

Health and Social Care Bill

House of Lords – Second Reading
11 October 2011

The NHS Confederation is the only body to bring together the full range of organisations that make up the modern NHS to help improve the health of patients and the public. This briefing sets out the changes that we believe would be necessary to give the reforms a greater chance of success. We have described our main proposals and also examined key themes in the legislation, making more detailed suggestions.

1. OVERALL VIEW

We support many of the proposals in this Bill. And changes made to the reforms after the Government's "pause" do answer some of the concerns we previously expressed about how the new structures might work. We particularly welcome: the recognition that commissioning requires the involvement of a wider range of health professionals; the commitment to provide more integrated care; and the introduction of a more flexible timetable for implementation.

But we remain to be convinced that the Government's reforms will deliver a coherent system and enable the NHS to tackle the most significant challenges it faces. These include:

a. Meeting rising demand with a budget that is flat in real terms

The biggest immediate challenge facing our members over the next four years is the requirement to deliver £20 billion of efficiencies – the 'Nicholson challenge'. In our survey of NHS chairs and chief executives carried out during the summer, 42 per cent said the financial situation was 'the worst they had ever experienced', while an additional 47 per cent said it was 'very serious'. This is why we believe the NHS needs to change to live within its means and meet rising demand. Otherwise there is a danger of a serious decline in the quality of care.

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In large part, these reforms do not directly address the Nicholson challenge. Many of the structural changes being proposed in the Bill will not take effect until 2013. Yet the key decisions determining whether the NHS meets the challenge need to be taken over the next 18 months. In our survey, our members ranked delivering NHS reforms and savings simultaneously' as by far the biggest barrier to delivering their objectives on efficiency and quality (85 per cent said it was among their top three concerns). The Government and Parliament need to do everything possible to ensure the Bill does not distract NHS leaders from the task in hand.

b. Improving quality of care

The biggest test of the reforms is whether they will improve care for patients. The jury is out on whether they will achieve this. We support clinical commissioning but it may take time for clinical commissioning groups to develop as strong commissioners. We are concerned that the National Commissioning Board may not have the levers to drive improvements in the quality of care – particularly primary care. And we are concerned that the desire to encourage patients to choose may not be supported by the availability of good comparative information.

WHAT WE MOST VALUE AND WHAT SHOULD CHANGE

Proposals we welcome in the Bill

Although we have more detailed concerns about their precise implementation, we generally welcome the Government's intention to:

- ensure commissioning is clinically led;
- reduce the Secretary of State's day-to-day involvement in the NHS, providing his overall accountability for the system is clear;
- focus on outcomes rather than inputs;
- establish Monitor as a sector regulator for the NHS;
- commit to completion of the roll-out of foundation trusts;
- offer patient choice and effective use of competition between providers within a balanced regulatory system that promotes integrated care;
- transfer responsibility for public health to local authorities;
- establish Health and Wellbeing Boards to take responsibility for developing and delivering joint local health and wellbeing strategies.

We are particularly pleased that the reforms provide an opportunity to move to a model for commissioning education and training that is driven by the immediate and longer-term need for the workforce to meet patients' needs. Employers in the NHS strongly believe that the system must be led by employers, in constructive dialogue with the professions.

- ➔ Ministers should retain their commitment to the principle of an employer-led system for commissioning education and training.

The changes we want to see

There are five key areas where we believe the reforms are in need of improvement:

1. **Our biggest concern following the recent changes is the risk of paralysis in commissioners' decision-making just when the NHS needs to be radical.**

The proposed NHS structure is much more complex than the present system. This has the potential to cause confusion and duplication, and it could mean local decision makers do not have the freedom and clarity they need to drive better care for their patients. The danger is that the NHS could find itself in paralysis at just the moment it needs to make key decisions that are crucial for the sustainability of parts of the NHS.

