Health and Social Care Bill
Public Bill Committee Written Evidence
7 February 2011

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 about their views on the proposed changes.

2. Summary of evidence

2.1. Our members support the government’s objectives. Empowering patients is clearly the right thing to do. We see real potential benefits in involving clinicians more closely in decisions about both the design of care and management of resources. We also see benefits in extending the range of providers in order to drive quality, efficiency and innovation. There are major opportunities to improve the way the NHS works for patients, if the reforms operate effectively.

2.2. However, after analysing the proposed new system, the NHS Confederation has identified some significant risks, worrying uncertainties and unexploited opportunities. The government has gone some way to addressing these since the White Paper was published in July but we still have a number of questions and concerns.

2.3. We agree that the health system needs to change in order to respond to its changing financial situation while continuing to achieve improvements in quality and outcomes. Indeed, the system is already geared up for change and we cannot afford for these reforms to fail. The key test will be whether the
new health system is better able to meet these challenges than the one it replaces. The focus in Parliament has to be on forensically analysing the Bill and making improvements so the reforms will have the best chance of success.

2.4. There are four main considerations that we encourage the Committee to keep in mind as they scrutinise the Bill:

- The Bill will need to strike the right balance between the aim of removing the Secretary of State and NHS Commissioning Board from the day-to-day running of the NHS, and ensuring co-ordination and accountability over the system.
- The Bill places a number of duties on different bodies. Sometimes these are unavoidably conflicting or competing. This means a balance will need to be struck in how these duties are applied in practice.
- These points make it all the more important to ensure the accountability mechanisms in the Bill are clear and sufficient, and those organisations or individuals that are responsible for holding others to account have sufficient powers to take appropriate action where they have concerns.
- The Bill will need to create a system that is self-improving, appropriately integrated, and capable of meeting the efficiency and financial challenge facing the NHS.

2.5. Our detailed written evidence below sets out (in bold text) the key areas we would ask the Committee to consider when analysing the Bill. Although we focus on changes to help improve the primary legislation, our concerns also relate to how the reforms will be implemented and to the behaviour of organisations once the new system is up and running. Looking at the legislation, below we discuss:

- autonomy and accountability mechanisms;
- integration, competition and choice;
- foundation trusts;
- reducing unnecessary bureaucracy;
- the new public health service.

3. Autonomy and accountability mechanisms

Overview

3.1. With central government loosening day-to-day control, which we welcome, there needs to be clarity about what is driving improvement in the system and who is going to get a grip when things go wrong. Accountability mechanisms need to be strong enough to ensure the system achieves its objectives – for example, improved outcomes and greater responsiveness to patients and communities – whilst not over-empowering top-down structures at the expense of local organisations’ freedom.
3.2. Having argued for a clear accountability framework in response to the White Paper, we are pleased the Bill goes some way to explain how commissioning consortia, the NHS Commissioning Board, and regulators will be held to account by the government, although much of the detail will be left to regulations. However, we have outlined our remaining concerns below.

**Performance and assurance of commissioning consortia**

3.3. The potential for the Secretary of State to direct the NHS Commissioning Board and for the Board to direct commissioning consortia through regulations and its ability to make an annual assessment of consortia still remains significant. The behaviour and accountability of the Secretary of State and the Board in exercising these powers will be important. The Committee should seek more clarity on how the Commissioning Board’s national mandate will be passed down to individual consortia. It will be important to consider how the performance of consortia will be assessed and how failure or potential failure will be determined. It will also be important to consider the extent to which consortia will have real autonomy to set their own priorities and to make commissioning decisions.

3.4. Part I, clause 21 sets out arrangements for the establishment of commissioning consortia. The government should also put in place an ongoing assurance system for consortia to help ensure they maintain strong governance arrangements with clear, transparent and robust decision-making processes to address any conflicts of interest. These governance arrangements and decisions should be subject to external audit and scrutiny. However, we would prefer tests to be applied to such arrangements rather than detailed and prescriptive guidance to be set. This would provide some assurance that organisations are suitably constituted whilst providing local organisations with the freedom to innovate and establish their own ways of working. The Committee should clarify what tests the government intends to apply to consortia governance arrangements.

**Ensuring patient feedback and complaints inform commissioning decisions**

3.5. The abolition of primary care trusts has implications for both the handling and the monitoring of complaints and feedback from patients, the public, and MPs.

3.6. 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 members of parliament should go to when a complaint concerns several services including primary care.

3.7. On complaints monitoring, if future commissioners – in GP consortia and the NHS Commissioning Board – are not informed about complaints and feedback on services, they will have incomplete information on which to base
their commissioning decisions. As a result there may be missed opportunities to drive up quality.

3.8. The Committee should ask the government how they see complaints handling and monitoring working under the changes outlined in the Bill.

Healthwatch

3.9. To be an effective voice for patients, provision should be made to strengthen the independence and autonomy of Healthwatch England from the Care Quality Commission (CQC) (part 5, chapter 1, clause 166) by, for example, giving it a dedicated budget and support team and the ability to set its own agenda. This would help to avoid any conflicts of interest between the two organisations. The Committee should satisfy itself that Healthwatch England has sufficient power and independence from the CQC.

