

# Health and Social Care Bill

## Public Bill Committee Written Evidence 24 June 2011

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### OVERVIEW

#### 1. ABOUT THE NHS CONFEDERATION

- 1.1. The NHS Confederation is the independent membership body for the full range of organisations that make up the modern NHS. We have over 95 per cent of NHS organisations in our membership including ambulance trusts, acute and foundation trusts, mental health trusts and primary care trusts plus a growing number of independent healthcare organisations that deliver services on behalf of the NHS.
- 1.2. We are uniquely placed to consult with and speak for the health system as a whole. To advise the Government on the reforms, we have been consulting extensively with our members across the country since July 2010 through engagement events, consultation, and other formal and informal mechanisms, to hear their views on the proposed changes.

#### 2. OUR VIEW OF THE CURRENT REFORM PROPOSALS

- 2.1. We would like to make clear that the NHS Confederation is in favour of NHS reform. Demand for healthcare is growing year after year and it is not sustainable to continue increasing indefinitely the proportion of national wealth that is spent on these services.
- 2.2. The changes the Government has made after the 'pause' answer some of our concerns about how the health reforms will affect the NHS. We welcome a wider range of healthcare professionals working with GPs on commissioning, an increasing emphasis on ensuring services for patients are integrated, and introducing a flexible timetable to manage transition to the new system. However, the changes open up new areas of uncertainty about whether the compromises that have emerged will work in practice.

Further detail is needed before we can be confident that these changes will deliver the outcomes intended by the Government.

- 2.3. We are also still concerned that the reforms do not sufficiently focus on the big challenges facing the NHS: making £20 billion of efficiencies over four years, providing a consistently high quality of care across the country, and providing better joined-up care for individual patients and their families. Even after the 'pause' we are not confident that the different elements of the reforms will fit together and deliver a coherent system for patients.
- 2.4. The behaviours of all the organisations in the new system will be critical to determining its success. There is a limit to which this can be enshrined in legislation. Therefore more thought needs to be given to the culture of the system and the way the actors within it work together in the interests of patients.
- 2.5. The changes made by the Government have raised a number of new questions about the health bill and wider reform programme. The key question is how the national and local organisations making up the new system will pull together to meet the big challenges facing the NHS. This will depend on getting the balance right in three key areas between:

**Central and local decision-making and financial control**

- 2.6. The role of the NHS Commissioning Board has been extended, which means decision-making and financial control are more centralised than previously anticipated and far more than is the case in our current health system. This is particularly the case in the early years of the NHS Commissioning Board when it will commission on behalf of any clinical commissioning consortia that are not ready to do so. We would like a duty or responsibility placed on the NHS Commissioning Board to build local capacity and capability so devolution of power to clinical commissioning consortia can take place steadily and safely. We would welcome a clear timetable for transition in areas where the NHS Commissioning Board is holding key national functions in the short term as a safeguarding measure, such as supporting leadership resources.

**Making timely decisions and engaging professionals and communities**

- 2.7. The new system could make it more difficult to make urgent decisions about reconfiguring local services when this will improve the quality of care

for patients, for example by moving care into bigger specialist centres or out of hospitals into local communities. Clinical senates will advise the NHS Commissioning Board on major service changes, local authorities can challenge substantial service reconfiguration proposals, and the Government's 'four tests' on reconfiguration will be retained including strong patient and public engagement. Consortia must be allowed the freedom to make decisions – and therefore bureaucracy must be kept to a minimum. We would welcome confirmation from Government that commissioning consortia will have the authority to make decisions about local reconfiguration, through open and transparent processes with appropriate timetables for carefully considering the evidence base and engaging clinical senates, local authorities, patients and the public.

### **Using innovation to drive up quality**

- 2.8. Forty per cent of NHS services are not covered by the NHS tariff, which sets a fixed fee for a particular treatment and means that a range of providers can be asked to demonstrate who can provide the best quality service for a fixed price. Non-tariff services include support for people with long term conditions, community services, ambulance services and mental health services. The Government has promised to extend and adapt the tariff to support the extension of 'any qualified provider' across a wider range of services so that providers can compete on quality not price. Given the technical difficulties and under-resourcing of work to extend the tariff to cover a wider range of treatments, this could obstruct and significantly delay the introduction of new providers just where innovation is most needed to improve the quality of patient care. We would welcome greater clarity from Government on how and when the NHS tariff will be extended to cover a wider range of treatments.
- 2.9. In addition to getting the balance right in these key areas, we have three key concerns that we would like Government to address.

