CHAPTER 7

2010–2015: The Health and Social Care Act, NHS Fragmentation

Abstract A change of government in 2010 brought fresh NHS reforms and a new *Health and Social Care Act* (HSCA, 2012). Both, along with the 2014, *Five Year Forward View* (NHSE) set the tone for this Chapter. We discuss how the continued emphasis on competition between providers, and the introduction of Clinical Commissioning Groups (CCGs) which replaced Primary Care Trusts (PCTs) as commissioners of community services, impacted on community nursing service management and delivery. Policy shifted in favour of a more co-operative approach to service provision and familiar agendas were set out for keeping people out of hospital with reform based around integration between health care sectors and between health and social care services. There was little change on the ground for district nurses in this era despite increasing emphasis on integrated care, collaborative, cross-sector working (i.e. with LA social care) and multi-disciplinary team management of complex patients. The HSCA 2012 began to unravel almost as soon as it was enacted, with the emphasis on competition undermined by the *Five Year Forward View* shift towards integration between sectors as a dominant organising principle. Community Health Services (CHS) were, to some extent, protected from the fragmentation associated with the Act, and in terms of district nursing practice, this era generated little change with patterns of service provision remaining very much as they were following the upheaval generated by the Transforming Community Services agenda.

D. Bramwell et al., *Community Nursing Services in England*,
https://doi.org/10.1007/978-3-031-17084-3_7

Keywords Fragmentation • CCGs • Commissioning • Integration • HSCA 2012

7.1 Historical Context

A new Government saw more changes for the NHS during this time and the White Paper—*Equity and Excellence: Liberating the NHS,* was published soon after the 2010 general election (DoH, 2010). Much has been written about the genesis and enactment of this wide-ranging NHS reorganisation, which was subsequently written into law as the Health and Social Care Act 2012 (HSCA, 2012) (Exworthy et al., 2016; Timmins, 2012). From the perspective of Community Health Services (CHS), and in keeping with our focus upon the impact of policy on community nursing service management and delivery, the important aspects of the reforms were a continued emphasis on competition between providers and the abolition of geographically based Primary Care Trust (PCT). As well as commissioning organisations in favour of GP-led commissioners whose populations were determined by the population covered by their GP 'members' (Checkland et al., 2012). At the same time, the regionally-based intermediate tier of NHS management, Strategic Health Authorities, were abolished, with most of their functions moving to a new national commissioning organisation, the NHS Commissioning Board (later known as NHS England) (Lorne et al., 2019). In 2012 responsibility for Public Health passed to Local Authorities.

The result of these changes was a significant increase in the fragmentation of the commissioning landscape, with responsibility for commissioning services for populations no longer vested in a single geographically based commissioner. This fragmentation had significant consequences for some complex types of service, for which responsibility was now split between as many as three different commissioning organisations (Checkland et al., 2018). Community service commissioning became the responsibility of GP-led Clinical Commissioning Groups, and as such community services escaped some of the most negative impacts of the 2012 Health and Social Care Act, as responsibility for their commissioning was vested in a single body. Whilst competition was more firmly embedded in the statutory framework underpinning the NHS, in practice, competitive tendering of community service contracts was rare, particularly after the high-profile collapse of a number of large-scale procurement exercises (National Audit Office, 2016).

Not long after the enactment of the HSCA (2012) policy shifted sharply in favour of a more co-operative approach to service provision. In 2014, the *Five Year Forward View* (NHS England, 2014) set out an ambitious agenda for further reform based around integration between health care sectors and between health and social care services. Underpinned by a familiar policy drive to keep people out of hospital, the *Five Year Forward View* envisaged new forms of integrated care providers which would bring together primary, community and acute care services to deliver services to geographical populations. Funding was provided to pilots known as 'Vanguards', and it was intended that these would test out new models of service delivery. In particular, it was envisaged that new types of provider organisations or alliances (known as Integrated Care Providers) would develop, underpinned by new forms of contract which would provide capitation-based funding. However, in practice, whilst the pilot funding did catalyse a number of local service integration initiatives, large-scale integrated service models were not developed (Checkland et al., 2019). Notwithstanding this failure, towards the end of this era the policy landscape clearly shifted towards the more integrated approach to service delivery, with CHS at their core.