3.10. To boost the power and relevance of its voice, local healthwatch should be representative of the local community or take regular and systematic steps to gather the representative views from the local community, including service users. The Committee should consider whether local authorities should be required to ensure local healthwatch is representative of the local community. 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.

4. Integration, competition and choice

Overview

4.1. Choice and competition are critical components of creating a patient-centred and patient-led NHS. The proposals on competition, procurement, and provider regulation, when implemented, could transform NHS provision from a managed system, with some internal competition, to a real regulated market similar to the regulated utilities, with the intention of significantly improving frontline services. In order for this vision to be realised, a major shift in understanding is needed about how providers will operate under regulatory rather than direct government control, with greater differences between services and fewer constraints on service change.

4.2. There is consensus in the health sector that cooperation and integration will often be beneficial to patients and taxpayers. The application of the Acts will need to allow competition to drive quality, value and innovation. At the same time, as in other complex sectors, a competition regime will need to be built up so that areas where patients and the taxpayer are best served by cooperation and integration are not jeopardised by competition law. It will also be important that the procurement rules the regulator sets allow integration and avoid the risk of services fragmenting.
Integration

4.3. Some fear that competition will undermine integration, but this is not intrinsic to the competition regime. This is more likely to be the result of poor management, culture, and the approach taken to procurement than a direct result of markets or the application of competition law. There are ways of organising care so competition is between integrated services that provide the whole package a patient needs.

4.4. The government has said that ‘the Bill will ensure that NHS commissioners will be subject to comparable prohibitions of anti-competitive conduct as those for providers under national competition law. The legislation will help prevent commissioners from taking individual actions or reaching agreements which restrict competition against the public interest.’ Clauses 63 and 64 are intended to ensure good procurement practice by the NHS Commissioning Board and by GP consortia. The Committee should examine whether the clauses achieve the government’s aim and also assess whether clause 55(3) – which requires Monitor to ignore its functions under sections 101 and 102 when carrying out competition, licensing or pricing functions – applies to any regulations in relation to commissioners under clauses 63 and 64.

4.5. The Committee should ensure the legislation makes clear that the promotion of competition is a key element of providing protection to patients and taxpayers. At the same time, the implementation of competition law in healthcare should recognise and encourage cooperative and integrated arrangements where these are clearly in patients’ and taxpayers’ interests.

4.6. As well as the promotion of competition, opportunities to integrate services may also be impacted by the design of the system. The Committee should ask the government whether the NHS Commissioning Board holding contracts for some parts of pathways and the GP commissioning consortia for others is likely to undermine integration.

The role of Monitor

4.7. The new economic regulator will have a large amount of power in the new system. We welcome Monitor’s overarching duty to protect and promote the interests of people who use healthcare services (part 3, chapter 1, clause 52 (1)). The Committee should consider whether the Bill (part 3, chapter 1, clauses 54 (e) and (f)) currently ensures that Monitor takes into account tax-payers’ interests. It will be important, if its decisions are to be acceptable and sustainable, for the regulator to retain the confidence of staff, public and patients. Monitor may in practice find it difficult to balance its different,

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1 Liberating the NHS: Legislative framework and next steps (15 December 2010). Paragraphs 6.87-6.89
competing objectives and much will depend on how this works.

4.8. The Committee should seek further clarity on how Monitor will be accountable, other than to the Secretary of State. We note that the public consultation and patient and public involvement requirements on Monitor appear to be minimal at present.

4.9. The Committee should consider seeking a requirement for Monitor’s annual report to cover how it has met its duties and obligations, and how it has resolved difficulties in satisfying all its competing duties.

4.10. The Committee should also consider clarity on the nature of Monitor’s duties around quality and safety. The Committee needs to satisfy itself that these are adequately described and that the Bill allows scope for Monitor to be held to account for how these duties are exercised. The Committee also needs to ensure that Monitor’s role does not duplicate that of the CQC, which also has responsibilities in this area.

4.11. We welcome the duty (part 11, clause 264) placed on Monitor to co-operate with the CQC. However, the nature of Monitor’s relationship with Healthwatch England and local healthwatch is unclear. This is significant given the impact Monitor’s decisions will have on patients. The Committee should ask the government to clarify whether local healthwatch are statutory consultees for Monitor beyond decisions relating to designated services (part 3, chapter 3, clauses 69-73). For example, local healthwatch is likely to have an interest in conditions placed in licensing requirements (part 3, chapter 4, clauses 87-93) and notification of enforcement action (part 3, chapter 4, clause 100).

Monitor and maximum tariffs

4.12. The introduction of price competition via maximum tariffs set by Monitor is a serious issue and should be approached with care. Where quality can be easily measured, we can see some potential benefits in allowing maximum tariffs with lower prices being arrived at through mutual agreement. Even so, very close attention will need to be given to quality. The evidence from the USA and the UK’s internal market in the 1990s is that because quality measurement is difficult there is a danger that price competition in one area can lead to quality being adversely affected in others, particularly those where it is less easily observed.