### **Avoiding unnecessary complexity**

- 2.10. The current NHS structure has 10 strategic health authorities and 151 primary care trusts that purchase primary and secondary care services from a range of providers. The proposed NHS structure is more complex with an NHS Commissioning Board, 4 strategic health authority clusters, 50 primary care trust clusters (which will be reflected in the regional NHS Commissioning Board in the longer term) and possibly around 250 clinical commissioning consortia that will purchase secondary care services. Clinical networks and clinical senates will support commissioning consortia and 150 local government health and well-being boards will work in

partnership with them. The NHS Commissioning Board will purchase primary care services. We would welcome clarity from Government on how complexity will be minimised in the new structure among a range of bodies with advisory roles, oversight responsibilities and decision-making authority.

### **Improving the quality of primary care**

- 2.11. We continue to be concerned about whether the NHS Commissioning Board will be able to performance manage primary care from a distance and whether it will have appropriate expertise. Apart from the problem of one national organisation managing more than 8,000 separate contracts, as well as those for dentists, pharmacists and optometrists, the absence of formal performance management responsibility could weaken the potential for commissioning consortia to drive improvements in primary care. It will be important for consortia to have leverage over quality and value for money in individual GP practices. We believe Government should clarify how the quality and value for money of primary care services will be monitored and improved, what the role of commissioning consortia will be in this, and what the relationship between the NHS Commissioning Board and commissioning consortia will be.

### **Managing failing services**

- 2.12. The design of a failure regime for providers has tended to focus on the complete failure of an NHS trust, but this is likely to be a very rare event. It is much more likely that an individual service such as a particular specialist area or a small district general hospital will become financially unviable or experience problems with quality or safety. The Health and Social Care Bill set out proposals to protect patients' access to essential services by designating which services should be subject to additional regulation, but the Government's response to the NHS Future Forum has withdrawn this proposal. We would welcome clarity from Government on how and when an appropriate failure regime will be designed, and how the NHS Confederation and its networks can contribute to this work.

## **DETAILED POINTS ON CLAUSES DUE FOR DEBATE**

This section sets out our current analysis and concerns about the Government's proposed changes to the Bill, together with our recommendations to the Committee. Given the limited time available to us to scrutinise the large number of amendments, we are likely to identify additional concerns over time as we and our members consider the practical implementation of the Bill.

### 3. ROLE AND POWERS OF THE SECRETARY OF STATE (*Clauses 1, 2, 3 and 4 and New Clauses 1-4*)

- 3.1. We have called for the Bill to make clear that the Secretary of State is accountable to Parliament, and through Parliament to the voters, for the promotion of a comprehensive health service and for the use of public money. We welcome the Government's proposal to clarify in the Bill the Secretary of State's ultimate accountability for the provision of services in the new system.
- 3.2. We also welcome the Secretary of State's powers to report on the performance of national NHS bodies (***New Clause 2***). This could be an important part of processes to hold various national bodies to account for how they discharge their responsibilities in practice, particularly how they fulfil their duty to co-operate.
- 3.3. The Government has tabled ***New Clause 4*** regarding the 'Secretary of State's duty as respects variation in provision of health services'. However, we believe this proposed clause is ambiguous. It is not clear, for example, that if services were put out to tender and this resulted in a 'variation in provision of health services' either by the public or private sector, whether this would be deemed to fall foul of this clause.
- 3.4. **The Committee should seek clarification of the intended meaning of this amendment.**
- 3.5. Ministers will have extensive powers of intervention in the event of 'significant' failure. We have commented previously on the need to ensure the Secretary of State's powers do not inappropriately restrict organisations' ability to make decisions. It is important that intervention by ministers is in practice limited to significant failures.
- 3.6. **The Committee should ask whether Ministers will have to demonstrate reasonable grounds for intervention.**

### 4. THE NHS COMMISSIONING BOARD (*Clauses 5, 11, 19, 20 and Schedule 1*)

#### **Role of the NHS Commissioning Board**

- 4.1. The NHS Commissioning Board should retain a clear focus on commissioning and avoid becoming a convenient location for a range of other functions. Where the Board is holding key functions (for example, leadership development resources) as a safeguarding measure, it should be responsible for developing a clear process and timetable for devolving them.

