RESEARCH PAPER 03/41
6 MAY 2003

The *Health and Social Care (Community Health and Standards) Bill:* Health aspects other than NHS Foundation Trusts

Bill 70 of 2002-3

Library Research Papers 03/38 and 03/39 cover the provisions in the Bill on NHS Foundation Trusts and on social care respectively. This Paper covers the other healthcare provisions in the Bill.

These include the creation of a new body, the *Commission for Healthcare Audit and Inspection*, provision for a new complaints procedure, for NHS hospitals to be able to recover ambulance and treatment costs in personal injury compensation cases, new provisions to bring dental services within the aegis of Primary Care Trusts, and reform of the welfare food scheme.

Most of the Bill covers England and Wales only. The provisions on compensation recovery and welfare foods apply also to Scotland.

Jo Roll

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Summary of main points

The Bill would create a new body for regulating and inspecting healthcare, the Commission for Healthcare Audit and Inspection (CHAI), which would rationalise work currently undertaken by the Commission for Health Improvement (CHI), which will be abolished, the health-related value-for-money work of the Audit Commission, and the functions of the National Care Standards Commission relating to the independent healthcare sector. (The NCSC will also be abolished as its social care functions are transferring to another body.)

The Bill also makes provision for Regulations that would enable CHAI to carry out an independent review function for NHS complaints and makes provision for other reforms of the NHS complaints system.

The Bill would also:

- enable the NHS to recover treatment and ambulance costs from organisations making compensation payments to people suffering personal injury.

- bring the provision of NHS dentistry, including General Dental Services, under the aegis of Primary Care Trusts in england, and Local Health Boards in Wales.

- provides for reform of the welfare food scheme

- makes various other miscellaneous changes, such as removing the requirement to cary out annual Protection of Children Act List and Vulnerable Adults checks for those staff in permanent NHS positions; and remove the requiremnt for the consent of the Treasury to be given when the Secretary of State makes loans to NHS Trusts.

CONTENTS

I Introduction

Library Research Paper 03/38 covers the provisions on NHS Foundation Trusts, which are contained in Part I of the *Health and Social Care (Community Health and Standards) Bill.* This Paper covers the other health aspects of the Bill. These include: quality standards, complaints, compensation recovery, dental services, welfare foods, provisions relating to NHS appointments, the Protection of Children Act and Secretary of State's loans to NHS Trusts. The Government has also said that it may add measures relating to the contracts of General Practitioners during the passage of the Bill through Parliament.[1]

Public and Parliamentary attention has overwhelmingly focused on the provisions relating to NHS Foundation Trusts; there has been relatively little comment on the other parts of the Bill. This Paper therefore does not attempt to cover all the other issues in the same depth. It concentrates on the creation of a new regulatory body, to be known as the Commission for Healthcare, Audit and Inspection (CHAI), then provides a short note on the remaining provisions.

II Standards and Complaints

(Audit and Inspection of Healthcare - Part 2 of the Bill)

The Bill would create a new body for regulating and inspecting healthcare, the Commission for Healthcare Audit and Inspection (CHAI), which would rationalise work currently undertaken by three different bodies. Among other things, this would bring together under one body the regulation of both public and private healthcare while placing responsibility for social services with a separate body. [2]

Most of CHAI's functions would relate to England but it would also have some functions relating to both England and Wales. For Wales alone, there are separate provisions, which would devolve to the Welsh Assembly some functions that are currently carried out by the Commission for health Imrpovement (CHI), which covers both countries. In England CHAI would encompass work of three existing bodies:

- the Commission for Health Improvement (CHI), which will be abolished
- the health value for money work of the Audit Commission (but not its auditing functions)
- the independent healthcare sector work of the National Care Standards Commission (NCSC), which will be abolished

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1 Department of Health Press Notice, "Health and Social Care (Community Health and Standards) Bill" 13 March 2003

2 A third Library Paper number 03/39 covers the social services aspects of the Bill.

The Bill also makes provision for Regulations that would enable CHAI to carry out an independent review function for NHS complaints.

The Government has said that subject to the passage of further legislation, the work of the Mental Health Act Commission will also be included.[3]

A. Background

The three bodies concerned in the formation of CHAI each have a different history. The Audit Commission was set up in the early years of the Thatcher Government; the Commission for Health Inspection was introduced by the Labour Government as part of a range of measures to improve quality in the NHS, and the National Care Standards Commission, though also set up by the Labour Government was part of a package of measures mainly designed to improve the regulation of social services and, as far as health was concerned, covered private healthcare only.

1. The Audit Commission

The Audit Commission covers a range of public services. Its role in auditing the work of local government can be traced back to 1846 when the District Audit Service was founded. The Commission itself was set up in 1983 under Part III of the *Local Government Finance Act 1982*, to audit and to examine the management of local government. In 1990 its role was extended to cover NHS bodies. It now has various other functions, including joint reviews of local education authorities with Ofsted and joint reviews of social services authorities with the Department of Health's Social Services Inspectorate.

The Audit Commission is a non-departmental public body sponsored by the Office of the Deputy Prime Minister with the Department of Health and the National Assembly for Wales. Recent reports have covered the accuracy of waiting lists and deliberate misreporting, operating theatres and why primary care expenditure on prescriptions is rising. These are available on its website.[4] Its main functions in relation to healthcare are to

- appoint auditors to all local NHS bodies who report on an audited body's financial statements, the financial aspects of corporate governance and arrangements to manage performance, including those for ensuring economy efficiency and effectiveness;

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3 HC Deb 26 February 2003 c645W

4 http://www.audit-commission.gov.uk/

- develop national studies designed to improve the economy, efficiency and effectiveness of services.[5]

The latter would transfer to CHAI.

