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Memorandum submitted by Bliss (HSR 01)

1. Introduction

2.1 Bliss is the UK charity dedicated to ensuring that premature and sick babies survive and go on to have the best possible quality of life. We provide practical and emotional support to families, provide specialist study days and training to support doctors and nurses to develop their skills, and campaign for essential change within government and the NHS.

2. Summary

2.1 Bliss welcomes the Government’s response to the listening exercise, particularly the fact that clinical networks will be retained and play a key role in providing expert advice to commissioners. However, we are seeking clarification about the following issues:

— The timescale when the NHS Commissioning Board will start to host neonatal networks and what interim arrangements will be in place to secure existing neonatal networks until this time.

— What the review of clinical networks will involve.

— What further guidance will be provided to the NHS on the relationship between neonatal and maternity networks.

3. Funding and Support for Neonatal Managed Clinical Networks

3.1 Bliss welcomes the fact that the Government’s response to the listening exercise makes clear that clinical networks will be retained. We are particularly pleased to see that networks will be hosted by the NHS Commissioning Board, as we recommended. However, we are seeking clarification about the timescale by which this will happen, and the Secretary of State’s assurances that interim arrangements will be made to secure existing neonatal networks, and their funding, while these new structures are being set up.

3.2 With the establishment of PCT clusters and other changes that have been occurring to local NHS structures in some areas over recent months, we have found that the bodies supporting neonatal networks are already beginning to undergo significant change. For example in London, due to a major management reduction programme across the capital, the management team responsible for the pan London perinatal network has been dissolved. Our key concern is the real sense of uncertainty facing many neonatal networks in the short term as NHS bodies continue to merge and reform before the NHS Commissioning Board is even operational.

3.3 The NHS Future Forum called for further work to be done to define clinical networks and review their range, function and effectiveness. While we agree that there are important lessons to be learnt about how different types of networks can be made as effective as possible, we are concerned that while this review is being conducted neonatal networks continue to face uncertainty about their funding and role.

3.4 We are also seeking assurances that this review of networks will make clear what patient and public involvement arrangements should be in place for these networks, given the Government’s commitment to “no decision about me without me”.

4. Maternity and Neonatal Networks

4.1 We are also seeking the Secretary of State’s clarification on how maternity networks, recommended in the White Paper, will work with neonatal networks to ensure the best possible outcomes for women and babies whether they receive care in mainstream maternity services or have need for a high level of intervention during pregnancy, birth and neonatal care. We believe that it is essential that further guidance is provided to the NHS on this matter to ensure that these two forms of networks complement one another as services continue to evolve. We would be keen to work with the Government on developing this guidance. Please find a position paper attached to this submission setting out our recommendations on how maternity and neonatal networks should operate in conjunction with each other.

Appendix 1: Bliss Recommendations on the Future of Neonatal Networks

1. Introduction

One in nine babies born in England are admitted to neonatal care because they are born too soon, too small or too sick. Bliss is the UK charity dedicated to improving the care that these babies receive.
Neonatal services are currently organised into 23 managed clinical networks across England. These neonatal networks coordinate services for premature and sick babies across a group of hospital units in a region. Each network includes at least one lead centre providing neonatal intensive care for babies born within the network region. Working with the lead centre are a number of both special care baby units providing lower intensity care and local neonatal units providing special care, high dependency and also short term intensive care for their local populations. The organisation of care into neonatal networks aims to ensure that babies receive the right care, in the right place, and at the right time, by appropriately experienced specialist health professionals, as close to home as possible.

In February 2011 Bliss conducted an audit of neonatal networks to identify their current priorities, clarify their existing funding arrangements and develop an understanding of their views on how the proposed NHS reforms will impact on their work. Responses were received from ten networks, detailing key achievements made since their establishment and concerns about whether their important role would be continued under the proposed reforms. This paper draws on the findings of this audit and a review of published standards, and sets out a number of key recommendations about how Bliss believes the Government’s proposed NHS reforms should be modified to improve outcomes for babies born premature and sick and their families.

2. Background and development of networks

The organisation of services for premature and sick babies into managed clinical networks was recommended by a Department of Health expert working group review of neonatal care in 2003.1 The key issue that this reorganisation was set up to address was the number of women and babies inappropriately transferred long distances for their care due to poor planning and a lack of capacity within local services.

The reorganisation was based on evidence from other countries that networked models of neonatal care produced the best outcomes for babies, with intensive care for the sickest babies being provided in specialist centres by appropriately skilled and experienced professionals. However, the 2003 review rejected a major centralisation of neonatal intensive care services due to the considerable length of time that many babies needed to stay in hospital, when compared with paediatric care, and the burden that centralisation would therefore have on the babies’ families.

Neonatal networks are also a fundamental principle of subsequent key policy documents, the NHS/Department of Health Toolkit for High Quality Services (Toolkit) and NICE Quality Standards for Specialist Neonatal Care. As Principle 1 of the Toolkit states:

“Neonatal care is a high-cost, low-throughput service in which expertise is a key determinant of the quality of outcome for the patient and the family. In order to provide equity of access to care of the highest standard, which produces the optimal outcomes, neonatal care must be organised in a managed clinical network to ensure appropriate expert treatment.”

The National Service Framework for Children, Young People and Maternity Services, published in 2004, first introduced the idea of managed maternity and neonatal care networks with the aim of integrating the care pathway from pregnancy to birth and neonatal care.3 Maternity and neonatal networks were again endorsed by the Royal College of Obstetricians and Gynaecologists’ 2008 standards for maternity care.4

The White Paper Equity and Excellence: Liberating the NHS again introduced maternity networks, however in this instance with the stated purpose of extending choice within maternity care.

Neonatal networks started being established across the country following the 2003 review. These took on a variety of forms until 2010, when the last network, Northern, was formally established as a managed clinical network with a formal governance structure and network manager in post. Maternity networks are also in place across some parts of the country, taking a variety of forms. However, with some notable exceptions, joint maternity and neonatal networks have not been widely established.

Example: Staffordshire, Shropshire and the Black Country

A maternity network coterminous with the neonatal network has been developing since 2005. Unlike the neonatal network, the maternity network has not had a consistent funding stream. The funding for a project manager and administrator to the maternity network has now come to an end as no further funding was identified for 2011–12. In the time that a project manager was in post, the maternity network achieved a number of things including auditing in utero transfers within Staffordshire, Shropshire and the Black Country maternity units, researching women’s experiences of in utero transfers, and the development of network-wide obstetric guidelines.

2 Toolkit for High Quality Neonatal Services, NHS and Department of Health, 2010, p39
3 Maternity Standard: National Service Framework Children, Young People and Maternity Services, Department of Health and Department for Education and Skills September 2004
4 Standards for maternity care: Report of a working party, Royal College of Obstetricians and Gynaecologists, June 2008
A West Midlands perinatal network was launched in September 2010 to harmonise the work of existing maternity and neonatal networks, with the objective of reducing variation in the outcomes of maternity and newborn care across the region, specifically perinatal mortality and morbidity. It is intended that the perinatal network will not supplant the existing networks but complement and liaise with them.

3. **Integration across maternity, neonatal and paediatric services**

“Implementation of newborn care pathways is intrinsically linked to maternity capacity. Whilst accepting that the majority of maternity care is about normal mothers and babies, it is vital that consideration is given to ensuring capacity is created for the transfer of mothers at high risk if delivering preterm infants. This does not appear to be addressed within the white paper aspiration for maternity networks which seems to be more about parental choice than ensuring that providers work together to provide for the high risk population of mothers and babies.” (Network Manager)

“I feel very strongly that maternity networks need to have a clear link with all be part of the existing neonatal networks to ensure that we are all travelling in a common direction. It seems inconceivable that the two could function separately and potentially be addressing the same issues in entirely different ways.” (Network Manager)

Bliss believes it is essential that there is close working across maternity, neonatal and paediatric care to ensure that services are joined up around the needs of women, babies and children. This is particularly important in light of the decision to commission neonatal services centrally by the NHS Commissioning Board, while maternity and paediatric services are commissioned locally by GP consortia. We strongly support the decision to commission all three levels of neonatal care together by the NHS Commissioning Board, putting an end to the fragmentation that exists in many areas under the current system where special care was commissioned separately from high dependency and intensive care. However, it is essential that the new framework builds in strong links across the pathway from pre-pregnancy care, to early years and beyond.

There are a number of ways in which networks could be set up to provide this integration across maternity, neonatal and paediatric care, including:

**Option 1:** Existing neonatal and maternity networks to merge to form perinatal networks

**Option 2:** Separate maternity and neonatal networks continue to exist, however both of the network boards to include representation from the other board, as is the case currently in Greater Manchester

**Option 3:** Separate maternity and neonatal networks continue to exist, however with the creation of an additional overarching perinatal network set up to complement and bring together the separate networks, as is the case in the West Midlands.

However, whichever of these models is adopted the objectives must include improving outcomes for babies admitted to neonatal care, improving maternal outcomes as well as promoting choice in maternity care. It is vitally important that the focus neonatal networks have brought to the improvement of services for babies born premature and sick over the last decade is not lost. Networks have played a key role in developing collaborative working and promoting high quality care through focusing clinical leadership.

Whichever network model is adopted, it is essential that links with paediatric services are also made to ensure there is continuity of care for babies born premature and sick beyond discharge and as they grow up. As one network representative commented:

“at a local level there is concern that responsibilities for the 0–2 years pathway will be separated from the 0–19 (years) pathway.”

To help ensure the above objectives are met, we believe that the governance arrangements for the networks, whichever model is adopted, must include the following:

- Lay representation from parents with recent experience of having babies cared for in neonatal services and mainstream maternity services
- Representatives from neonatal nursing and medicine, obstetrics and midwifery and paediatrics
- Commissioner representation from both NHS Commissioning Board and GP consortia
- Public Health Service representative

We also believe that networks should promote strong links with:

- Health and Wellbeing Boards
Health and Social Care Bill

HealthWatch

Maternity Service Liaison Committees

4. Competition versus coordination

Networks have been defined as:

“A linked group of health professionals and organisations from primary, secondary and tertiary care, working in a coordinated way that is not constrained by organisational or professional boundaries to ensure equitable provision of high quality, clinically effective care... The emphasis... shifts from buildings and organisations towards services and patients.”

It is therefore a central aim of managed clinical networks to engender collaboration across organisational boundaries. However, as a consequence of the emphasis placed on increased competition between provider organisations in the proposed NHS reforms, concerns have been raised about the future of networks and the role they play in promoting this cross-organisational collaboration.

Under the proposed reforms, competition and choice are seen as key drivers of service improvement. However, neonatal care is a highly specialist emergency service, in which ensuring babies receive the right care in the right place is central to achieving the best possible outcomes. This is potentially inconsistent with full parental choice of where their baby is cared for. It is the co-ordination of care across different NHS organisations, rather than competition between them, that is vital to the provision of high quality services for premature and sick babies.

We strongly believe that this form of competition and choice is not an appropriate driver for service improvement within the context of neonatal care. However we believe other measures of quality, for example outcomes of care and satisfaction with services are key to driving up standards. In addition, other incentives and levers, such as Commissioning for Quality and Innovation (CQUIN) payments and Quality, Innovation, Productivity and Prevention (QUIPP) should be used to encourage service improvement.

While Bliss does not believe that choice should be a key driver of neonatal services, we do support the intention set out in the White Paper to “extend maternity choice and help make safe, informed choices throughout pregnancy and in childbirth a reality—recognising that not all choices will be safe or appropriate for all women.” However, the emphasis on women’s ability to make an informed choice is an important one, and we believe the information women receive during pregnancy about their care options must be improved.

We believe that maternity or perinatal networks must cover a certain population size to provide women with the option of a number of different care providers. We therefore believe that a number of GP consortia should come together under one maternity network. In addition, as increasing maternity choice will pose a considerable challenge to commissioners, we support the Royal College of Midwives’ recommendation to limit women’s choice to the maternity network area in which they live or work.

5. Networks’ relationship to providers and commissioner bodies

“The strength of networks is in their neutrality as an ‘honest agent’.” (Network Director)

“The Managed Clinical Networks do not fit easily with the commissioner/provider divide since both are represented on the Board. In my view that is a great strength... The regular discussions between commissioners and providers at the Network Board meetings are constructive and enable an understanding of the issues related to delivering the service from both perspectives.” (Network Manager)

Neonatal networks as they are currently established play an important role in bringing provider and commissioner bodies together. The Toolkit sets out this bridging role provided by networks:

“The managed neonatal network has a dual role within the commissioner-provider relationship, both advising commissioners and supporting co-ordination and benchmarking/audit throughout the patient pathway.”

Respondents to Bliss’ audit of neonatal networks highly valued this dialogue between commissioners and providers which networks facilitated. A number of respondents spoke about the importance of networks as a neutral arbiter between the two functions.

6 Equity and Excellence: Liberating the NHS, Department of Health, July 2010
7 Response to the Department of Health consultation—Liberating the NHS: Greater choice and control, Royal College of Midwives, January 2011
8 Toolkit for High Quality Neonatal Services, NHS and Department of Health, 2010, p16
We urge the Government to ensure that the new NHS structures being introduced guarantee the continuation of this important dialogue and joint working between commissioners and providers of maternity and neonatal services. We believe this can be achieved through commissioner representation on networks and hosting of neonatal and maternity networks by commissioner bodies.

6. Networks’ funding arrangements

“There is concern that (provider led networks) will lead to ‘network capture’ by the larger tertiary units and will result in smaller units feeling vulnerable and without a voice. When these roles within some networks have been placed in the provider arm the network management often find themselves drawn into managing and maintaining Trust corporate business, making them no longer impartial.” (Network Director)

The experience gained from the establishment of neonatal networks is that the investment of resources and time into their management and leadership has been essential to their success. Where informal networks of individual professionals and providers have been set up, for example some maternity networks, progress has been slow. We therefore urge the Government to ensure that maternity and neonatal networks, or perinatal networks, are sufficiently resourced and supported to operate as managed clinical networks, rather than existing as informal networks. We believe that a network manager, the dedicated time of a lead clinician, lead nurse, as well as some clerical support and operating costs are vital for the effective running of a network.

Current funding arrangements for neonatal networks vary across the county. Funding for a number of networks comes from Specialised Commissioning Groups and others from PCTs. In some networks funding is split between PCTs and NHS Trusts. Respondents to Bliss’ audit perceived the hosting of neonatal networks under the current system by more “neutral” PCTs and SCGs as key to the co-operation of the different provider Trusts.

The White Paper suggests that maternity networks should be provider-led. However, we believe it is essential for the effective working of the service that one provider organisation is not allowed to dominate. We recommend that an outside organisation, other than the NHS Trusts responsible for providing care, is involved in the running of the network, including for example holding the networks’ funds and chairing the network. We believe that the NHS Commissioning Board must have a role in ensuring that the different providers of neonatal and maternity services are on an equal footing in relation to the network’s decision making. As mentioned above, we believe the NHS Commissioning Board and GP consortia should host the networks.

The social enterprise model has been suggested for the future of cancer networks, however, there are no such organisations currently operating in neonatal services, and as such would likely experience difficulties in gaining the support and confidence of neonatal care providers.

We therefore recommend that the NHS Commissioning Board and GP consortia commit to funding neonatal and maternity networks, or perinatal networks, by contracting with them to provide expertise and commissioning support.

7. Summary of recommendations

1. It is essential that the new NHS structures ensure strong links across the pathway from pre-pregnancy care, to early years and beyond. We believe this can be achieved through joint working between maternity and neonatal networks, or through the creation of joint perinatal networks.

2. Whichever network model is implemented locally, the objectives of co-existing maternity and neonatal networks or joint perinatal networks must be to improve outcomes for babies admitted to neonatal care and improve maternal outcomes—not just to promote choice in maternity care.

3. We do not believe that competition and choice are appropriate drivers of service improvement within the context of neonatal care. However, other measures of quality, for example outcomes and satisfaction with services are essential for driving up standards.

4. We urge the Government to ensure that the new NHS structures guarantee the continued dialogue between commissioners and providers of maternity and neonatal services. We believe this can be achieved through commissioner representation on networks and hosting of neonatal and maternity networks, or perinatal networks, by commissioner bodies.

5. It is essential that parents with direct and recent experience of mainstream maternity services, and parents who have experienced complications in their pregnancies and had babies to neonatal care are represented on the networks’ governance boards. Networks covering both maternity and neonatal services must include representation from both groups of parents.
6. Maternity, neonatal and perinatal networks must be sufficiently resourced and supported to operate effectively as managed clinical networks, rather than existing as informal networks.

7. The NHS Commissioning Board must have a role in ensuring the different providers of neonatal and maternity services within a network region are on an equal footing. We also recommend that the NHS Commissioning Board and GP consortia fund the running costs these networks, by contracting with them to provide expertise and commissioning support.

June 2011

Memorandum submitted by the National Federation of Occupational Pensioners (HSR 02)

National Federation of Occupational Pensions

1.1 The National Federation of Occupational Pensioners (N.F.O.P) is the oldest and largest occupational pensioners’ organisation in the UK, with 90,000 members nationwide organised into 185 branches.

Summary

2.1 We welcome the Bill’s overall aim of increasing patient choice and empowerment and we support any moves to allow older people to feel that services are more responsive to their—often complex—needs. We also applauded the Government for its decision to reconsider and amend the Bill. We are confident from the Government’s response to the Future Forum Report that many of the concerns we raised in our evidence to the Public Bill Committee in February will be satisfactorily addressed through Government amendments in Committee Stage.

2.2 However, our members remain concerned about the impact the Bill will have on the quality of services they receive through the NHS. Many older people will not be able to take advantage of greater choice that the Bill will provide as many are not able to make use of the internet to research providers, treatment or drugs. They will continue to rely on their GP or other health practitioner to guide them—and will want to be entirely confident that the advice they receive is not based upon a potential conflict of interest or motivated by budgetary considerations.

2.3 Older people form one of the patient groups which is least able to “vote with its feet” over the choice of consortium to which they belong due to reduced mobility and complex needs. It is therefore particularly important that the Government and the Bill Committee take account of their concerns about how the Bill will affect them.

2.4 N.F.O.P welcomes the proposed amendments to make GP consortia more accountable through a governing body with decision-making powers. We particularly welcome the inclusion on this body of a lay member with responsibility for championing patient and public involvement, however we feel that the Government should take further steps to ensure that all patients are properly represented in the decisions made by consortia.

2.5 Changes to the Bill’s provisions on Monitor, with a greater emphasis upon protecting and promoting patients’ interests instead of promoting competition, are very welcome. However N.F.O.P remains concerned about the introduction of increased competition into the NHS and the consequences that this will have upon standards of patient care. The recent exposure of practices at the Winterbourne Care Home, run by private sector company Castlebeck, has demonstrated some of the possible consequences of increased private sector involvement in the healthcare sector.

GP Consortia and Local Accountability

3.1 Many older people have a good relationship with their GP, and may welcome a greater role for their trusted local doctor in the commissioning process. Amendments to Clauses 21 and 22 in the Committee Stage of the Bill will give greater detail on the structure of commissioning consortia including the existence of a lay member of the Governing Body with responsibility for championing patient and public involvement. We believe that the existence of this member is a step in the right direction towards greater patient involvement. However we have concerns that many of the patient groups which would most benefit from representation in this way are those which are most difficult to consult and involve, such as older people, immigrant communities and those with lower levels of formal education. Therefore, in order to ensure the full consideration of these groups in the decisions made by consortia, the Government should issue full guidance on patient engagement techniques for hard-to-reach patient groups.

3.2 The Bill will require local authorities to establish a Health and Wellbeing Board which has as its main duty to prepare with the commissioning consortia a joint statement of strategic needs and a health and wellbeing strategy, to which the commissioning consortia must have regard (Clauses 176 to 178). We...
welcome proposals to allow for greater inclusion of democratic representatives on the Boards and greater rights for the Boards to ensure that consortia take account of their plans. However, we remain concerned that with local authority budget reductions, the Health and Wellbeing Board may not have the resources to hold consortia to account.

3.3 Furthermore, we are very concerned the reforms may result in greater inequalities in healthcare provision and an increased “postcode lottery”. Whilst we recognise that local discretion can be an important part of meeting the needs of local people, we fear that older people will be more likely to suffer from inequalities as they may be reluctant, or unable, to change their GP even if the service they receive is of a lower standard. We would welcome a clear statement of intent from the Government on this important issue.

**Monitor and Competition**

4.1 We welcome plans to prevent “cherry picking” by private companies through safeguards developed in conjunction with the Royal Colleges, however we note that the general direction of travel in health policy remains focused towards the introduction of greater competition, with the “Any Qualified Provider” provisions due to come into force in April 2012.

4.2 N.F.O.P believes that moves towards greater competition in the health service should not be seen as inevitable and would like to reassert its concerns from experience in the postal services sector. We have concerns that if Monitor follows the same route as Postcomm in the postal services sector then increased competition will lead to severe damage being done to the NHS in the same way that Postcomm has damaged Royal Mail. Increased competition in the NHS, including allowing failing Foundation Trusts to go to the wall, will result in uncertainty amongst older people on how they will receive the treatment upon which they rely.

4.3 The Bill provides for the regulation of Foundation Trusts to be removed from Monitor, and for all NHS Hospital Trusts to become Foundation Trusts. To achieve this separation of hospitals from SHA, DoH and Monitor Regulation, the burden of compliance will fall upon the Council of Governors. Under Part 4 of the Bill (Clause 148) there is to be increased statutory duties and responsibilities for Governors and this is a cause for concern. N.F.O.P is pleased that the transition period for Monitor to relinquish its regulatory role will be extended to 2016. This period will be needed to address the real issues of increasing the levels of knowledge and understanding of Governors if they are adequately to fulfil their role of holding the non-executive Directors to account.

**Further Information**

5.1 We would be delighted to provide further information to you in writing, or by meeting you.

June 2011

Memorandum submitted by Dr Michael Lloyd (HSr 03)

My expertise is as an EU expert having spent 40 years working on EU economic and legal issues, including time spent as a European Commission official and as an economic adviser to the European Parliament.

**Summary**

The fundamental problem with the Bill is the underlying premise that *competitive markets* are the best way of cost-effectively delivering high quality health (and social care) services. Not only is this economic proposition challengeable, but the placing of such emphasis on competition involves economic and legal risks in a legally uncertain and complex EU-wide context.

**General Competition Issues.** The emphasis on competition and the establishment of autonomous sub-national health care markets in the Bill means that there is a high degree of uncertainty as to the impact of competition policy and law. There is a strong likelihood, given policy developments in the EU, that future competition rulings may adversely affect the delivery of health and social care services in the UK. The *Fenin* case does not offer the protection for health services that the Department of Health assumes. (NB It should be noted that UK national competition policy will itself move in this direction; including any rulings of the Monitor, as well as the OFT and the Competition Commission).

**Procurement and Commissioning.** Both existing and future procurement and commissioning will require the significant and increasing application of EU public procurement procedural rules (already under-going a substantial revision) to the delivery of health and social care services. Though, of itself, this development need not necessarily be detrimental to such delivery, it will require considerable sophistication of approach. The current expertise in PCTs will need to be drawn on (assuming it remains available) and extended. In
particularly there are likely to be problems where commissioning bodies and health service providing groups are the coterminous.

**Mergers and Abuse of Dominant Positions.** Here problems are already surfacing in relation to the merging of Hospital Foundation Trusts to secure economies of scale. The likelihood of successful challenge from smaller groupings—public, voluntary, and private—may be expected. The issues of the use of dominant positions, via predatory pricing, may also be the subject of adverse rulings. The danger is that sensible arrangements, in patients’ interest, may well be prejudiced by developments in this area of competition policy.

**State Aid Challenges.** This is a complex area, but one that will give rise to concern if it is held that an undertaking providing health or social care services, in competition with a non-publicly funded undertaking, has been provided with funding from state resources on terms different from that available in a competitive market economy, and be likely to affect trade between Member States. It can readily be seen that a key issue is whether specific health and social care services markets will be held to be markets which extend into other EU countries.

1. **Introduction**

   1.1 This submission concentrates on the introduction, via the Bill, of an “external NHS market” for the provision of health and ancillary services. It examines the key EU competition issues from economic and legal viewpoints. However, it should be stressed that subsequent, more detailed research and analysis will be required to positively identify the specific areas which will be likely to inhibit the efficient and equitable delivery of health and social care services in England.

2. **General Competition Aspects**

   2.1 The introduction of competition and competitive markets, *on the scale envisaged in the Bill*, will change fundamentally the functioning of the NHS. It is naive and misleading to suggest that the Bill, even in its revised form, simply represents an evolution of the current marginal elements of existing competition in the NHS. Moreover, the emphasis on competition and the establishment of autonomous sub-national health care markets via the Bill—supported by the on-going evolution of national and EU competition impacts and influences in the health and social care sectors—means that there is a *high degree of uncertainty* as to the impact of competition policy and law on the new health services environment. It may be felt that this is a risk worth taking in the Bill improves the provision of health services. However, the main risks and uncertainties appear to lie in the direction of a weakening of the NHS underlying principles of solidarity and universality via the substantially increased application of competition policy and law.

   2.2 The Bill contains an inherent conflict between its, apparent, desire to deliver greater integration and collaboration in providing health care services in the interests of patients (ie customers) and its focus on establishing *competitive markets*. Whatever may be stated about restricting competition if it interferes with collaboration or patient choice this will not prevent CAs in real situations from giving preference to competition over integration; this is their role and their raison d’etre. Competition will be the *objective* and integration and collaboration will be *constraints*. Indeed, this essential irreconcilability (see below) suggests that *any* amendments in this fundamental area of the Bill will need to be radical. This problem may be seen in the context of the supposedly revised powers of Monitor in the new Bill.

   2.3 The revised Bill indicates that “the main duty of Monitor, in exercising its functions, is to protect and promote the interest of people who use health care services: (a) by promoting competition where appropriate, and (b) through regulation where necessary.” It is clear that competition (the “where appropriate” is a meaningless qualification in practice and almost certainly in law) is seen as the principal way of “promoting and protecting” the customers of health services (ie “people who use health services”). This is a convoluted way of saying patient choice.

   2.4 However, the notion that this in any way establishes *twin* objectives for Monitor, one being competition and the other being patient choice, is naive for two reasons:

   — In mathematical/logical terms there can be only one maximand; the other “objective” will be a constraint

   — In legal terms, insofar as the establishment of competitive markets remain the key objective then competition policy and competition law, UK and EU, *will* override other objectives such as integration, collaboration, patient choice.

   2.5 The above introduction of “patient choice” as an “objective” for Monitor simply adds confusion. It is suggested that competition *impliments* patient choice. In fact, the notion that competitive markets will empower patients (viewed essentially as customers for health services) is vacuous. Competition in this context is not the competition between runners in a race, nor is it the, sensible, emulation of best practice which goes on the NHS at present; it is *competition for market shares* (The eminent economist Joan
2.6 The claim that such competitive markets will empower patients (viewed essentially as customers for health services) is misleading. Patients wish, essentially, to be guided by health service professionals as to which clinical procedure they require, either to cure or to ameliorate the condition with which they present. (Price, as NHS patients, is irrelevant to them; though not to the commissioner or provider). This is completely different from their position as customers deciding which mobile phone to purchase from which store and to which phone network to be connected. No-one is suggesting that patients’ views on their treatment should be ignored, particularly in the area where health care and social care meet. But it is disingenuous to argue that citizens as patients will ever be in the same position as citizens as supermarket customers. However, this vision of patients as customers is not limited to the UK; other European countries, notably the Dutch, have already ventured down this route. This Bill will influence how health and social care services will be viewed in the EU and in the development of an EU-wide health and social care services market.

2.7 There appears not to be any strong appetite among EU countries (buttressed by the “subsidiarity” principle as indicated in the Lisbon Treaty) to indulge the Commission’s desire to establish a de jure EU-wide health care market. Nonetheless, successive European Court of Justice (ECJ) rulings (see below on the Fenin case), and their interpretation by the Commission, will continue to lead to the gradual “widening” of national systems into a de facto EU health care and social care system.

2.8 Hence, the notion that the use of the Monitor as a health sector regulator (see below) to insulate the modified NHS from the application of EU competition law (or for that matter general UK competition law), and that this will be sufficient protection is, to say the least, disingenuous. The Field Forum report accepted at face value the assertion by the Department of Health that the Bill does not alter the application of competition law (national or EU law) in the NHS. That the bill does not change the situation is trivially true. However, as far as EU (and, therefore, national) competition law applicability to the health services sector is concerned there are a number of points to observe.

2.9 Commissioning Bodies. In relation to competition law overall the Department of Health is relying on the Fenin case to suggest that commissioning bodies are not to be regarded as undertakings and hence are not subject to EU competition law. However, and particularly as the position in relation to health and social care in a developing EU-wide market is concerned such reliance may prove unsound. The Fenin case did confirm that the purchasing activity of a commissioning body could not be dissociated from the consumption of the procured services in the market. But the European Court of Justice (ECJ) did not rule on the other key issue raised by Fenin; as to whether health services were to be judged to be an economic market activity as opposed to a social activity based on solidarity. It avoided the issue by ruling the argument of the plaintiff as inadmissible on a technicality, ie it has not been raised with Court of First Instance (CFI) initially. This lacuna is worrying.

2.10 The Bill is clearly focused on establishing a competitive market for health and social care services. Moreover, the fact that the Dutch have already moved in this direction and other countries are following (partly because of pressure on public budgets) means that parts of the EU are moving in a manner which will lead to the de facto establishment of an EU health and social care market, with a mixture of public and private providers. This situation increases significantly the likelihood of a new ECJ ruling which may well remove whatever protection appears to be provided by Fenin (which affords by no means comprehensive cover as specific circumstances could mean competition law may still apply, in the absence of a new ruling).