- 4.2. **The Committee should seek clarity about how any non-commissioning functions held by the NHS Commissioning Board will be devolved and ask whether it will be required to develop a timetable.**

**NHS Commissioning Board: accountability and engagement**

- 4.3. Given the extended role of the NHS Commissioning Board, there is an even greater need for it to be accountable, not just to the Secretary of State but at all levels. Although the Government's response to the NHS Future Forum made clear that clinical commissioning groups' governance arrangements should comply with Nolan principles of public life, they have not proposed to apply this to the NHS Commissioning Board.
- 4.4. **The Committee should press the Government to require the Board to comply with Nolan principles and have a properly established board which meets in public and publishes its papers.**
- 4.5. Changes to **Clause 19** appear to mean the NHS Commissioning Board will be expected to consult patients and the public about *any* changes to services, rather than 'significant' changes. Depending how the legislation is applied, this could undermine its ability to take decisions and set priorities.
- 4.6. **The Committee should ask how the Government will ensure this is applied in a way that is proportionate and workable.**
- 4.7. We welcome the commitment that the Board will have a national director responsible for patient and public engagement. It is important this is translated into practical engagement, not least in relation to primary care services. The Board should have duties to engage with both national and local HealthWatch in drawing up its plans, and be required to consult with local HealthWatch when making decisions to dissolve clinical commissioning groups.
- 4.8. **The Committee should seek clarification on how and in what circumstances the NHS Commissioning Board will be expected to engage with national and local HealthWatch.**
- 4.9. It is vital that information from complaints informs commissioning decisions (**Clause 19**). The Board should have a duty to publish information about any complaints received about its commissioning decisions and how it has responded, and a duty to publicise arrangements for dealing with complaints. It should be required to publish an annual report setting out

how it has discharged its responsibilities for involving patients and the public in its commissioning plans and decisions.

- 4.10. **The Committee should ask the Government to clarify expectations of the NHS Commissioning Board in relation to complaints handling.**

#### **Performance management of primary care**

- 4.11. We continue to be concerned about whether the NHS Commissioning Board will be able to performance manage primary care from a distance and whether it will have appropriate expertise. Apart from the problem of one national organisation managing more than 8,000 separate contracts, as well as those for dentists, pharmacists and optometrists, the absence of formal performance management responsibility will weaken the potential for commissioning consortia to drive improvements in primary care. We recommend that the Board be required to actively seek feedback from consortia on its performance as a commissioner of primary care.
- 4.12. It will be important for consortia to have leverage over quality and value for money in individual GP practices. Given the valuable role that peer review can play in performance management, we would like the Board to use its powers to delegate management of GP contracts to commissioning consortia wherever they are confident that the consortium has appropriate systems in place to manage this effectively.
- 4.13. **The Committee should ask the Government to clarify how the quality and value for money of primary care services will be monitored and improved, what the role of commissioning consortia will be in this, and what the relationship between the NHS Commissioning Board and commissioning consortia will be.**

## **5. CLINICAL ADVICE ABOUT COMMISSIONING**

- 5.1. We welcome in principle the involvement of a wider range of healthcare professionals in commissioning at both a national and local level, having argued that setting up clinical advisory bodies to support consortia could represent a positive way forward. Mental health providers particularly welcome the concept of managed mental health networks offering support and input to commissioning, albeit there will be a distinct need to make sure networks are made up of a wide range of mental health professionals and colleagues from services such as housing and social care, as well as mental health clinicians.

- 5.2. It will be important that the clinical networks and clinical senates include input from a wide range of health professionals. For example, community health services represent a large part of the health service, costing over £11 billion per annum and employing some 250,000 staff, but there has been no specific reference to engaging community health service professionals. It is also unclear how clinicians' work within networks and senates will be funded; even if the roles are unpaid, senior locum cover and travel expenses will have to be funded for a large number of people.
- 5.3. **We would like the Committee to ask about what kinds of health professionals will be engaged in providing advice and support to commissioners, and how this will be funded.**
- 5.4. The establishment and running of these multiple networks and senates alongside health and well-being boards, the National Institute for Health and Clinical Excellence (NICE) and Public Health England has the potential to become extremely complex and confusing.
- 5.5. **The Committee should ask:**
- 5.5.1. **how the new system for securing clinical input will be made coherent and streamlined**
  - 5.5.2. **what status and authority ministers envisage for the advice and recommendations from these entities – including what will happen where clinicians' and the public's views conflict**
  - 5.5.3. **how complexity will be minimised in the new structure among a range of bodies with advisory roles, oversight responsibilities and decision-making authority.**