To help address this, we want Ministers to commit to developing the detail of the system in a way that enables and supports effective decision making by CCGs. Ministers should:

- ➔ Confirm that clinical senates will not have a veto over CCG plans. Senates should be advisory and a source of evidence.
- ➔ Commit to designing the detailed remits and powers of all the actors in the system to minimise confusion, gaps and duplication and be as clear as possible.
- ➔ Agree to develop new standards for reconfiguration, to enable these decisions to be both timely and locally led. This will ultimately benefit patient care. The current system includes too many overlapping ways for decisions to be referred on, often simply introducing many years of delay rather than fostering clinician, patient and public engagement. Ways of improving this include:
 - using the Secretary of State's four tests as a mandatory quality assurance test to be completed one month after the closure of any consultation to ensure that they have been met by the process;
 - introducing a three month deadline for the right of overview and scrutiny committees to refer decisions to the Secretary of State;
 - requiring collective agreements for local authority overview and scrutiny where boundaries are crossed. This is to stop multiple referrals over many years, which add expense and delay but do not help patients and the public.

2. **Most commissioning needs to be as close as possible to the patient so that decision-makers better reflect local patients' needs.** We are particularly concerned that the NHS Commissioning Board's commissioning decisions, particularly for primary care, could be far removed from local circumstances, and that there may be a lack of support for building effective local clinical commissioning groups.

We want to see:

- ➔ A new duty on the NHSCB to build and support CCG commissioning competence and capability so responsibility can be devolved as appropriate. We also want an explicit ministerial commitment to hold the Board to account for this, measuring progress.

3. **Mechanisms to drive quality of care need improving, and more must be done to prevent quality and financial failures.**

In the existing system we already need to address overlap, gaps and confusion between various regulators and professional bodies. Ministers should commit now to ensuring that, in future, the outcomes frameworks at various levels and the roles of the various regulators align and avoid duplication and gaps. Clear mechanisms for enabling and learning from complaints are also required.

The overall aim of the quality and financial failure regimes should be to secure and protect patient access to safe and high quality care delivered by sustainable organisations. We want ministers to commit to further developing the system, both to allow emerging problems with quality and finances to be identified early by commissioners and providers, and to incorporate mechanisms to support organisations which are in danger of failing to deliver high quality care and/or be sustainable financially, with the aim of preventing the need for formal intervention.

- ➔ The findings of the Francis Inquiry, and our joint NHS Confederation, Local Government Group and Age UK Commission on care and compassion, are likely to indicate further changes are required and Ministers should commit now to revisiting this issue once the Inquiry has reported.

4. **The emerging healthcare system needs to be properly resourced, with clear financial arrangements and strong leadership.** Given the changes being made to the system, it is essential that organisations are properly resourced if they are to have a fighting chance of helping to deliver high quality healthcare and the savings that need to be made. The Government need to:

- ➔ Urgently clarify the running costs of clinical commissioning groups. This needs to be adequate for the role they are fulfilling. Ministers should commit to adequate management resources for CCGs and to keeping the cost allocation under review to ensure it does not unhelpfully constrain the effectiveness of CCGs.
- ➔ Publicly champion the value of good management. Good management will play a vital role in ensuring the system delivers the best outcomes for patients and uses resources efficiently. The continued denigration of NHS managers

as wasteful fat cats and bureaucrats is shameful, inaccurate and unwarranted. The Government needs to put forward a more positive vision to motivate the leaders of new organisations, and leaders in existing organisations who are crucial for securing a smooth transition to the new system.

5. The key test for how, where and when competition and integration are used must be the impact on quality of care for patients and value for money to tax-payers. Tailored economic regulation should support this approach.

We strongly support the use of competition and choice wherever they benefit patients and the taxpayer. We also support the role of Monitor as a healthcare-specific regulator to ensure that the relevant legislation is applied in a way that is tailored to the NHS' circumstances and focuses on the patient interest. We are pleased with the increased emphasis on integration of services following the 'pause'. However, some further development is needed to enable the new system to deliver efficient and effective care for the benefit of patients. The Government therefore need to:

- ➔ Confirm that the definitions of 'integration' and 'integrated care' to be used by Monitor will allow different kinds of integration. For example: bringing together specialist services like trauma at one site, or integrating a person's health and social care into one package, or offering a 'package' of care across a large population.
- ➔ Make a commitment that commissioners will not be subject to overly detailed, prescriptive guidance from Monitor. Monitor should be tasked with overseeing the development of a national framework for local use in supporting decision making around when each mechanism (competition, integration and choice) will be most effective, and able to take action if providers or commissioners operate outside it.
- ➔ Recognise the scale of the task of extending the tariff and commit to ensuring Monitor is adequately resourced to do this. Though extending the tariff is the best way to ensure competition is on quality, it must be recognised that getting the tariff right is a highly complicated task, some existing tariffs may not be right, and, with many of the more 'straightforward' areas already on tariff, this task is becoming even more difficult.
- ➔ Commit to keeping the tariff under ongoing review to ensure that it always makes clear financial (as well as ethical) sense to commissioners and providers to deliver the right care for patients.