2.11 Providers. As indicated above there is, as yet, no definitive EU case law on whether health services, in a competitive market context, are economic or social. In general, private and public providers of all services may be regarded as undertakings if they are engaged in an economic activity (any provider may, of course, engage in economic activity for some of its functions but not others). It is this key issue for the health (and social care) services which will sooner rather than later be ruled on by the ECJ. It is not unreasonable to suppose—partly based on the opinion of the Advocate-General in the Fenin case—that health and social care services will, generally, be defined, in health systems that are based on competitive market structures, as economic activities. The question is do we want to take the, very real, risk of this happening?

3. Procurement/Commissioning Issues

3.1 Potential problems may initially arise in this area. Obviously within the NHS, and particularly within PCTs, there is valuable experience in using appropriate public procurement procedures—including the use of EU procedures (eg NHS Manchester have provided a useful reference handbook on the various procedures and their practical and legal implications)—and in being aware of the need to seek value for money and where competition may be beneficial in this regard. However, the position is continuously
developing, including in particular the EU public procurement rules as they apply to the provision of health and social care services. The European Commission is part way through a wide consultation exercise prior to a major reform of the rules.

3.2 Not all the changes which may be expected will be adverse as far as health service commissioning and procurement are concerned. The introduction of the “competitive dialogue” procedure (see below) in 2006 is an example of such a positive change. However, this change was introduced to avoid the improper use of the “negotiated procedure” (see also below) to ensure that this latter procedure was used only exceptionally, as it was supposed to be used.

3.3 Currently, health and social care services proper (as opposed to ancillary activities, eg the building of a clinic) are classified as Type B Services and are not subject to the full public procurement procedures. These services have nonetheless to be procured in a fair and transparent manner (ie not anti-competitively) and the contract award notices have to be published in the OJEC. One of the possible reforms being considered by the European Commission is to abolish the distinction between these Type B services and the Type A Services that are subject to the full public procurement procedures.

3.4 The underlying thrust of the European Commission’s position, buttressed by case law from the ECJ, is to establish a genuine EU-wide health and social care services procurement market. In itself this may perhaps be welcome; though there are issues concerning the allocation of resources. However, the prevailing orthodoxy—if the health and social care services markets are to be subject to competition in the manner prescribed by the Bill—this will lead to competitive market structures and functioning prevailing over issues of health services’ patient interests.

3.5 In relation to the application of the EU public procurement rules, though GP Commissioning bodies, as with GPs themselves, are likely to be private undertakings they will, nonetheless, be regarded as bodies governed by public law, and hence subject to the public procurement rules. Other NHS commissioning bodies will be similarly defined.

3.6 As indicated above, it is likely that, for the time being, perhaps the majority of “pure” health services may be defined as Type B services and hence not subject to the full rigours of the formal public procurement procedures. If this were to change, as it could, then a far greater proportion of health service expenditure would be covered by the rules, and exposed to potential challenges.

4. MERGERS AND ABUSE OF DOMINANT POSITIONS

4.1 Problems with mergers are already arising from informal advice from the CCP (the precursor of Monitor’s role in the Bill) to hospital foundation trusts in areas where hospitals wish to combine to form larger groupings to deliver more efficient health services.

4.2 The issues surrounding the potential for the abuse of a dominant position are obviously linked with the issue of mergers. It may be that the merger itself—entailing a large undertaking—may not itself be the problem, but its pricing or commissioning/procurement policies may be.

4.3 Competition policy in this area is critically dependent on the definition of markets, always a difficult and contentious issue surrounding the issue of whether or not substitute products or services exist and are available. Initially, the European Commission was accused, correctly, of defining markets in such a manner as to validate a priori the existence of dominance and abuse. The Commission now uses a methodology which relies on a definition which pays greater attention to whether or not there is substitutability between products/services to define the market. This is particularly complex where health services are concerned as there are many alternative procedures. Again it is the possibility for uncertainty in future potential EU rulings which gives rise to concerns.

4.4 For instance a possible, though not unrealistic, scenario might be

Scenario A. A large conurbation has two hospitals, one large and the other a District General Hospital (DGH), and a community clinic. The clinic—which has viability problems—provides a variety of health and social care services, including, among other services, family planning, substance abuse advice, and physiotherapy. The clinic uses the services of local GPs with special interests.

The Commissioning Consortium decide to integrate all of the services provided by all three organisations into one single network and encourage the local consortia to consider a tender to provide the combined services.

Will this be possible without infringing competition law?

The problem that arises in this scenario surrounds the creation of a dominant, combined service provider which might be challenged as excluding other potential providers of some of the services.
5. **STATE AID ISSUES**

5.1 State aid problems are likely to arise where the provision of public funds—which may in specific circumstances be construed as providing state aid to the recipient organisation/undertaking—is made in a full competitive market for health care and social care. The definition of state aid is not straightforward as it relates not simply to the fact of state funding being made available, but to the terms on which the aid is provided and affects trade across the EU. It can readily be seen that a key issue is whether specific health and social care services markets will be held to be markets which extend into other EU countries.

5.2 The issues here are complex but this does mean that the involvement of public funds in an economic area where there is a mix of competitive markets with both economic and social services delivery may give rise to state aid challenges.

*June 2011*

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**Memorandum submitted by Cancer Research UK (HSR 04)**

**CONTEXT**

1. Cancer Research UK’s ambition is for the UK to have world class cancer outcomes. We know that our outcomes currently lag behind the best performing countries in the world, even though we fund world-class research and are responsible for developing many of the innovative treatments that have aided improved cancer survival here and elsewhere in the world.

2. It is essential that the Health and Social Care Bill is fit for purpose to deal with the challenges that the NHS in England will face in the next few years. It is vital that cancer services continue to deliver improvements in treatment for patients in a system of changing responsibilities where significant efficiency savings are being made.

**SUMMARY**

3. We welcome the Government’s response to the Future Forum report and, in particular, the proposed changes on research. Establishing research as part of the core culture of the NHS—from the Secretary of State to Clinical Commissioning Groups—is critical if we are to improve cancer survival. Patients who are treated in places where clinical research is integral to patient care can access new treatments more quickly, and are more likely to survive their cancer. We are also pleased the Government has committed to ensuring the treatment costs of patients taking part in research are paid by the NHS. This will help avoid unnecessary bureaucracy and delays.

4. We welcome the commitment to clinical networks and clinical senates. Involving a range of experts in cancer commissioning and ensuring different parts of the service are joined up is crucial to delivering high quality treatment for a complex set of conditions like cancer.

5. Achieving the Government’s ambition of saving an additional 5,000 lives per year by 2015 will require:

   — Ensuring Clinical Commissioning Groups and the NHS Commissioning Board obtain appropriate advice from cancer commissioning experts where appropriate.

   — A requirement that Clinical Commissioning Groups work with local authorities to input into and design services to promote awareness and early diagnosis of cancer.

   — Ensuring Clinical Commissioning Groups and the NHS Commissioning Board have access to expertise and measures in place to uphold their duty to promote research.

6. This briefing focuses on three key issues of concern for Cancer Research UK. First, expertise in commissioning cancer services, second, the role of public health in promoting awareness and early diagnosis of cancer, and third, embedding research within the new NHS structures.

**EXPERTISE IN CANCER COMMISSIONING**

7. We welcome the Government’s commitment to establishing clinical senates and strengthening clinical networks. We also welcome the commitment to including clinicians and healthcare professionals in Clinical Commissioning Groups. Involving a range of experts in cancer commissioning and ensuring different parts of the service are joined up is crucial to delivering high quality treatment for a complex set of conditions like cancer.
8. Commissioning of cancer services is not as good as it could or should be and information about the quality of cancer services that would aid commissioning is not fully utilised by the health service. Commissioners require information about what an excellent service looks like and the current quality of different cancer services if they are to commission effectively. In addition, commissioners benefit from advice about appropriate levels at which to commission certain services.

9. Good practice guidelines will no doubt encourage Clinical Commissioning Groups to “buy in” appropriate support for cancer commissioning, but we are concerned by conversations we have had with GPs. They highlight that finances will be tight, that there will be no compulsion to use this expertise and that GPs with a special interest in cancer will potentially be more likely to utilise their own expertise and buy in support than others.

— Recommendation: Clinical Commissioning Groups and the NHS Commissioning Board should be required to obtain appropriate advice from cancer commissioning experts where appropriate.

THE ROLE OF PUBLIC HEALTH IN AWARENESS AND EARLY DIAGNOSIS

10. There is a concern that the reform programme will risk fragmenting cancer services, at least in the short term. The Government must commit to working hard to guard against this. We welcome the commitment which guarantees the future of clinical networks as the place where clinicians from different sectors come together to improve the quality of care across integrated pathways. This will maintain the vital expertise in coordinating learning, disseminating initiatives and ensuring non-duplication of effort that has been developed by cancer networks.

11. The creation of Public Health England poses a risk to the efforts to improve the early diagnosis of cancer. To ensure cancer is diagnosed as early as possible, local authorities and GPs will need to work together. Local authorities will have shared responsibility with Public Health England, who will commission national campaigns where evidence supports them, for raising awareness of the signs and symptoms of cancer and encouraging early presentation. GPs will have an interest in public awareness and responsibility for the patient once they present with suspected cancer. To guard against fragmentation, local authorities and GPs should be jointly incentivised to prioritise early diagnosis, including by having shared indicators in the Public Health and NHS Outcomes Frameworks.

12. The burden of cancer is increasing rapidly: it is expected that there will be 100,000 more cases per year over the next 15 years in the UK. New treatments are becoming increasingly sophisticated and expensive. At a time of cost pressures in the NHS, the combination of these factors is likely to mean even less money spent on prevention and early diagnosis—the very areas that could help to counter the epidemiological pressures. There is concern that the new arrangements will exacerbate rather than address these concerns.

— Recommendation: We would like local authorities to be responsible for providing services for promoting awareness and early diagnosis of cancer. We would like guidance issued requiring Clinical Commissioning Groups to work with local authorities to input into and arrange services to promote awareness and early diagnosis of cancer.

EMBEDDING RESEARCH IN THE NHS

13. We are pleased that the Government has committed all parts of the NHS to promoting and supporting research. We particularly welcome the commitment for Clinical Commissioning Groups to have a duty to promote research and innovation.

14. Clinical research studies in the NHS are vital in cancer research, whether they are epidemiological studies or clinical trials of interventions. Ongoing support for cancer research is critical to underpin improvements in cancer services, and outcomes. An essential component of this support is ensuring that research is embedded across the NHS, and that the barriers to setting up research studies at the local level are removed.

15. Ongoing support for cancer research is critical to underpin improvements in cancer services, and ultimately, outcomes. Patients treated in research-active environments receive better care and the UK has led the way in increasing the number of cancer patients involved in clinical trials. Research conducted in the NHS has supported many breakthroughs in cancer treatment and service design.

— Recommendation: Sufficient measures need to be put in place to enable Clinical Commissioning Groups and the NHS Commissioning Board to uphold their duty to promote research. These measures should include guidance on how treatment costs of patients taking part in research will be met within the system, together with clear and measurable targets to monitor the conduct of research in the NHS.
KEY MESSAGES ABOUT CANCER RESEARCH UK:

— We spent circa £334 million on research in 2009–2010;

— We receive no Government funding for our research;

— We are a national charity with local roots—90% of the population lives within 30 miles of one of our research sites;

— For every pound we receive, excluding retail, 80p is available to spend on our work to beat cancer*

— We fund over 4,000 scientists, doctors and nurses throughout the UK.

* This includes our life-saving research, information and work we do to influence public policy.

June 2011

Memorandum submitted by Peter Roderick, (public interest lawyer) (HSR 05)

SUMMARY OF EVIDENCE

The proposed amendment to Clause 1 of the Bill (to leave it out—Amendment 1), and the proposal to substitute a new section 1 for the current section 1 of the National Health Service Act 2006 (Amendment 174), indicate that the duty on the Secretary of State in section 1(2) of the Act to provide or to secure provision of health services in England is still to be abolished. The effect of these proposed amendments would, if enacted, be to replace this duty with a new duty on the Secretary of State to exercise the functions conferred by the 2006 Act so as to secure that services are provided in accordance with the 2006. Whether this would have the same legal effect as the current section 1(2) can only be determined in the light of an analysis of the functions conferred by the Act (as amended by the Bill), and it is not possible in the short time between the re-committed amendments and the first sitting of the Public Bill Committee on Tuesday 28 July to express a confident opinion. There are several questions that, in my respectful submission, the Committee needs to pose, and which the Government must answer, to assist in this regard, and this evidence lists a number of those questions in the form of suggested questions to the Secretary of State. As the nature of the proposed substitution of section 1 of the 2006 Act includes a new section 1(2) which requires the functions conferred by the Act (and the Bill’s proposed amendments) as a whole to be considered, in my further respectful opinion, the Committee needs to address associated provisions.

EVIDENCE

1. I submit this evidence on my own behalf as a public interest lawyer and concerned citizen, without party political or organisational affiliation. I was called to the Bar by Gray’s Inn in 1982. Since May 2011, I have prepared three legal analyses and notes relating to abolition of the duty on the Secretary of State to provide or secure provision of health services in England, and these are available on www.dutytoprovide.net. Since then, I have been in contact with many individuals and organisations who are also concerned with this issue, including my MP, members of the House of Lords and the media.

2. The proposed amendment to Clause 1 of the Bill (to leave it out—Amendment 1), and the proposal to substitute a new section 1 for the current section 1 of the National Health Service Act 2006 (Amendment 174), indicate that the duty on the Secretary of State in section 1(2) of the Act to provide or to secure provision of health services in England is still to be abolished.

3. The effect of these proposed amendments would, if enacted, be to replace this duty with a new duty on the Secretary of State to exercise the functions conferred by the 2006 Act so as to secure that services are provided in accordance with the 2006. Whether this would have the same legal effect as the current section 1(2) can only be determined in the light of an analysis of the functions conferred by the Act (as amended by the Bill), and it is not possible in the short time between the re-committed amendments and the first sitting of the Public Bill Committee on Tuesday 28 July to express a confident opinion.

4. There are several questions that, in my respectful submission, the Committee need to address, and which the Government must answer, to assist in this regard, and in the following paragraph I list a number of those questions in the form of suggested questions to the Secretary of State. As the nature of the proposed substitution of section 1 of the 2006 Act includes a new section 1(2) which requires the functions conferred by the Act (and the Bill’s proposed amendments) as a whole to be considered, in my further respectful opinion, the Committee needs to address associated provisions.

5. My 18 suggested questions are as follows, grouped under four headings:
1. **The Secretary of State’s duties**

1. To ask the Secretary of State to specify each of the functions conferred by the *National Health Service Act 2006*, as that Act would be amended if the *Health and Social Care Bill* as re-committed to the Public Bill Committee was to be enacted, which he must exercise so as to secure that services are provided for the purposes of promoting a comprehensive health service in accordance with section 1(1) of the Act.

2. To ask the Secretary of State if he will specify the reason or reasons why section 1(2) of the *National Health Service Act 2006*, which requires him to provide or to secure provision of health services, needs to be amended.

3. To ask the Secretary of State if he will consider not abolishing the “duty to provide or to secure provision” of health services placed on him by section 1(2) of the *National Health Service Act 2006*.

4. To ask the Secretary of State to specify those elected persons or bodies which would determine (a) those services, and (b) the level of those services, which would be provided in accordance with the *National Health Act 2006* if the *Health and Social Care Bill* was to be enacted.

5. To ask the Secretary of State if he will specify each provision in the *Health and Social Care Bill* as re-committed to the Public Bill Committee that would impose a duty to provide or to secure provision of health services in England on any public or private body.

6. To ask the Secretary of State to specify his functions in the *Health and Social Care Bill* which would guarantee (a) that additional services and facilities for the care of pregnant women, breastfeeding women, and young children, required to be provided by him now in accordance with section 3(1)(d) of the *National Health Service Act 2006*, will continue to be provided as a part of the health service, and (b) that those services will be provided equally throughout England without geographical variation.

7. To ask the Secretary of State to specify his functions in the *Health and Social Care Bill* which would guarantee (a) that additional services and facilities for the prevention of illness, people who are ill, and ongoing healthcare for those leaving hospital, required to be provided by him now in accordance with section 3(1)(e) of the *National Health Service Act 2006*, will continue to be provided as part of the health service, and (b) that those services will be provided equally throughout England without geographical variation.

2. **Rights and entitlements to (free) health services**

8. To ask the Secretary of State if he will specify those provisions of the *Health and Social Care Bill* which he considers would, if enacted, affect the right and/or entitlement to health services of people in England.

9. To ask the Secretary of State to guarantee that if the *Health and Social Care Bill* was enacted, hospital, medical, surgical, nursing and ambulance services would continue to be provided as a right and/or entitlement equally across the whole of England.

10. To ask the Secretary of State to specify those services which, in light of the proposed amendment in the *Health and Social Care Bill* to section 1(3) of the *National Health Service Act 2006*, would not be provided as part of the health service in England.

3. **Commissioning**

11. To ask the Secretary of State to specify the reasons why the *Health and Social Care Bill*, as re-committed to the Public Bill Committee, does not impose a duty on commissioning consortia to provide or to secure provision of health services, such as medical services, nursing services and ambulances.

12. To ask the Secretary of State to confirm that the *Health and Social Care Bill*, if enacted in its current form, would give the responsibility for deciding what constitutes “a reasonable level of health services” to the commissioning consortia, and removes this responsibility from the Secretary of State.

13. To ask the Secretary of State to specify what provisions there are in the *Health and Social Care Bill* to prevent commissioning consortia deciding that health services and facilities for the care of pregnant women are not a priority.

14. To ask the Secretary of State to specify the duties and powers which the *Health and Social Care Bill* would, if enacted, impose or confer on clinical commissioning groups in order to provide, secure provision of, or arrange for provision of health services in England; and, if no such duties and powers can be specified, to explain why that is the case.

15. To ask the Secretary of State to explain whether, if the *Health and Social Care Bill* was to be enacted, a commissioning consortium could consist (a) only or mainly of companies or of individuals representing
such companies, and (b) only or mainly of non-UK (including US) companies or of individuals representing such companies.

16. To ask the Secretary of State to specify those provisions in the Health and Social Care Bill which would, if enacted, ensure that members of a commissioning consortium would be individual GPs in private practice.

4. POSSIBILITY OF INTRODUCTION OF MEANS-TESTING

17. To ask the Secretary of State to specify how section 1(3) of the National Health Service Act 2006 would, if the Health and Social Care Bill was to be enacted, prevent current and future recipients of health services in England from being means-tested in respect of health services.

18. To ask the Secretary of State if he will specify the provisions of the Health and Social Care Bill that allow for means-testing in relation to receipt of health services; and, if none can be specified, if he will guarantee that such mean testing will not occur.

June 2011

Memorandum submitted by Mencap (HSR 06)

HEALTH AND SOCIAL CARE BILL 2011 AND THE NHS FUTURE FORUM

During the NHS listening exercise, Mencap helped to co-ordinate a 40 strong charity coalition calling for the voice of all patients, including those with a learning disability, to be put at the heart of the proposed changes to the NHS.

The joint statement (See Appendix C) issued by these charities secured national media coverage, but more importantly, partly contributed to many of the key requests met in whole or in part through the Government’s response to the report published by the NHS Future Forum. Mencap is pleased to see the positive moves made by the Government on this issue.

TWO KEY POINTS MENCAP WOULD LIKE TO SEE CONSIDERED BY MEMBERS OF THE BILL COMMITTEE

As sections of the Bill return to the Committee, Mencap has focussed on two key points that were not conclusively addressed by the Government in its response.

1. Within the Government’s response to the NHS Listening Exercise the following statement was made around the commissioning of learning disability services:

“(Within the NHS commissioning board) clear arrangements will be needed for key services or areas that may require dedicated professional and clinical leadership. This may include…services for people with learning disabilities”

Mencap would appreciate any clarity that could be brought to the role the NHS Commissioning Board will play with regards to learning disability—as it is vitally important to get right the commissioning of services for those with some of the most complex needs.

Mencap endorses the proposal for services for those with Profound and Multiple Learning Disabilities (PMLD) being commissioned by the Clinical Commissioning Groups with oversight provided by the NHS Commissioning Board.

In March 2010, Professor Jim Mansell was commissioned by the Department of Health to write the Raising Our Sights report (March 2010) which highlighted how effective local services can be when provided in community and local settings for people with PMLD. This is a model which is endorsed by Mencap.

2. The second issue concerns the importance of ensuring that local Healthwatch is subject to the Freedom of Information (FOI) Act. In response to a parliamentary question (Hansard, 8 June 2011, column 355W–58066), Mr Simon Burns suggested that the Government were considering adding local Healthwatch to the schedule of organisations covered by the Freedom of Information Act. Mencap would welcome any clarity Members of the Bill Committee could secure from Ministers as to whether it is the government’s intention to add local Healthwatch to the FOI Act.

APPENDIX A—ABOUT LEARNING DISABILITY

A learning disability is caused by the way the brain develops before, during or shortly after birth. It is always lifelong and affects someone’s intellectual and social development. It used to be called mental...
handicap but this term is outdated and offensive. Learning disability is NOT a mental illness. The term learning difficulty is often incorrectly used interchangeably with learning disability.

APPENDIX B—ABOUT MENCEP’S INTEREST IN HEALTH

Mencap have a long standing interest in the health of people with a learning disability and was awarded the Civil Society overall charity of the year award in June 2011 for its campaigning work in this area.

Research has shown that people with a learning disability still experience worse health outcomes and health inequalities than the general population.

Mencap’s Death By Indifference report (2007) highlighted the six premature, avoidable deaths of people with a learning disability in the NHS.

These shocking deaths led to a government ordered independent inquiry (Sir Jonathan Michael/Healthcare for all) as well as an investigation by the Health Service Ombudsman (6 Lives report).

Since these reports, progress has been made within the NHS, but performance is inconsistent.

A recent progress update to the Ombudsman (6 Lives Progress Report, DH, 2010) showed that concerns remain around poor use of mental capacity legislation and lack of health services being reasonably adjusted.

With the changes proposed in the Health and Social Care Bill, the challenge is to ensure that progress in driving better health outcomes for all people with a learning disability is not lost.

Mencap leads the Getting it Right campaign, which is a coalition of charities and Royal Colleges working together to realise better health outcomes for all disabled people (including those with learning disability), collaborating on this Bill.

APPENDIX C—JOINT STATEMENT ON HEALTH REFORMS ISSUED BY 40 CHARITIES, 27 MAY 2011

“Listen up”—charity statement

This is a time of great uncertainty in the NHS. This uncertainty does not help anyone. The Government’s “Listening Exercise” is therefore to be welcomed. The Department of Health needs to use this time to substantially improve the Health and Social Care Bill.

Although the upheaval in NHS is a considerable challenge to all of those involved in health and social care, it is also an opportunity to address long standing inequalities. Currently, the Health and Social Care Bill does not live up to the aspirations set out in the Government’s White Paper.

In order to put patients at the heart of the NHS, improve health outcomes for all and empower clinicians, we believe the Government must:

1. Ensure GP Consortia effectively engage with all patients and put them at the heart of their plans.

2. Improve integration across health and social care by strengthening the role of health and wellbeing boards and the NHS Commissioning Board

3. Create a Healthwatch that is independent, well-resourced, transparent and able to act as an advocate for all patients.

4. Include measurements for outcomes of the most vulnerable.

5. Ensure children’s services are embedded in health and social care.

6. Improve access to specialised services for those with complex needs


9 http://www.civilsociety.co.uk/charityawards/shortlist/shortlist/disability/content/9006/mencap
Memorandum submitted by Kath Dalmeny and Joe Short (HSR 08)

1. This submission addresses matters contained within the Health and Social Care Bill (revised version published by the Coalition Government, Thursday 23 June, 2011), and concentrates on issues where we have a special interest in, and questions which we would like the Committee to be aware of when scrutinising the Bill.

A) BACKGROUND TO THE INDIVIDUALS SUBMITTING THIS EVIDENCE

2. This paper is submitted by Kath Dalmeny and Joe Short, who do not have specific legal expertise. We are friends of public interest lawyer Peter Roderick, who has submitted evidence to the Public Bill Committee separately. In this matter, we act independently of any organisation or political party, as concerned citizens with a strong personal interest in the future of the National Health Service. We established the website www.dutytoprovide.net on 9 June 2011 with the purpose of sharing the expert legal opinion of public interest lawyer Peter Roderick on specific and fundamental legal implications of the original government’s Health and Social Care Bill, which proposed removal of the “duty to provide or secure provision of healthcare” placed on the Secretary of State since the establishment of the National Health Service in 1946.

3. We have since been in discussion with several MPs, members of the House of Lords and stakeholder organisations in the health and other related sectors to encourage consideration of some fundamental legal questions in the scrutiny of the Health and Social Care Bill, resulting in several parliamentary questions, verbal briefings and media reports—all relating to the original version of the Bill. We will encourage more such scrutiny through our limited sphere of influence as concerned citizens, with no specific political or organisational affiliation on this matter, and also hope that this submission will help to inform and shape the scrutiny that the Public Bill Committee will undertake.

B) SUMMARY OF CONCERNS AND FORMAT OF THIS SUBMISSION

4. Following the “period of listening” and the Future Forum report, the Government has revised the Health and Social Care Bill and the latest version was published on Thursday 23 June 2011. We understand that this revised Health and Social Care Bill will be passed to the Public Bill Committee in Parliament, with your scrutiny process beginning on Tuesday 28 June 2011.

5. We believe this process allows very little time for detailed and independent scrutiny, and think this time scale is unduly short for the proper consideration of the fundamental legal issues that we think the revised Health and Social Care Bill contains. On initial reading of the revised Health and Social Care Bill, we think there are still very big issues with the wording of the revised Bill and remain very concerned that fundamental changes to the basis of the National Health Service will slip through without the public and parliamentary debate they deserve. However, we have neither the time nor the resources to produce or commission a full and robust legal opinion ready for the beginning of the Public Bill Committee process on Tuesday 28 June 2011.

6. We therefore pose our concerns in the form of questions, below, plus recommended actions for the Secretary of State to make the implications of the changes clear to people in England who will be directly affected by the changes proposed, now and for generations to come. We therefore believe these questions demand urgent clarification and hope that the Public Bill Committee will be able to help set in motion the process to answer them, and for those answers to be placed in the public domain, and raised in parliament for proper debate and scrutiny. For example, will enactment of the revised Health and Social Care Bill (intentionally or by omission) result in:

   — no duty to provide, nor any duty to secure provision of services, imposed on the Secretary of State or any other body
   — no specification of which are priority health services that must be provided, and which can be at the discretion of commissioning consortia
   — no elected body determining what health services will be provided
   — significant geographical differences in provision of health services
potentially, in the future, provision of some health services being means-tested
potentially, in the future, provision of some health services requiring a financial contribution from the patient

7. We believe that there is sufficient evidence in the new draft of the Health and Social Care Bill to warrant strong public concern. We also believe that such questions need to be answered—as a matter of priority—before citizens and their parliamentary representatives in the House of Commons and the House of Lords can make informed decisions about whether or not to support the recommitted Health and Social Care Bill in its passage into law.

C) RECOMMENDATIONS TO THE SECRETARY OF STATE TO CLARIFY THE PROPOSED CHANGES TO THE NATIONAL HEALTH SERVICE

8. We believe that the public and many of their representatives in the House of Commons and House of Lords are unclear as to the implications of certain details of the revised Health and Social Care Bill. We believe that they therefore lack the full information and analysis to enable them to make informed decisions about whether or not to support the Health and Social Care Bill in its passage into law. We think, therefore, that the Secretary of State should make a comprehensive statement, giving full details of:

— what functions are conferred on the Secretary of State in the Health and Social Care Bill that he must exercise so as to secure that services are provided for the purposes of promoting a comprehensive health service in accordance with the National Health Service Act 2006;
— any changes in rights and/or entitlement to health services for people in England that will result from enactment of the Health and Social Care Bill in its current form;
— any guarantee he can give that, following changes proposed in the Health and Social Care Bill, the full list of priority health services identified and listed in the National Health Service Act 2006 will continue to be provided, and also that these will be provided as a right and/or entitlement equally across the whole of England.

9. Further, we think the Secretary of State should make a statement, confirming that:

— the latest version of the Health and Social Care Bill, if enacted in its current form, still gives the responsibility for deciding what constitutes “a reasonable level of health services” to the commissioning consortia, and removes this responsibility from the Secretary of State.

10. We ask the Public Bill Committee to use what influence you have to require the Government and Secretary of State to give a full and comprehensive statement on these crucial matters.

D) LEGAL QUESTIONS ARISING

11. The following text sets out our questions arising from initial reading of the revised Health and Social Care Bill (published Thursday 23 June, 2011)

E) UNDER THE TERMS OF THE REVISED HEALTH AND SOCIAL CARE BILL, WHAT DUTIES ARE PLACED ON, OR REMOVED FROM, THE SECRETARY OF STATE?

12. Since 1946, when the NHS was established, there has been a legal duty on the State to provide or secure provision of medical services. The Coalition Government’s Health and Social Care Bill—even in its revised form—would remove this duty. The Secretary of State will now have certain “functions” established by the Bill. But without detailed legal scrutiny, it is not clear if these would guarantee the continuation of certain duties and services, and also for those duties and services to apply or be provided throughout England, without geographical variation. We therefore pose the following questions and urge the Public Bill Committee and parliamentary representatives to scrutinise the revised Health and Social Care Bill on this basis:

— What are the functions that are conferred on the Secretary of State in the Health and Social Care Bill that he must exercise so as to secure that services are provided for the purposes of promoting a comprehensive health service in accordance with the National Health Service Act 2006?
— Is there any provision in the Health and Social Care Bill that places a duty to provide health services in England on any public or private body? We think there is not.
— Is there any guarantee that services and facilities for prevention of illness, people who are ill, and ongoing healthcare for those leaving hospital will continue to be provided as part of the public health service, and also that those services will be provided equally throughout England, without geographical variation? The Secretary of State currently has a duty to provide or secure provision of these services, and they are specified in the NHS Act 2006, but these do not appear explicitly in
the revised Health and Social Care Bill, published 23 June 2011, neither as a duty for the Secretary of State, nor for the commissioning consortia.