## **6. COMMISSIONING CONSORTIA / CLINICAL COMMISSIONING GROUPS** *(Clauses 6, 9, 10, 21, 22, 23, 24 and schedules 2, and 3)*

### **Decision making authority of commissioning consortia**

- 6.1. The new system could make it more difficult to make urgent decisions about reconfiguring local services when this will improve the quality of care for patients, for example by moving care into bigger specialist centres or out of hospitals into local communities. Clinical senates will advise the NHS Commissioning Board on major service changes, local authorities can challenge substantial service reconfiguration proposals, and the Government's 'four tests' on reconfiguration will be retained including strong patient and public engagement.

6.2. Further clarity is needed about how commissioning consortia will be held to account by the Board. Whilst only the NHS Commissioning Board will have the power of veto over commissioning consortia's decisions, a large number of groups that commissioners must consult have links back to the Board and the degree to which they can in practice also exercise a veto is unclear. We believe it needs to be made clearer that, whilst various bodies *advise*, it is ultimately for commissioners to *decide* – though they should set out their rationale where they have gone against advice. Clarity about the status of guidance (particularly which elements represent compulsory policy) will also be essential.

6.3. **The Committee should:**

6.3.1. **ask the Government to confirm that commissioning consortia will have the authority to make decisions about local reconfiguration, through open and transparent processes with appropriate timetables for carefully considering the evidence base and engaging clinical senates, local authorities, patients and the public**

6.3.2. **ask the Government to consider a duty on the NHS Commissioning Board to promote the autonomy of local commissioners**

6.3.3. **seek clarity on how the Commissioning Board will assess failure or potential failure of commissioning consortia**

6.3.4. **seek a commitment that local commissioners' decision making about applying competition and choice will not be subject to detailed, overly prescriptive guidance**

6.3.5. **ask about the future of the Independent Reconfiguration Panel.**

**Accountability and governance of commissioning consortia**

6.4. We welcome the focus on ensuring strong and transparent governance of commissioning consortia. We are particularly pleased that both the Government and the Future Forum agreed with our recommendation that Nolan principles should be applied to commissioning consortia, as we have argued consistently for this. We are also pleased in principle that health and well-being boards will play a greater role in holding commissioning consortia to account, though commissioners need clear decision making authority.

6.5. We welcome the concept of engaging a wider group of professionals in commissioning. However, we are concerned that intention to require the inclusion of a nurse and secondary care specialist on every commissioning consortium's governing body confuses advice with governance and may

add little clinical value since clinical senates will give clinical advice. It may also be very difficult in practice to find a nurse and secondary clinician living in the local area but with no conflict of interest. As with clinical networks and senates (see above) there is also the question of who will fund professional and lay participation.

6.6. **The Committee should ask the government how it will ensure the specialist input on commissioning consortia boards has a broad overview of clinical services and not just their own specialism.**

6.7. **The Committee should seek clarity on how professional and lay participation on these boards will be funded.**

#### **Alignment between NHS and local authority boundaries**

6.8. We welcome greater alignment between the boundaries of NHS and local authority bodies – benefits of this are likely to include better integration between health and social care and other local authority functions such as housing. However, we would have concerns if the new approach has the effect of undermining or stalling progress and enthusiasm where commissioning consortia that cross boundaries or are not geographically linked have already been established.

6.9. **The Committee should ask ministers how they will ensure that this does not slow down the establishment of commissioning consortia where good progress is being made.**

#### **Commissioning consortia's role in quality and safety**

6.10. Commissioners have a crucial role to play in driving up quality and monitoring safety through their monitoring and decision making, though the boards of provider organisations will remain primarily responsible for quality and safety. It will be essential for the NHS Commissioning Board to define the nature of the responsibility of commissioners in relation to quality and safety, as part of the overall system.

6.11. **The Committee should ask how and when the responsibilities of commissioners in relation to quality and safety will be specified.**

6.12. We agree with the Government that the quality premium requires careful consideration and design to ensure that there are sufficient incentives in the system but that these do not have unintended consequences.