3. THE BILL'S KEY THEMES: WHAT ARE THE ISSUES AND WHAT NEEDS TO HAPPEN

LOCAL COMMISSIONING FOR PATIENTS

The NHS Confederation sees benefits in involving clinicians more closely in decisions about both the design of care and management of resources. It is right that the proposed Clinical Commissioning Groups (CCGs) should be led by primary care clinicians, but we welcome the Government's clarification that CCGs should involve a wider range of healthcare professionals at both a national and local level. It will be important that clinical commissioning groups and their support structures are properly resourced.

Clinical senates are due to be hosted in the NHS Commissioning Board but it will be important to clarify their roles, responsibilities and accountabilities.

- ➔ It is important for the Government to confirm that clinical senates will be advisers to clinical commissioning groups, rather than another veto holding layer in the system of formal decision-making. Equally, senates should not take on a performance management role.

If the NHS is to meet its efficiency targets and deliver care closer to patients, tough decisions will need to be made about changes to services. When changes are proposed to health services, it is essential that clinicians and local communities are thoroughly engaged in a decision-making process which is open and transparent to gain the trust of the local population and allow genuine involvement. However, the risk under the changes put forward following the listening period is that the increased complexity to the structure of the NHS slows down or prevents decision-making either through more bodies becoming involved in decisions, or where it is not clear which organisation is ultimately in charge.

The right balance therefore needs to be struck between efficient decision-making and engaging with different bodies, clinicians, patients and the public.

- ➔ Similarly, the Government needs to confirm that, whilst the health and wellbeing board's advice should be sought on commissioning decisions, it is ultimately for commissioners to decide. Otherwise, there is a danger that important decisions could be slowed down or blocked with consequences for finances and patient care.

Financial rewards

There has been debate on whether clinical commissioning groups should receive financial rewards for effective commissioning. We believe that the incentives, rewards and sanctions driving performance improvement need to be powerful enough to encourage clinicians to take their commissioning role seriously, but not so powerful or crude they risk distorting the patient/doctor relationship in clinical decision-making. These should include but not be limited to financial incentives.

We recognise there are genuine risks of actual or perceived incentives for clinicians not to act in their patients' interests which would be damaging to the profession and the wider NHS, and these risks need to be guarded against.

Matching boundaries for local authorities and clinical commissioning groups

There are strong reasons for aligning NHS and local authority boundaries to help encourage and enable joint working, particularly between health and social care, and between NHS and public health services. However, there are some occasions when it may be sensible to draw NHS boundaries differently to a local authority's. For example, if a large hospital cares for patients in an area that cuts across one or more councils' boundaries, it may be more logical for a CCG to cover the hospital's, rather than the local authority's, area.

Where a CCG proposes to cross local authority boundaries, the authorisation process should require them to explain how they would manage joint working effectively.

NATIONAL COMMISSIONING FOR PATIENTS

The role of the NHS Commissioning Board could potentially centralise decision-making and financial control to a far greater extent than in our current health system. This will be particularly the case following the establishment of the NHS Commissioning Board when it will initially commission on behalf of any clinical commissioning groups that are not ready to do so. It will also have responsibility for the commissioning of primary care and specialised health services.

The NHS Confederation has for many years argued for most forms of commissioning decision-making to take place as close as possible to the patient in line with principles of subsidiarity. There is a danger that if power and decision-making is overly centralised it will lead to inflexible approaches which undermine local decision-making and disengage local patients and clinicians. **We cannot afford to miss this opportunity to genuinely devolve power from the centre to fit healthcare decisions to local needs.**

The NHS Commissioning Board should publish its plans for holding clinical commissioning groups to account as soon as possible so that clinicians can be clear what level and form of accountability to the centre they can expect.