— Is there any guarantee that services and facilities for the care of pregnant women, breastfeeding women, and young children, will continue to be provided as a part of the public health service, and also that provision of these services will continue to be provided equally throughout England, without geographical variation? The Secretary of State currently has a duty to provide or secure provision of these services, specified in the NHS Act 2006, but these do not appear explicitly in the revised Health and Social Care Bill, published 23 June 2011, neither as a duty for the Secretary of State, nor for the commissioning consortia.

— Which parts of the Health and Social Care Bill impose duties or confer powers on elected individuals or bodies to provide or to secure provision of health services in England?

— Which elected person or organisation would, under the terms of the Health and Social Care Bill, determine those services that must be arranged by the commissioning consortia (under section 3(1) of the Health and Social Care Bill), such as hospitals, doctors, nurses and ambulances?

— What are the reasons why section 1(2) of the National Health Service Act 2006, which requires him to provide or secure provision of health services, needs to be amended by the Health and Social Care Bill?

— Why won’t the Secretary of State simply retain the “duty to provide or secure provision of health care services” placed on him by the 1946 National Health Service Act, in sections 1(2) and 3(1) of the NHS Act 2006?

F) UNDER THE TERMS OF THE REVISED HEALTH AND SOCIAL CARE BILL, WHAT CHANGES ARE THERE IN THE RIGHTS AND/OR ENTITLEMENT TO HEALTHCARE SERVICES FOR PEOPLE IN ENGLAND?

13. We think it remains unclear exactly how the Health and Social Care Bill will affect the rights and/or entitlement to healthcare services for people in England. This may have implications for the level of service provided; the range of services provided; what commissioning consortia consider to be the priority for service provision; and potentially whether or not people could be means-tested or charged a fee for health services in future. We therefore ask:

— What changes in rights and/or entitlement to health services for people in England will result from enactment of the Health and Social Care Bill?

— What guarantee is there that, following changes proposed in the Health and Social Care Bill, the full list of priority health services identified and listed in the National Health Service Act 2006 will continue to be provided as a right and/or entitlement equally across the whole of England?

— What powers in the Health and Social Care Bill affect the right and/or entitlement of people in England to receive health services?

— Which services, in light of section 1(3) of the National Health Service Act 2006, and the subsequent amendments proposed in the Health and Social Care Bill, will not be provided as part of the National Health Service in England?

— How—in precise legal terms—does the Health and Social Care Bill protect current and future recipients of health services in England from means testing with regard to the health services they receive?

— How—in precise legal terms—does the Health and Social Care Bill protect current and future recipients of health services in England from being charged a fee for the health services they receive?

G) UNDER THE TERMS OF THE REVISED HEALTH AND SOCIAL CARE BILL, WHAT ARE THE DUTIES OF THE COMMISSIONING CONSORTIA?

14. One of the main provisions of the Health and Social Care Bill is the establishment of commissioning consortia. Many questions remain regarding their duties. Note that we mean the precise legal term “duty” and not the less precise term “accountability” or “transparency”. Accountability and transparency are both very important, but a proper, legally enforceable “duty” lays the foundation stone on which accountability and transparency can be built. We therefore pose the following questions and urge the Public Bill Committee and parliamentary representatives to scrutinise the revised Health and Social Care Bill on this basis:
— Why has a “duty to provide or secure provision of healthcare services” not been placed on commissioning consortia, including medical services, nursing services and ambulances?

— What provisions are there in the Health and Social Care Bill to prevent commissioning consortia deciding that health services and facilities—such as for the care of pregnant women, or the provision of ambulances—are not a priority?

— What provisions in the Health and Social Care Bill allow for limitations to be placed on universal rights and/or entitlement to health services? Could a commissioning consortium decide, for example, that certain types of health service will not be provided?

— Under the new arrangements proposed in the Health and Social Care Bill for health services in England, will it be possible for a private healthcare provider to become a commissioning consortium? (And as a supplementary question, could that private healthcare provider be from outside the UK, including the US?)

June 2011

Memorandum Submitted by Action on Hearing Loss (HSR 13)

SUMMARY

We would like clarified:

— How the duty to improve the quality of services will translate to an improvement of audiology services on a local level.

— How the duty to reduce inequalities will translate into a reduction in communication barriers for people with hearing loss accessing and benefiting from health services.

— How the duty to promote user involvement will translate into making all patient advocacy activities inclusive of and accessible to people with hearing loss.

— How the duty to obtain appropriate advice will translate to ensure that all commissioners observe best practice and quality standards when commissioning audiology services.

— How the duty to encourage integrated working will translate to ensure integration of services across the whole audiology pathway, including access to rehabilitation and follow-up services.

— How the wider scope of Joint Strategic Needs Assessments to include future needs of the local population will translate to respond to the fact that with an ageing population the demand for audiology and hearing loss services will grow.

DUTY AS TO IMPROVEMENT IN QUALITY OF SERVICES

1. We welcome the provision in the Bill to place a duty on The Secretary of State and the Board and clinical commissioning groups to improve the quality of services [Part 1, Clause 2, 1A] [Part 1, Clause 19, 13D] [Part 1, Clause 22, 14L]. In light of the ageing population, the numbers affected by hearing loss are projected to rise. Now is a crucial time to improve services, information and support for people who are deaf or hard of hearing. Promoting public health, providing early diagnosis and intervention, and supporting wider needs, also make economic sense as such strategies can help to prevent social isolation and improve employment outcomes.

2. Important developments have shaped services for people with hearing loss but there are still huge barriers to access. Currently, only one in three people with hearing loss have accessed hearing aids, leaving four million people in the UK with unaddressed needs. Diagnosis of hearing loss is ad hoc and can take on average 10 years. Evidence suggests that GPs fail to refer up to 45% of people reporting hearing loss, for an intervention such as a referral for a hearing test or hearing aids.

3. There is also a serious lack of integration between health and social care and vital rehabilitative services such as lipreading classes and hearing therapy are also at risk of closure or decline. Many people being diagnosed with hearing loss receive no signposting to community services that can improve their independence, health and wellbeing.

4. To improve quality of services we are calling on the Government to: deliver more accessible and integrated services, closer to people’s homes; develop quality standards that take account of the whole pathway—linking public health, clinical and social needs; reclassify lipreading from a leisure activity to an
essential communication skill, and provide funding for classes all over the country, and ensure that hearing therapy is not lost.

5. We seek clarification on how the duty on the Secretary of State and Board to improve quality of services will be implemented locally by clinical commissioning groups.

**Duty As to Reducing Inequalities**

6. We welcome the duty on the Secretary of State and the Commissioning Board and clinical commissioning groups to reduce inequalities between patients with respect to their ability to access health services and the outcomes achieved for them by the provision of health services [Part 1, Clause 3, 1B] [Part 1, Clause 19, 13F] [Part 1, Clause 22, 14N (a and b)]. We would welcome clarification as to how stringent these duties will be, and whether there will be a particular duty to reduce communication barriers for patients with hearing loss.

7. Currently, lack of deaf awareness amongst healthcare staff and limited access to communication support for people with hearing loss creates significant healthcare barriers, and service users with hearing loss do not enjoy equal access to and outcomes from NHS services.

8. Health services must commit to making services fully accessible to patients with hearing loss. This means ensuring appointments can be booked not just on the phone but by email, text or text-to-speech relay services, ensuring that staff are all fully deaf aware and providing timely access to interpreters where required.

9. Research shows that more than a quarter of patients with hearing loss have difficulty getting an appointment with their GP, where surgeries won’t book appointments by email, web or text. Of those patients who see their GP, a third are left unclear about the diagnosis after the visit because of communication difficulties. Almost a third (30%) of British Sign Language (BSL) users avoid going to see their GP because of communication problems. Research shows that 70% of BSL users admitted to A&E units were not provided with a BSL interpreter to enable them to communicate.

10. Information regarding options for people with communication support requirements available on admittance to hospital would ensure that patients and service users are more adequately supported when stressed or anxious and accessing NHS services. Deaf awareness amongst staff is particularly important in acute settings. Healthcare staff also need to ensure that hearing aid users have well maintained and working hearing aids fitted at all times, and check regularly that patients can hear.

11. Reducing late presentation of conditions is also a means to help reduce health inequalities. At present it takes people an average of ten years to receive a diagnosis of hearing loss, a delay which can exacerbate other health conditions and lead to isolation from the work place and from friends and family networks.

12. The isolation that results from a hearing loss being allowed to develop, the withdrawal from accessing services such as a GP or pharmacist and the adaptation that people make in terms of avoiding communication with others, all lead to a reduction in the ability to access healthcare services when needed.

**Duty As to Promoting User Involvement**

13. We welcome the duty on the Board and clinical commissioning groups to promote the involvement of patients and their carers in decisions about the provision of health services to them [Part 1, Clause 19, 13L] [Part 1, Clause 22, 14N(c)] [Part 1, Clause 22, 14P] and the need to enable patients to make choices with respect to aspects of health services provided to them [Part 1, Clause 22, 14N(d)].

14. We encourage individuals to become local hearing loss champions and help shape the development and delivery of hearing services. We would like to ensure that all patient advocacy activities are inclusive of and accessible to people with hearing loss.

**Duty As to Obtain Appropriate Advice**

15. We welcome the duty placed on the Board and clinical commissioning groups in the Bill to obtain advice from persons with professional expertise relating to the physical or mental health of individuals [Part 1, Clause 19, 13G] [Part 1, Clause 22, 14O] and would like to clarify through committee stage what form this duty will take and confirm that they will take advice on all conditions, including hearing loss, and that advice gained by the Board will then be passed on to all clinical commissioning groups.

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10 RNID “A Simple Cure” 2004
11 RNID “A Simple Cure” 2004
12 RNID “A Simple Cure” — 2004
16. Hearing loss is a major public health issue which carries a serious impact on life quality, potentially leading to more complex mental health and social needs. If audiology and hearing loss services are to be commissioned by local groups, it is vital that these groups have the necessary expertise, that information about audiology and hearing loss services and information on wider health and social care services is readily accessible to people with a hearing loss, and that services are operated to a high standard.

17. We are particularly concerned that GPs have low awareness of the needs of people who are deaf or hard of hearing. Recent research shows that GPs fail to refer up to 45% of people reporting hearing loss for any intervention, such as referral for a hearing test or a hearing aid. This suggests that GPs would benefit from advice about the importance of early intervention in creating positive outcomes for people with hearing loss.

18. We welcome the introduction of clinical networks and clinical senates and would like to see hearing loss represented across both groups. We would like to see audiology and hearing loss champions sitting within every local authority, responsible for tracking relevant developments in technology, clinical procedures and models of service delivery, and for keeping clinical commissioning groups fully aware of these. We would also like to see some clinical commissioning groups becoming centres of excellence in specialised areas including audiology and hearing loss and the NHS Commissioning Board and clinical networks playing a fundamental role in identifying and disseminating good practice.

19. It is essential that the effectiveness of the audiology services that are commissioned by clinical commissioning groups is accurately measured. Action on Hearing Loss calls for agreed quality standards for audiology services that will apply to the any qualified provider model of services, and calls for NICE Quality Standards to reflect the needs and patient experiences of people with hearing loss and deafness.

20. With growing public spending constraints, we are concerned that audiology and hearing loss services will be assigned relatively low priority by commissioners, or that there will be active rationing through restrictive eligibility criteria (as has already been proposed by some PCTs). The national NHS Commissioning Board should ensure that rehabilitative services—which can have such positive effects on quality of life, activity, participation and independence, especially in later years—are not overlooked by clinical commissioning groups in favour of acute services that have more obvious and more easily measured short-term effects (for example, on mortality and morbidity) and that eligibility criteria for services are set at a universal level.

DUTY TO ENCOURAGE INTEGRATED WORKING

21. We welcome the duty placed on the Board in the Bill to seek more integrated working between clinical commissioning groups and local authorities in arranging for the provision of services [Part 1, Clause 19, 13J]. We would like to see a duty to ensure join up between health and social care services and providers in particular. We would welcome Ministers clarifying how this duty will take place in practice on a local level.

22. There are many services that people can be signposted to once they have been diagnosed with a hearing loss and fitted with a hearing aid, such as community equipment to help them adapt their home to their hearing loss and to services such as our Hear to Help projects that help new hearing aid users learn basic maintenance and upkeep of the devices. Lipreading classes help people with hearing loss to maximise communication, build confidence and increase their independence.

23. However, we know that at present this signposting does not always take place, as a recent survey showed that four out of five people (79%), when fitted with a hearing aid, received no information about other services or assistive technology, which might help to maximise their independence and wellbeing.

24. We would like to see a duty on local service commissioners and providers to develop hearing loss strategies and plans in partnership with local health, social and voluntary organisations and people with hearing loss, and to promote innovation and integration of services across the whole pathway, including access to rehabilitation and follow-up services.

JOINT STRATEGIC NEEDS ASSESSMENTS

25. We welcome provisions in the Bill that Joint Strategic Needs Assessments will now have a wider scope to include future needs of the local population [Part 5, Clause 189, 3(c)]. It is essential that these assessments take hearing loss into account.

26. The current level of unaddressed hearing loss and demographic change leading to an ageing society mean that the demand for audiology and hearing loss services will grow.

14 Ibid.
27. Hearing loss is a major public health issue affecting over 10 million people in the UK—one in six of the population. As our population ages this number is set to grow and by 2031 there will be more than 14.5 million people with hearing loss in the UK.

28. Although it is clearly a public health issue that demands action, hearing loss is not currently on the public health agenda. We are calling for hearing loss to be put on the public health agenda of Public Health England, Health and Wellbeing boards, Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies. We are also calling for JSNAs to be refreshed to recognise and tackle the high levels of unmet need around hearing loss.

29. Making population assessments around hearing loss is complicated by the current levels of unmet need. Issues of stigma and inbuilt barriers to services mean that one in three people who could benefit from hearing aids currently do not use them.

30. JSNAs should therefore recognise the need for accessible services that would encourage those with hearing loss to access hearing checks and hearing aids. JSNAs also need to account for those with hearing aids who may need to receive ongoing social support to ensure hearing aids are fully utilised. This could be through services such as our Hear to Help, as well as lipreading classes and hearing therapy to help maintain communication skills, independence and wellbeing.

31. We recommend that JSNAs are refreshed to help tackle the high levels of unmet need around hearing loss and to promote prevention, early intervention, and ongoing social support for people with hearing loss.

32. We would welcome clarification during committee stage as to how future needs of the population will be assessed and the level of evidence that will be required to demonstrate a future need that must be taken into account.

ANNEX

— Hearing loss is a major public health issue affecting over 10 million people in the UK—one in six of the population. As our population ages this number is set to grow and by 2031 there will be more than 14.5 million people with hearing loss in the UK.

— There are two million people in the UK who use hearing aids, but a further four million people who could benefit from their use but don’t currently have them.

— Over half (55%) of people over 60 have a hearing loss and 90% of patients over 81.

— On average, there is a 10-year delay in people seeking help with their hearing loss, in which time they can become isolated from the workplace and from friends and family networks. This delay can also exacerbate other health conditions.

— Diagnosis of hearing loss in adults is opportunistic and ad hoc.

— Evidence suggests that GPs fail to refer up to 45% of people reporting hearing loss, for an intervention such as a referral for a hearing test or hearing aids.

— There is a lack of integration between health and social care for hearing loss.

— Poor access to health services for people with hearing loss causes health inequalities in terms of access to, and outcomes from NHS services.

— Hearing loss can impact on health, wellbeing and employment.

June 2011

Memorandum submitted by UNISON (HSR 14)

SUMMARY AND PROCESS

1. UNISON believes that the Bill remains fundamentally flawed and—based on a preliminary assessment of the new amendments—appears more convoluted than ever. UNISON’s main areas of concern remain: a vast and damaging extension of competition; abolition of the private patient income cap; and the

16 Davis, A. “Hearing in Adults” 1995
17 Davis, A. et al. “Acceptability, benefit and costs of early screening for hearing disability: a study of potential screening tests and models” (Health Technology Assessment 2007; Vol. II: No. 42)
unravelling of national structures for staff pay, bargaining, and terms and conditions. It is also increasingly clear that Government claims to have brought back the responsibility of the Secretary of State for the NHS are not true. UNISON continues to believe that goals such as increasing clinician involvement and providing a greater say for patients could be achieved by other means.

2. UNISON is also concerned about the process. To begin with, only 64 of the Bill’s 299 Clauses are being recommitted to the Committee, despite the huge amount of criticism and debate around the Bill. The latest government amendments to the Bill were only published three days before the oral evidence sessions at the Committee, and there are 181 of them. The latest Briefing Notes appeared the day before this first session of Committee and we do not yet have a revised Impact Assessment at all. This leaves virtually no time for an adequate assessment of the changes to the Bill. This will inhibit proper scrutiny of the recommitted Bill, undermining the whole point of the Government’s “listening exercise”.

3. There are many issues that the Government has ignored completely in its changes to the Bill. UNISON’s submission is therefore obliged to focus in the main on those areas that the Committee is being allowed to debate again. But this does not detract from the seriousness of problems in the following areas:

— the use of a commercial insolvency regime meaning that wards, units or entire hospitals could be forced to shut or sold off to other providers;
— the continuation, albeit in delayed form, of the Any Qualified Provider (AQP) policy that, although not in the Bill itself, underlies many of the changes and will have a big impact on services and staff;
— the failure to retain national workforce structures for terms and conditions, pay and bargaining;
— the plan to abolish the private patient income cap.

The latter is of particular concern, the more so given the oral evidence of Prof Steve Field to the Public Bill Committee on 28 June 2011 when he stated the following:

— “If you wanted a gut feeling from what was happening in the listening exercise—the feeling was actually the private cap should stay because people felt that would provide the protection”;
— “To be honest, we didn’t put as much in our report as perhaps we could have done. In fact, it was one area, when we reread the paper at the end, we might have been stronger on”; and
— “…if you opened the cap it may be more likely to be under … EU law, and from competition and from Monitor.”

SECRETARY OF STATE RESPONSIBILITY FOR THE NHS

4. While the latest Government amendments do add a new clause designed to provide reassurance around the responsibility of the Secretary of State to promote a comprehensive health service, the wording of the 2006 National Health Service Act is still changed from the Secretary of State having to “provide or secure the provision of services” to having to “exercise the functions conferred by this Act so as to secure that services are provided in accordance with this Act”. This puts the delivery of services increasingly at arm’s length and away from Parliamentary scrutiny.

5. Moreover, the main thrust of Clause 9 of the Bill remains unamended: the NHS Act 2006 is changed so that it is GP consortia not the Secretary of State that must arrange for the provision of health services. This means that consortia will determine what actually constitutes the health service, potentially opening the door to consortia charging “top-up” payments for certain services they deem as being outside of their definition of health services. Clause 10 says consortia must arrange for the provision of services “as it considers appropriate”—giving consortia great leeway in how they exercise this. Clause 4 on “autonomy” remains unamended and grants greater freedoms to how bodies such as consortia carry out their functions. There is still no direct duty of comprehensiveness on consortia. Clause 5 retains the wording that the National Commissioning Board is responsible for arranging the provision of services.

6. All of this serves to undermine the accountability of the NHS to Parliament, by putting the provision of health services increasingly at arm’s length. It opens up the way for the comprehensive and free nature of NHS services being undermined as consortia could look to shed expensive or unprofitable services, or to charge for them. It increases the likelihood of a postcode lottery of provision, with different consortia providing different services. Open rationing is already beginning to take place in PCTs for items such as knee operations and IVF treatment—this will only get worse when the profit motive becomes the driving force. This could be exacerbated by the proposed development of a new Right to Challenge, in which single
issue groups may demand certain extra services in their locality. UNISON is also concerned that there has so far been insufficient investigation of the potential impact this could have on the VAT exemption enjoyed by the NHS.

**Openness and Transparency**

7. The Government amendment to improve the openness and transparency of consortia is too weak including a get-out clause for consortia that want to avoid meeting in public: the wording says “except where the consortium considers that it would not be in the public interest to permit members of the public to attend a meeting or part of a meeting”. There is too big a loophole.

8. There is a similar problem with the amendment to ensure boards of directors of foundation trusts be open to the public: FT constitutions “may provide for members of the public to be excluded from a meeting for special reasons”—there is no explanation about what these “special reasons” are, so this is also open to abuse.

9. To make these changes stronger, the Government should ensure that consortia and FTs are subject to the Public Bodies (Admission to Meetings) Act 1960, which gives access to the public and press. PCTs and SHAs are currently covered by this. This is certainly the opinion of lawyers on how the Bill could be improved.19

10. There is also no mention of a register of interests to ensure that those involved with a consortium who are also shareholders in other companies can be held to account.

**Monitor and Competition**

11. Although the clause relating to Monitor’s remit has been changed, it remains an economic regulator—contrary to the recommendation of the Future Forum. This is still completely inappropriate for the NHS—it must be treated as distinct from the railways or privatised utilities.

12. There is only one small change to the whole of Part 3 Chapter 2 (entitled “Competition”) meaning that all the increased exposure the NHS can expect to the Competition Act, the Enterprise Act, the Office of Fair Trading and the Competition Commission remains intact. This means that mergers may have to go to the Office of Fair Trading and the Competition Commission for approval, meaning that such issues are not clinically-led or -evidenced decisions but are based on competition law.

13. Monitor’s responsibility for “promoting competition” has been removed but added to the Bill are repeated references to “preventing anti-competitive behaviour” (same for the NHS Commissioning Board). In practice, this could end up meaning something very similar.

14. David Bennett from Monitor told the Public Bill Committee on 28 June 2011 that he did not expect the amendments to change Monitor’s powers. This is also the opinion of lawyers consulted by the Health Service Journal in the past week. Bevan Brittan LLP Partner David Owens said: “I’m not sure they have made much in the way of substantive change. They have changed the emphasis—but Monitor is still going to have concurrent powers under the Competition Act with the Office of Fair Trading. That implies the expectation is competition law is going to apply to providers.” 20

15. Government moves to balance competition with integration appear to be very lop-sided, with the latter little more than window dressing. Monitor, the NHS Commissioning Board and consortia must secure that health services are “provided in an integrated way”. But nowhere in the amendments is there anything to define what this means or to add substance to the proposals, compared to Government amendment 178 that adds in some definition of “anti-competitive behaviour”.

16. There are greater restrictions placed on when providing services in an integrated way can be done: only when it would improve quality or reduce inequalities. It would be stronger if Monitor had to promote integration when it was simply in the interests of patients. Crucially there also appears to be no way of enforcing the need to provide services in an integrated way: where are the references to preventing anti-integrative behaviour?

17. Similarly there is nothing added to the Bill on cooperation or collaboration such as a duty to promote collaboration. The Future Forum recommended that Monitor should promote collaboration and integration as well as choice.

18. It is not clear yet how the existing Principles and Rules of Cooperation and Competition (PRCC) will be incorporated into Monitor’s structures (or the Panel that enforces these), but it is worth noting how heavily weighted the PRCC are in favour of promoting competition: only one of the ten principles is about cooperation.

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19. The Government response to the Future Forum said that “the Bill does not change EU competition law”. This is not the point; the Bill was never going to change the EU’s own laws. What it did, and will still do, is make it more likely that EU laws can be invoked by disgruntled private providers. Activity carried out for social purposes is generally not subject to EU competition law. However, the more private providers that are encouraged to deliver healthcare the less clear this exemption becomes.

20. The Government has freely admitted that once the policy of Any Qualified Provider brings in a wider diversity of providers to the NHS, then EU competition law is more likely to be applicable: health minister Simon Burns’ written answer March 2011: “as national health service providers develop and begin to compete actively with other NHS providers and private and voluntary providers, UK and EU competition laws will increasingly become applicable”.

21. Other commentators agree with Burns’ assessment: a recent legal contribution to the British Medical Journal confirmed that “the reforms further open up the NHS to EU competition law”; lawyers and academics have confirmed elsewhere that the more the government forces competition into the NHS the harder it will be to argue that EU law does not apply. Government plans designed to devolve responsibility for the NHS to the local level instead run a very real risk of handing over a greater say to the EU.

 ROLE OF THE PRIVATE SECTOR

22. The initial Government response to the Future Forum on 14 June seemed to acknowledge the dangers of consortia outsourcing their commissioning functions. However, the formal Government response of 20 June clarified merely that “statutory responsibility for decisions continues to rest with the responsible NHS commissioner” and, crucially, that “this does not in any way preclude NHS commissioners from using external agencies to provide commissioning support”. So the wholesale outsourcing of the commissioning of services remains very much a possibility and nothing in the latest government amendments to the Bill will stop this.

23. The Government has made much of its plans (included in new amendments 22, 100, 177) to block the Secretary of State, Monitor and the Board from embarking on a deliberate policy to increase the role of the private (or public) sector in delivering services. But this statement and these amendments are deeply disingenuous: the government already has a policy (Any Qualified Provider) that will inevitably bring in a greater number of private providers even if this is not its explicit aim. Equally, plans to enforce a “level playing field” will clearly boost the prospects of the private and the community/voluntary sector. And other government initiatives such as the Right to Provide and the Right to Challenge will disadvantage existing public providers. Most importantly, these amendments put a legislative block on the NHS being the “preferred provider” of services in the future, so that the path to greater privatisation is assured over time. The Government has not done any analysis of what this policy would rule out and what impact it would have on the NHS.

24. The recent examples of appalling treatment of patients at the Winterbourne View private hospital and the ongoing uncertainty around the future of Southern Cross provide ample illustration of the dangers of opening up care services to a wider range of private providers.

 CHERRY-PICKING

25. Any company obliged to maximise returns for its shareholders will always look to take on low-risk, high-profit services regardless of Government attempts to discourage them from doing so. Minor changes around the edges will not be sufficient when one of the explicit aims of the government white paper is to bring in a greater number of providers through the Any Qualified Provider policy.

26. Government plans to block cherry-picking with the addition of a new clause designed to reflect the costs incurred in delivering healthcare (presumably to take into consideration issues such as the NHS paying for training of staff and carrying out more complex procedures) relies heavily on the Government/Monitor being able to set a complex and comprehensive tariff regime to reflect these nuances. This is an extremely difficult task and developing new tariffs has proved particularly challenging in recent years so, if not impossible, such a task will take years to complete. What happens in the interim?

27. The Government has continually refused to give any commitment to staff terms and conditions or to staff retaining access to the NHS pension when services are transferred out of the NHS. This makes it easier for other providers to undercut national terms and conditions, particularly if restrictive tariffs are set that encourage providers to make cuts in these areas.

21 House of Commons, written answers, 7 March 2011, Simon Burns MP response to Tom Blenkinsop MP
Price competition

28. UNISON still has concerns that price competition could result from a combination of the latest Operating Framework (that refers to the “opportunity for providers to offer services to commissioners at less than the published mandatory tariff price”) and the new ultra-competitive system devised for the NHS.

29. The promise in paragraph 5.42 of the Government’s formal response to the Future Forum requires commissioners to follow “best value” principles when tendering for non-tariff services, rather than simply choosing the lowest price. There is so far no reflection of this in the latest Government amendments to the Bill.

30. If the Government is serious in its assertion that price competition is not its intention, then a change is needed to the Operating Framework to rule it out completely, along with the revised Procurement Guide from July 2010.

31. The previous Government’s final Operating Framework did refer to moving to a position “where national tariffs represent the maximum price payable by a commissioner”. But the context was very different; this was within a managed and integrated system, where commissioners were to be given more leeway to push down the prices charged by existing providers, not to open the door to providers to outbid one another on who could offer the lowest price. Introducing maximum pricing into a system of unconstrained market forces is bound to lead to competition on price.

32. The recent example of commissioners in south west London negotiating below tariff prices for urgent admissions is exactly the type of activity that the new system is likely to block as “anti-competitive”.

Health and Wellbeing Boards

33. UNISON believes that plans for Health and Wellbeing Boards need to be strengthened further by insisting that they must agree to local commissioning plans and by ensuring greater democratic involvement. For them to express real democratic accountability, at least a majority of the Board should be elected councillors; ideally all voting members should belong to the HWB.

34. UNISON also supports the addition of a representative of the local Schools Forum to the list of those sitting on a Health and Wellbeing Board; as currently worded there is a role for directors of children’s services but not for representatives from education—Health and Wellbeing Boards should join-up services across areas. The Boards also lack the input of trade union representatives, to ensure the staff voice is heard.

June 2011

Memorandum submitted by The National Children’s Bureau (NSB) (HSR 15)

Summary

NCB and the Every Disabled Child Matters campaign (EDCM) welcome the government’s efforts to improve its proposals for health service reform, particularly in relation to wider clinician engagement in commissioning and the integration of health, social care and health-related services. However, our concern that children and young people, including those with complex needs, are not at the heart of these reforms still remains. We urge members of the Public Bill Committee to secure assurances from government that it will:

— ensure that every commissioning consortium’s governing body includes a clinician with experience in providing care to children, including those with complex health needs

— ensure that all children and young people have a voice in the healthcare system, through both Healthwatch and commissioning consortia

— strengthen the Bill so that Health and Wellbeing Boards “must”—rather than “may”—encourage integration across health, social care and health-related services, which include education, early childhood and youth services.

Every commissioning consortium’s governing body must include a clinician with experience in providing care to children with complex health needs

Government is seeking to amend clause 21 of the Bill (inserting section 14JC) to provide for regulations which can prescribe the types of healthcare professionals that must be represented on the governing body.
of a commissioning consortium. Government has committed to ensuring that the governing body includes at least one nurse and one doctor who is a secondary care specialist.

NCB and its partners across the children’s sector have been calling for changes to the health reforms to ensure that health commissioners have a thorough understanding of children and young people’s needs. We were concerned that GPs do not always have the depth of experience and understanding of children’s healthcare needs, particularly for those with complex needs—such as disabled children and children in care. Our concerns reflect Sir Ian Kennedy’s review of children’s NHS services, which highlighted gaps in GPs’ paediatric training and experience.