- 6.13. **The Committee should seek clarity on both how the quality premium will work and how it is to be funded.**

#### **Commissioning regional services**

- 6.14. We previously highlighted our concern that the NHSCB holding contracts for some parts of pathways and consortia for others could undermine integration. Similarly, the relaxation of the April 2013 deadline for commissioning consortia (which we support) does mean that regional services (services with a regional element include ambulance services, trauma, stroke and cancer) will then be commissioned from a variable mix of commissioning consortia and NHSCB in each region (potentially with a mix of national and local understanding and agendas to consider). This may make it very challenging to commission services that fit together well for patients.
- 6.15. **The Committee should seek clarification about how commissioning will operate in these circumstances.**

## **7. TRANSITION TO THE NEW SYSTEM (Clauses 28, 29 and 176)**

#### **Transition timetable**

- 7.1. We agree there is a need to find a balance between maintaining momentum and allowing more time to recognise that some organisations may not be ready to take on their full responsibilities on the current timetable.
- 7.2. We welcome the introduction of a flexible timetable to manage the transition to the new system. As we set out in our response to the NHS Future Forum, a variable-speed approach to the new commissioning architecture is sensible, but there will need to be strong incentives for and support to local practices to form viable commissioning consortia in a timely manner. As mentioned in the section on the NHS Commissioning Board above, we also need to ensure the new system is not over centralising and there is real momentum towards the important goal of phasing responsibility and decision making powers to the local level. We believe the Board should have a duty or responsibility to build capacity and capability within commissioning consortia so that devolution of power and responsibility can occur steadily and safely.
- 7.3. **The Committee should ask the Government whether it will introduce such a duty for the Board.**

### **Clarity during the transition**

7.4. There may be some legal issues to resolve if all commissioning consortia are to be established as legal entities by April 2013 (for example, will commissioning consortia be able to delegate their statutory responsibility as well as their commissioning activities to the NHS Commissioning Board?). It will be necessary to ensure that there is a clear process and accountability for local decision-making during the transition, and clarity about arrangements for public health functions including emergency planning at a regional level. Further clarity is also needed about the future status of Primary Care Trust clusters so that a proper transition to the NHS Commissioning Board can be planned and staff are given some certainty regarding their likely futures.

7.5. **The Committee should ask the minister when clarification on these points will be available.**

### **The future home of the medical deaneries (Clause 28)**

7.6. The Government has said that during the transition, deaneries will continue to oversee the training of junior doctors and dentists, and be given 'a clear home within the NHS family'. Skills and expertise from the current SHA and medical deanery commissioning functions must be secured by the new system, while still separating commissioning from training delivery. One of a number of options is to place responsibility for education and training in large hospitals, though this must not become a permanent solution by default.

### **Foundation Trust deadline (Clause 176)**

7.7. The softening of the 'drop dead' date for FTs could mean a slower pace to achieving a whole FT sector. However, some trusts, while understanding the need to get to FT status at pace and being committed to this, welcome this approach as it allows more scope to get to grips with major and immediate changes and challenges. There is a difficult balance to be struck between maintaining momentum and a safe and stable transition.

7.8. **The Committee should satisfy itself that there will be a clear end point for all Trusts that have not been able to take on FT status by April 2014.**

## **8. COMPETITION, CHOICE AND ECONOMIC REGULATION**

8.1. The NHS Confederation supports the use of competition and choice wherever they benefit patients and the taxpayer. The independent and third sectors have an important role to play in delivering the best patient

care. We agree with the Future Forum that the debate on choice and competition has become unhelpfully polarised.

- 8.2. We believe the appropriate use of competition is right for patients because:
- 8.2.1. providers from the private and voluntary sectors have proved that they can deliver the appropriate standards of quality and efficiency
  - 8.2.2. evidence suggests that the right sort of competition between providers drives improvements in quality and efficiency
  - 8.2.3. competition is one route to improving patient choice
  - 8.2.4. not all our healthcare services are as good as they should be. We cannot allow any provider to have a permanent hold over services when they have failed to deliver to the appropriate standards.
- 8.3. We do not regard competition and integration as necessarily contradictory. The NHS Confederation welcomes the increased emphasis on ensuring services for patients are integrated. While much of the debate focuses on integration between health and social care (which we support) vertical integration in services such as stroke can also deliver significant benefits for patients and the reforms need to enable this to happen. We are also pleased that the Government has heeded our argument that innovative approaches such as single budgets for health and social care and integrated tariffs should be explored and we look forward to contributing to the NHS Commissioning Board's work on this.