As part of supporting decentralisation, commissioning guidance from the NHS Commissioning Board should not be mandatory although clinical commissioning groups should be held to account by the NHS Commissioning Board and the local Health and Wellbeing Boards for their decisions.

- ➔ To help ensure decision-making is de-centralised we believe a duty should be placed on the NHS Commissioning Board to build capacity and capability at a local level so that devolution of responsibility for commissioning to clinical commissioning groups can take place steadily or safely. The Board should also be required to demonstrate measurable progress on this.

- The NHS Commissioning Board should also look to create opportunities for CCGs with proven competence and governance standards to take on the commissioning of primary care as well as secondary care. Similarly, where suitable, local authorities should consider asking CCGs to commission social care.

Accountability of the Board

The NHS Confederation remains concerned about the accountability of the NHS Commissioning Board to the public. Given its extensive powers it needs to come under much greater scrutiny than is currently planned to give confidence in and legitimacy to its decisions and to ensure decisions are not being unnecessarily taken at the centre rather than by more local organisations.

Clinical commissioning groups are being required to meet in public, publish their minutes and details of contracts, and the authorisation process will ensure they have governance requirements consistent with the Nolan principles of public life. They will also be expected to engage with HealthWatch and other patient groups. **We do not see any defensible reason why the same standards of accountability should not apply to the NHS Commissioning Board for commissioning decisions it makes.**

A key part of gathering feedback about both the provision and commissioning of services will be monitoring complaints data. We believe there should be a duty on the Board to:

- Publicise arrangements for how it deals with complaints
- Monitor and to have regard to any complaints received about commissioning decisions (both its own and those of CCGs) and about the services it commissions
- Publish information about complaints received.

ACCOUNTABILITY OF THE SECRETARY OF STATE

The Government has improved the Bill to clarify ministers' ultimate accountability and the Secretary of State's duty to promote a comprehensive health service. We understand Peers are considering changes to the wording around the Secretary of State's responsibilities. Whatever form of words are used, we believe they should make it absolutely clear that the Secretary of State should be accountable for the overall system in line with the NHS Constitution.

Autonomy clauses

The Bill provides clauses (4 and 20) to require the Secretary of State and the NHS Commissioning Board to allow individuals exercising functions in the health service to exercise those functions freely – so far as it is in the interests of the health service.

Providing the Secretary of State's overall accountability is clear, we strongly support these clauses as they should discourage unnecessary micro-management of the system. **We would like to see these retained.** The balance to allowing the health

service and regulators to exercise their functions freely is to ensure the accountability and regulatory mechanisms are clear.

COMPETITION, INTEGRATION, AND ECONOMIC REGULATION

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.

While competition is not the right approach in all circumstances, we believe the appropriate use of competition is often right for patients because:

- Providers from the private and voluntary sectors have proved that they can deliver the appropriate standards of quality and efficiency;
- Evidence suggests that the right sort of competition between providers can drive improvements in quality and efficiency;
- Competition is one route to improving patient choice;
- Some of our healthcare services are not as good as they should be. It would be perverse to allow any provider to have a permanent hold over services when they have failed to deliver to the appropriate standards.

Following the Future Forum's recommendations, the Bill now contains a number of references to 'integration', and we are pleased with this increased emphasis. However, integration can mean different things to different people.

- ➔ The Government therefore need to specify on the record that the definitions of 'integration' and 'integrated care' to be used by Monitor will allow different kinds of integration. For example: bringing together specialist services like trauma at one site, or integrating a person's health and social care into one package, or offering a 'package' of care across a large population.

It is also important to be clear that competition and integration are not mutually exclusive – in some situations the best care for patients may be achieved through competition for a contract to provide a highly integrated service covering a large population. Decisions about how competition is applied locally, including where and how to use integration to deliver the best outcomes, must be taken locally. **The key test for how, where and when competition and integration are used must be the impact on quality of care for patients and value for money to tax-payers.**

The Government also needs to:

- ➔ Make a commitment that commissioners will not be subject to overly detailed, prescriptive guidance from Monitor. Monitor should be tasked with overseeing the development of a national framework for local use in supporting decision making around when each mechanism (competition, integration and choice)

will be most effective, and able to take action if providers or commissioners operate outside it.