“Despite the high number of children coming into their surgeries, many GPs have little or no experience of paediatrics as part of their professional training. This means that, technical competence notwithstanding, many GPs lack the confidence to assess and treat children effectively, something that comes from specialist training and experience”

Children with more complex needs, including disabled children, will mostly be in contact with a paediatrician to assess their needs and coordinate their health care, rather than their GP. This often includes consultation on common ailments which are not related to their long-term conditions, meaning many GPs will have limited experience of the needs of such children.

The Government’s proposed amendment is therefore welcome as it recognises the need to engage a range of clinicians in commissioning. However, we want to see this strengthened to guarantee that experts in child health are represented in every commissioning consortia’s governing body.

Can the Minister provide assurances that regulations will prescribe that the governing body of each commissioning consortia must include a clinician with experience in providing healthcare for children with complex needs?

CHILDREN AND YOUNG PEOPLE’S VOICES MUST BE HEARD IN THE HEALTHCARE SYSTEM

The NHS Futures Forum report made the case for measures enabling patient involvement and public accountability to explicitly include children: “there needs to be a voice for the 11.78 million children and young people who have no vote and cannot influence the democratic process”.

In their response to the Futures Forum, government committed to amending the Bill to:

“add an explicit requirement that local HealthWatch membership is representative of different users, including carers”

Government has tabled a number of welcome amendments regarding patient involvement. However, membership of Healthwatch, and the representation of children’s views in particular, does not appear to have been addressed in the Government’s initial amendments.

Currently, the level and quality of children’s engagement in the health sector varies considerably across the country. In particular, local involvement networks (LINks), which the Bill will transform into local Healthwatch, are not always clear that children and young people are part of their remit, and they struggle to develop the skills and access the tools needed to work with confidence with younger members of the public.

We therefore welcome Government’s efforts to strengthen the Bill in relation to patient and public involvement. However, we believe a more explicit direction is needed to ensure that children and young people are not an afterthought in the development of Healthwatch and other mechanisms to promote service user engagement. The NHS Futures Forum report made the case for measures enabling patient involvement and public accountability to explicitly include children. We want this to be reflected in the Bill.

Can the minister clarify the Government’s approach to ensuring that Healthwatch will be representative of different service users, and to making sure the voices of children and young people are heard?

Can the Minister provide assurances that statutory guidance on commissioning consortia’s duty to promote patient involvement will provide specific advice on involving children and young people, including groups that struggle to be heard (such as disabled children, children in care and children in the youth justice system).

HEALTH AND WELLBEING BOARDS MUST HAVE A STRONGER ROLE IN INTEGRATING HEALTH, SOCIAL CARE AND HEALTH-RELATED SERVICES FOR CHILDREN AND YOUNG PEOPLE

Integrated planning and service delivery is particularly important for children and young people’s health. The most effective health promoting interventions for this age group are often those delivered through non-health settings, such as schools and colleges, Children’s Centres and youth services.

The NHS Futures Forum has made clear that there should be greater integration of services for children and young people—beyond just health and social care—especially for those with complex needs.

“We believe integration should cover… integration across health, public health, education, and social care…[T]here is a real opportunity to improve care by bringing together all the funding…for disabled children or those with child protection needs. This principle of ensuring care is joined up across health and social care and education reflects the vision of the Government’s Green Paper on children with special educational needs and disability currently out for consultation”(26) [own emphasis added]

Government has tabled a number of amendments(27) to give NHS commissioners a duty to exercise their functions with a view to securing integration across health, social care, and health-related services.

NCB and EDCM welcome these amendments. However, we are surprised that the provisions covering the role of Health and Wellbeing Boards in promoting integration have not been given equal strength. Currently, clause 192 (paragraphs 3 and 4) states that Health Wellbeing Boards “may”—rather than “must”—encourage integration across health, social care and health-related services. If Health and Wellbeing Boards are to work effectively in partnership with NHS commissioners and hold commissioners to account, their duties regarding integration must be aligned and consistent.

Will the minister clarify how the role of Health and Wellbeing Boards will support the government’s proposed integration duties for NHS commissioners, and how it can be ensured that integration covers the full range of health-related services for children, including education, early childhood and youth services?

June 2011

Memorandum submitted by the Specialised Healthcare Alliance (HSR 16)

EXECUTIVE SUMMARY

1. There are four main issues that the Alliance wishes to draw to the attention of the Public Bill Committee:

a) Accountability of the NHS Commissioning Board (NHSCB)

The Alliance welcomes the new duty placed on the Secretary of State to keep the NHSCB under review regarding the carrying out of its functions. However, the Alliance is seeking clarification around how these “functions” will be defined and how this review will fit with the current requirement on the Secretary of State to assess the NHSCB’s performance. The Alliance is also keen to understand whether guidance issued to CCGs will also apply to the NHSCB in relation to its direct commissioning functions.

b) Integration between NHSCB and clinical commissioning groups (CCGs)

The SHCA is seeking clarification regarding how the sub-national structure of the NHSCB will ensure that specialised and local commissioners can work together to deliver an integrated service for patients. In particular, the Alliance considers that the proposal to have four SHA clusters as a precursor to four sub-national offices of the Board is insufficient in number to reflect provider geography and patient flows in specialised care.

c) Patient and public involvement

The Alliance welcomes the strengthening of the duties and requirements on the NHSCB regarding patient and public involvement. However, the Alliance would like clarification concerning any guidance which will be given to the NHSCB on patient and public involvement in the discharge of its direct commissioning functions.

d) Competition and failure regime for providers

The Alliance attaches great importance to the designation of specialised providers, as set out in the Carter Report on specialised commissioning in 2006. This ensures adequate patient volumes to sustain requisite levels of clinical expertise to deliver high quality, safe services—a key lesson of the Bristol Inquiry. The

26 Ibid p16
27 Amendments to clauses 19 (inserting section 13J) and 22 (inserting section 14OC)
Alliance is therefore seeking clarification that Monitor's newly defined duty and functions will not prevent the designation of providers of specialised services. More information is also required on the system which will be put in place to protect essential services in the event of provider failure.

A) **ACCOUNTABILITY OF THE NHS COMMISSIONING BOARD (NHSCB)**

2. The Alliance welcomes new clause 1 which clarifies that the Secretary of State will retain accountability for securing the provision of services. The Alliance understands that the Secretary of State will not secure services directly, but do so through exercising his functions in relation to the NHS bodies, which will include setting the mandate to the NHSCB.

3. The mandate to the NHSCB will set out those services that the Secretary of State expects the NHSCB to commission directly, including specialised services for smaller patient populations. The Alliance therefore welcomes this clarification that ultimate responsibility for securing the provision of specialised services will rest with the Secretary of State.

4. The Alliance also welcomes the new duty placed on the Secretary of State (new clause 2) to oversee and hold to account the national bodies, including the NHSCB.

5. New clause 2 states that the Secretary of State must “keep under review the effectiveness of the exercise” by the national bodies “of functions in relation to the health service in England.” The Alliance is seeking clarification regarding exactly how these functions will be defined (for example will they include the duties placed on the NHSCB in the Bill) and confirmation that, in relation to the NHSCB, the Secretary of State’s review will take into account the mandate to the NHSCB and the NHSCB’s annual business plan. The Alliance would also like to understand how this review process would relate to the current requirement on the Secretary of State to produce a letter, which is based on the NHSCB’s annual report and which assesses the Board’s performance.

6. New clause 2 also states that the Secretary of State “may” include his review of the national bodies in his annual report. The SHCA believes instead that it should be a requirement on the Secretary of State to include his review of the national bodies in his annual report on the performance of the health service.

7. The SHCA notes that the NHSCB will be required to produce guidance to the CCGs on various topics, for example amendment 114 introduces a power for the NHSCB to issue guidance to CCGs on the discharge of their duty to obtain clinical advice. The Alliance is keen to learn whether this and other guidance issued to CCGs will also apply to the NHSCB in relation to its direct commissioning functions.

8. The Alliance notes the clarification of the Secretary of State’s powers of intervention, whereby they would only be used in the event of a “significant” failure of the NHSCB to perform its functions (amendments 81–83). The Alliance welcomes the explanation in the government’s briefing notes on the amendments to the Bill that a significant failure would include failure by the NHSCB to commission a particular service that it was required to commission, which would include specialised services.

B) **INTEGRATION BETWEEN NHSCB AND CLINICAL COMMISSIONING GROUPS (CCGs)**

9. The Alliance welcomes the various amendments tabled by the government which aim to encourage integration, for example amendment 73 places a new duty to promote integration on the NHSCB.

10. The Alliance also welcomes the emphasis on networks and the introduction of clinical senates as a means to encourage integration and a broad range of clinical input in commissioning—both by the NHSCB and CCGs. It is essential that such arrangements provide for patient and public representation.

11. The Alliance notes, however, the lack of detail regarding how the commissioning functions of the NHSCB and CCGs will be integrated to ensure seamless patient pathways for those patients requiring both specialised and non-specialised services.

12. The Alliance recognises that the clustering of SHAs and PCTs will form the basis of a sub-national structure of the NHSCB. However, the Alliance is looking for clarification regarding how the sub-national structure of the NHSCB will ensure that specialised and local commissioners can work together to deliver an integrated service for patients. In particular, the Alliance considers that the proposal to have four SHA clusters as a precursor to four sub-national offices of the Board is insufficient in number to reflect provider geography and patient flows in specialised care.

13. At the same time, the Alliance stresses the need to guard against an overly complex structure, where various bodies' responsibility for and involvement in commissioning decisions is unclear or differs across the country.
C) PATIENT AND PUBLIC INVOLVEMENT

14. The Alliance welcomes the intention of amendment 64, which requires the Secretary of State to consult HealthWatch England prior to publishing the mandate to the NHSCB.

15. The Alliance welcomes the requirement on the NHSCB to explain in its annual business plan how it proposes to discharge its public involvement duties (amendment 78). The SHCA also welcomes the introduction of a new duty on the NHSCB to “promote patient involvement of each patient” (amendment 70). Amendment 111 places a similar duty on CCGs and gives the NHSCB the power to provide guidance to CCGs about the patient involvement duty. The Alliance would like clarification regarding any guidance which will be given to the NHSCB on patient and public involvement in the discharge of its direct commissioning functions.

16. Amendment 70 also introduces a “duty as to patient choice” on the NHSCB. It is important to note that choice of provider for patients requiring specialised care may necessarily be limited (this is explored further in section d) below), but that the Alliance supports choice for these patients regarding other aspects of their care, for example choice of treatment.

D) COMPETITION AND FAILURE REGIME FOR PROVIDERS

17. The SHCA has consistently highlighted the merits of the designation of providers of specialised services, as recommended in the Carter Report on specialised services (2006). Designation allows commissioners periodically to designate a certain number of providers for a particular service based on a nationally agreed set of patient-centred, clinical, service, quality and financial criteria. The Alliance supports the Carter Report’s view that designation of specialised providers helps to secure an appropriate concentration of clinical expertise and activity to safeguard patient access to high-quality, cost-effective services located to maximise geographical convenience.

18. The Alliance was therefore concerned that Monitor’s original duty to “promote competition” would have prevented the designation of providers of specialised services. As such, the Alliance welcomes the re-casting of Monitor’s main duty, in particular the requirement it places on Monitor to ensure quality in the provision of services (amendment 148).

19. However, questions remain, which mean that the Alliance is still concerned that in certain cases, Monitor could seek to prevent the designation of providers of specialised services. For example, how will Monitor balance the two parts of its main duty (promoting provision of health care services which is both “economic, efficient and effective” and which “maintains or improves the quality of the services”)?

In addition, how should “the interests of people” who use services be defined in the new requirement on Monitor to prevent anti-competitive behaviour in the provision of services which is “against the interests of people who use such services” (amendment 149)? Finally, what would happen in the case of a conflict between the requirements on Monitor to prevent anti-competitive behaviour and to enable health care services to be provided in an integrated way (amendment 149)?

20. The Alliance is therefore seeking clarification that Monitor’s newly defined duty and functions will not prevent the designation of providers of specialised services.

21. The Alliance notes that the government’s response to the NHS Future Forum report suggests that the NHSCB, in consultation with Monitor, will set out guidance on how choice and competition should be applied to particular services (paragraph 5.20). The Alliance is looking for clarification that this guidance would include specialised services and would take into account the principles of designation.

22. The Alliance notes the Government’s decision to withdraw their proposal for certain “essential” services to be “designated” to ensure their continued provision in the event of provider failure (NB. this is a different definition of designation from that set out by Carter). The SHCA recognised that such designated services were likely to include a reasonable number of specialised services. The Alliance is therefore seeking clarification regarding the system which will be put in place to protect essential services in the event of provider failure.

June 2011

Memorandum submitted by The Patients Association (HSR 17)

During the pause in the passage of the Health and Social Care Bill, the Patients Association carried out a survey of well over 1,000 patients and held six independent Listening Events throughout the country which were attended by over 200 members of the public, patients and their families and Carers. This enabled us to collect the views of a cross section of the public regarding the Bill. As a result of our research
conducted with members of the public, the PA has drawn up several recommendations in regarding the proposed NHS reforms, which are detailed at the end of this letter.

In addition, we would like to make the following general points.

— The PA accepts the intention of the Government’s Health and Social Care Bill is to put the patient at the heart of the NHS and we support the overall principles of a NHS that is led by clinicians with patients at the centre.

— We welcome initiatives that result in a truly patient centred system of healthcare. We welcome a reduction in bureaucracy if this frees up funding to be reinvested into frontline services. We welcome a focus on patient involvement in services, if this is truly representative of ALL patients.

— However, our concerns with the current Bill is that it represents a huge restructure of the NHS that needs to be delivered against a backdrop of £20 billion savings—to be achieved by the NHS by 2014. Not only do we believe this is a near impossible ask of the NHS and it is in danger of having a detrimental effect on patient care and frontline services.

— Our research has shown that there are already cuts being made to frontline services. Research conducted by the Patients Association in March this year, showed a drop in the number of elective surgical procedures conducted in 2010, coupled with an increase in waiting times for many patients. Following calls to our Helpline from patients and healthcare professionals who are concerned about access to elective surgery and increases in waiting times, we asked every Trust in England to provide data on the number of surgical procedures conducted in 2009 and 2010 in the following categories-

  — Hip Replacements
  — Knee Replacements
  — Bariatric Surgery
  — Hernia Operations
  — Tonsillectomies
  — Adenoid Operations
  — Gallstone Operations
  — Hysterectomies
  — Cataract Operations

The responses showed that there were 10,757 fewer procedures carried out across these nine categories in 2010 compared to 2009. This included 11% fewer Tonsillectomies, 6% fewer Knee replacements, 3% fewer Hip replacements and 51% fewer Bariatric procedures.

— The research also showed that patients have to wait longer for some procedures, including Hip replacements, Knee replacements, Hysterectomies, Adenoid operations and Gallstone operations. On average patients are waiting eight days longer for Hip and Knee replacements, and six days longer for Hysterectomies (Report attached).

— The increase in the number of phone calls, emails and letters to our Helpline from patients who are concerned about waiting times for operations has risen considerably between 2010 and 2011. In the first six months of 2010 cases of this nature represented 8% of overall cases logged on our Helpline. In the same period in 2011 it represented 18% of cases logged.

— The majority of calls are from people that are complaining that they have waited for longer than 18 weeks for operations or treatments, and most involve waits for operations such as hip or knee replacements. Patients are always very concerned and disappointed to hear that the 18 week wait is no longer binding on hospitals.

**Recommendations**

Below is a list of the Patients Association’s recommendations, informed by patients, carers and members of the public. We would like the Coalition Government to consider these recommendations as part of its Listening Exercise and amendments to the Health and Social Care Bill. The NHS Constitution was
created to protect the NHS and sets out what patients can expect from NHS services, their rights and responsibilities. The Coalition Government must ensure that any proposed reforms respect and adhere to the Constitution.

1. Many patients do not understand the proposed reforms. The Coalition Government needs to urgently explain them in clear, everyday language that avoids the use of NHS jargon. Case studies and examples of what the changes would mean to patients would aid understanding.

2. The move to GP commissioning is not welcomed by the vast majority of patients who fear it will damage the relationship between doctor and patient. Patients want to know how GPs will manage the conflict between buying the best services for patients and balancing the budget and how patients will be able to action choice if their GP is tied in to a contract with a specific service provider. There needs to be real accountability to patients and GP consortia must publish their patient engagement strategy and account books.

3. “Any willing provider” is not welcomed by patients. Private providers will be focused on cherry picking the most profitable services, rather than providing quality services for patients. It is feared that this policy will result in privatisation of the NHS, depletion of resources from the NHS and instability.

4. The provision of well-run out-of-hours services needs to be addressed by the Coalition Government and these services advertised to patients at a local level.

5. With a number of organisations now involved in local healthcare—Local Authorities, Health and Wellbeing Boards, HealthWatch and GP consortia—patients do not understand who is responsible and who is accountable for their care. Local accountability needs to be based on statutory law and clearly defined and communicated to the public in layman’s terms.

6. A strong patient voice is needed at a local level. HealthWatch needs to be independent, properly resourced, advertised, hold statutory powers and be supported both centrally and at a local level. The Coalition Government should not rely on volunteers alone to provide Local HealthWatch functions—this is perceived as the Coalition Government not taking patient involvement seriously.

7. HealthWatch England’s position within the CQC compromises its independence—this conflict needs to be resolved.

8. The NHS reforms are too extensive and are happening too quickly. They are also poorly timed when the country is facing a period of financial austerity. The pace of the reforms needs to be slowed down and significant changes—such as GP commissioning—properly tested, instead of being rolled out in the guise of a “pilot”.

9. There is a place for reducing bureaucracy in the NHS and involving healthcare professionals and frontline staff in the planning of services. However, patients do not believe the Coalition Government’s reforms will achieve this. Rather than overhauling the NHS, the Coalition Government should identify and spread examples of good practice.

10. “Shared decision-making” and “Choice” are welcomed by patients but these initiatives need to be supported with the right information for patients. Patients need accessible, relevant information that enables them to understand their options and discuss these with healthcare providers.

11. For “Shared decision-making” and “Choice” to work, healthcare professionals need to ensure that they communicate effectively with patients, putting them at ease and enabling them to take part in discussions about their healthcare.

12. “Shared decision-making” should extend to families and carers of patients, if appropriate.

June 2011

Memorandum submitted by The Royal College of Surgeons (HSR 18)

1. The Royal College of Surgeons welcomes the opportunity to submit written evidence to the Public Bill Committee on the Health and Social Care (Recommitted) Bill. The College supports the aims of the reforms to modernise the healthcare system. We believe that cutting bureaucracy and giving patients and their clinicians the right to decide the best treatment for individuals is fundamentally right. We believe that commissioning should be based around the patient who should be supported by the relevant clinicians and healthcare staff.
2. The RCS welcomed the NHS Future Forum report and the Government’s response. We believe both reports have added clarity on many of the points raised by the College throughout the consultation process. The College has urged that the NHS should be allowed to get on with making the plans laid out in the Health and Social Care Bill a reality without delay.

3. Below are our specific comments to the Public Bill Committee on the Health and Social Care Bill on the key themes of the Government’s response which are relevant to surgery (clinical advice and leadership, patient accountability, choice and competition, developing the healthcare workforce and public accountability and patient involvement).

CLINICAL ADVICE AND LEADERSHIP

4. The Government’s response states the “NHS Commissioning Board to seek clinical advice through regional clinical networks and Clinical Senates”. The RCS has called for both clinical representation on the NHS Commissioning Board and for more detail on the sub-national commissioning structure in the NHS. The RCS welcomes these proposals as a positive addition to address these concerns in the Bill. The RCS has an established regional network of surgeons across the surgical specialties and we look forward to utilising these networks to engage with the new NHS structures as they are established.

5. The RCS awaits further detail on the membership of the Clinical Senates, how they will be involved in advising the NHS Commissioning Board and how these Senates will engage with other healthcare professions as well as the Medical Royal Colleges. The RCS would also like to see more detail on how Clinical Senates will be able to engage with local clinical commissioning groups, and what the geographical structure of Clinical Senates will be.

6. The RCS similarly awaits further information on the embedding of clinical networks, how these networks will be involved in advising the Commissioning Board and how the clinical issue of focus for each network will be decided.

7. The Government’s response also states that “at least one secondary care specialist doctor appointed to clinical commissioning groups’ governing bodies”. The RCS has consistently called for meaningful engagement between clinical commissioning groups (CCG) and surgeons. We therefore welcome the commitment for secondary care clinicians to work with the CCGs, via their governing bodies. However, we would like to see more detail on how the governing bodies will be involved in the day to day operations of the CCGs, what obligation the CCG will have to take forward any advice given by the governing body and report its decisions back to the governing body, and how the clinical representatives on the governing body will be recruited and appointed.

8. It is also stated in the Government’s response that “The NHS Commissioning Board to draw on the expertise of a range of healthcare professionals. The Board will establish close links with the Royal Colleges and other professional bodies, so that partnership working across a wide range of experts is firmly entrenched at a national level”. The RCS welcomes this commitment for the NHS Commissioning Board to draw upon the leadership and clinical expertise that already exists in the Royal Colleges and professional bodies. The RCS has established national and regional networks which draw together the breadth of surgical expertise from within the profession so we are able to provide advice and support at all levels.

CHOICE AND COMPETITION

9. The RCS welcomes the commitment for competition on quality, rather than price where this would benefit the patient. The RCS has been clear that a defined standard of treatment and care should drive commissioning and not the lowest price, and it is reassuring that this commitment has been strengthened in the proposed legislation.

10. The RCS also welcomes the commitment to establish through Monitor further safeguards against the “cherry-picking” of services. The RCS has outlined its seven principles and standards for competently commissioning a surgical service, which include making provisions for follow-up and acute readmissions, the education and training of staff and measurement of outcome (see Annex A). If commissioners adhere to the seven principles and standards it should ensure the delivery of comprehensive and competent services that avoid provider destabilisation by cherry-picking. Furthermore the proposed introduction of an evaluation of clinical complexity to support tariff setting will ensure that patients with complex needs are able to access treatments they need and that providers are reimbursed accordingly.

11. The College welcomes the Government’s change in emphasis on Monitor to encourage “integration not competition” between all providers of health and social care. This is especially important in surgery, where patients encounter many different health professionals along their care pathway. The RCS looks forward to working with Monitor to help implement and develop integration across clinical pathways.
12. However, the RCS are cautious about plans for the phased extension of any qualified provider and the potential for this to destabilise existing services and clinical interdependencies. The College looks forward to further detail about how this phased extension will happen and the required safeguards.

13. We welcome the Government’s commitment for a “Duty to promote research across all levels of commissioning”. There is a continuing need for the promotion of research and innovation and the RCS welcomes the additional commitments made by the Government. As a member of the Association of Medical Research Charities (AMRC), the RCS has said that it is necessary for all commissioners from local to national to consider research and for it to be promoted amongst clinicians and also amongst patients who may be interested in participating in research.

EDUCATION AND TRAINING

14. The College welcomed the Government’s commitments in the recent “Developing the Healthcare Workforce” consultation. In this consultation document we supported the commitments to fully engage clinicians in workforce planning processes and in the commissioning and delivery of education and training both nationally and locally. We also supported the reaffirmation of the “important role for the medical Royal Colleges in ‘devising and delivering education in their specialties’”.

15. In the Government’s response to the NHS Future Forum’s report we welcome the commitment for “an explicit duty for the Secretary of State to maintain a system for professional education and training as part of the comprehensive health service”. The RCS also believe it is essential for clear and effective interim arrangements to be put in place to ensure the high quality training in the NHS is maintained while Health Education England and the associated structures are established. The College looks forward to working with Government as the plans for educating and training the healthcare workforce are developed.

PATIENT AND PUBLIC INVOLVEMENT

16. The RCS welcomes the emphasis in the Bill on the embedded rights of patients in the NHS Constitution.

17. The RCS believes that there needs to be a clear, transparent system for patients which enables them to understand which services are available, the quality of these services and how one can make a complaint or give feedback about the service they have received. The reinforced requirement of candour in the event of a mistake provides a clear opportunity to re-examine the causes of closed, blame cultures in the NHS and take positive steps to promote an open environment of learning and continual service improvement. In addition, as a clear and vital part of transparency in the NHS, the RCS believes that hospitals should publish information about their outcomes according to the NHS Outcomes Framework as well participate in national clinical audits. We believe that such a move would enable greater and more informed patient choice.

ANNEX A

COMMISSIONING A COMPETENT SURGICAL SERVICE

College position statement

The Royal College of Surgeons believes that a defined standard of treatment and care set by the profession should drive commissioning and not the commercial interests or convenience of the provider. Standards of care and outcome requirements should be incorporated into the decision-making process for commissioning services in order to achieve the best care and outcomes for patients. Within the proposed arrangements for the delivery of healthcare, commissioners will be able to exercise clinical judgement and have the power to safeguard and ensure the quality and standard of care.

The College believes that in order to ensure the delivery of comprehensive and competent services commissioners should adhere to the following principles and standards when taking commissioning decisions:

1. Training the healthcare workforce—a contractual commitment to training and the ability to deliver the standards and outcomes agreed and published by the profession.

2. Educating the healthcare workforce—a contractual commitment to provide appropriate education and continuing professional development opportunities for all health professionals.

3. Clinical audit—contractual agreements to ensure participation in clinical audit and publication of audit outcomes.

4. Research and development—contractual agreements to ensure participation in high quality research which is essential for advancing and improving patient care and outcomes.
5. Commissioning a complete service—ensuring the service includes arrangements for full emergency provision at the appropriate level to manage the follow-up of patients, including complications.

6. Measuring outcomes—outcomes to be measured coherently to enable comprehensive benchmarking across the NHS, with the data made available to the profession and used to inform practise and improve patient safety.

7. Appropriate impact on the local healthcare economy—when commissioning a service, a full assessment must be made of the impact of the decision on the patients’ pathway of care (ie ensuring that the patient will experience a seamless pathway across different providers) and the impact of the commissioning decision on related services (eg clinical interdependencies) in order to safeguard patients’ access. Such assessments should include a consideration of the best available evidence used to support the decisions.

The College further believes that in order to maintain these standards for quality, commissioners of healthcare should ensure providers are able to make sufficient time available in the form of Supporting Professional Activities (SPA) within the consultant contract to allow consultants wishing to be involved in training, education, audit, research etc to do so. By acting in this way commissioners will demonstrate a high degree of senior level commitment to all the elements of a clinician’s role which contribute significantly to an increasingly safe and high quality health service.

June 2011

Memorandum submitted by the United Kingdom Acquired Brain Injury Forum (HSR 19)

RESPONSE TO GOVERNMENT BRIEFING

United Kingdom Acquired Brain Injury Forum: A forum representing professionals who work with people who have had an Acquired Brain Injury (ABI).

Every year over 100,000 people survive a brain injury. This group of patients come under neurological services but are different in many ways to other neurological conditions. Their brain injury is acquired and they continue to have a normal length of life (life expectancy). Rehabilitation following ABI therefore takes on a very important element of recovery and life long support needs.

We welcome the Government’s approach to difficulties within the Health and Social Care Bill. We believe the listening exercise has been productive and are pleased with many of the recommendations from the Future Forum.

The Future Forum acknowledged the concerns we raised during the listening exercise with the Neurological Alliance and National Voices, but we do not feel they have all been satisfactorily addressed. Specifically, services for the neurological conditions and of the people we represent with acquired brain injury.

We would like to work with the Department of Health and the Government to promote good decisions and appropriate solutions for the eight million adults living with neurological conditions in England, many of whom have an ABI and a normal life expectancy. We believe the following would better serve this group

CLINICAL SENATES AND NETWORKS

1. Neurology should be represented on each clinical senate

If clinical senates are to provide guidance and leadership to clinical commissioning groups, this needs to include neurology. At present, there are no pathfinder consortia that have chosen to look at neurology as a special area of interest. This could be because of knowledge and skills gaps in what good quality neurological services should look like. To help clinical commissioning groups fill this gap, clinical senates must provide leadership in this area. The best way to do this would be to make sure that neurology specialists are represented in each clinical senate.

2. Neurological networks should be funded and embedded throughout the NHS

There are some excellent examples of neurological networks in England. However, these are patchy with some areas struggling to get off the ground. Without proper support, guidance and funding from the Department of Health/NHS this situation is likely to remain, or possibly even deteriorate.

One of the best examples of a neurology network is in the North East. This network was funded and fully supported. It worked with service users, carers, clinicians and social care to help develop a more integrated service—exactly the model that the Government support. It was the only funded neurological network in the country. However, as is often the case with neurology which seems low on many priority
lists, this network is at risk because of changes to the NHS. Because of changes in staff and structures, as well as decreased funding, this network is now working with the cardio-vascular network to try and survive the transition process.

The Government/Department of Health should follow the recommendation of the Future Forum and look at the most effective forms of networks and spread best practice.28

The Government/Department of Health should provide support for existing networks to help them through the transition process.

We are pleased to see the Government recognise the importance of networks and clinical senates. We look forward to confirmation that these will cover the eight million people across England living with neurological conditions.

**COMMISSIONING FOR LESS COMMON CONDITIONS**

1. The Future Forum reflects the concerns we raised about the future of commissioning for less common conditions.29 However, we do not believe that the Government’s response addresses these.

2. The Health and Social Care Bill must address the “strategic gap”30 in commissioning less common conditions.

3. The authorisation process of clinical commissioning groups must include assessment of how they will collaborate to commission less common conditions.

4. Clinical commissioning groups must have a duty to work collaboratively to commission for less common conditions.

5. The NHS Commissioning Board must monitor, and where necessary enforce, commissioning of less common conditions.

6. To help support this, there should be an advisory group for neurology within the NHS Commissioning Board—in line with the Future Forum recommendation.31

7. Pathfinder consortia have big differences in the population sizes they cover and some of them cover a relatively small population size. If this is the case with clinical commissioning groups we do not believe that smaller groups will be able to commission neurology services effectively.

8. People with neurological conditions need an integrated neurology multi-disciplinary team. This should include a range of clinicians and specialists, for example physiotherapists, specialist nurses, consultants and occupational therapists.