4.13. It will be essential for Monitor and the NHS Commissioning Board to weigh the risks to quality and safety when deciding whether to set maximum tariffs. It will also be important for commissioners to keep quality and safety at the forefront of their minds when making commissioning decisions. To mitigate these risks, the Committee should ask the government to develop a package of safeguards. We have two specific suggestions for
what such a package should include:

4.13.1. The Government should develop mechanisms to allow the healthcare system to examine and learn from the outcomes of setting maximum prices.

4.13.2. Monitor's annual report should set out its reasons for permitting maximum tariffs for specific services, and how it is monitoring the impact on quality of these decisions.

Health and well-being boards

4.14. Health and well-being boards could be an important part of the NHS system architecture. They have the potential to plan services and bring the local system together. The Committee will want to satisfy itself that they have sufficient powers to undertake these functions. Much of its ability will depend on the capacity, resources, relationships and behaviours that are developed at a local level.

4.15. Despite the required membership of a representative from the local Healthwatch and a local councillor, we do not believe that health and well-being boards will automatically strengthen local democratic legitimacy. While this will depend in part on local relationships and approach, it is important that the Bill creates the right architecture for the local health and well-being board to support these ends. The Committee could consider duties on the health and well-being board to consult the local community, to publicise its work, and to hold open meetings.

Clinical networks

4.16. There has been concern from a number of organisations and MPs about whether clinical networks will survive. In many parts of the country they have helped to integrate care pathways and improve the quality of care provided, providing valuable support and clinical expertise to the local NHS. We were pleased to hear the future chief executive of the NHS Commissioning Board, which would be responsible for ensuring their expertise remains in the system after 2012, recently reassuring cancer networks that he 'cannot imagine a period where we would not have vibrant cancer networks operating in the system'.

4.17. The Committee should ask the government to explain its plans for all clinical networks (for example, trauma and stroke networks), setting out whether it intends for these to survive in their present form and, if not, what other arrangements would be put in place to ensure necessary collaboration between specialists.

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2 Sir David Nicholson, NHS Chief Executive, giving evidence to the Public Accounts Committee’s evidence session on Health Landscape Review, 25 January 2010 (Q209).
5. **Foundation trusts**

5.1. The NHS Confederation agrees that the private patient income cap (part 4, clauses 149-150) on foundation trusts should be scrapped. The Committee should oppose any moves to constrain foundation trusts’ ability to provide independent services. The ending of the cap will enhance patient choice, enable foundation trusts to expand their services to patients, and bring in additional resources for the benefit of NHS patients.

5.2. The Committee should oppose any changes to the deadline for aspirant trusts to become foundation trusts by 1 April 2014 (part 4, clause 164). This will be a challenging target date, but to delay the date would be to undermine the momentum and attention necessary to ensure that system reforms can be implemented.

5.3. The NHS Confederation’s Foundation Trust Network will be appearing before the Committee and will comment in more detail on aspects of the Bill impacting on foundation trusts.

6. **Reducing unnecessary bureaucracy**

6.1. We agree with the government that providing appropriate, reliable and accessible information is vital if patients are to make the most of opportunities to make choices in relation to the health and care they receive.

6.2. However, it will be important to ensure that the reforms do not add significantly to bureaucracy for NHS organisations. This will be particularly important for the government to consider in the development of outcome measures where NHS organisations may have to meet high expectations of information provision.

6.3. The Committee should consider placing a responsibility on the Secretary of State to periodically review the level of bureaucracy on NHS commissioners and providers and take action to reduce any unnecessary bureaucracy (for example, duplication of information requirements).

6.4. Similarly, the Committee 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.

7. **The new public health service**

7.1. 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.
7.2. PCT public health teams currently provide expert input into supporting the PCT’s commissioning of health services. The Government has not yet been clear whether this function, to support commissioners, will transfer to local authorities. If this is to be the case, we would urge the Committee to ensure the Bill makes clear that public health professionals in local authorities need to provide this support to GP consortia in future. Adequate funding for this will also be required.

7.3. The Secretary of State will become responsible for Health Protection Agency responsibilities. However it may be difficult for a government body to be seen to provide the same independent and impartial advice as is being provided now by an independent organisation. Ensuring the independence of directors of public health will help to retain some impartiality.

Appointment of Directors of Public Health

7.4. Part 1 Clause 26 of the Bill sets out the appointment process for Directors of Public Health. There has been a view that local authorities should be able to appoint or terminate the contract of a Director of Public Health without the involvement of the Secretary of State. However, we would urge the Committee not to amend this part of the Bill as the Secretary of State’s involvement provides some protection to Directors of Public Health. The role of the Director of Public Health should be sufficiently powerful to operate effectively within the new structures and should retain the responsibility to independently assess and report on public health. Furthermore, by moving to local authority employment, public health staff lose the protection provided by the NHS Constitution and the right to whistleblow.