- ➔ Recognise the scale of the task of extending the tariff and commit to ensuring Monitor is adequately resourced to do this. Though extending the tariff is the best way to ensure competition is on quality, it must be recognised that getting the tariff right is a highly complicated task, some existing tariffs may not be right, and, with many of the more 'straightforward' areas already on tariff, this task is becoming even more difficult.

Monitor's remit

We believe that the creation of a sector regulator is an essential part of the new system. A specialist sector regulator increases the ability for existing EU and UK competition law to be applied in a tailored way that takes into account the NHS' specific circumstances, rather than in a generalist way by the OFT or the law courts. The creation of Monitor does not, by itself, extend competition law.

The failure regime

At report stage in the House of Commons, MPs passed Government amendments setting out how to deal with organisations that have failed. A separate briefing on these amendments can be [found online here](#). This is a highly complex area in which most if not all policy solutions have potential downsides, and the House of Commons had very little time with which to review the amendments.

The overall aim of the quality and financial failure regimes should be to secure and protect patient access to safe and high quality care delivered by sustainable organisations. The failure regime must not be simply a means of propping up inefficient providers, nor should it simply transfer a financial problem from providers to commissioners. The interventions under the failure regime must therefore be designed to secure a viable service in the medium term.

Alongside formal failure regimes, the system as a whole needs further development to allow problems to be identified early by commissioners and providers, and incorporate mechanisms to support organisations which are in danger of failing to deliver high quality care and/or be sustainable financially with the aim of preventing the need for formal intervention. This is a better way of addressing the need to prevent organisations from failing than 'lowering the bar' for formal intervention by regulators or the NHS Commissioning Board.

- ➔ The Government should put on the record their commitment to use the failure regime to allow and promote redesigning services to make them more efficient, not to prop up inefficient services nor to simply transfer financial problems from a provider to a commissioner.

The failure regime will also need to take into account the conclusions of the Francis inquiry which is due to report in the New Year.

ISSUES FOR FOUNDATION TRUSTS

We strongly support the aspiration for all trusts to attain foundation trust status. Following the recent listening exercise, the Government softened its commitment to requiring all remaining NHS trusts to gain authorisation as foundation trusts by April 2014. We welcome this flexibility as it will allow some NHS trusts to get to grips with major and immediate challenges.

The private patient income cap

It is clearly important to ensure sufficient NHS care is available for NHS patients, but the private patient income cap (PPIC) is not the right way to achieve this. Private patient income is a means of securing additional investment for the benefit of NHS patients. With an expansion of the provider market it would be unfair to allow independent sector providers to be able to provide care to both NHS and private patients, but to restrict the activity of NHS providers – particularly where NHS providers have spare capacity or unused beds. The PPIC should therefore be removed.

The Government has indicated its intention to require foundation trusts to produce separate accounts for NHS and privately-funded services. Foundation trusts have always been clear about the need for transparency in the way in which they will use any funding under the cap for the benefit of NHS patients. We want to be reassured that the new accounting requirements will minimise the burden of bureaucracy. One option may be to adopt a system similar to that which requires charities to separate restricted and unrestricted income and expenditure.

PATIENT AND PUBLIC INVOLVEMENT

We welcome the Government's commitment to strengthening patient and public involvement at a local and national level, although the precise way in which patients and the public will be engaged needs to be spelt out much more clearly. This includes spelling out how shared decision-making between patient and clinician will happen.

We are pleased that recent changes to the Bill will require the CQC to respond to advice from HealthWatch England and the Secretary of State will have to consult HealthWatch on the NHS Commissioning Board's mandate.

However, throughout the life of the Bill we have remained concerned that it does not address the lack of independence and autonomy of HealthWatch England from the 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 should include:

- The ability to set its own agenda;
- The ability to speak out publicly where it considers this appropriate (including against the CQC);
- 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.
- ➔ In addition, the Government needs to ensure that adequate funding is allocated to HealthWatch England and local healthwatch. It is also important for the Government to clarify how complaints handling and monitoring will work in relation to primary care and the decisions of commissioning consortia.

ISSUES FOR LOCAL GOVERNMENT

Health and Wellbeing Boards

The NHS Confederation welcomes the proposed creation of health and wellbeing boards. They provide an opportunity to bring together the expertise of the NHS, local government and local communities. Through the development of the Joint Strategic Needs Assessment and joint health and wellbeing strategy, they offer a good opportunity to address health inequalities.