9. For these to be cost-effective they need to be commissioned for a population size of at least 250,000 and preferably even greater. (As was identified in DoH Commissioning for specialised services). Clinical commissioning groups covering a smaller population and working in isolation are unlikely to deliver the services that people with neurological conditions need.

10. As we previously stated, no pathfinder consortia are looking at neurology as a special area of interest.

11. Many neurological conditions do not have a NICE guidelines, specifically, none that follow the patient into the Community for long term condition support and re-access to Acute care. It is therefore extremely unlikely that an audit or system to monitor quality or standards of practice can be completed to assess for provision of services. Motor neurone disease, which was the example quoted by the Future Forum when it raised the difficulties of commissioning for less common conditions, falls into this category. So do many other neurological conditions.

12. Without explicit statutory protection that complements the identified DoH Commissioning of specialised services and better metrics papers to ensure there is a method to monitor the commissioning of Acute and Community services for less common conditions, neurology services will fall through this “strategic gap”.

13. To support these changes we recommend that a neurology advisory group is a part of the NHS Commissioning Board.

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28 Clinical advice and leadership: A report from the NHS Future Forum. P12, 2.27–2.29
29 Clinical advice and leadership: A report from the NHS Future Forum. P10, 2.11
30 Clinical advice and leadership: A report from the NHS Future Forum. P10, 2.12
31 Clinical advice and leadership: A report from the NHS Future Forum. P16, 3.16
14. The Future Forum recommended that “further consideration should also be given to leadership for less common conditions”. We are sure that the Government would recognise the importance of neurology when considering less common conditions such as ABI. We are able to help the Department of Health introduce this.

15. We believe it is essential that the commissioning services for less common conditions forms part of the authorisation process for clinical commissioning groups. This will make sure that the importance of collaborative working is recognised from the outset.

July 2011

Memorandum submitted by the Health Foundation (HSR 20)

In our evidence to the Public Bill Committee on the Health and Social Care (re-committed) Bill we are focusing upon changes that need to be made to the Bill to put patients centre stage and create an NHS in which the principle of “No decision about me without me” can become a reality.

1. EXECUTIVE SUMMARY

1.1 For the NHS to be a first class health service, we need people to be given the right support so that they can be in control of their own health and healthcare decisions.

1.2 The NHS needs to transform the way it helps people to become involved in their own care and supports people to make choices. A system that offers true choice supports everyone to make good daily choices about their health. It supports people with the choices about what sort of healthcare they need and what type of treatment would suit them, as well as who provides that treatment.

1.3 In order to embed the principle of “No decision about me without me” into the daily experience of patients and their families, an essential first step will be some specific changes to the Health and Social Care Bill.

1.4 The Health Foundation welcomes the NHS Future Forum’s recommendation of a more sophisticated approach to the choice agenda with a strong emphasis on genuine involvement in care. We also welcome the apparent shift in the Government’s thinking about choice from a focus on choice of provider to a broader conception that encompasses choice of treatment.

1.5 We are recommending the following changes to the Health and Social Care Bill relating to the creation of new duties of patient involvement and patient choice for the NHS Commissioning Board and commissioning consortia:

— Creation of a separate duty of individual patient involvement in decisions about their own treatment. This should be expressed as a section in its own right, not a sub-section of the duty about reducing health inequalities. And a clear distinction should be made between the current duty of collective involvement in decisions about provision of services to the community and this new separate duty of individual patient involvement.

— Inclusion of a new duty of patient choice. This should also be expressed as a section in its own right, not a sub-section of the duty about reducing health inequalities.

— Inclusion of an explicit definition of choice on the face of the Bill. The Health Foundation’s definition of choice, which is cited in the NHS Future Forum’s report Choice and Competition, Delivering Real Choice, is:

— Choice of services to support healthy living
— Choice of provider and the way in which care is provided
— Choice of treatment including self-management support.32

— These new and separate duties of individual patient involvement and patient choice should use language which is as strong as lawyers advise is practical in order to enshrine the duty as mandatory, rather than discretionary.

— We urge the Committee to support amendments 68, 69, 70 and 109, 110, 111 tabled by the Rt Hon Simon Burns MP, Minister of State for Health which will create new duties on both the

32 NHS Future Forum (2011), Choice and Competition, Delivering Real Choice, p.15
NHS Commissioning Board and commissioning consortia as to patient choice and to promote involvement of each patient. We do, however, maintain that we would like to see a definition of patient choice on the face of the Bill.

2. Creating an NHS with the principle of “No decision about me without me”

Why is it necessary and important to support people to take an active role in their health and healthcare?

2.1 For the NHS to be a first class health service, we need people to be given the right support so that they can be in control of their own health and healthcare decisions.

2.2 The NHS needs to transform the way it helps people become involved in their own care and make choices about how they look after their health, what tests and treatments they have, and how their care is provided. For many years, the NHS has said to patients “This is what we’re going to do to you”. But that isn’t involvement nor is it choice. It’s not “No decision about me without me”.

2.3 A system where people are supported to be involved as active partners in their own care needs to offer true choice. True choice encompasses supporting people to make good daily choices about their health. It includes supporting people with the choices about what sort of healthcare they need and what type of treatment would suit them, as well as who provides that treatment. They are all choices that matter and that people want. Examples of these types of choice are included in the appendix.

How are people currently involved in their health and healthcare?

2.4 People who use the NHS consistently say that the choices and decisions that matter most to them are choices about the treatment and care they receive. Examples of these sorts of decisions include whether to have surgery and what type of surgery to have, and which medication to take, where there are options.

2.5 Research shows that patients care more about being able to exercise choice in relation to these types of questions than they care about being able to choose between providers of healthcare, eg which hospital or GP to use.33

2.6 Currently in England, the NHS performs very poorly in involving people in treatment decisions, despite the degree of priority patients attach to such involvement. The latest data published by the Care Quality Commission shows that 48% of adult inpatients are not involved as much as they want in decisions about their care and treatment and there has been little improvement in this since 2002.34

What are the benefits of people being supported to take an active role in their health and healthcare?

2.7 Shared decision making is the involvement of patients as equal partners in their healthcare. Tools to support shared decision making can include self-management support, access to personal health records, personal health budgets, care planning and decision aids.

2.8 The White Paper, Equity and Excellence: Liberating the NHS, looked set to address the problem of the absence of patients’ involvement in their health and healthcare with its central and welcome emphasis on the principle “No decision about me without me”. However, the Health and Social Care Bill frames the concept of involvement primarily in terms of the public’s involvement in the provision of services not in terms of an individual’s involvement in daily decisions about treatment and care. In the Bill, choice is limited primarily to choice of provider rather than choice of the type of care and the way in which it is delivered.

2.9 As a result of these omissions, the Health and Social Care Bill misses the opportunity to reap the benefits that have been proven through research to result from shared decision making. Benefits include:

- fewer patients choosing major surgery, creating cost savings
- better treatment adherence, creating greater effectiveness and value
- improved confidence and coping skills
- improved health behaviours such as greater exercise and reduced smoking
- more appropriate service use, particularly fewer emergency admissions.35 36 37

33 Coulter, A. “Do patients want a choice and does it work?” BMJ 2010;341:c4989
For clinicians, a lack of shared decision making can compromise their effectiveness: the impact of clinicians’ interventions can fall short if patients do not have the understanding or motivation required to adhere to treatment options or desired lifestyle changes. For commissioners, it means that the services provided may not deliver the best outcomes for patients or meet their individual preferences. For patients, it means that they may not receive the care that best meets their needs and they may remain as passive recipients of care rather than taking an active role in managing their own health.

2.11 Failing to see patients as partners compounds the problems that lead to them being treated without dignity or respect. We are a long way from “No decision about me without me”.

2.12 The government must transform what remains a very paternalistic health service and remove the enforced dependency that the current system and culture creates. There is good international evidence\(^{38,39}\) and practical experience from within the UK that shows that this is possible.\(^{40}\)

### CONCLUSIONS OF THE NHS LISTENING EXERCISE

#### The NHS Future Forum’s recommendations

3.1 The Health Foundation welcomes the NHS Future Forum’s recommendation of a more sophisticated approach to the choice agenda with a strong emphasis on genuine involvement in care.

3.2 We welcome the NHS Future Forum’s statement that “shared decision making should be the norm, and that the declaration of ‘no decision about me, without me’ must permeate the culture throughout the health and care system”.\(^{41}\) This is expanded upon in Patient Involvement and Public Accountability.\(^{42}\)

3.3 In his summary report of the Future Forum’s review Professor Field states: “In looking at what choice in the NHS means, the Forum is clear that, in line with the NHS Constitution, choice must be more than just choice of provider.”\(^{43}\) He recognises that “more needs to be done to deliver real choice” and this underpins their recommendation for a “choice mandate”.\(^{44}\)

3.4 The NHS Future Forum goes on to argue that “Choice is too limited and citizens are too little involved in their own care and treatment. The health service has so far often failed to deliver on the promise, ‘No decision about me without me’”.\(^{45}\)

#### The Government’s response to the NHS Future Forum and proposed changes

3.5 The Health Foundation has welcomed a noticeable shift in the way the Prime Minister is speaking about choice, from defining choice primarily as choice of provider to a broader definition. For example in his speech of 7 June he stated “When patients do have their say, and are able to make choices, it makes a massive difference. When they get involved in their care they get better results, and they manage long-term conditions more successfully too.”\(^{46}\) This was reiterated in a later speech.\(^{47}\)

3.6 The Health Foundation welcomes the Government’s promise to amend commissioners’ duties to involve patients and carers to better reflect the principle of “No decision about me without me.” We also welcome the government’s proposal to amend the Bill to strengthen and emphasise commissioners’ duty to promote choice, in line with the right in the NHS Constitution for patients to make choices about their NHS care and to receive information to support those choices.

3.7 We look forward to the opportunity to respond to the Government’s consultation on the choice mandate. We hope the mandate will retain the broad definition of choice proposed by the NHS Future Forum and encompassing principles including personalising care, improving outcomes, delivering choice and enabling informed citizens.\(^{48}\) We hope that this choice mandate will be appropriately supported by the NHS system architecture.

### HOW MUST THE HEALTH AND SOCIAL CARE BILL SUPPORT THIS AMBITION?

4.1 In its current form the Health and Social Care Bill is insufficient to embed the principle of “No decision about me without me” into the daily experience of patients and their families.

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\(^{38}\) ibid  
\(^{39}\) The Health Foundation (2011). Helping people help themselves: a review of the evidence considering whether it is worthwhile to support self-management.  
\(^{40}\) The Health Foundation has worked with over 500 clinical staff and 1000 patients in eight health economies across the UK through our Co-creating Health programme; see http://www.health.org.uk/areas-of-work/programmes/co-creating-health. Our MAGIC programme is building shared decision making into primary and secondary care in Newcastle and Cardiff. See http://www.health.org.uk/areas-of-work/programmes/shared-decision-making/.  
\(^{41}\) NHS Future Forum (2011), Summary report on proposed changes to the NHS, p.26  
\(^{42}\) NHS Future Forum (2011), Patient Involvement and Public Accountability, pp.13-14  
\(^{43}\) NHS Future Forum (2011), Summary report on proposed changes to the NHS, p.24  
\(^{44}\) ibid  
\(^{45}\) NHS Future Forum (2011), Choice and Competition, Delivering Real Choice, p.5  
**Patient involvement**

4.2 The Health and Social Care Bill includes duties “as to reducing inequalities, promoting patient involvement etc” (clause 19, page 17, section 13F and clause 22, page 30, section 14N). These duties require both the NHS Commissioning Board and commissioning consortia to “have regard to the need to promote the involvement of patients and their carers in decisions about the provision of health services to them” and “enable patients to make choices with respect to aspects of health services provided to them”.

4.3 We strongly welcome these duties but regret that promotion of the involvement of individual patients is combined with the duty as to reducing inequalities. Furthermore the Bill does not give the duty to promote patient involvement the same prominence it gives the NHS Commissioning Board and commissioning consortia’s duties regarding public involvement (clause 19, page 18, section 13L and clause 22, page 31, section 14P). There is a risk that individual patient involvement is overlooked by the managers and health professionals who will be acting upon the legislation.

4.4 The Health Foundation strongly urges the following changes:

— Creation of a separate duty of individual patient involvement in decisions about their own treatment. This should be expressed as a section in its own right, not a sub-section of the duty about reducing health inequalities.

— A clear distinction should be made between the current duty of collective involvement in decisions about provision of services to the community and this new separate duty of individual patient involvement.

**Choice**

4.5 Choice within the Health and Social Care Bill refers primarily to choice of provider and falls short of the breadth of choices that need to be supported to help people stay healthy, manage their own health and make decisions that result in the outcomes that matter most to them.

4.6 There are three types of choice people make around health and healthcare. Some of these are choices that we all make every day about our health and how we use the NHS. Some are choices that people make less frequently and are one-off decisions.

4.7 The Bill should include a new duty of patient choice. The Bill should also include an explicit definition of choice on the face of the Bill. The Health Foundation's definition of choice, which is cited in *Choice and Competition, Delivering Real Choice*, is:

— Choice of services to support healthy living

— Choice of provider and the way in which care is provided

— Choice of treatment including self-management support.

4.8 Furthermore, every patient interaction needs to be built upon the foundations of dignity, privacy and autonomy. This already exists as a duty for providers within the existing regulatory system but it needs greater attention in order to become a reality for every patient all of the time. Recognising the autonomy and dignity of the patient is essential for shared decision making because when these basic needs are not being addressed—when people are in fear or pain, or are not treated with respect—they cannot begin to participate as equal partners in their own care.

4.9 Both these new duties of individual patient involvement and patient choice should use language which is as strong as lawyers advise is practical in order to enshrine them as mandatory, rather than discretionary.

5. **Health Foundation view of amendments tabled as at 24 June 2011**

5.1 The Health Foundation welcomes the amendments 68, 69, 70 and 109, 110, 111 tabled by the Rt Hon Simon Burns MP, Minister of State for Health which will create new duties on both the NHS Commissioning Board and commissioning consortia as to patient choice and to promote involvement of each patient. We urge the committee to support these amendments.

5.2 We do, however, maintain that we would like to see a definition of patient choice on the face of the Bill.

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54 NHS Future Forum (2011), *Choice and Competition, Delivering Real Choice*, p.15
6. **Oral Evidence**

   6.1 The Health Foundation would be happy to give oral evidence to the Public Bill Committee should it be helpful to their consideration of the Bill.

7. **Appendix**

   The Health Foundation's definition of choice

<table>
<thead>
<tr>
<th>Choices to support healthy living, including:</th>
<th>Choice of provider and the way in which care is provided, including:</th>
<th>Choice of treatment including:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Choice to have a healthy diet</strong></td>
<td><strong>Choice of GP</strong></td>
<td><strong>Whether or not to have a diagnostic or screening test, e.g. pregnant women have a choice about whether to screen for abnormalities</strong></td>
</tr>
<tr>
<td><strong>Choice to exercise regularly</strong></td>
<td><strong>Choice of hospital</strong></td>
<td><strong>What type of treatment to have, e.g. people with ongoing knee pain make a choice about whether to have surgery or whether to have physiotherapy</strong></td>
</tr>
<tr>
<td><strong>Choice to reduce health limiting behaviours e.g. smoking and alcohol</strong></td>
<td><strong>Choice of self-management course</strong></td>
<td><strong>Whether to learn more about how to manage their own health through a self-management programme</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Choice of maternity provider</strong></td>
<td><strong>Which medication to take, where there are options</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Choice of end of life care provider</strong></td>
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<td></td>
<td><strong>Within choice of provider there needs to be choice about how care can be accessed:</strong></td>
<td></td>
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<tr>
<td></td>
<td><strong>Choice of appointment time</strong></td>
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<tr>
<td></td>
<td><strong>Choice of location</strong></td>
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<tr>
<td></td>
<td><strong>Choice of style of interaction e.g. face-to-face, by phone or text, in writing, by email, via social networking</strong></td>
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**July 2011 Memorandum submitted by the Royal College of Paediatrics and Child Health (HSR 21)**

1. The Royal College of Paediatrics and Child Health (RCPCH) is a charity established by Royal Charter in 1996, with over 12,000 members in the UK and overseas. We are responsible for the training and examination of paediatricians in the UK. The RCPCH is integral to leading the way in child health and the pre-eminent body setting standards for UK paediatrics.

2. The Royal College of Paediatrics and Child Health (RCPCH) is pleased to have the opportunity to comment on clauses of the *Health and Social Care Bill* that have been recommitted for examination by the Public Bill Committee. We have paid particular attention to clauses of the Bill that we feel may have particular implications for children’s health.

3. **Arrangements for provision of health services (Clauses 9–11)**

   3.1 RCPCH agree with the proposed amendment to Clause 9 which extends the responsibility for each clinical commissioning group (CCG) to commission services for “every person present in its area”. This will ensure that CCGs serve their entire populations, and not just patients that are registered with primary care. CCG must take particular care to serve the needs of the 22% of their population that will be under 18, and in particular those that are most vulnerable and hard to reach by primary care, such as travellers, asylum seekers or those in the youth justice system.

4. **NHS Commissioning Board (Clause 19)**

   4.1 We support the establishment of clinical senates to advise clinical commissioning groups and the NHS Commissioning Board. As the NHS Future Forum suggests, the establishment of a clinical senate centred around the needs of children and young people will be an essential element of this framework. The placement of these senates within the NHS Commissioning Board, and with an advisory role with respect to clinical commissioning consortia is an important step in assuring that the complex needs of children are not overlooked.

   4.2 We support the amendments to the Bill suggested that embed the involvement of patients more firmly in the work of the NHS Commissioning Board. We would like to draw particular attention to the need to engage children and young people’s views of provision of care, a previous blindspot identified by the Future Forum:
4.2.1 “We heard particular anxiety about involvement of children by the NHS or rather its absence, which respondents thought contributed to poorer outcomes for children (in some childhood cancers for example) than in other comparable countries and the high rates of inappropriate admissions to hospital.”

(Patient Involvement and Public Accountability: A report from the NHS Future Forum, p15)

4.3 The RCPCH has particular expertise in participation with this particular group as set out in our recent publication Not just a phase and would hope to be involved in development of this programme.

4.4 The involvement of secondary care clinicians on clinical commissioning groups is also an important step to ensuring joined-up commissioning and that the pathways are appropriate for those with complex needs, such as disabled children with multiple conditions. However, we share concerns voiced by other commentators that the recruitment of a nurse or secondary clinician to consortia with no “conflict of interest” may be problematic in practice. Clinicians would be appointed as professionals on the panel and a more realistic approach could be for any potential conflict of interest to be openly stated and worked around as happens in other institutions, for example non-executive directors.

5. Abolition of SHAs and PCTs (Clauses 28–29)

5.1 As the Future Forum report suggests, transition arrangements to deal with the loss of deanery functions from Strategic Health Authorities (SHAs) need to be put in place as soon as possible. While the DH response to the Future Forum report offers assurances that arrangements will be put in place, we seek clarity at the soonest opportunity as to what these will entail to mitigate any destabilisation of the system and impact on trainee morale and aspiration.

5.2 Similarly, the relaxation of the timetable is welcome, but again, commissioning arrangements need to be robust to ensure that in areas where clinical commissioning consortia are not fully developed by April 2013 services remain integrated.

6. General duties of Monitor and choice and competition (Clause 56)

6.1 We support the adjusted role of Monitor, and support choice and competition where they drive better care for patients. However, we retain concerns that these principles may not be appropriate for many children’s services, as their complex nature means that integration and cooperation are far more beneficial to smooth and efficient care pathways than choice and competition.

6.2 We particularly welcome the introduction of a clearer duty on Monitor to secure appropriate clinical advice in carrying out its functions.

7. Public involvement (Clauses 178–180)

7.1 As outlined above, we believe the lack of planning for involvement of children and young people in decisions about their health has been a particular weakness of the reforms so far. We require assurances and more importantly frameworks and explicit detail about how their views will be represented on HealthWatch England and local HealthWatch, as well as informing the work of the NHS Commissioning Board and Health and Wellbeing Boards.

8. Joint Strategic Needs Assessments (JSNAs) and Health and Wellbeing Boards (Clauses 189–193)

8.1 We welcome the clarification of the role and responsibilities of the Health and Wellbeing Boards in the government’s response to the NHS Future Forum. However, Health and Wellbeing Boards offer an excellent opportunity to make a real impact on children’s health in local communities, but the Boards duties in this area need to be made more explicit to grasp this. While the membership of the Health and Wellbeing Board is not statutory, we believe the presence of a community paediatrician on the Boards would be vital in ensuring a child-focused public health strategy, in line with the recommendations around early intervention by the Allen and Field reviews. As elsewhere, whilst we welcome the new duty to involve users and the public on boards, we believe greater clarification of these duties with regard to including children and young people is required.

July 2011

Memorandum submitted by Dr Lucy Reynolds (HSR 22)

I am an academic studying the implications for costs and for health outcomes of the 2010 Health and Social Care Bill.

I should like to make two brief comments to the Committee on the genesis and implications of competition in the healthcare reform, and also one on the proposed amendments to Clause 1 on the duty of the Secretary of State for Health in respect of his future duties concerning provision of health care.
1. **COMPETITION AND COOPERATION**

   The outsourcing of services through the market via commissioning is a way to privatise these services. If they are not thereafter provided by the public sector, then they have been privatised.

   Commissioning is intrinsically competitive, and its use requires the Government to regulate it according to EU competition law. This regulatory function was given to Monitor but following the amendments it now resides with the NHS Commissioning Board. If it is removed from there it will probably default back to the Director General of Fair Trading who enforces competition in the rest of the economy.

   If the wish is to eliminate competition from the system and instead promote cooperation, then the commissioning itself must be removed from the reform. Otherwise any cooperation between organisations involved in health care provision can be interpreted as anti-competitive behaviour, which is illegal under EU competition law.

   Removing competition would involve scrapping the present Bill because commissioning is central to this reform.

2. **DETERIORATION IN QUALITY**

   Competition (through the commissioning mechanism) in the reformed NHS will be on price not on quality, except where a tariff has been set. The majority of the NHS budget applies to services for which no tariffs exist. This includes the entire mental health and community care budgets. [http://www.healthpolicyinsight.com/?q=node/1024](http://www.healthpolicyinsight.com/?q=node/1024)

   While it is possible to argue (albeit on very dubious evidence) that competition at fixed price might elevate quality, it is absolutely clear that competition on price exerts downward pressure on quality.

   A medical negligence barrister (QC John Whitting) has commented publicly on the likely effects of these reforms in reducing the quality of services and increasing medical errors: [http://www.newstatesman.com/blogs/the-staggers/2011/06/care-nhs-health-clinical](http://www.newstatesman.com/blogs/the-staggers/2011/06/care-nhs-health-clinical)

   He makes the point that not only will the number of accidents rise as cost pressure causes overwork and deskillning, but that the extra costs of compensating the victims could outweigh any savings in cost achieved through price competition.

3. **DENATIONALISATION: CLAUSE 1**

   The original wording of Section 1 of the reform was intended to denationalise the NHS. The proposed Kendall/Thornbury amendment (Clause 1, page 2, line 4,) does not entirely close this possibility.

   “To provide” implies arranging service delivery through the public sector.

   The Kendall/Thornbury suggestion to amend the clause to say “to provide or secure the provision of services” is much better than the original wording from Andrew Lansley (“to promote”) but still could be held by a court to imply that this duty could be adequately discharged by making sure the private sector provides the services.

   Safest would be just to remove this clause from the Bill as suggested by Simon Burns.

*July 2011*

**Memorandum submitted by the Finance and Leasing Association (HSR 23)**

1. The Finance and Leasing Association represents the UK’s providers of equipment finance through leasing and hire-purchase. Our members are banks, independent asset finance companies, or captive finance companies owned by equipment manufacturers. In 2010 FLA members provided £19.6 billion of new finance to UK businesses and the public sector. Our members lease essential medical equipment to many NHS trusts.

2. In our submissions to the Department of Health last year we pointed out that the proposed failure regime for Foundation Trusts (FTs) without designated services could lead to higher costs. Medical equipment rental charges, for example, could increase because of the risk that a FT without designated services could become insolvent during the contracted rental period. This problem did not seem to apply to FTs with designated services.

3. In its response to the NHS Future Forum report, the Government indicted it would withdraw its proposal for FTs to designate services, although there appears to be no such amendment in the re-
committed Bill. If there were no designated services this could, presumably unintentionally, lead to the possibility of any FT becoming insolvent and hence wider increases in healthcare costs.

4. We recommend that the Committee request that the Government explain the status of its proposals on designated services and especially how any such changes could impact on the insolvency proposals in Clause 125.

*July 2011*

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**Memorandum submitted by National Voices (HSR 24)**

**SUMMARY**

1. National Voices has welcomed the Government’s vision of Putting Patients First, and wants to see it implemented through the Bill as effectively as possible.

2. National Voices participated fully in dialogues during the “pause” in the Bill and welcomed both the report of the NHS Future Forum, and the Government’s response. The amendments subsequently proposed by the Government will take us a further step towards achieving the vision.

3. However, we also argue that it is necessary to strengthen some of the provisions of the Bill still further, including:
   a. commissioners’ duties to individual patient involvement
   b. commissioners’ duties to obtain expert advice, and
   c. commissioners’ duties to collective public involvement

4. We also wish to signal to the Committee some areas in which the new or amended clauses give rise to further questions or concerns with regard to the operation of the new structures, and the secondary legislation and guidance that may follow. These include:
   a. the date for the establishment of HealthWatch
   b. how the clinical networks and senates will operate
   c. the nature of the mandate to the NHS Commissioning Board
   d. the regulations for governance of clinical commissioning groups (CCGs)

**ABOUT NATIONAL VOICES**

5. National Voices is the national charity coalition for health and social care. It strengthens the voice of people who come into contact with the NHS and care services, and of the voluntary organisations that work for them. Our broad membership, rooted in people’s experience, represents millions of people, and covers a diverse range of health conditions and communities.

6. Our particular interests in this Bill are with regard to “Putting Patients First” (integrated services, shared decision making, participative care planning, self-management support, and the information, education and support to achieve these); and “accountability” (transparency, accountability to patients and the public, democratic legitimacy, and citizen involvement in the wider decisions about health and social care services).

7. To date National Voices has had the following engagement with the *Health and Social Care Bill 2011*:
   a. together with ten other national charities, calling for changes to the original Bill to strengthen PPI, accountability and transparency
   b. providing the Committee with written and oral evidence on the original Bill
   c. providing its chief executive, Jeremy Taylor, to be a member of the NHS Future Forum panel and to help to draft its recommendations
   d. participating, and securing the participation of its members and of patients, service users and carers, in listening events during the “pause”
Defining patient involvement

National Voices recommends:

8. Amend Clause 19 paragraph 13N and Clause 22 paragraph 14N to include an additional sub-clause defining “patient involvement” for the purpose of that section, drawing on wording from the regulations for registered providers under the Health and Social Care Act 2008.51

9. This definition should include ensuring that patients, carers and patient representatives (if any) can, in particular:

   i. give their views and experience of care and treatment they receive, to which commissioners must have regard

   ii. be provided with appropriate information, and support to use it, in relation to their condition and to available services

   iii. be provided with appropriate information, and support to use it, about all available treatment choices, including risks

   iv. participate in decisions about care and treatment, and in planning their care,

   v. have opportunities and support to manage their condition and their chosen care, and

   vi. be involved in such other ways as commissioners deem appropriate and as may be specified in guidance issued by the Commissioning Board.

Justification

10. The Government amendments for the twin patient involvement duties on commissioners in Clause 19(13FA) and Clause 22(14NA) are a response to the NHS Future Forum’s call to strengthen and clarify these duties.

11. National Voices welcomes the changes proposed. The duties are separated from surrounding duties; made to apply to “each patient”, thereby clarifying that they operate at the right level; and applied to “all functions” of the commissioners, thereby “wiring” patient involvement into the system.

12. However, the Government has not accepted the need to define the meaning of “patient involvement” in statute. Instead it will be elaborated in national guidance. We continue to argue that this is an historic mistake.

13. “Patient involvement” is an evidence-based practice which can lead to benefits including increased patient knowledge and confidence to self-manage; increased satisfaction and a better experience of services; greater likelihood of treatment being “appropriate” to the patient’s circumstances, values and preferences; and increased treatment adherence and use of appropriate screening and other preventive measures.52 The practice of sharing decisions about treatment can reduce unwarranted geographical and demographic variation in treatment. These benefits are recognised by the government in its White paper vision.

14. In short, this is a win-win proposition which can achieve better outcomes in the domains of effectiveness and patient experience, while also getting the maximum public value from limited healthcare resources. As such, these clauses are among the most important in the Bill for their relevance to the “Nicholson challenge”.

15. Unfortunately, despite the evidence base, and despite professional regulation placing duties on doctors, nurses and midwives to work in partnership with their patients in these ways,53 patient involvement is still not mainstream practice in the NHS.

16. For example, in national patient surveys, between one third (primary care) and one half (inpatients) of all patients say they were not as involved as they wished to be in decisions about their care and treatment—proportions which have not changed since the surveys began in 2002.54

17. Likewise, the practice of participative, personalised care planning for people with long term conditions is still marginal. For asthma, one of the most prevalent chronic conditions, only 10% of people...
with asthma in England have a written personal asthma action plan. For epilepsy, a 2009 survey suggested the figure is 13%.

18. One reason that patient involvement has not become widespread is that commissioners have not demanded changed models of care and treatment from their providers. Hence the mechanisms provided through this Bill are extremely important.

19. A second reason is that throughout the NHS, professionals and organisations have a poor understanding of what “patient involvement” is, and what it includes.

20. It is frequently taken to mean “better customer care”, as when NHS organisations and general practices focus on involving patients in improving reception facilities and booking systems, while ignoring the need to change consultation styles.

21. Many professionals believe it is something which “we already do”, and are reluctant to re-examine their practice.

22. “Patient involvement” is also frequently confused with collective involvement, as the most recent parliamentary Inquiry on the subject concluded:

“Patient involvement and public involvement are distinct and are achieved in different ways. The conflation of these distinct terms and the confusion about the purpose of involvement has led to muddled initiatives and uncertainty about what should be done to achieve effective patient and public involvement.”

