this is now looking as if it may change. There had been fear among GPs that the senates could create a power struggle with CCGs and, as such, the Government is keen to ensure the senates work “in dialogue” with CCGs, rather than ruling them. As with the rest of the new health order, the role of the priests may change or cease to exist all together. At the time of writing, the purpose of these two bodies seems to be to guide and advise.

Temple steps

The temple steps are key parts of the structure as they allow people to access the temple itself. They provide the interface or route of access between the temple and the people. The health reforms have created what can be split into two broad steps.

The upper step can be considered to be the **Local Authorities** and the **Clinical Commissioning Groups**. These two organisational levels will be how patients access either public health or mainstream health services. CCGs have probably been the most controversial of the two. They were originally intended to be GP-led consortia, but will now include at least one nurse and one secondary care clinician. Many concerns have been raised about whether the experience exists at this level for effective commissioning and this remains to be seen, however, in theory it does bring commissioning down to more local level. Local Authorities will now be responsible for the public health of their populations. This is a quite an increase in responsibility and again, concerns have been raised about how much support Directors of Public Health will be given and where the accountability and responsibility for delivering the public health agenda should lie.

The lower step represents the bodies that are in place to provide checks on the Local Authorities and CCGs. These are the **Overview and Scrutiny Panels** which exist in most Local Authorities already and the **Health and Wellbeing Boards**.

Conclusion

As is so often the case with NHS reform, just as soon as everyone feels they understand it, someone comes along and reorganises it. The temple analogy is based on the information available at this moment in time; as the Bill progresses through the House of Lords and the turbulent summer gives way to the autumn the structure may change once again. It seems new information and new announcements are coming by the day and no one is entirely clear when the dust will settle, let alone what will be visible once it does.

For now it seems that the structure that is materialising still gives ample power to bureaucratic organisations. And Cameron's claim that the reforms will reduce, not increase, bureaucracy seems pretty hollow at the time of writing. The attention has been focussed on certain headline-grabbing changes such as the CCGs and Public Health England, but once viewed as a whole, the reforms do propose a defined, if not entirely clear, health structure for patient, clinician and manager to navigate. It is possible that the organisations will change and move in importance. For now at least we have a good idea what the Government is intending to create; what it will actually create is another matter entirely.

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