#### **Monitor's remit**

- 8.4. The NHS Confederation believes the creation of a sector regulator is an essential part of the new system and we are keen to contribute to its detailed design. Following the changes made during the pause, a clearer articulation of the role of Monitor in the system is required.
- 8.5. There will be some apprehension around extending Monitor's jurisdiction over all FTs up to the end of 2016 as Monitor's special responsibility for FTs' success could give it a conflict of interest.
- 8.6. **The Committee should request a clearer explanation of how Monitor will be expected to manage the potential conflict of interest arising from the decision to extend its responsibility for the FT compliance regime to 2016.**
- 8.7. The Government has tabled a number of amendments to the Bill (for example, to **Clause 67**) which require Monitor to examine "anti-competitive behaviour which is against the interests of people who use such services".

- 8.8. **The Committee should seek clarification on how this amendment sits alongside the existing principles and rules on co-operation and competition which it proposes to retain – these refer to ‘patients and taxpayers’ interests’ and not just ‘the interests of people who use such services’.**
- 8.9. The Government has stated it will remove from the Bill the proposed power for Monitor to require an existing provider to allow another provider access to its facilities. We support this in principle.

#### **Need for clarity on dispute resolution**

- 8.10. The Government’s latest proposals would give the NHS Commissioning Board the lead role in determining the extent of competition and choice, through guidance, in consultation with Monitor. We are concerned that there is no clear dispute resolution procedure in the event of a major difference of view between the Board and Monitor. One approach may be to specify that the Secretary of State would resolve any dispute regarding policy issues, and the OFT would resolve any dispute on legal competition issues.
- 8.11. **The Committee should ask the Government to clarify how disputes between the NHS Commissioning Board and Monitor over competition and choice will be resolved.**
- 8.12. Similarly, though we welcome the retention of the Cooperation and Competition Panel (CCP) within Monitor, the CCP and Monitor may hold different views on what is in ‘the interests of patients and taxpayers’. Again, there is no dispute resolution procedure. Though, given CCP has no powers of direction, Monitor may in theory be able simply to not implement a CCP view with which it disagrees. This approach would probably lead to the plaintiff straight to the courts.
- 8.13. **The Committee should ask the Government to clarify how disputes between the CCP and Monitor will be resolved.**
- 8.14. **The Committee should also seek further details of how the ‘Chinese wall’ between Monitor and the Cooperation and Competition Panel will operate.**

#### **Duty to promote integration**

- 8.15. The Government has stated that Monitor will be required to support the delivery of integrated services for patients where this would improve quality of care for patients or improve efficiency and will be expected to make the

best trade off between the benefits of competition and integration. However, safeguards may be needed to ensure that Monitor's new duty to promote integration avoids the trap of promoting integration for the sake of integration: the key deciding factor should be the benefit to patients.

- 8.16. Similar considerations apply to the proposed new duty for commissioning consortia to promote integrated services. It will also be important for Monitor to operate and behave in a way that acknowledges this duty on commissioners – so that commissioning consortia do not find themselves subject to criticism from the NHS Commissioning Board for not promoting integration enough whilst simultaneously being challenged by Monitor for promoting integration too much.
- 8.17. **The Committee should ask how Monitor will ensure there are demonstrable benefits to patients whenever it promotes integration.**
- 8.18. Work to develop a better understanding of what form of competition will deliver the best outcomes for patients at different stages of long-term condition pathways would be particularly valuable in helping commissioners decide how and when services should be bundled or integrated.
- 8.19. **The Committee should ask about the Government's plans in this area.**
- 8.20. In addition, a greater degree of clarity and consistency about what is meant by 'integration' is required, including recognition that this should include integration between secondary and community health providers (vertical integration). We would welcome a commitment that, where possible, the competition and procurement rules and guidance will be written in such a way that there is clear scope for a range of highly integrated models. This should include scope for pricing, currencies and contracts to be adjusted locally to allow for more integrated systems of delivery.

#### **Monitor and patient and public engagement**

- 8.21. Monitor's work will have a significant impact on patients and the 'patient interest' is supposed to be the core rationale for its approach. The NHS Confederation's previous submission to this Committee noted that the public consultation and patient and public involvement requirements on Monitor appeared to be minimal. It is also unclear how it will establish what

the interests of patients are. We do not believe it can rely solely on linking to HealthWatch England for this.