23. Without clear definition, the Government’s vision of Putting Patients First is likely to go the way of every previous intention to create a “patient-centred” NHS—an aspiration which already dates back a decade to the NHS Plan 2001, and which is still unrealised.

24. We disagree with the Government that such a definition should be elaborated through guidance from the Commissioning Board. Such guidance, whether from the Department of Health or from professional bodies, has had weak impact throughout the last decade. Commissioners are much more likely to take note of and to fulfil their duties as laid down in legislation.

25. It may be possible to provide the definition through secondary legislation, as with the regulations for providers under the Health and Social Care Act 2008. However, we note that there is no specific set of regulations currently mentioned in the Bill (including the new amendments) to which it would be appropriate to attach this definition.

26. For these reasons, National Voices and its members, and the charities with which we are working in coalition on this legislation, continue to argue that for the new structures of commissioning to have real impact, there is a requirement for a clear, statutory, system-wide definition of “patient involvement”.

27. There is already legal wording approved by Parliament in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These are binding on all providers, and there would be powerful advantage in ensuring that both commissioners and providers are working to a common specification.

Involving patients and patient groups as experts

National Voices recommends

28. Amend the government’s revised clauses 19(13G) and 22(14O). These currently state:

“The [Board/consortium] must obtain advice appropriate for enabling it effectively to discharge its functions from persons who (taken together) have a broad range of professional expertise in—

a. the prevention, diagnosis or treatment of illness, and

b. the protection or improvement of public health.”

29. The word “professional” should be removed and an additional sub-clause added along the following lines:

55 Asthma UK/Ipsos-Mori survey 2010
56 Time for change, Epilepsy Action, 2009
57 See, for example, the findings of the “Point of Care” programme, King’s Fund, 2009
58 House of Commons Health Select Committee, Third Report, Session 2006–07, Inquiry into patient and Public Involvement in the NHS
c. the experience of people who have accessed or been in receipt of relevant services, as well as those who do not or cannot access relevant services

30. Amend clauses 19(13L) and 22(14P) in such a way as to provide for the involvement of expert patients, carers and their organisations in monitoring, reviewing and redesigning services and pathways.

31. This amendment should remove the reference to “informing or consulting” and provide a form of words which encompasses meaningful and continuous involvement, including with targeted patient and population groups, in all stages of the commissioning process.

Justification

32. In this section we wish to focus on two areas of the Bill: the twin duties on commissioners to obtain advice from experts [Clause 19(13G) and Clause 22(14O)]; and the twin duties to involve the public [Clause 19(13L) and Clause 22(14P)].

33. The Government has proposed amendments to the duty to obtain advice which we warmly welcome. National Voices and its charity coalition partners have argued strongly that all relevant professionals with expertise on our conditions should be involved in commissioning for those conditions, and we believe the amended clauses meet that demand.

34. However, we have argued that all people with expertise should be involved—and that this includes patients and carers, and their organisations, whose experience relates to:

a. the experience of people accessing and using services, and those who are unable to achieve access

b. the entitlements of people accessing and using services, and

c. the optimum design of services in order to meet people's needs and deliver best practice

35. Individual patients and carers, and peer groups of patients and carers, who have lived through an illness or are continuing to live with a chronic condition will have views and experiences to offer about where services have gaps or failures, and how they could be better designed and commissioned.

36. Patient and carer organisations have an aggregated knowledge of these matters gained from their everyday and continuing contacts with patients and carers, including through providing help, support and information to them.

37. In addition, patient and carer organisations often have a well developed knowledge of NICE guidelines and standards, the indicators of best practice and effectiveness, and the entitlements of patients and carers to receive these. This expertise may often be greater than that of local commissioners, especially in the case of less common conditions.

38. This individual and collective experience and expertise offers considerable additional value to the NHS for quality improvement. However, that value is too often untapped.

39. The value of this experience and expertise lies in a domain of “involvement” that is not currently recognised in the Bill's formulations. It is not part of “patient involvement”—the involvement of an individual in his or her own care and treatment. Nor is it part of “public involvement”, which is usually understood as being collective public involvement in consultations about service change.

40. More specifically, it lies in the domain of “co-design” and “co-commissioning” of services. This means the involvement of specific groups of experienced service users in the process of monitoring, reviewing, redesigning and recommissioning services that are relevant to those groups.

41. This type of involvement is proactive, continuous and targeted, with a direct influence on commissioning decisions, and therefore much more likely to produce meaningful change and benefits than population-wide consultation.

42. Services which have been co-designed by their user group are more likely to be used effectively, to be safer, and to create a better patient experience—the three domains of quality improvement, to which commissioners have a duty.

43. At national level, strategies in which patient organisations have been closely involved as co-designers, such as the cancer strategy, have been demonstrably successful in improving outcomes and experience, and in identifying innovations such as the development of new service models for cancer survivors.
44. At local level, an example of bringing this kind of experience and expertise to bear is Neurological Commissioning Support (NCS), which works alongside health and social care commissioners, to ensure that people affected by long-term neurological conditions are at the heart of commissioning, producing clear recommendations to deliver better outcomes for services in neurology.\(^{10}\)

45. A joint initiative from the MS Society, the MND Association and Parkinson’s UK, NCS works with commissioners to audit and redesign services by involving people with relevant conditions. In Gloucestershire, 2009–10, NCS helped commissioners from the NHS and local authority to audit their existing services, to decommission those which people with the conditions said were ineffective or poor, and to design new services that deliver a better experience as well as meeting the standards set in the national framework. Service users whom NCS engaged as a reference group have continued to work with the PCT to ensure recommendations are followed through, and indeed have formed their own regional alliance to continue to press for improvements and innovations.

46. National Voices believes it is essential that this kind of co-design and co-commissioning of services becomes widespread under the new structures, to improve quality and to help meet the “Nicholson challenge”. The Bill is a key opportunity to open the way for this to happen.

47. National Voices therefore recommends amending the government’s revised clauses 19(13G) and 22(14O). These currently state:

“The [Board/consortium] must obtain advice appropriate for enabling it effectively to discharge its functions from persons who (taken together) have a broad range of professional expertise in—

a. the prevention, diagnosis or treatment of illness, and

b. the protection or improvement of public health.”

c. the experience of people who have accessed or been in receipt of relevant services.

48. The word “professional” should be removed and an additional sub-clause added along the following lines:

49. National Voices further recommends amending clauses 19(13L) and 22(14P) in such a way as to provide for the involvement of expert patients, carers and their organisations in monitoring, reviewing and redesigning services and pathways.

Additional matters

50. In this section we wish to inform the Committee with regard to the questions and concerns that have arisen during the pause or as a result of the Government’s new amendments, and which follow from the primary legislation itself.

HealthWatch England

51. As noted by National Voices in its oral evidence to the Committee on 28 June 2011, we believe there is a case to reconsider the date for establishment of the HealthWatch England committee of the Care Quality Commission.

52. During the transition period, emerging clinical commissioning groups, including the pathfinders, will be supported by the National Commissioning Board, which begins its establishment in shadow form in October 2011. There is a lack of parallel provision for emerging HealthWatch organisations, where the establishment of HealthWatch England is planned for October 2012.

Operation of clinical networks and senates

53. National Voices, its members and charity coalition partners strongly welcome the government’s decision, in response to the NHS Future Forum, to preserve, support and develop clinical networks. No further detail has been provided on how these, and the associated clinical “senates”, will be organised and funded. Nor is it clear how they will be used to advise and influence commissioning decisions at national, regional and local level.

54. The Government’s intention is that these will not be “organisations” and will be hosted by the Commissioning Board, hence they are not included in the Bill itself.

55. However, without further information and direction from the Government as to how they will operate, it is difficult to assess the extent to which the intentions of the revised clauses 19(13G) and 22(14O) are likely to be achieved in practice.

\(^{10}\) http://www.csupport.org.uk/
56. In particular we are interested to know:

a. what the “senates” consist of and how they relate to the networks

b. whether networks are likely to be banded together for similar areas of care—such as the maternity and neonatal networks that are currently separate

c. whether, being hosted by the national board, networks and senates will operate only from the national level—noting that for many conditions the more relevant contribution would be at regional or local levels

d. whether, as the NHS Future Forum recognised may be desirable, patients and patient groups are to be involved in the senates

*Lay people on the governing bodies of clinical commissioning groups*

57. The Government’s new clauses state that regulations will describe how CCGs should select lay members, and will be able to stipulate a minimum and a maximum number of such members.

58. National Voices strongly believes that these regulations should not set a maximum number. It should be open to the CCG to have as many lay members as it chooses on its governing body, including deciding to have a lay majority. Principia Partners in Health, a pathfinder CCG in Nottingham, has a lay majority on its board, and is a strong advocate for the benefits of so operating.

59. National Voices also believes that lay members should not be drawn from out of the commissioning area of the CCG, but from within the population for which it commissions. They should not repeat the “non-executive director” role that has been used for PCTs; but act as representatives of the concerns and priorities of local stakeholders, in a similar way to parent or foundation governors in schools.

60. National Voices further believes that, as the NHS Future Forum recognised, there will be a need to train and support these individuals in the fulfilment of their roles.

_July 2011_

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**Memorandum submitted by the National Association of Links’ Members (HSR 25)**

**Making Healthwatch Work**

*Patient and Public Involvement in Health and Social Care*

**Key Points**

— Healthwatch must be independent if it is to be an effective body representing the public interest in the NHS and social care.

— Government plans for Healthwatch create a major conflict of interest. Healthwatch cannot be accountable to and funded by local authorities—the bodies which commission and provide the services that Healthwatch monitors and scrutinises.

— Funding must be “protected” if the intentions of the Bill in respect of Healthwatch are to be realised. To do otherwise would lead to the misuse of public funds intended to enhance the representation of the public in the health and social care system.

— Local HealthWatch must be seen by patients and the public and particularly by users of social care services, as independent and serving their needs. If Healthwatch is made accountable to the local authority the public will have no confidence that it will stand up for them when things go wrong

— We must learn the lessons from Mid-Staffordshire Foundation Trust and the numerous care homes which have become places of oppression and agony for the residents. Healthwatch can’t be both the champion of the public and the poodle of the local authority.

HealthWatch offers the opportunity to build a highly effective system for the involvement of patients and the public in health and social care. But, unless the Bill is amended HealthWatch will fail to meet the vision of an informed consumer champion for health and social care.
1. **Independence and Accountability**

1.1 Healthwatch must be independent if it is to be an effective body representing the public interest in the NHS and social care.

1.2 A body that is commissioned, funded and performance managed by a local authority will be perceived to be subject to influence, direct or indirect, from the officers, Councillors and be unable to make unbiased reports and interventions.

1.3 Local HealthWatch must be seen by patients and the public and particularly by users of social care services as independent and serving their needs. If Healthwatch is made accountable to the local authority, the public will have no confidence that it will stand up for them when things go wrong.

1.4 We must learn the lessons from Mid-Staffordshire Foundation Trust and the numerous care homes which have become places of oppression and agony for the residents. Healthwatch can’t be both the champion of the public and the poodle of the local authority.

2. **Conflicts of Interest**

2.1 Government plans for Healthwatch create a major conflict of interest. Healthwatch cannot be accountable to and funded by local authorities—the bodies which commission and provide the services that Healthwatch monitors. Local Healthwatch must accountable to Healthwatch England.

3. **Funding for Healthwatch Must Be Protected**

3.1 Funding must be “protected” if the intentions of the Bill in respect of Healthwatch are to be realised. To do otherwise will lead to the misuse of public funds intended to enhance the representations of the public in the health and social care system.

3.2 The experience of Local Involvement Networks in securing adequate funding for their work from the grants made to local authorities by the Department of Health, does not inspire confidence that there will be adequate funding for the greatly extended functions given to Local HealthWatch.

3.3 Local authorities have already cut funding to LINks by up to 76% (average cut 24%). Without adequate funding there will be no consistent Local HealthWatch service, the public will be confused and the reputation of HealthWatch will be irreparably damaged.

3.4 The simple practical solution is for Healthwatch to be funded by Healthwatch England.

4. **Potential for the Misuse of Money Intended for Healthwatch**

4.1 The Government intends to spend £60 million on Healthwatch building in functions which include service monitoring, acting as the champion for the community in health and social care, complaints advocacy, information and advice. But many local authorities intend to use the money to fund a range of branded services called Healthwatch. The money will be dissipated undermining the intention to establish powerful and effective bodies for users of health and social care services.

5. **Integrated Not Dis-integrated**

5.1 Healthwatch must be a body that can use all sources of intelligence to inform its work—from patients, carers, users of social care, the voluntary sector, safety committees, inquiries into incidents and accidents and the outcomes of complaints investigations. It must be the best informed body in each area, able to use the information it collects to intervene at the highest level when things go wrong, and the protect the public. Allowing local authorities to spend the money on dis-integrated Healthwatch will do nothing to increase the safety, access and effectiveness of services.

6. **Pathfinders**

6.1 Funded Pathfinder LINks are required as soon as possible to ensure that the development of Healthwatch is based on new and inspiration approaches developed through action learning.

7. **Clinical Commissioning Groups**

7.1 It is essential that the Bill states that Healthwatch has a specific duty to represent the public in clinical Commissioning Groups. We find it incomprehensible that the government is to spend £60 million on public involvement, but not specifically include local Healthwatch in these arrangements. Healthwatch will have a seat on the Health and Wellbeing Board where is will represent the public and it is similarly appropriate that it does so directly within the decision making processes of NHS commissioning.

7.2 We believe that it is essential that s242 (National Health Service Act 2006) should be amended to include Clinical Commissioning Groups and the National Commissioning Board.
8. **Healthwatch England**

8.1 A great deal of work is in progress throughout the country by Local Involvement Networks, Councils and Primary Care Trusts to plan and prepare for Local HealthWatch. HealthWatch England will have an important relationship with Local HealthWatch: setting standards, training members, establishing lines of communication between local Healthwatch, the National Commissioning Board, Monitor, the CQC and the Secretary of State.

9. **Healthwatch England is to be established at the same time as Local HealthWatch.**

This makes no sense. It is needed in October 2011 to pave the way, in collaboration with LINks, the NHS and local authorities for local Healthwatch which start in October 2012. This will enable relationships to be developed before plans for the establishment of Local HealthWatch are finalised.

9.1 Elections to Healthwatch England from local Healthwatch are essential to ensure accountability in both directions, and to prevent Healthwatch England from becoming isolated and detached from local Healthwatch.

9.2 Locating Healthwatch England within the CQC without democratic accountability will result in the HWE becoming absorbed into the CQC and losing its identity. We value the proposed close working relation between CQC and HWE, but think it is doomed unless it is accountable and demonstrably independent.

10. **Publicising Healthwatch**

10.1 Department of Health has said that there will be national branding for HealthWatch but no national publicity campaign to encourage people to understand what it offers, how it can help them, and how to contact Local HealthWatch. It is absurd to set up a new system with major functions in relation to the needs of the public in the health and social care system, but not tell the public it is happening and how to access its services.

10.2 It is not in the public interest, or the interest of the Coalition Government, for HealthWatch to be set up in a way that will mean that, despite the work of volunteers, staff and many committed people in local areas and the DH, that it will fail.

**Proposed Amendments to Amending the Health and Social Care Bill**

**Public Involvement, Local Government and Commissioning**

1. Members of the Board of HealthWatch England should be elected from the membership of local HealthWatch to ensure that HWE is locally accountable.

2. HealthWatch England must deal with both health and social care issues.

3. The CQC, Secretary of State, the NHS Commissioning Board, Monitor and English local authorities should not only respond to matters raised by HealthWatch England but must say what action they intend to take

4. HealthWatch England must provide the CQC with information, advice and recommendations about the views of people and local HealthWatch on health and social care services. May is too weak.

5. Reports produced by HealthWatch England must be distributed to local HealthWatch in addition to Parliament and the Secretary of State.

6. If the Secretary of State intends to take action against HealthWatch England for failing in its statutory duties, local HealthWatch must be consulted before any directions are issued.

7. As local HealthWatch will be a “body corporate” it should be clearly stated that the activities of local HealthWatch unambiguously derive from their duties to the public and not secondarily from the duties of the local authority.

8. The role of local HealthWatch in making recommendations to HealthWatch England or the CQC must be strengthened.

9. Members of local HealthWatch must have indemnity so that they can speak out freely and take part in all activities required to fulfill their duties.

10. Local HealthWatch must not be the same organisation as a Host, local authority, an NHS Trust, Foundation Trust, Primary Care Trust, Strategic Health Authority or Commissioning Consortium.

11. The Independent Advocacy Service should be provided at a level that meets local need.
12. The Independent Advocacy Service should provide a service for people with complaints about social care and complaints about health care.

13. Clinical Commissioning Consortia must be added to the local bodies that are required to provide information to local HealthWatch and respond to their reports and recommendations.

14. Clinical Commissioning Consortia must be added to the local bodies that are required to enable local HealthWatch to again access to services for the purpose of enter, view and observe the carrying on of health and social care activities.

15. The NHS Commissioning Board must ensure compliance with a duty of candour by all bodies providing and commissioning NHS services when an adverse event, incident or error has occurred in the care or treatment of patients.

16. The NHS Commissioning Board shall secure the involvement of individuals and local HealthWatch in commissioning decisions, and strengthen involvement.

17. Clinical Commissioning Consortia must secure the involvement of individuals and local HealthWatch in commissioning decisions, and strengthen involvement.

July 2011

Memorandum submitted by the Chartered Society of Physiotherapy (CSP) (HRS 26)

INTRODUCTION

This submission sets out the CSP's concerns at the revised proposals and new amendments to the Health and Social Care Bill ("the Bill") as it is re-committed in part to the public bill committee following the Government's response to the NHS Future Forum report. The CSP notes that the latest Government amendments to the Bill were only published three days before the oral evidence sessions of the Committee began. This has given little time for professional organisations and other stakeholders to consider the implications of these proposed amendments.

The CSP's concerns focus on four key areas: the role of the Secretary of State, competition, commissioning (including workforce planning), and the role of physiotherapists and other AHPs in decision-making and commissioning.

BACKGROUND

The CSP is the professional, educational and trade union body for the UK's 50,000 Chartered physiotherapists, physiotherapy students and support workers.

Physiotherapists offer clinically effective and cost-efficient services for patients, across healthcare sectors and along the whole patient pathway, in the management of long term conditions, rehabilitation, return to work, mental health and public health. Physiotherapy enables people to move and function as well as they can, maximising quality of life, physical and mental health and well-being. Physiotherapists help keep people out of hospital and prevent re-admissions, and they promote the health benefits of regular physical activity. Physiotherapists use manual therapy, therapeutic exercise and rehabilitative approaches to restore, maintain and improve movement and activity, keeping people mobile, active and independent. Physiotherapy supports people across a wide range of areas including musculoskeletal disorders; many long-term conditions, such as stroke, MS, COPD, and Parkinson's Disease; cardiac and respiratory rehabilitation; children's disabilities; cancer; women's health; continence; obesity management; mental health; and falls prevention. Physiotherapy is founded on a strong evidence base, an evolving scope of practice, and clinical leadership.

PART 1, CLAUSE 1.

THE ROLE OF THE SECRETARY OF STATE, AND MAINTAINING NHS SERVICES “FREE AT THE POINT OF NEED”

1. The CSP notes that the Government amendments do add a new clause giving the Secretary of State responsibility to “promote a comprehensive health service”. However the wording of the 2006 National Health Service Act is still changed from the Secretary of State having to “provide or secure the provision of services” to “act with a view to securing the provision of services for the purposes of the health service in accordance with this Act”. Physiotherapists are concerned that Clause 9 of the Bill remains unchanged so that consortia not the Secretary of State must arrange for the provision of health services. Clause 10 says consortia must arrange for the provision of services “it considers appropriate”. There is still no duty of comprehensiveness on consortia. This puts the delivery of health services increasingly distant from Parliamentary scrutiny.
2. The CSP is concerned that the proposed Health and Social Care Bill as it currently stands could undermine the comprehensive and free nature of NHS services. The CSP believes that it increases the likelihood of a “postcode lottery of provision” with different consortia providing different services and different quality services. There is a real danger that decisions will be made on cost and not on clinical need. Open “rationing” is already beginning to take place—for example some orthopaedic procedures and some physiotherapy services are already being cut despite the coalition Government pledge to protect frontline services.

3. The CSP believes that the Bill leaves the door open to charges being introduced for NHS services at a point in the future. As the Bill currently stands, although NHS services will be free at the point of use they clearly will not be free at the point of need. The CSP would therefore like to see the principle that the NHS remain “free at the point of need” enshrined in the legislation and an explicit commitment built in to ensure that all services currently provided by and funded by the NHS will remain free of charge to patients.

**PART 3—COMPETITION**

4. The CSP remains seriously concerned that the Health and Social Care Bill—even when amended as the Government proposes—will drive increased open market competition in the NHS. The CSP believes the Bill—together with the expansion of the “Any Qualified Provider” policy—will actually serve to strengthen the role of competition in the NHS. Physiotherapists are very concerned about the unintended negative consequences this could have on patient care.

5. The Bill—even with the current proposed amendments—will lead to the NHS becoming an open market for health care providers over time, starting with community services, and then moving on to secondary care. This will inevitably fragment pathways of care and could in fact limit the “choices” for many older or vulnerable patients who may be unable to navigate a more complex system with little or no robust information about the track record or quality of new private providers. The Government has not conducted an analysis of the impact of this change in direction on the NHS. There is no evidence that this would be of greater benefit to patients—and significant evidence that it could have a negative impact on the quality of patient services.

6. We agree that the duty on Monitor to promote competition should be completely removed. The CSP is concerned that Monitor’s remit still remains primarily as an economic regulator—contrary to the recommendation of the Future Forum. Monitor is still going to have concurrent powers under the Competition Act with the Office of Fair Trading. The CSP understands that this implies that there will be an extension of the applicability of EU competition law to providers of NHS services. Although Monitor’s responsibility for “promoting competition” has been removed, repeated references to “preventing anti-competitive behaviour” have been added in. At present the Government’s moves to balance competition with integration do not appear to be truly balanced and the CSP believes there is a disproportionate emphasis on competition. Monitor, the NHS Commissioning Board and consortia must secure that health services are “provided in an integrated way” but there is no definition of “integrated” and the CSP can see nothing added to the Bill on “improving co-operation or collaboration”. The Future Forum recommended that Monitor should promote collaboration and integration as well as choice. The CSP would like to see the Bill strengthened to place a clear duty on Monitor to promote integration when it is simply “in the interests of patients” and not only when it would “reduce inequalities or improve quality”. There are clear benefits to securing better integration within healthcare, for example of all health services along the patient pathway as well as improving the integration between health and social care services. Physiotherapists can play an important role in delivering this.

7. The CSP believes that the Government’s proposed changes to “prevent competition for its own sake”, will not in effect be adequate when the Government’s clear intention is to bring in a far greater number of providers with the expansion of the “Any Qualified Provider” policy from April 2012. The CSP is aware of at least one situation where the introduction of such a model has already increased the number of providers of musculoskeletal services for example to more than 15. The CSP believes that this must be confusing for patients and could create a constant “churn” of providers who cannot remain in business without firm contracts for fixed periods of time or any certainty of a minimum volume of work. We believe this is a recipe for chronic instability in the delivery of health care.

8. There are a limited number of physiotherapy services already operating under an “Any Qualified Provider” model in the UK. As a result of the previous “Practice Based Commissioning” pilots, physiotherapists working in those areas have contacted us with concerns about their own experiences of restrictions on or rationing of treatments (built into contracts) which are affecting the quality of their service and impacting on patient outcomes. This will also lead to greater fragmentation of patient care pathways with more confusion and less choice for patients (especially if patients’ ability to self refer to physiotherapy is lost); less sharing of good practice and less effective workforce planning.
9. Furthermore, we do not believe the proposed changes to the Bill will completely prevent price competition. The CSP has deep concerns that price competition could easily result from the new competitive system proposed for the NHS, when combined with the references in the latest NHS Operating Framework to the “opportunity for providers to offer services to commissioners at less than the published mandatory tariff price”.

10. The Government’s response to the Future Forum stated that it would require commissioners to follow “best value principles” when tendering for non-tariff services. There is no reflection of this promise in the Government’s proposed amendments to the Bill. The CSP would like to see a specific amendment to the Bill introduced to secure a duty on commissioning consortia to follow best value principles when commissioning or tendering for non-tariff services.

11. Furthermore the CSP would like to see a duty on commissioning consortia to only introduce new providers or greater competition where there is evidence of a clinical need to do so and evidence that increased competition will increase quality.

12. The CSP would also like an amendment introduced to actively prevent commissioning consortia from applying price criteria when commissioning new or existing services.

13. The Government has stated that “Any Qualified Provider” models will only be implemented in areas where there is a national or local tariff; however, where there is a local tariff different prices could be set in different areas. We are concerned that over time, as commissioners from different areas talk to each other, this will result in a race to the bottom on price—the exact opposite of the Government’s stated intention to improve quality and consistency of services for patients. This is of particular concern to us because there is currently no national tariff for physiotherapy services.

14. The CSP is concerned that the expansion of “Any Qualified Provider” will also encourage a “race to the bottom” on workforce terms and conditions of employment. The CSP would like to see amendments to the Bill to ensure that decent and fair workforce standards as enshrined in the “NHS staff passport” are incorporated into the contracts offered by all providers of NHS funded services. The qualification process for “Any Qualified Provider” must take account of the ability of a provider to support training, development and career pathways for the future workforce (such as providing student clinical placements) as well as the current workforce. Commissioners should be required to put in place arrangements for monitoring this as part of the overall performance management process.

Part 1—Clinical Advice and Commissioning

15. The CSP notes that the benefits of wider multi professional input into commissioning of services were recognised by both the Future Forum and the Government in its response to the Future Forum. However, the CSP is concerned that the Bill is still unclear and lacking in detail on exactly how a wide range of clinicians will input to decision making at local level. We believe that clinicians who know their local communities/populations and know their local health and social care services should be actively involved and represented on clinical senates and clinical commissioning consortia.

16. The CSP would like to see greater clarity about the range of clinicians to be represented on clinical senates and commissioning consortia. We believe the Bill needs to clearly set out the level of accountability between clinical senates and clinical commissioning consortia.

17. The CSP would also like to see stronger safeguards to avoid a potential conflict of interest from GPs in clinical commissioning groups being both providers and commissioners of services.

18. The CSP notes that the Future Forum report proposed that an explicit duty be set for the Secretary of State to “maintain a system for professional education and training as part the comprehensive health service”. The CSP is concerned that the Bill is insufficiently specific on maintaining and planning for an adequate health workforce for the future. Local level workforce planning and skills networks could lead to boom and bust in the supply of qualified professionals—like physiotherapists—in the future. A healthcare workforce for the future will need to be educated and trained—and all providers of services, whether they are NHS, independent or private providers—must contribute to the training of the future workforce. At present a lack of information about the non NHS workforce has been a major obstacle to developing comprehensive and effective workforce planning. Workforce planning should take account of needs across the whole health and wellbeing economy. The CSP believes that regional level co-ordination and national oversight must be maintained, and that this should be made explicit in the Bill. Use of the “Electronic staff record” should include all staff employed by NHS employing organisations, and non NHS employers should be obliged to provide equivalent data.

Part 1 and Part 5—the voice of physiotherapists and AHPs in clinical commissioning decisions.

19. While the CSP has welcomed the recent amended proposals to open up the commissioning process to a wider range of clinicians, we are disappointed that under the new proposals there will not be a
mandatory voice for the Allied Health Professions (AHPs) on the clinical commissioning groups and other statutory bodies such as the NHS Commissioning Board.

20. Physiotherapists work across sectors and care pathways, providing the “bridge” between hospital, primary and community care; and alongside their AHP colleagues, physiotherapists are central to the delivery of integrated care and keeping patients out of hospital, particularly through rehabilitation.

21. We believe that AHPs have a critical role in the commissioning and design of health and social care services. The CSP would urge you to consider amending the Bill to ensure that AHPs have a clear voice on the NHS Commissioning Board, the Clinical Commissioning Groups, Clinical Senates and the Health and Wellbeing Boards.

22. Physiotherapists could also make a key contribution to the drawing up of “Joint Health and Wellbeing Strategies’ and Joint Strategic Needs Assessments” as physiotherapy makes a key contribution to public health as well as to the management and treatment of a wide range of health conditions.

23. The recent NHS staff tracking survey, carried out by the COI, found that almost half of NHS staff (49%) feel that the care the NHS delivers to patients will get worse over the next few years; and in a survey of CSP members in March 2011, 89% either agreed or strongly agreed that “patient care will suffer as a result of these changes to the NHS”.

24. We are keen to ensure that the appropriate safeguards are in place to protect against the unintended negative consequences of the NHS reforms on patient care.

July 2011

Memorandum submitted by the Neurological Alliance (HSR 27)

People with neurological conditions—The neglected eight million

1. About the Neurological Alliance

The Neurological Alliance is the collective voice of 80 brain and spine charities, representing the eight million people in England with a neurological condition.61 The Alliance campaigns for access to high quality, joined-up services and good information for every person diagnosed with a neurological condition, from their first symptoms, throughout their life. More information is available at www.neural.org.uk

2. Quality care for people with neurological conditions

People with neurological conditions rely on a specialist multidisciplinary team of nurses, physiotherapists, speech and language therapists and others to maximise their independence and quality of life. The Bill proposes that these services be commissioned at a local level by clinical commissioning groups.

Our key concern is that some such groups will cover a relatively small population area, meaning that it will not be cost effective to commission services for less common conditions. Effective commissioning necessitates a population size of a minimum of 250,000 but ideally larger.62 Otherwise, there are not likely to be enough people living with neurological conditions to make it efficient. Therefore, clinical commissioning groups covering a small population and working in isolation are unlikely to deliver the services that people with neurological conditions need or provide value for money for the public purse.