7.1.1 The Role and Function of Community/District Nursing Services

Against this background of a renewed focus upon shifting care into the community, the Department of Health (2013) along with the Queens Nursing Institute produced a framework, *Care in local communities: A new vision and model for district nursing*. In this was described the specific roles of district nurses in population and caseload management, delivering care for patients with long term conditions, preventive support as well as end of life care. In looking to the future, the document set out the requirements needed from the service to meet local population health care demands, whilst at the same time recognising that this depended on raising the profile of the service in order to attract nurses into it. Together with *Compassion in Practice* (DoH, 2012) these frameworks were intended to build competencies that would enable district nurses to meet the needs and expectations imposed by different healthcare settings and in particular by new models of service provision structured around integrating care (ibid.). District nursing services were meant to deliver services that promoted health and well-being and encouraged self-care in the person's own

home, independence, local surgery and community. However, to be effective these services needed to be locally led and appropriately integrated with social care.

Likewise, for the new care models to become a reality, staff needed to have a right skill mix and values that would support new ways of working (ibid.). In *Transforming Primary Care* (DoH, 2014), the government acknowledged that new ways of working required changes to be made to the traditional professional boundaries with an expectation that staff would be able to take on new roles that benefit patients. Joint working was encouraged particularly through the increased use of new technology to enable sharing of information about patients and make timely and effective decisions. District nurses were seen as central to the policy directed towards improving health outcomes by delivering community care, reducing admissions and supporting early discharge from hospitals. However, such policy documents and frameworks generated little change on the ground, with a continued focus upon teams of nurses overseen by qualified district nurses, alongside case managers or Community Matrons taking on a case load of the most complex patients.

7.1.2 The Management of Community/District Nursing and Population Covered

During this era, there was little change in the formal management arrangements for district nursing services. The CHS provider organisations—whether standalone or integrated with Acute Trusts—continued to operate services based around the commissioning of services under a block contract. However, at local level, in keeping with the ethos of the *Five Year Forward View* (NHS England, 2014) and the renewed emphasis on integration between services, some providers began to work more closely with other services such as social care, setting up integrated teams and broadening the use of multi-disciplinary teams to manage the health of the frail elderly. For example, in Greater Manchester, so-called Local Care Organisations were established (Walshe et al., 2018). These brought together community health and social care services into integrated teams, which were usually co-located. However, whilst teams potentially functioned in a more joined-up way, professionals retained their existing line management arrangements, and joint management boards had no statutory or formal decision-making powers, and funds were not formally shared. Thus, decisions continued to be made by the Boards of the

individual organisations, albeit with a strong ethos towards working in partnership. Such on-the-ground integration arrangements may support the delivery of more joined up care for patients, but professional tensions remained, with differences in terms and conditions between the different professions potentially problematic, alongside ongoing difficulties around data sharing (Mitchell et al., 2019).

More generally, whilst CHS engaged positively with a variety of integration initiatives, many of which included attendance at multi-disciplinary team meetings to support the co-ordinated delivery of care to frail elderly patients, day-to-day district nursing services continued to be delivered by teams of district nurses with a mix of skills and qualifications, generally covering geographical populations albeit with ongoing relationships with local GP practices.

7.1.3 Financing Community/District Nursing Services

During this short era, CHS continued to be delivered according to block contracts, with all of the complexities that such contracts bring in terms of managing increases in activity (Sussex, 2010). As discussed above, the *Five Year Forward View* (NHSE, 2014) proposed the development of new contractual models by which groups of providers would work together under a capitation-based contract (Sanderson et al., 2018), but such contractual models did not, in fact, develop. In 2015, a guide to commissioning Community Health Services was published by Monitor, which was at that time the organisation charged with regulating NHS Foundation Trusts. The report summarised the difficulties that commissioners reported that they experienced in commissioning community services:

> Commissioners said their greatest challenge in improving community services is a lack of robust activity, cost and quality data. Recording of data for community services has been poor historically. Because a wide range of community services is paid for with a fixed-sum payment, providers have had little incentive to understand the costs of individual services. Commissioners sometimes find it difficult to know whether providers are delivering value for money. In some cases, commissioners said, a lack of robust activity and cost data has hampered their efforts to determine costs for new pathways of care or for particular populations. (Monitor, 2015, p. 9)

Monitor reported that in 2013/2014 CHS accounted for £9.7 billion of NHS spending, with the vast majority of this allocated according to block contracts. 87% of services were provided by NHS providers, with this breaking down as 42% standalone Community Trusts, 18% integrated with Acute Trusts and 27% integrated with Mental Health Trusts. 7% of expenditure was with independent providers, and 4% third sector. More than 90% of CCGs contracted with a single large community provider for the vast majority of their services. Thus it would seem that the HSCA 2012 push for a more competitive approach had not generated any substantive change in the sector. The report goes on to summarise commissioners obligations under competition regulations, and to encourage 'competitive dialogue' in actively commissioning services, rather than continuing to roll over existing contracts, concluding with an exhortation to use the opportunities associated with the Vanguard programme to develop new contractual models or payment systems.