- 8.22. **The Committee should ask for clarification on how Monitor will engage with patients and the public and how it will establish the interests of patients.**

**Using Any Qualified Provider (AQP) to improve patient services**

- 8.23. The Government has stated that it will phase in the extension of Any Qualified Provider (AQP), starting from April 2012. We have argued for a phased approach and in principle we are pleased this will be adopted. AQP should be rolled out as widely as is in the interests of patients.
- 8.24. Forty per cent of NHS services are not covered by the NHS tariff, which sets a fixed fee for a particular treatment and means that a range of providers can be asked to demonstrate who can provide the best quality service for a fixed price. Non-tariff services include support for people with long term conditions, community services, ambulance services and mental health services. The Government has promised to extend and adapt the tariff to support the extension of 'any qualified provider' across a wider range of services so that providers can compete on quality not price. Given the technical difficulties and under-resourcing of work to extend the tariff to cover a wider range of treatments, this could obstruct and significantly delay the introduction of new providers just where innovation is most needed to improve the quality of patient care. We would welcome greater clarity from Government on how and when the NHS tariff will be extended to cover a wider range of treatments. **(Clauses 114 – 117)**
- 8.25. **The Committee should ask whether the current level of investment in extending the tariff is adequate, and what timescale the government expects this to proceed to.**
- 8.26. In this context we also note that the Government intends to introduce a specific duty on Monitor in setting the national tariff to ensure that efficient providers are paid fairly, taking into account the clinical complexity of the cases that they treat. More sophisticated pricing is needed, but designing prices that 'reflect clinical complexity' will itself be a complex task, has not been sufficiently resourced and depending on how it is designed it could result in tariff inflation.

### **Failure regime for providers**

- 8.27. The Health and Social Care Bill set out proposals to protect patients' access to essential services by designating which services should be subject to additional regulation, but the Government's response to the NHS Future Forum has withdrawn this proposal. Given it is not possible for a perfect market in healthcare services to operate everywhere (for example, rural areas where the population may be too small to support essential services) the requirement for a mechanism to address the question of identifying and ensuring the provision of essential services remains. Commissioners and providers need the Government's approach to this to be clarified as soon as possible.
- 8.28. **The Committee should ask ministers how and when they plan to address the question of identifying and ensuring the provision of essential services where a 'perfect' market cannot operate.**
- 8.29. The Government's full response to the Future Forum also stated its intention to develop an effective failure regime. We agree a failure regime is urgently needed and progress in this area should be a priority. The NHS Confederation and its networks would welcome the opportunity to contribute to this work. The design of a failure regime for providers has tended to focus on the complete failure of an NHS trust, but this is likely to be a very rare event. It is much more likely that an individual service such as a particular specialist area or a small district general hospital will become financially unviable or experience problems with quality or safety. We believe the failure regime must:
- 8.29.1. Incorporate clear criteria and expert, independent external scrutiny of these decisions
  - 8.29.2. Be applied in a way which is independent of Government
  - 8.29.3. Allow a managed transition where providers stop providing services, so that patient care is not disrupted.
- 8.30. **The Committee should ask the Government to clarify how and when an appropriate failure regime will be designed.**

## **9. FOUNDATION TRUSTS**

### **Separate accounts for NHS and private work**

- 9.1. The Government is proposing to require foundation trusts to produce separate accounts for NHS and private-funded services. Foundation trusts have always been clear about the need for transparency in the way in

which they use any funding under the cap for the benefit of NHS patients. They will use the freedom afforded by the lifting of the private patient income cap to enhance patient choice, enable foundation trusts to extend their services to patients and bring in additional resources for the benefit of NHS patients. The Government should minimise the burden of bureaucracy associated with this. One approach may be to adopt a system similar to that which requires charities to separate restricted and unrestricted income and expenditure.

9.2. **The Committee should seek an assurance from the Government that bureaucracy will be minimised.**

9.3. **Relaxation of 2014 deadlines for trusts to receive FT status**

9.4. Please refer to the earlier section regarding transition to the new system.

## **10. HEALTHWATCH (*Clauses 178, 179, 180 and schedule 15*)**

10.1. We welcome the Government's commitment to strengthening patient and public involvement at a local and national level. We are pleased that the CQC will be required to respond to advice from HealthWatch England and the Secretary of State will have to consult HealthWatch on the NHS Commissioning Board's mandate.