Therefore, we are calling on the Government to ensure that these groups work together where appropriate to achieve effective provision of specialist quality services. This would ensure that people with less common neurological conditions have access to the healthcare they need, wherever they live in England.


62 For many rarer neurological conditions a significantly larger population is more realistic for effective commissioning. For example, a population of 500,000 will only include 30 people with motor neuron disease.
3. THE FUTURE FORUM AND THE GOVERNMENT’S RESPONSE

We welcome the Government’s response to the Future Forum report and the changes it has made to the Bill. We believe the listening exercise has been productive and we support many of the Future Forum’s recommendations.

The Future Forum acknowledged concerns we raised during the listening exercise, relating to commissioning for less common conditions. However, the Government’s response did not satisfactorily address these concerns. We hope they will now be addressed as the Bill resumes its passage through Parliament.

4. COMMISSIONING FOR LESS COMMON CONDITIONS

The Future Forum report states:

“There was also concern about the future commissioning of services for less common conditions, such as Motor Neurone Disease, which require specialised support for a small number of patients”.63

The report is referring to our argument that services for less common conditions will not be efficiently and cost effectively commissioned by clinical commissioning groups covering a small population size. (See paragraph 2. above.) The Government has previously referred to this issue as “low volume” commissioning and the Neurological Alliance therefore used this term in previous briefings64.

5. OUR RECOMMENDATIONS (1)—CLINICAL COMMISSIONING GROUPS MUST WORK TOGETHER

The Government’s response to the Future Forum report does not, in our view, substantively address this problem. We believe the following changes are necessary in order to ensure that everyone with less common neurological conditions has access to the services they need:

— The Health and Social Care Bill must address the “strategic gap”65 in commissioning for less common conditions.

— The authorisation process for clinical commissioning groups must include assessment of how they will collaborate to commission services for less common conditions. This will make sure that clinical commissioning groups recognise the importance of collaborative working from the outset.

— Clinical commissioning groups must have a duty to work collaboratively to commission for less common conditions

— The NHS Commissioning Board must monitor, and where necessary enforce, commissioning of services for less common conditions.

— There should be an advisory group for neurology within the NHS Commissioning Board—in line with the Future Forum recommendation.66

These changes are necessary because without explicit statutory protection, combined with specific monitoring of the commissioning of less common conditions, neurology services will fall through the “strategic gap”. At clinical commissioning group level there is a real risk neurology will be overlooked. Not one pathfinder consortium is looking at neurology as a special area of interest. Added to this, many neurological conditions do not have a NICE guideline and are therefore extremely unlikely to have a quality standard under the new system, meaning there is no official statement of what constitutes quality care.

6. OUR RECOMMENDATIONS (2)—NEUROLOGY NETWORKS AND CLINICAL SENATES

While the government response does not respond to calls for clinical commissioning groups working together, we welcome its support for clinical senates and networks. We support the Government’s view that these can help provide more integrated care, including for less common conditions. However, the following are necessary in order to deliver real improvements for people with neurological conditions:

— Neurology should be represented on each clinical senate in order to provide the necessary skills and leadership to assist clinical commissioning groups to commission effectively for neurology.

— Neurological networks should be funded and embedded throughout the NHS

64 The term “low volume” has been used in the set of consultation documents Liberating the NHS and in the explanatory notes to the Health and Social Care Bill.
65 Clinical advice and leadership: A report from the NHS Future Forum. P10, 2.12
66 Clinical advice and leadership: A report from the NHS Future Forum. P16, 3.16
— The Government should follow the recommendation of the Future Forum and look at the most effective forms of networks and spread best practice.

— The Government should provide support for existing networks to help them through the transition process.

— The formation of clinical senates and networks should be a priority. They should be in place to support clinical commissioning groups when they start taking full responsibility for commissioning from April 2013.

Supporting evidence

There is evidence to support our argument that neurology networks can make a real difference to patient care. There are some excellent examples of neurological networks in England, though in some places they have struggled to get off the ground. Without proper support, guidance and funding from the Department of Health this situation is likely to remain, or possibly even deteriorate.

One of the most successful neurology clinical networks is in the North East. This network was funded and fully supported. It has worked with service users, carers, clinicians and social care to help develop a more integrated service—exactly the model that the Government support. It was the only funded neurological clinical network in the country. However, as is often the case with neurology, which seems low on many priority lists, this network is at risk because of changes to the NHS. Because of changes in staff and structures, as well as decreased funding, this network is now working with the cardio-vascular network to try and survive the transition process.

July 2011

Memorandum submitted by the Association of British Healthcare Industries (HSR 28)

Notes on this memorandum

This document follows the structure of the Government response to the Future Forum report.

Summary

— Commissioners should consult the appropriate specialists—The duty that Clinical Commissioning Groups have to “obtain advice” from hospital doctors should be strengthened to ensure that they consult with the clinically appropriate specialist when developing a commissioning framework for a particular condition.

— Governance of Commissioning Bodies—It should be explicitly written into the legislation that Clinical Commissioning Groups should include hospital clinicians on their governing bodies.

— Innovation and Research—Annual Reports published by the National Commissioning Board and Clinical Commissioning Groups should demonstrate how they have fulfilled their duties in regard to promoting innovation.

— Health and Wellbeing Boards—A key function of Health and Wellbeing Boards should be to assess how local commissioners are performing against national benchmarks in terms of innovation.

— Better information for Patients—It should be made clear in the legislation that patients are required to be given information about the full range of treatments available.

Chapter 3

Multi-professional involvement in commissioning

This section relates to amendments 71, 72, 112, 113, 114 and 135.

1. The ABHI very much welcomes the broader involvement of clinicians in Clinical Commissioning Groups (CCG). We believe that this has the potential to equip CCGs with crucial specialist knowledge when commissioning often quite specialist services.

2. However, the amendments 72, 112 and 113 only require CCGs to “obtain advice” from a broad range of professionals with expertise in the “prevention, diagnosis or treatment of illness” and in the “protection or improvement of public health”, appropriate for enabling them to effectively discharge their functions. Moreover, amendment 114 introduces a power for the National Commissioning Board to issue guidance to clinical commissioning groups on the discharge of their duty to obtain advice.

67 Clinical advice and leadership: A report from the NHS Future Forum. P.12, 2.27–2.29
3. The ABHI believe the duty to “obtain advice” should be strengthened with clear direction given that CCGs are required to consult with the clinically appropriate specialist when developing commissioning framework for a particular condition. This should be made clear in the guidance issued by National Commissioning Board. Moreover, the input of secondary clinical specialists in CCG governing boards should be formalised in the legislation (we have added to this in our comments on Chapter 4).

4. The ABHI warmly welcomes amendment 135 which requires the Board to include in its annual performance assessment of CCGs an assessment of how effectively they have fulfilled their duty to obtain advice.

**Research and Innovation**

This section relates to amendments 115 and 116.

5. The ABHI is very pleased with these amendments as they place a duty on CCGs to have regard to the need to promote research on matters relevant to the health service, and impose a duty on CGCs similar to that which is already on the NHS Commissioning Board in the exercise of its functions to promote innovation in the provision of health services. This will ensure that CCGs actively seek to innovate when exercising their functions as commissioners.

6. This is important as historically there has been a poor link between the development of new treatments and technologies, and their adoption in the NHS to provide better care at better value.

7. To further address this challenge, the ABHI would recommend the NHS Commissioning Board's annual report should demonstrate how it has taken into account the NHS's role as an innovation champion. This duty should also be extended to the CCGs.

8. The ABHI is very pleased to see that the Government proposes to table amendments which will place a specific duty on the Secretary of State to have regard to the need to promote health service research and the use of health service evidence obtained from research.

**Chapter 4**

**Strengthening Health and Wellbeing Boards**

This section relates to amendments 125 to 133.

9. The ABHI is pleased to see a strengthened role for Health and Wellbeing Boards. In particularly, we think it is positive that CCGs have a duty to consult Health and Wellbeing Boards in relation to their commissioning plans—this is part of a broader requirement on Health and Wellbeing Board involvement.

10. However, the ABHI would recommend that a key function of Health and Wellbeing Boards should be to assess how local commissioners are performing against national benchmarks in terms of innovation in their treatment specifications.

**Strengthening Governance Arrangements of Clinical Commissioning Groups**

This section relates to amendments 95, 98, 100 to 101 and 104 to 106.

11. As stated in our response to the section dealing with multi-professional involvement in commissioning, the ABHI supports initiatives to involve clinicians in the governing boards of CCGs. Provided that governing bodies are properly constituted, the ABHI welcomes regulations that require CCGs to obtain the approval of its governing body before exercising specified functions.

12. The ABHI is also pleased that these amendments ensure that governing bodies must meet in public, increasing their accountability.

13. While it is positive that the amendments allow CCGs to specify the categories of people who must be members of the governing body, and it is clear the Government intends that membership must include at least two lay members, one registered nurse and one doctor with secondary care experience, this has not been explicitly written into legislation. Although the ABHI notes the intention to allow for flexibility and local decision making, we do feel the requirement to appoint specialist secondary clinicians to the governing bodies of CCGs within the legislation would remove any ambiguity.

**No Decision About Me Without Me**

This section relates to amendments 68 to 70 and 109 to 111.
14. The ABHI supports measures that increase the quality of information offered to patients and widening the scope patient choice. Moreover, it is good that the range of people involved has been increased to include relatives and carers.

15. Guidance offered by the National Commissioning Board to CCGs on the patient involvement duty need to clear about the meaning of “involvement” and “choice”. Modern medicine offers a range of treatments for many conditions and it is important that patients are aware all the information about the full range of treatments available. It is crucial that this information is presented in a manner which is easy to access by even the most vulnerable of patients.

16. In order to support this process guidance from the National Commissioning Board should include advice on the development of decision aids. We suggest that the National Commissioning Board seeks to identify and endorse organisations that can offer quality, informed advice on the full range of treatments that might be available. Such organisations might include, but not be limited to, patient advocacy groups, medical supply trade associations and individual manufacturers. This duty could be made clear in the legislation.

July 2011

Memorandum submitted by Devon County Council on behalf of the Strategic Director People (HSR 29)

1. Devon County Council wholeheartedly welcomes the Government’s amendments to the 

   Health and Social Care Bill in relation to:

   — The role of health and wellbeing boards in the joint commissioning of health and social care services;
   — User and patient involvement in decision-making;
   — Enhancing the local democratic legitimacy of health services; and
   — Co-terminosity between local authorities and clinical commissioning groups

2. The Council wishes to draw the following three areas to the Committee’s attention:

2.1 Clinical networks and senates—there are more checks and balances in the modified Bill than there were in the original Bill, particularly in relation to the functions of the health and wellbeing boards (HWB). The Council understands that clinical networks and senates will work at the regional and sub-regional levels to look at health and social care pathways. The input of social care, local government and public health at those levels will be important. However, the role that clinical senates and clinical networks might have in relation to HWB and clinical commissioning consortia at local level needs to be clearer.

2.2 Integration of health and wellbeing—whilst the Bill promotes the integration of health and social care, the Council is concerned that it does not necessarily integrate health and wellbeing. This is the case in relation to the responsibilities of clinical commissioning groups for emergency care where there must be integration with local authorities’ functions for safeguarding, mental health services and services for homeless people.

2.3 Public health—the proposed responsibilities, accountabilities and relationships for public health between the national and local levels are not yet clear. It is unfortunate that the timescale for the passage of the Health and Social Care Bill is not aligned with the Government’s response to the Public Health White Paper. Whilst the amendments to the Bill do not touch on provisions in relation to public health, it is vital that any legislative implications of the transfer of responsibilities for health protection and health improvement to local authorities are considered as part of the current process.

July 2011

Memorandum submitted by the Chartered Institute of Public Finance and Accountancy (HSR 30)

CIPFA welcomes the opportunity to contribute to the developing proposals for health service reform in England. Given its position as the only professional accountancy body specialising in the public services, CIPFA is well placed to support the proposed transition of the NHS.
CIPFA, the Chartered Institute of Public Finance and Accountancy, is the professional body for people in public finance. Our 14,000 members work throughout the public services, in national audit agencies, in major accountancy firms, and in other bodies where public money needs to be effectively and efficiently managed.

As the world’s only professional accountancy body to specialise in public services, CIPFA’s portfolio of qualifications are the foundation for a career in public finance. They include the benchmark professional qualification for public sector accountants as well as a postgraduate diploma for people already working in leadership positions. They are taught by our in-house CIPFA Education and Training Centre as well as other places of learning around the world. We also champion high performance in public services, translating our information and guidance, courses and conferences, property and asset management solutions, consultancy and interim people for a range of public sector clients.

Globally, CIPFA shows the way in public finance by standing up for sound public financial management and good governance. We work with donors, partner governments, accountancy bodies and the public sector around the world to advance public finance and support better public services.

Summary

CIPFA would advice that each Clinical Commissioning Group should have an Accountable Office and Chief Financial Officer that are Board level appointments.

This submission focuses on the governance of Clinical Commissioning Groups;

1. Schedule 2 of the Bill requires Clinical Commissioning Groups to appoint Accountable Officers. We note that the Schedule envisages that an Accountable Officer may be appointed to a role covering more than one Consortium. It may be that the Accountable Officer is neither an employee of the Consortium, nor a member (in his or her own right) of that Consortium. Because of the critically important role of the Accountable Officer, not only in terms of ensuring compliance with the Consortium’s obligations, but also in terms of ensuring value for money, CIPFA believes that there should be a formal requirement for the Accountable Officer to be appointed as an executive Board member of the Consortium.

2. We support the comments made by the House of Commons Health Committee in its Fifth Report of 2010–11 that key governance matters should be dealt with by way of secondary legislation rather than by local NHS management decision, to ensure compliance with minimum professional standards. We strongly recommend that the status of the Accountable officer should figure within this requirement.

3. We note that Schedule 2 goes on to deal with a number of specific powers and responsibilities, including such matters as trust funds, external financing agreements and keeping proper accounting records. However, the Schedule is silent on the essential matter of ensuring that an appropriately qualified person is appointed to lead the technical function. CIPFA would advise that a further requirement of secondary legislation is that there should be a Chief Financial Officer (CFO) for every Clinical Commissioning Group, and that this post should automatically be at executive Board member level.

4. Accountable Officers need to be able to rely on the professional skills of their CFOs.

5. In summary The CFO will not only need to hold the financial reins of the Group, and ensure that resources are used wisely to secure positive results but to manage the financial challenge related to the ageing population and improvements in technology and pharmaceuticals. (the £20 billion national challenge)

6. CFOs require the knowledge, skills and experience to be able to articulate to Accountable Officers and Board Members—who may not have in depth experience in corporate management the requirements of financial stewardship and corporate governance, relating to a wide and multi-disciplinary remit.

7. As well as demonstrating top class skills personally, CFOs will need to develop properly resourced teams that are capable of managing a complex structure of formal and less formal relationships, including partnerships with other Consortia, and voluntary and community groups.

8. In more depth the role of the Clinical Commissioning Group CFO can be expected to be varied and complex from:
   — Statutory duties relating to accountability, probity and governance;
   — Understanding how the Clinical Commissioning group’s financial allocation has been prepared; how this will change in terms of expected population and age profile changes within the local population and preparing a five year financial plan to manage underlying cost pressures, service change, innovation and transition;
   — Managing an in year resource allocation of between £1 billion & £2 billion;
— Payments and collecting receipts;
— Maintaining the integrity of financial systems;
— Treasury management;
— Counter Fraud;
— Providing comprehensive financial reports for the Board;
— Preparing the annual report and accounts and statement on internal controls;
— Leading on standing orders, standing financial instructions and a scheme of reservation and delegation;
— Having a comprehensive understanding of the NHS Finance regime and mechanisms such as how Commissioners make payments to Providers under the Payment by Results Tariff;
— Establishing Bank Accounts;
— Ensuring support services are specified and evaluated;
— Ensuring Internal and External Audit arrangements in place;
— Input into supply side strategies;
— Input into service specifications and market development strategies; and
— The costing of Workforce and Education strategies.

9. A number of the transactional roles could be undertaken within a shared service arrangement but the statutory lead for financial management, financial reporting, financial planning and advice should remain with the Chief Financial Officer and the Accountable Officer, both Board level appointments.

July 2011

Memorandum submitted by over 100 members of the public (HSR 31)

1. I submit this evidence as I am very worried about the proposed changes and amendments to the NHS bill.

2. It is my understanding that the Government proposes to change the wording of those parts of the Bill—sections 1, sections 2 and sections 3[1]—that ensure the Secretary of State for Health not only has a duty to promote but also to provide or secure general and listed health services in England.

3. The Government asserts that the change in wording will not alter the duty on the State to both promote and provide general and specific health services in England.

4. If the duty to provide health services is not, in essence, being changed in any fundamental way there is no case for altering the wording of the 2006 NHS Act in this respect.

5. There is, however, a case against changing it. If amendments are made to these sections, the whole Bill needs to be fully re-examined in light of the amended clauses in order to confirm that the Bill does not change the duty on the State to provide health services. However, sufficient time has not been allowed to undertake adequate legal scrutiny of the Bill as a whole.

6. In the absence of adequate legal scrutiny, Parliament and the electorate simply do not know what the proposed amendments—and the new Bill as a whole—will mean in practice.

7. I am therefore writing as a member of the electorate to make clear that I strongly oppose any change to the wording of sections 1, 2 and 3[1] of the 2006 NHS Act.

In summary:

The current legal framework enshrines the founding principles of the NHS, ensuring that it remains publicly provided and accountable, comprehensive, universal, equitable, funded by taxes and free at the point of delivery. The duty on the Secretary of State for Health to provide as well as promote both general
and listed services is the lynchpin in this legal framework. The most convincing legal evidence to date has been that this Bill removes the duty to provide health services. The government must allow adequate time for proper scrutiny of the amended Bill, in its entirety, to ensure it no longer abolishes either the general duty on the Secretary of State to provide or secure provision of health services in England or the specific duty to provide listed services. Until that time, no change should be made to sections 1, 2 and 3[1] of the 2006 NHS Act. Only this will ensure the State retains its duty to provide or secure as well as to promote comprehensive health services in the England. Given that the government says there is no intention to remove the duty to provide services, no amendment to the 2006 NHS Act should be necessary.

July 2011

Memorandum submitted by members of the public (HSR 32)

I would like to submit the following comments on the competition aspects of the health bill.

Even after the Government’s changes there will be a huge increase in profit-motivated activity in the NHS. Although the timetable has slowed, the policy of “any qualified provider” remains. The policy direction is therefore the same, despite an obvious shift in presentation. “Choice” is in and “competition” is out—now tainted by public disquiet and controversy. Yet the two are inextricably linked in policy terms and it is misleading to suggest otherwise.

Worryingly, we are advancing competition policy despite the considerable evidence that it will have a negative impact. Only one UK-based study has been cited in support of the Government’s plans. Given the level of concern, we need to limit the role of competition in the English NHS until it can be properly evaluated.

Specific issues raised by the competition amendments

1. What protection is there against a Southern Cross style situation? What prevents essential public services being threatened by the way commercial companies choose to run and finance their business? The potential danger of allowing the private sector to control large parts of our healthcare services has not been adequately thought through.

2. It is unrealistic for the government to claim to be able to stop “cherry-picking”. Any company trying to maximise its return for shareholders will always seek low-risk, or high-return contracts. How can the government change this fundamental aspect of commercial activity? Its plan to do this through the tariff is untested and complex. The risk of “cherry-picking” will surely increase with the number of private providers.

3. The Government’s stated intention to shift towards integration and away from competition is not reflected in the amendments. The bill is now unclear in the way it sets out the functions it creates. For instance, Monitor will take on the current role of the Cooperation and Competition Panel, but only one of their guiding principles relates to collaboration. The emphasis is still therefore very much weighted towards promoting competition.

4. The Government is removing Monitor’s power to specifically open up areas to competition, yet there is no recognition that EU law may force the NHS to allow private sector bidding for contracts. Private providers have made it clear they will pursue this issue into the courts. This was side-stepped by the Future forum, but has been repeatedly raised—notably by independent legal opinion. It should now be properly addressed.

5. The bill should keep in place the limit on the amount of money NHS hospitals can make from private patient income. It is inevitable that removing the cap will lead to NHS staff and beds being used to secure income from private work. It will also raise inequity with richer NHS patients being given the chance to jump the queue.

6. The Government has stated that it will block non-tariff competition, where there is no fixed tariff. How will the Government ensure the lowest priced provider is not chosen and avoid falling standards in quality? This possibility is not reflected in the amendments to the bill. It is shocking that the Government wants to proceed with these plans, with little or no evidence that they will improve NHS provision, and a lot of evidence that there is no protection from private companies exploiting the NHS for profit, to the detriment of the best quality care for ALL patients.

July 2011
Memorandum submitted by the Royal College of General Practitioners (HSR 33)

INTRODUCTION

1. The Royal College of General Practitioners (RCGP) is the largest membership organisation in the UK solely for GPs. Founded in 1952, it has over 42,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with enormous expertise in patient-centred generalist clinical care.

2. RCGP welcomes the opportunity to submit written evidence to the Public Bill Committee on the Health and Social Care (Recommitted) Bill. The College understands that the NHS needs to change. We acknowledge and welcome the focus in the proposed reforms on patient outcomes, choice and value for money. We welcome placing General Practitioners (GPs) at the heart of planning services for their patients, and increasing professional and patient involvement in health service design and funding decisions, and accept competition in provision of services where it adds value to existing services without risking essential services or damaging equity of access or outcome. We welcome an increased focus on prevention, reducing health inequalities, and improving joint working between health and social care.

3. The Government’s response to the Future Forum and the proposed amendments are an encouraging step in the right direction, and this suggests that the Government has taken on board at least some of our concerns. We acknowledge that in a number of the areas where we raised concerns amendments have been tabled which seem to move in the direction we have called for including greater integration, patient voice and avoidance of conflicts of interest.

4. We do, however, continue to have a number of areas of concern where we look to the Committee to ensure the legislation provides the clarity and rigour that is needed.

5. When we presented evidence to the Committee mention was made of a survey of RCGP members. Initial results can be viewed here.

DUTY OF SECRETARY OF STATE

6. As a consequence of establishing independent commissioning groups and an independent NHS Commissioning Board, and—by extension—the Secretary of State’s power to direct these bodies as he could the SHAs and the PCTs, the Bill removed the Secretary of State’s current direct duty to “provide or secure the provision of services”.

7. Although we welcome amendments 54 to 56 that ensure that the Secretary of State’s duty to promote a comprehensive health service will be retained along with ultimate accountability for providing or securing the provision of services, we are concerned that this does not a direct accountability.

8. Rather than securing services directly (as before the reforms), the Secretary of State will be exercising his duty to provide in future through his non-directive relationship with the NHS bodies to be established through the Bill, for example the NHS Commissioning Board by way of the “mandate”.

9. Ministers will be responsible, not for direct operational management, but for overseeing and holding to account the national bodies—in particular, the NHS Commissioning Board and the regulators—backed by powers of intervention in the event of significant failure. The RCGP continues to believe that responsibility must ultimately lie with the Secretary if State for securing the provision of NHS services.

MULTI-PROFESSIONAL INVOLVEMENT IN COMMISSIONING

10. The RCGP has long called for other health professionals to be involved in commissioning and believe that closer working with these colleagues will be a much better way of achieving care that crosses organisational boundaries.

11. NHS chief executive Sir David Nicholson has also recently said that structures based on PCT clusters would remain in place as “local arms of the NHS Commissioning Board”—even where Clinical Commissioning Groups (CCGs), or GP consortia, were ready to take the majority of the budget.

12. There is a danger that this could lead to CCG becoming mere “agents” of the Board rather than having freedom to innovate and meet needs of local populations.

13. We have also have major concerns that there is a vastly increasing bureaucracy that, rather than freeing consortia to commission what is appropriate locally and lead service redesign, will instead constrain it further.

14. With the new announcements the structure of the NHS is looking even more confusing and bureaucratic with: the National Commissioning board; SHA clusters; regional NCB bodies; clinical senates;
PCTs; local NCB bodies; Health and Wellbeing boards; Clinical Commissioning Bodies. We estimate that the number of statutory organisations will almost treble.

15. We look to the Committee to strictly limit through amendments Clinical senates and other bodies to advisory roles and ensure that the emphasis on GP commissioning leadership is not lost. It is crucial that GPs be given the freedom and autonomy to lead the decision-making and design of future integrated health systems drawing on the support of other health, social care and third sector services. We support clinician-led commissioning but continue to believe that GPs are best placed to lead this process.

16. We are concerned that there appear to be no safeguards against the wholesale privatisation of commissioning support, in other words the outsourcing of commissioning work to organisations with a conflict of interest in relation to providers of services and whose activities and processes are not as transparent as those in the public sector. Furthermore, retaining the link with the public health function, based in local authorities, is essential and is undermined by such outsourcing from the Clinical Commissioning Groups to such entities.

EQUAL TREATMENT OF PUBLIC AND PRIVATE SECTORS

17. We are encouraged by amendments that would prevent Monitor, current or future Ministers and the NHS Commissioning Board from pursuing any deliberate policy to increase private provision of NHS services

18. However, if the Government wish to encourage innovation, the development of social enterprises or new models of delivering good patient care in the NHS then Ministers may have to be partial—the NHS and those who rely on its services need the Government to be a champion. For example the Government’s commitment to “promoting” the “right to provide”—the ability for staff to form social enterprises or mutuals to drive innovation and improve the quality of services—in section 5.39 of its response to the Future Forum would be in direct contravention of this rule.

19. In the absence of any duty on the NHS Commissioning Board, CCGs, Monitor and the CQC to have regard to the risk to existing essential services, such as A&E, ITU, training and research, when authorising or encouraging new market entrants, then the proposal of neutrality between the NHS and private providers leaves NHS service vulnerable to being undermined or destabilised. The RCGP does not oppose clinically-led planned hospital service closures in relevant circumstances but we fear for the welfare of the sickest or most vulnerable patients if existing essential services are undermined or destabilised.

20. Furthermore the proposal in amendment (148) to in respect of Monitor’s duties there is a duty on Monitor to exercise its functions with a view to enabling services to be provided in an integrated way, where this would improve their quality or the efficiency of their provision, or where it would reduce inequalities for patients. This is encouraging, although the continuing emphasis elsewhere on competition and choice runs a real risk of undermining integration., there will need to be an ongoing review of its role by the Bill committee. The fear is that it will no longer be possible to deliver integrated services in practice, especially where integration relies on close collaboration between different NHS providers and commissioners, and could be seen as anti-competitive.

21. Without this, Monitor would remain focused on preventing anti-competitive behaviour where this harms patients but not be concerned with anti-collaborative behavior.

INTEGRATED CARE

22. The RCGP welcomes the amendments that make it explicit in the Bill and in regulations under the Bill that clinical commissioning groups will be responsible for arranging emergency and urgent care services within their boundaries, and for commissioning services for any unregistered patients who live in their area.

23. Amendment 149 places a new duty on Monitor to exercise its functions with a view to enabling services to be provided in an integrated way, where this would improve their quality or the efficiency of their provision, or where it would reduce inequalities for patients. This is encouraging, although the continuing emphasis elsewhere on competition and choice runs a real risk of undermining integration., there will need to be an ongoing review of its role by the Bill committee. The fear is that it will no longer be possible to deliver integrated services in practice, especially where integration relies on close collaboration between different NHS providers and commissioners, and could be seen as anti-competitive.

24. Our definition of integrated care is primary care led, multiprofessional teams, where each profession retains their professional autonomy but works across professional boundaries, ideally with pooled budgets and ideally with a shared electronic (GP) record. The teams help create seamless care, with the social and specialist practitioners able to link back to their host organisations.

25. Whilst commissioning has to be extremely well done—it is not the sole answer and the provision must be designed around modern concepts of service delivery, by doctor from both primary and secondary cares, other clinicians, managers and patients to meet the needs of the patient and their journey through the system.
26. There are perverse incentives that still need to be addressed. Hospitals are incentivised through the tariff whereas GPs are performance managed to reduce patients going into hospital. In the present day, these two systems are still working in opposite direction. There is a need to look at tackling this issue through provider reforms, such as pooled budgets for primary, secondary and social care and the development of the GP record.

HEALTH INEQUALITIES

27. Amendments 68 to 70 and 109 to 111 emphasise the importance of the NHS Commissioning Board and clinical commissioning groups’ duties in relation to reducing inequalities and promoting patient choice and patient involvement by separating them out. However, in order for the reforms to have a real effect in this area there should be an emphasis on the National Commissioning Board commissioning extra GPs in under-doctored areas.

28. For example the North West SHA region has a shortfall of 13% or 630 full time equivalents (FTE) GPs, while South Central SHA has an excess of 27% or 570 GPs. Statistics also illustrate a strong north/south divide in GP provision—the five southernmost SHAs have 23% more GPs per weighted population than the five northernmost SHAs.

29. The situation for PCTs is just as bad. Very substantial inequity exists with a greater range than at regional level. The range is from 30% under-provided to 70% overprovided compared with the England average.

30. However, there is still a lack of sufficient financial incentives for GPs to work in deprived areas and this must be addressed.

31. These amendments (68–70 and 109–111) introducing the new clause 13FB and 14NB change the duty on commissioners and the NHS Commissioning Board regarding choice from “having regard to the need to” promote patient choice and public involvement to “act with a view to” enabling patients to make choices”. In the explanatory notes (paragraph 59, pp 14–5) it states that “act with a view to” is a stronger duty than “have regard to the need to”. However, the duties on both CCGs and the NHS CB to tackle health inequalities and unfair access remains at the “have regard to the need to” level of duty. The RCGP believes it is wrong that tackling health inequalities and unfair access is now a lower priority for CCGs and NHS CB than promoting choice.

BETTER USE OF NICE GUIDELINES AND PROMS

32. We welcome that amendments clarify that the NHS will be required to fund drugs already recommended by NICE, and that NICE will continue to provide definitive guidance to the NHS for the use of new drugs and health technologies.