7.1.4 Summary

The HSCA, 2012 began to unravel almost as soon as it was enacted, with the emphasis on competition undermined by the *Five Year Forward View* shift towards integration between sectors as a dominant organising principle. The Foundation Trust regulator, Monitor, appears to have taken the view that the way in which the circle could be squared between greater competition and better integration was via the competitive awarding of large-scale contracts to alliances of different types of providers, as well as to single independent providers. The extent to which this has actually occurred is unclear, with competitive tendering more common in some regions than others. A National Audit Office report suggests a combination of reluctance on the part of NHS commissioners in many areas, and some failures in commissioning practice may have influenced this (National Audit Office, 2016). CHS were, to some extent, protected from the fragmentation associated with the Act, and in terms of district nursing practice, this era generated little change with patterns of service provision remaining very much as they were following the upheaval generated by the Transforming Community Services agenda. At local level, various integration pilots and initiatives supported the development of multidisciplinary teams, with ongoing emphasis on the need to develop services to keep people out of hospital. District nursing practice remained largely unchanged, other than something of a shift towards case management of

complex patients by senior nurses. Day-to-day services continued to be delivered by teams of nurses and health care assistants, led by qualified district nurses. The continued use of block contracts and limited availability of high-quality data about service activity or outcomes rendered investment or innovation difficult to achieve on any scale (Monitor, 2015).

References

Checkland, K., Coleman, A., Billings, J., Macinnes, J., Mikelyte, R., Laverty, L., & Allen, P. (2019). *National Evaluation of the vanguards programme*. Policy Research Unit in Commissioning and the Healthcare System (PRUComm).

Checkland, K., Coleman, A., Segar, J., McDermott, I., Miller, R., Wallace, A., Peckham, S., & Harrison, S. (2012). *Exploring the early workings of emerging clinical commissioning groups: Final report*. Policy Research Unit in Commissioning and the Healthcare System (PRUComm).

Checkland, K., Hammond, J., Sutton, M., Coleman, A., Allen, P., Mays, N., Mason, T., Wilding, A., Warwick-Giles, L., & Hall, A. (2018). *Understanding the new commissioning system in England: Contexts, mechanisms and outcomes*. University of Manchester: Policy Research Unit in Commissioning and the Healthcare System (PRUComm).

DoH—Department of Health. (2010). *Equity and excellence: Liberating the NHS*. Department of Health.

DoH—Department of Health. (2012). *Compassion in practice National Vision and strategy for nurses*. Department of Health.

DoH—Department of Health. (2014). *Transforming primary care*. Department of Health.

DoH—Department of Health Public Health Nursing. (2013). *Care in Local Communities—A new vision and model for district nursing*. Department of Health.

Exworthy, M., Mannion, R., & Powell, M. (Eds.). (2016). *Dismantling the NHS? Evaluating the impact of health reforms*. Policy Press.

HSCA. (2012). Health and social care act 2012. Retrieved August 20, 2021, from https://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

Lorne, C., Allen, P., Checkland, K., Osipovic, D., Sanderson, M., Hammond, J., & Peckham, S. (2019). *Integrated care systems: What can current reforms learn from past research on regional co-ordination of health and care in England? A literature review*. Policy Research Unit in Commissioning and the Healthcare System (PRUComm).

Mitchell, C., Tazzyman, A., Howard, S., & Hodgson, D. (2019). *Understanding and supporting the integration of health and social care at a neighbourhood level*

in the City of Manchester. University of Manchester: NIHR Collaboration for Leadership in Applied Health Research and Care Greater Manchester.
MONITOR. (2015). *Commissioning better community services for NHS patients*. Monitor.
National Audit Office. (2016). *Investigation into the collapse of the uniting care partnership contract in Cambridgeshire and Peterborough*. NAO.
NHS England. (2014). *Five year forward view*. NHS England.
Sanderson, M., Allen, P., Gill, R., & Garnett, E. (2018). New models of contracting in the public sector: A review of alliance contracting, prime contracting and outcome-based contracting literature. *Social Policy and Administration, 52*(5), 1060–1083.
Sussex, J. (2010). *Competition in the NHS: 'Payment by results'*. OEH.
Timmins, N. (2012). *Never again? The story of the health and social care act 2012. A study in coalition government and policy making*. The King's Fund.
Walshe, K., Lorne, C., McDonald, R., Coleman, A., & Turner, A. (2018). *Devolving health and social care: Learning from greater Manchester, project report*. University of Manchester.