### **Empowering local people**

10.2. We agree that local HealthWatch should be required to have membership that is representative of different users, including carers and children. However we feel that the legislation could go further to empower local people. Where local people feel the local HealthWatch is failing to represent the views of key groups of service users adequately, there should be provision to raise this with the local authority and/or HealthWatch England. HealthWatch England should be able to provide mandatory advice to the local body on how to ensure it reflects the range of community views.

10.3. **The Committee should ask how local healthwatch's effectiveness in gathering the representative views of the local community will be assessed, and what avenues are open to patients and the public if they feel the local healthwatch is failing to represent the views of key groups adequately.**

- 10.4. **Given local authorities will fund local healthwatch, the Committee should also ask what safeguards will be implemented to address the potential conflict of interest where a local healthwatch scrutinises services which are funded by the local authority, such as social care.**

**Using patient feedback and complaints to inform commissioning decisions**

- 10.5. We were disappointed that the Government's response did not cover how the complaints system could inform decisions. If commissioning consortia are not informed about complaints and feedback on services, concerns raised by patients cannot inform their commissioning decisions. As a result there may be missed opportunities to drive up quality. Complaints handling is particularly important in relation to primary care because there is a known reluctance among people to complain about their GP or other primary care provider. It is also unclear who patients (and MPs) should go to when a complaint concerns several services including primary care.
- 10.6. **The Committee should ask the government when they will clarify how they see complaints handling and monitoring in relation to primary care and the decisions of commissioning consortia working.**

**Independence and autonomy of HealthWatch England**

- 10.7. We are concerned that the Bill does not address the lack of independence and autonomy of HealthWatch England from the Care Quality Commission (CQC). To work effectively HealthWatch needs to be seen as a strong independent voice for patients that is a resource for the whole system, not just an arm of the CQC. Key requirements to secure independence include: the ability to set its own agenda; the ability to speak out publicly where it considers this appropriate; a dedicated, annual budget to support the work of the organisation; a dedicated support team to work in the interests of the organisation; and an independent appointment of panel members according to Nolan Principles following open public recruitment.
- 10.8. **The Committee should satisfy itself that HealthWatch England has sufficient power and independence from the CQC.**

**Reducing unnecessary bureaucracy**

- 10.9. The Government should consider placing a duty on health and well-being boards, local healthwatch, and overview and scrutiny committees to avoid duplication of information and inspection requirements on local providers.
- 10.10. **The Committee should ask how duplication and overlap of information and inspection requirements will be avoided in the new system.**

### **Links between local healthwatch and health and well-being boards**

- 10.11. Local healthwatch should have powers to make formal representations to the health and well-being board and the relevant local authority scrutiny about the local services, including issues of access, quality and people's experiences of those services, and that they should have a duty to respond within a specific timeframe.
- 10.12. **The Committee should ask how ministers envisage local healthwatch improving the quality of local services.**

## **11. HEALTH AND WELL-BEING BOARDS (*Clauses 189 – 193*)**

### **Powers of health and well-being boards**

- 11.1. We are pleased to see the Government outlining the role and powers of health and well-being boards clearly, something which we called for. However, it needs to be made clearer that, whilst the health and well-being board's advice should be sought, it is ultimately for commissioners to *decide* – though they should set out their rationale where they have gone against advice.
- 11.2. We welcome the right of health and well-being boards to refer back to commissioning consortia local commissioning plans that are not in line with the health and well-being strategy. They should also hold local authorities accountable for their public health expenditure. However the behaviours of all involved will be critical. For example, it will be important that reconfiguration proposals that would benefit patients cannot be prevented by short-term political considerations. We would like the Government to monitor how this works in practice and whether disagreements are resolved effectively.
- 11.3. Before establishing any commissioning consortium, the NHS Commissioning Board will be required to seek the views of emerging health and well-being boards. We believe health and well-being boards should work with commissioning consortia in relation to their strategies, but giving them a formal role in consortia authorisation risks creating an unnecessary conflict of interest given commissioning consortia will be represented on health and well-being boards.

### **Local accountability of health and well-being boards**

- 11.4. We welcome the new duty to involve users and the public. Health and well-being boards should be required to publicise their work and to hold open meetings, in line with the Nolan principles of public life. To better support joint working, we would prefer them to agree with local stakeholders their membership and ways of working.
  
- 11.5. **The Committee should satisfy itself that the health and well-being boards will be clearly accountable locally for the discharge of their functions to benefit the local community and users of local health and social care services.**