33. The RCGP believes it is essential that a fair, national and transparent framework is established for making the difficult decisions about the best use of (limited) resources—and believes if anything the current role of NICE should be strengthened.

34. As well as this, there will need to be better use of NICE guidelines. These guidelines are currently disease specific but as patients in many cases have several related problems, there are resultant four or five different guidelines for one patient—and some of these guidelines are mutually exclusive. As a result, GPs are led to concentrate on measurement rather than clinical judgement.

35. With specific reference to the use of Patient Reported Outcome Measures (PROMs), we have expressed previously our reservations about their accuracy and efficacy, and would press for much greater trialling before widespread and expensive implementation. It is vital to avoid crude ratings-based systems and the kind of skewed information gathering (wherein only aggrieved patients are motivated or encouraged to contribute).

36. We also note the necessity that feedback be collected anonymously and analysed independently, to avoid unnecessary and distressing patient-clinician conflict. GPs themselves would welcome improved options to offer feedback to other clinicians and services—for example the ability for rapid access e-mail feedback to care pathway leads.

FEDERATED GP PRACTICES TO HELP SHARE EXPERTISE, SHARE RESOURCES, REDUCE VARIATION

37. The RCGP will continue to promote the development of high quality, effective patient centred care, with GPs at the heart of NHS service delivery. The RCGP believes that provider side reforms could deal with many of the issues without the need for repeated organisational change or by many of the proposed reforms.

38. We would strongly recommend the development of the RCGP Primary Care Federations model. Federations, or provider organisations, are made up of GP practices as well as other providers from social,
mental health; community and secondary care (as appropriate), and include private and third sector providers. Federations can form the basis for locally determined education and training activities, peer support, service development and service improvement etc. Federations allow for a local focus as well as ensuring joint working and planning meeting the needs of the population. Under this system most health problems would be dealt with in primary care close to patients’ homes, with hospitals reserved for acute illness, specialised investigations and major surgery.

39. As well as commending the Federated model of care, we believe the way forward should be to:

— Ensure joint responsibility for patients within a geographical area, removing the perverse incentives for hospitals to maximise income by increasing activity and GPs to reduce expenditure by restricting access to specialist services. It seems that, at the second decade in the 21st Century, that we should be considering patients in an area as “our patients” “our services” and “our care” rather than continuing this artificial divide between hospitals, community, primary and social care.

— Improve the role and scope of generalist practitioners by building teams of generalist nurses, doctors and other health and social care professionals who have a range of broad-based skills;

— Increase the number of general practitioners with the understanding that better investment in general practice improves patient outcomes, improves public health and is better value for money; (Since 2009 the number of full time equivalent (FTE) practitioners has fallen by 2.4%. The Treasury Minute on the Public Accounts Committee Report (16 February 2011) has already identified that there are considerable GP shortages in areas of highest need. We agree with the conclusions of this report that, “The Department should identify, as a matter of urgency, what measures can be implemented to drive up the numbers of GPs in deprived areas … to encourage GPs into areas of greatest health need”. Workforce issues should be dealt with alongside the new commissioning responsibilities such that GPs, in under-doctored areas, will be able to continue to offer frontline, personal and accessible care. The workforce also continues to age with only 14,938 (42.5%) of practitioners in 2010 under the age of 45 compared with 14,028 (49.1%) in 2000 while those over 55 number 7,812 (22.2%) of the total compared with 7,834 (21.8%) in 2009 and 4,990 (17.5%) in 2000.)

— Ensure that general practitioners have sufficient training to meet their increasingly complex work by extending the current three-year training;

— Ensure that patients are able to register with a good GP of their choice, close to their home, who is able to provide accessible, personal and co-ordinated care;

— Have a greater focus on shared working across primary, secondary and social care;

— Improve care systems for patients that promote total care, rather than disease-led care pathways;

— Maintain the focus on improving patient outcomes—especially for those disadvantaged by personal and socioeconomic circumstances;

— Support initiatives which allow for a better patient and public voice within the NHS and which enable people to play a greater part in their society;

— Support initiatives, such as Teams-without-walls that allow generalists and specialists to work together to provide treatment closer to patients’ homes;

— Invest in better end-of-life care, such that patients receive tailored care at the end of their life that reduces the reliance on unnecessary and unwanted hospital care;

— Ensure continued investment in research and development;

— Continue to invest in high quality general practice premises.

40. This model of care puts the needs of patients at the heart of the NHS and is one we would commend to the Committee.

July 2011
Memorandum submitted by the Council of Deans of Health (HSR 34)

Further to the publication of the Government’s response to the NHS Future Forum report, I am writing to the committee in relation to amendments to the Health and Social Care Bill that are being considered at present.

The Council of Deans of Health is a membership organisation representing the voice of the deans and heads of UK University faculties for nursing, midwifery and the allied health professions. Our mission is to promote and enhance the quality of nursing, midwifery and allied health professional education and research in collaboration with other key partners, through our representative role as the principal source in higher education of informed opinion and advice.

The Government Response to the NHS Future Forum on 20 June stated that “we will introduce an explicit duty for the Secretary of State to maintain a system for professional education and training as part of the comprehensive health service”. The Council of Deans of Health strongly welcomes this commitment which highlights the responsibility of the Secretary of State to ensure that the system of education and training remains in place.

Subsequent to this publication, a set of Government amendments were tabled on 23 June in order to incorporate the new commitments made by the Government in its response to the recommendations of the Future Forum. However within these amendments, there is no amendment relating to the new duty regarding education and training.

We would emphasise the importance of the new duty being part of the final legislation. It is unclear if this will be bought forward at a later stage of the Bill’s progress through both Houses, but we wanted to draw this to the attention of the Public Bill Committee as they consider other amendments.

In relation to other amendments within the Bill we also welcome the amendments relating to both the S of S and the NHS Commissioning Board having a duty to promote research and hope that the Bill committee will support these.

July 2011

Memorandum submitted by the Local Government Group (HSR 35)

LGA KEY MESSAGES

The Local Government Group has lobbied hard for a much greater role for Health and Wellbeing Boards and for a higher focus on a place-based approach and on integration of health and care services to improve health and wellbeing outcomes. As such we were pleased to see progress in relation to the powers for Health and Wellbeing Boards, a greater focus on place-based and whole population approaches, and stronger requirements to integration. But there is still more we can do to ensure the Bill is fit for purpose.

We believe that many of the revisions (suggested by the Future Forum and agreed in principle to by the Government) to the Bill have the potential to strengthen the role of local authorities and put far greater emphasis on local health and wellbeing needs but we are worried about that the amendments do not always reflect the rhetoric accurately.

W E WELCOME THE FOLLOWING THREE CHANGES

— The renewed focus on a place-based approach to health and wellbeing commissioning, as suggested by the Future Forum and supported by the Government in its initial response, through the alignment of boundaries between first-tier councils and clinical commissioning groups; and the requirement that clinical commissioning groups will have to plan for the whole population of an area, rather than just their patient list. The Government response to the Future Forum recommendations states: “We accept the recommendation in the Forum’s report that the boundaries of clinical commissioning groups should not normally cross those of local authorities. Any departure from this will need to be clearly justified”. We do not see this commitment expressed clearly in the Bill amendments however and we continue to urge that this is displayed on the face of the Bill.

— The strengthened emphasis on patient and public involvement which is now embedded in the governance structure of all local bodies, including foundation trusts, clinical commissioning groups and health and wellbeing boards;

— The commitment to greater transparency and standards of good governance for all NHS commissioners and providers. This includes the requirement that commissioning groups and foundation trusts have public meetings. We will seek to ensure that all health commissioners and
providers are subject to the same standards of good governance to which all local authorities comply.

We recognise however that not all of the changes that the Government highlighted in its response to the Future Forum have made their way into the Bill at this stage.

**WE WANT TO SEE IMPROVEMENT IN THREE AREAS:**

We have identified three areas where there has been a positive response from the Government following the Future Forum recommendations but we feel need to change further. These are:

— **Health and Wellbeing Boards**—We welcome the Government’s recognition that the powers of HWBs need to be strengthened in order to ensure coordination and joining up of commissioning plans with the health and wellbeing needs of the area but we feel that proposals need to go further. The Future Forum recommended that HWBs “agree” clinical commissioning group plans. The Government amendments require consortia to involve HWBs “at all stages” and to be able to refer back to the commissioning consortia or upwards to the NHS Commissioning Board. However we feel this falls short of the power of sign-off and in the LG Group’s opinion, this is not sufficient to ensure that commissioning plans are firmly based on the health and wellbeing needs and priorities of the local community.

— **Clinical Commissioning Groups**—We have a number of concerns regarding the Clinical Commissioning Groups (CCGs), formally known as GP commissioning consortia. First, the name sends the wrong message with a focus on clinical issues rather than health and wellbeing. We suggest they are renamed Local Health Commissioning Groups to underline the fact that services will need to go further and wider than NHS treatment and include social care, public health and prevention. Second, we support the Government’s view that GP-led commissioning is the way to re-engage commissioning plans to addressing local health needs and improving health outcomes. Adding clinical experts from providers weakens the focus on commissioning for health improvement and is more likely to concentrate on NHS provider interests. Also, we understand that the clinical representatives will be drawn from outside the local area in order to avoid conflicts of interest. But this means the representatives will lack the local expertise and knowledge, which is one of the main aims of this reform. On a broader point, we feel that GP-led commissioning will need to take advice from a wide range of health, social care and other professionals but their role should be to give advice, not to make commissioning decisions. As such it is inappropriate for them to be members of CCGs.

— **Integration**—We welcome the renewed focus on integration but we feel that most of the changes simply reinforce the benefits of integration to the NHS rather than taking a whole-systems and person-centred approach, which looks at integration from the perspective of service users. The Ministerial announcement regarding revisions to the Health and Social Care Bill acknowledged the Future Forum’s recommendations regarding the need for greater integration but we feel that this is not reflected in the revisions to the Bill. The revisions also do nothing to address our concerns regarding safeguarding issues, and ensuring the particularly vulnerable groups do not fall through the cracks between services—such as homeless people and people in need of emergency mental health services.

LG GROUP DETAILED VIEWS ON REVISIONS TO THE BILL

**Coterminosity**

1. The Government has indicated that it will follow through on the Future Forum recommendation that the boundaries of clinical commissioning groups do not cross over those of the local authority unless there is a clear and justifiable reason for it to do so. The response suggests that a reason for not following local authority boundaries could be the need for CCGs to reflect local patient flows. To support this, when establishing clinical commissioning groups, the National Commissioning Board will be required to seek the views of the local HWB and where the boundaries do not align with local authority boundaries; there will need to be a clear demonstration of how integration of health and social care services will be achieved. Coterminosity of boundaries is something that the LG Group has been lobbying to ensure effective integration.

2. This commitment to coterminosity is not clearly reflected in revised amendments to the Bill. We have received assurance from the Secretary of State in a letter to the Chairman of the Local Government Group that this is the intended direction but we still ask that this is stipulated in the legislation itself. Furthermore, we do not consider the need to reflect patient flows to secondary care as a justifiable reason for not following local authority boundaries. Quite the contrary, setting up CCGs on the basis of patient flows to hospital will simply reinforce commissioning to treat sickness in hospital rather than redesigning person-centred and place-based commissioning closer to home to promote health and wellbeing and prevent people needing hospital treatment.
3. Not aligning boundaries will make it very onerous for clinical commissioning consortia who may have to involve anywhere up to three HWBs and three separate local Health Watch groups, and a whole range of other community based patient and service user groups in the formulating their commissioning plans. This is easily solved by aligning boundaries with that of the local authority and makes sense as services that have an impact on health and wellbeing are often provided at a local authority level.

**Clinical commissioning groups and health and wellbeing boards**

4. The requirement for clinical commissioning groups to have a governing body that will meet in public and include at least two “lay members” will go some way to ensuring that their decision-making processes are transparent and locally accountable. However, they will also need to build wider relationship with the rich tapestry of patient and public involvement bodies that already exist in most localities, including Health Watch, to ensure that there is full accountability.

5. The requirement to involve HWBs throughout the process of developing their commissioning plans is of course welcome and provides a stronger direction than the previous version of the Bill. While HWBs are not being given a “veto” over commissioning plans (the LG Group has never proposed a veto), they will have the ability to refer plans back to the group or onward to the NHS Commissioning Board for further consideration. LG Group considers that the powers of referral upwards to the NHS Commissioning Board or back to commissioning groups will, in practice, ensure the commissioning plans reflect the priorities outlined in the Joint Health and Wellbeing Strategy. We envisage that the referral upwards to the NHS Commissioning Board would only be used in the last resort if after local consideration of plans is not effective in attaining consistency between commissioning plans and the priorities identified in the Joint Health and Wellbeing Strategy. This is far stronger than the previous requirement for GP commissioning consortia to “have regard to” to the JSNA and the JHWS.

6. However, we continue to support the Future Forums recommendation that HWBs should “agree” commissioning plans to ensure that they are consistent with the needs identified in JSNAs and the priorities of the JHWS. This would ensure that local priorities are thoroughly embedded in commissioning plans and the HWBs and CCGs are joint partners in addressing the health and wellbeing needs of their population. Anything less is not in line with what we and the Future Forum consider to be appropriate local accountability and coordination of commissioning plans.

7. HWBs will be given a formal role in authorising CCGs and the NHS Commissioning Board will have to take HWBs views into account in their annual assessment of commissioning groups. This change goes some way to addressing the LG Group’s call for stronger duties on CCGs to work with HWBs.

8. HWBs will have a new duty to involve users and the public. We strongly support this revision and the revisions which require CCGs to involve patients, carers and the public in decisions about the provision and commissioning of health services.

9. We support the freedom for local authorities to determine the precise number of elected members on a HWB. We support maximum flexibility on the composition of HWBs, including having a majority of elected members if that is what the local authority chooses to do. In our view this is an appropriate expression of localism.

**Clinical Senates**

10. We welcome the proposal to establish Clinical Senates to provide clinical and other commissioners with a broad range of professional expert advice and for them to include representation from adult social care and other local authority services that contribute to improved health and wellbeing outcomes. It will be important for the Clinical Senates to provide advice on the design of care pathways that promote health and wellbeing and prevent or minimise the need for hospital admissions.

**Focus on whole populations**

11. CCGs will now be responsible for their whole population, rather than just their registered patients. This will address some concerns of the LG Group of the potential for vulnerable populations, ie homeless people, falling through the cracks of responsibility. This is a welcome clarification to the Bill.

12. While the Government has stated that it is not appropriate for individual vulnerable groups to be named on the face of the Bill, we believe that the accompanying regulation must specify the responsibilities that clinical commissioning groups have towards particular vulnerable groups and HWBs should refer back commissioning plans which do not adequately address the particular needs of vulnerable groups such as those with emergency mental health needs, homeless people, people with dementia, HIV and AIDS etc.

13. We are concerned that children and adults safeguarding is not given adequate consideration in the Bill. There is still a lack of clarity on how each component part of the NHS architecture—in particular the NHS Commissioning Board and CCGs—will be held accountable for safeguarding issues.
Integration of health and social care

14. We support the revisions that give integration a more prominent focus with a duty on CCGs to promote it and a requirement placed on Monitor to support it. HWBs will be given a stronger role in promoting joint commissioning and the integration of health and care. CCGs will have the freedom to form partnerships with local authorities and other groups to commission services. This change is a direct response to LG Group concerns about the Bill’s lack of reference to social care integration. However, the wording of the revised clauses appears to suggest that the primary aim of integration is to improve health services and health outcomes, and to address health inequalities. While we support this intention, we feel that it is too narrowly focused on integration for the benefit of health services, rather than for improving all services, including social care and other council services. We strongly believe that the primary objective of integration should be the improved experience of service users, and improved health and wellbeing outcomes.

15. Councils have a strong track record in commissioning the complex mix of services necessary to support vulnerable people and improve their health and wellbeing outcomes. CCGs need to work with councils to ensure these groups are adequately supported and safeguarded. Local government can play a significant role in delivering better health and wellbeing outcomes, not only in public health, but in supporting commissioning a broad mix of services—including housing, leisure and recreation, participation in the wider community as well as social care—and deliver greater integration: a person-centred “total health and wellbeing” model.

16. Local government has a range of expertise to support better commissioning:

   — significant experience in commissioning services, developing markets, and procurement, including in health, particularly adult social care;
   — human resources, legal, IT, financial, property management and other back office functions;
   — insights about the local community, community engagement and empowerment;
   — communication and complaints handling infrastructure; and
   — advice and support on statutory requirements, for example on Freedom of Information requests, compliance with the single equality duty etc.

17. Local authorities can also use a combination of partnership working and the legal powers at its disposal, including potentially the general power of competency, to effect change and promote new models of services, such as mutuals and user-led organisations which provide greater choice and control.

18. We are still seeking clarification about the end destination of unaccounted for essential PCT functions such as free nursing care and safeguarding duties for adults and children.

Health overview and scrutiny arrangements

19. Oversight and scrutiny will continue to apply as it currently does, subject to changes in the Localism Bill. There is no evidence that the architecture for health scrutiny needs to be changed. The involvement of full council in determining substantial variations and consequent referral to the Secretary of State risks introducing additional bureaucracy to the process of consultation and referral.

20. We welcome the intention that HWBs will be subject to oversight and scrutiny by the existing statutory structures for the overview and scrutiny of local authority or health functions and that the existing statutory powers of local authority overview and scrutiny functions will continue to apply.

21. We strongly welcome extension of health scrutiny powers to facilitate effective scrutiny of any provider of any NHS-funded service, as well as any NHS commissioner.

Public Health England

22. Public Health England (PHE) will be established as an executive agency of the Department of Health rather than a department within it. This, we hope, will help clarify its relationship with councils and HWBs. However we remain concerned at the lack of reference in the amendments to PHE and its role as an executive agency. We await the publication of the Public Health Command Paper on 13 July for precise clarity on the relationship between PHE, the NHS Commissioning Board and HWBs.

23. We remain concerned at the level of central direction that the Secretary of State will retain. This goes against the localist spirit of the original proposals. In particular, Clause 14 of the Bill would give the Secretary of State power to make regulation requiring local authorities to exercise certain public health functions, with the ability to specify particular public health services, facilities or
steps that one, several or all local authorities must provide. Clause 27 requires local authorities to have regard to Secretary of State publications—we believe in sector led development, not central prescription.

— In its original White Paper and subsequent Legislative Framework and Next Steps document, the Government indicated that the Bill would establish the basic legal architecture of a new public health service—Public Health England. PHE is still not mentioned in the revised clauses and we seek urgent clarification on how PHE will be put on the face of the Bill.

— We continue to seek urgent clarification on the public health budget: specifically, the overall funds available, what proportion will be allocated to local authorities and what will be retained centrally and what restrictions will be placed on local authorities in respect of using the budget. We are increasingly concerned about the reports of more and more money from the budget being used to pay for central commitments such as health visitors, public dentistry etc. If councils are to adequately deliver on the new public health responsibilities, they need to be given the resources to match their ambition especially at a time of major cuts to their budgets.

July 2011

Memorandum submitted by Mrs Hannah Basson (HSR 36)

The emphasis from “competition” to “choice” means there is to be no change in the future vision of the NHS. Patients have choice now and still want what is local. No mention of EU Competition Law has been made by the Future Forum so, presumably, patients may still end up having to travel a long way for care when their local DGH has been closed due to being undercut. Remember that if a hospital runs a unique service, it still needs its other services to remain viable in order to survive as a whole. (Please note EU competition law has been cited as the reason Bombardier just lost the rail contract to Siemens.) The Government only shows one study to promote the “competition/choice” argument. Death by Market Power studied patient activity and outcomes where fixed-pricing was used. This gives a very different picture to a free market where cost can override quality.

The bill recommendations state that “cherry-picking” will not be possible, but it already happens. There is no way it can be stopped where profit is pursued.

Southern Cross should serve as a stark warning of what happens when profitteering enters health provision. Circle, also, does not own its own properties. They are leased from Health Properties, who have the same chief executive as Circle. An example of competition and profit in health care is being played out in Bath and North East Somerset at present. Circle want more work (to cover the cost of their michelin-starred chef and 5* board no doubt) so are creating legal issues with the BANES healthcare buyers. The problem coming to light here is that free-market enterprise has to run at surplus, but this not how free healthcare can operate and it will cost more for the tax-payer. Not that this would concern Circle as they run much of their profit through tax-havens.

Another issue to the tax-payer and to the ideal of free healthcare at the point of access is the bed cap on private patients in hospitals. This must be reinstated before NHS-proper hospitals see a further divide between rich patients and those who are totally reliant on the NHS.

July 2011

Memorandum submitted by the Association of North East Councils (HSR 37)

1. The Association of North East Councils is the political voice for local government in the North East. It represents all 12 local authorities in the North East, throughout Northumberland, Tyne and Wear, Durham and the Tees Valley on issues of concern to them and the communities they serve. It is a cross-party organisation, with all of its members democratically elected and accountable politicians.

2. All of our member authorities are keen to take advantage of the opportunities offered by the Health and Social Care Bill to improve health outcomes for the people of the North East, working with our health partners. All 12 local authorities are part of the early implementers network for the establishment of Health and Wellbeing Boards. Collectively, the Association has established a Task and Finish Group of elected members from the 12 authorities to carry out a rapid review of the opportunities and challenges presented by the Bill, and the key issues needing to be addressed; the Group is due to present its recommendations in early autumn.
3. The Association had a number of concerns about the Bill as originally published and raised these concerns as part of the Listening Exercise. We are pleased to note that the Government’s proposed amendments to the Bill include a number of changes for which the Association has lobbied, including the broadening of the membership of clinical commissioning groups and the duty placed on them to promote integrated services; the stronger role envisaged for Health and Wellbeing Boards with the clear expectation that commissioning plans will be in line with the Health and Wellbeing Strategy; safeguards against price competition and “cherry picking”; and the requirement on Monitor to protect and promote patients’ interests.

4. In this context we have some concern about the remarks of Professor Steve Field (Guardian, 28 June) that the changes could still leave hospitals vulnerable to European Union law, when it had appeared that this issue had been settled. No doubt the Public Bill Committee will wish to obtain expert advice on this issue as well as seeking clarification from the Government.

July 2011

Memorandum submitted by the Faculty of Sexual and Reproductive Healthcare and the British Association for Sexual Health and Hiv (HSR 38)

1. THE NEED FOR A NATIONAL TARIFF IN GENITO-URINARY MEDICINE (GUM) AND SEXUAL AND REPRODUCTIVE HEALTH (SRH) SERVICES

1.1 This briefing note has been written for members of the Health and Social Care Bill Committee, in advance of the debate on the clauses in relation to Clause 114 on “Pricing” of the Health and Social Care Bill, scheduled to be debated on Tuesday 12 July.

1.2 The briefing makes the case for a national tariff in GUM and SRH to protect high quality services, encourage prevention work alongside clinical care, improve outcomes, realise cost savings and integrate care.

2. THE ROLE OF TARIFF IN PUBLIC HEALTH

2.1 On 22 March, Health Minister Simon Burns tabled the following amendment:

“I beg to move amendment 400, in clause 104, page 95, line 21, leave out from first “the” to end of line 23 and insert: “public health functions of the Secretary of State, or of a local authority, under the National Health Service Act 2006.”.

“The amendment makes it clear that the national tariff cannot cover public health services, which are the responsibility of the Secretary of State and local authorities, rather than of Monitor and the NHS commissioning board. Committee members will note that nothing in the Bill will stop the Department of Health from seeking advice from Monitor on public health pricing, but services commissioned by the Department and local authorities will not be subject to the national tariff.”

2.2 Any Qualified Provider (AQP) will be introduced to community services from April 2012 and, in order to prevent price competition, will be restricted to services with national or locally set “tariff” prices. Currently very little community work is covered by a tariff and given the diversity of community services and the scale of challenge in developing comprehensive national tariffs the Department of Health has stated “we will be heavily reliant on local price setting (tariff) for the initial implementation of choice of any qualified provider”.

2.3 It is a complex process to develop a tariff and clearly the Department of Health would not be able to develop a national tariff for all aspects of community services in time for the April 2012 introduction of AQP in community services.

2.4 However there has been a national tariff in GUM for some time and extensive work has recently gone into developing an integrated tariff for GUM and SRH by the London Sexual Health Programme on behalf of the London Primary Care Trusts.

2.5 Given the development of tariffs in GU and SRH, we are asking that the committee re-consider Clause 114 and make provision for national tariff to cover public health services where appropriate or where a tariff has been developed, as is the case in GU and SRH.

68 It should be noted that HIV care will be commissioned by the National Commissioning Board, for which a national tariff is being developed. This briefing is therefore solely focussed on recommending how GUM and SRH services can be fairly remunerated for all other STI and Reproductive Healthcare services.
3. Ensuring high “quality” community services the same level of protection as other NHS services.

3.1 As stated above, there can be limitations to developing national tariffs in community services, but where a community tariff can, or has, been developed such as in SRH and GUM then it should be applied nationally to:

— Ensure competition is on quality, not on an arbitrary “local price”;
— Reduce the risk of variations in price;
— Guard against providers being able to “cherry-pick”; and
— Protect high quality community services in the same manner as other NHS services.

4. 10 reasons for a national tariff for GUM and SRH

4.1 The Sexual Health tariff will be a set of payments that reflect the cost of the providing the care. Payments are based on clinical pathways (about 150 of them) that cover the broad range of work carried out in SRH and GUM clinics.

4.2 The tariff will help equal out payments so that they actually reflect the level of service provided and type of treatment given. This will mean that sexual health services reflect aspirations set out in the White Paper where, “money will follow the patient through transparent, comprehensive and stable payment systems across the NHS to promote high quality care, drive efficiency, support patient choice.”

4.3 The tariff will support the drive to integrate SRH and GUM services which offers efficiencies and is a central aim of the Health and Social Care Reform Bill.

4.4 A large proportion of sexual health service delivery focuses on the prevention of sexual ill health (STI screening, Chlamydia screening programme) and the prevention of unplanned pregnancy. Ensuring these pathways are priced accurately, via a tariff, allows for a whole range of effective health promotion and prevention activities to be delivered alongside clinical care.

4.5 A tariff is key to ensuring that future GUM and SRH services are appropriately remunerated for the important public health work that they do and they are intended to drive good practice and increase access to sexual health services.

4.6 The tariff would allow for a direct link to be made between outcomes and payment. They are based on best-practice pathways and should deliver the highest standard of care.

4.7 A tariff allows for the development of prices that are setting-independent and could be used by a variety of providers.

4.8 A localised tariff price would not be applicable in sexual health, because patients do not necessarily respect health authority borders.

4.9 A localised tariff price would not be appropriate in sexual health because providers should be paid the same regardless of where the patient comes from.

4.10 Extensive time and resource was invested in developing an integrated tariff for GUM and SRH by the London Sexual Health Programme on behalf of the London Primary Care Trusts. It is unlikely that new Directors of Public Health will be able to replicate that work, and it would be an unnecessary use of resources for each of them to spend time “reinventing the wheel”.

4.11 National tariffs, by guaranteeing an adequate funding stream, will also help to protect the sexual health proportion of the ringfenced budget being used for other services provided by local authorities.

5. About sexual health services

5.1 Sexual health services incorporate a wide range of care activities predominantly covering the management of sexually transmitted infections and the provision of contraception. These activities range from the very basic (provision of condoms) to the very complex (management of tertiary syphilis or medical gynaecology in the community). A range of different service delivery models are in existence which generally fall into three groupings:

5.2 Genito Urinary Medicine (GUM)—services that manage sexually transmitted infection and HIV. Currently funded by a national tariff.
5.3 Sexual and reproductive health (SRH)—services providing contraception and reproductive healthcare. Largely funded under block contracts

5.4 Integrated Sexual Health (ISH)—services providing both GUM and SRH and often with mixed funding arrangements

— At present GUM services are paid a flat rate for each visit to their clinics, however this is still a nationally agreed tariff.

— SRH services are paid by block contracts—that is they are paid a lump sum for the totality of their work. This means that SRH services aren’t always paid for the work that they actually do, it also makes service development to meet public health need difficult.

— A tariff for HIV is currently under development, and HIV will be commissioned nationally by the National Commissioning Board and therefore does not sit within the purview of public health.

6. The Faculty of Sexual and Reproductive Healthcare

6.1 The Faculty of Sexual and Reproductive Healthcare (The Faculty) is a faculty of the Royal College of Obstetricians and Gynaecologists and is the leading body representing the interests of doctors involved in sexual and reproductive healthcare. The Faculty has a membership of over 15,000, the majority of whom are GPs, the remainder being doctors working in the community in Sexual and Reproductive Healthcare. In early 2010 the Government established the new medical specialty of “Community Sexual and Reproductive Health”, to formalise the training of community based specialists in women’s health with a leadership role and relevant of public health training. The Faculty sets National clinical and service standards and awards competency based qualifications to specialists and GPs in the field of Sexual and Reproductive healthcare (SRH) which includes contraception, basic management of sexually transmitted infections, community gynaecological care.

The British Association for Sexual Health and HIV

6.2 The British Association for Sexual Health and HIV—BASHH—was formed in 2003 through the merger of the Medical Society for the Study of Venereal Diseases (MSSVD; established 1922) and the Association for Genitourinary Medicine (AGUM; established 1992). The Association’s membership of 700 includes medical practitioners, scientists in the field of medicine and other healthcare workers who have shown a commitment to the GU specialty. The objectives of BASHH are:

— To promote, encourage and improved the study and practice of the art and science of diagnosing and treating sexually transmitted diseases including all sexually transmitted infections, HIV and other sexual health problems.

— To advance public health so far as it is affected by sexually transmitted diseases and to promote and encourage the study of the public aspects of sexually transmitted diseases including all sexually transmitted infections, HIV and other sexual health problems.

— To advance the education of the public in all matters concerning the medical specialty of Genitourinary Medicine, to include the management of HIV infections and the broader aspects of sexual health.

— To promote a high standard in the medical specialty of Genitourinary Medicine to include the management of HIV infections and the broader aspects of sexual health.

July 2011