If health and wellbeing boards are to bring greater democratic accountability and legitimacy to commissioning decisions about healthcare, they must be accountable to the local community for their commissioning decisions. Similarly, they must empower local people to take part in decision-making to ensure that commissioning decisions reflect local needs and aspirations. They will have to work with traditionally non-health related services such as education, employment, housing and transport in order to achieve improvements in addressing the determinants of health and reducing health inequalities.

Public health

The NHS Confederation welcomes the strengthened role of local government in public health, including public mental health, given the impact local government can have across departments and sectors including education, transport, leisure, housing and economic development.

Ensuring public health remains at the heart of the NHS will be essential. The financial incentives should include prevention and early intervention initiatives within contracts and ensure the tariff does not disincentivise health improvement efforts to develop a system that encourages good health, and does not just treat illness.

However the way that the new system is set up is complex. To take the example of child health and child public health services, after 2015:

- Local authorities will be responsible for commissioning all child public health services
- The NHS Commissioning board will be responsible for commissioning health visitors, and for immunisation services.
- Clinical commissioning groups will be responsible for child health and maternity services.

We therefore risk people falling through the gaps between services because care has been fragmented.

- **The Government need to assert how fragmentation will be avoided and how integrated care pathways will be effectively commissioned.**
- **The Government also needs to specify how it will ensure that during emergencies the public health system will be able to operate as a single integrated system to respond effectively to a major crisis.**

Our members also remain concerned that local authorities will have insufficient money available to commission all of the public health services. This could have a significant impact across councils and the NHS and ultimately affect patients. **The Government urgently need to clarify the level of funding available to help councils and the NHS to plan for the future.**

Health inequalities

- We believe there should be a duty in the Bill for local authorities to reduce health inequalities as part of their new public health responsibilities.

Councils are uniquely placed to tackle such inequalities due to their responsibilities for education, housing, transport and other factors that impact on health.

The Government are also proposing to use a 'health premium' to give extra money to those areas that reduce health inequalities. We need to be careful that this does not simply reward those areas where it is easiest to tackle inequalities and divert money away from areas where fundamental problems may slow progress. The Government should commit to keeping the premium under review as it is rolled out.

Safeguarding

We have raised concerns throughout the life of the Bill that it is unclear who will take the lead on the commissioning of specialist doctors and nurses responsible for safeguarding children within the NHS.

- The Government urgently need to establish an accountability framework for safeguarding children, young people, and vulnerable adults so that it is clear in the new system who needs to take charge.

EDUCATION AND TRAINING

We are pleased that the reforms provide an opportunity to move to a model for commissioning education and training that is driven by the immediate and longer-term need for the workforce to meet patients' needs. Employers in the NHS strongly believe that the system must be led by employers, in constructive dialogue with the professions.

There are well known examples in the English NHS where historic education and training planning and practices have led to a significant mismatch between what patients need now and what is actually being provided, for example, the current over-

supply of surgeons and under-supply of midwives in some areas. Where there are not enough trained staff in a specific area or specialism, this can impact on quality and waiting times. Where there are too many staff, this represents an unsustainable use of taxpayers' money.

In addition, education and training needs are changing significantly. New models of delivering care that are both more efficient and better involve patients will require more flexible working across the whole healthcare workforce. The current policy move to increase clinical leadership will require leadership development to be further embedded in the core education of clinicians in future. Similarly, the expectation that public health has a focus across the system is likely to change training requirements.

The Government has also indicated that it is considering how to ensure all providers contribute to the costs of education and training. **We agree that every organisation that benefits from the education and training of professionals should contribute to it.** However, we recognise this is a departure for some organisations and could lead to difficult discussions, especially as NHS provision becomes increasingly diverse. Introducing 'duties' would be an appropriate mechanism to achieve this and issues with this approach for small service providers can and should be addressed locally within skills networks.

As a broader range of organisations contribute financially they will expect equitable access to high-quality training. The independent sector already does a significant amount of training for non-medical professions in relation to softer skills. Some independent providers may be enthusiastic in future about taking greater responsibility for training, particularly if they provide a greater range of procedures and care.