2. The Commission for Health Improvement (CHI)

The establishment of the Commission for Health Improvement was one of a range of measures designed to improve quality in the NHS announced by the Labour Government in its White Paper on the NHS in 1997.[6] It was set up under the *Health Act 1999* and started operating in April 2000. That Act introduced a number of other "quality" measures, including a requirement that NHS to be subject to a general duty of quality.[7] The *NHS and Healthcare Reform and Healthcare Professions Act 2002* (not all of which is yet in force) gave CHI more powers and more independence. The aim, as described in the Government's 10 year NHS Plan, was to get rid of the "postcode lottery" of care, which, in the Government's view, had arisen because of the lack of national standards for the NHS since its creation in 1948.[8] CHI's current roles are to:[9]

- carry out a rolling programme of reviews of arrangements for clinical governance in all NHS bodies (including monitoring NICE guidance), i.e. investigating how good the organisation's system for quality control are
- carry out specific investigations where there have been serious service failures (managerial or clinical)
- review the implementation of national standards set by the National Institute for Clinical Excellence (e.g. in relation to particular medicines), National Service Frameworks (e.g. for particular services and groups, such as old people, cancer, mental health) and other NHS priorities set by government
- provide advice and guidance on the implementation of clinical governance

The *NHS Reform and Healthcare Professions Act 2002* gives CHI the power to:

- inspect NHS organisations and services

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5 Department of Health Statement of purpose,January 2003,

6 *The New NHS: Modern, Dependable*, Cm 3807, December 1997: http://www.doh.gov.uk/statementofpurpose/sopchaicsci.pdf

7 The *Health Act 1999*, section 18

8 Department of Health, The NHS Plan, Cm 4818 paragraph 2.14: http://www.nhs.uk/nationalplan/

9 Details of its work and its reports are available on its website: http://www.chi.nhs.uk/ See also Statement of Purpose, Department of Health, *The Commission for Healthcare Audit and Inspection (CHAI) and the Commission for Social Care Inspection (CSCI)*, January 2003: http://www.doh.gov.uk/csci/sopchaicsci.pdf and various Written Answers, including HC Deb 27 March 2003 c407-8W and 28 April 2003 c 255W

- assess NHS bodies and publish annual comparative performance ratings in England, (This would in practice include the star system of awards and developing new indicators for measuring performance)
- commission national clinical audits and manage annual surveys of staff and patients in England
- recommend that government take special measures where CHI finds that NHS services are unacceptably poor or where there are serious failures in the way that they are run (including replacing the board).
- Publish an annual report to Parliament and the National Assembly for Wales on the state of services to NHS patients

3. National Care Standards Commission (NCSC)

The National Care Standards Commission was set up under the *Care Standards Act 2000* and started operating in April 2002.[10] A large number of the areas that it covers fall into the social services category, which, under the Bill's provisions would be transferred to a new Commission for Social Care Inspection. (This would also include nurses' agencies.). Currently, the NCSC also registers and inspects private and voluntary hospitals and clinics as well as exclusively private doctors. The independent (private sector and voluntary) healthcare functions would transfer to CHAI.

Under the *Care Standards Act 2000* many independent healthcare establishments had to register for the first time. Before that private healthcare facilities were only regulated in so far as they counted as "nursing homes" under the *Registered Homes Act 1984*. The definition of "nursing homes" under the 1984 Act included not only what are conventional regarded as nursing homes but also hospices, psychiatric hospitals and nursing homes, maternity homes and any premises where certain surgical procedures were carried out. GPs' surgeries used only for consultations and dentists' surgeries were unregulated (although individual GPs and dentists were, as now, accountable for their own professional conduct to their regulatory bodies, the General Medical Council and the General Dental Council).[11]

In carrying out its work the Commission has to take into account national standards set by government and the relevant Regulations. The standards relating to healthcare are on is website,[12] as are other details about the Commission's work and the plans for CHAI. The Commission can also take enforcement action where breaches of the Regulations occur or where service users are at risk; it advises the Secretary of State on the availability and

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10 http://www.caresta ndards.org.uk/
11 See Library Research Paper 00/52
12 http://www.doh.gov.uk/ncsc/independenthealthcare.pdf

quality of the services that it regulates; and deals with complaints about regulated services.[13]

B. Development of Government Policy

1. Regulation

In April 2002, the Government set out its proposals for a more coherent system of regulation and inspection. The following extract from ***Delivering the NHS Plan*** announced the Government's proposals and its rationale for them:

> 10.5 In order to ensure clearer public accountability we will strengthen the system of inspection for health and social services. The current system has evolved rapidly. But early experience is demonstrating that the arrangements are fragmented. This is burdensome on front line staff and also creates a lack of clarity for the public. The Bristol Royal Infirmary Inquiry recommended that the number of bodies inspecting and regulating health and social care should be rationalised. The Inquiry also recommended that regulation of the public and private health sectors should be brought together. The Government accepts these recommendations.
>
> 10.6 At present the Audit Commission, the National Care Standards Commission and the Commission for Health Improvement (CHI) all play an important and effective role in regulating and assessing healthcare performance. Whilst each has made an important contribution to improving standards, the same local NHS organisation can face multiple uncoordinated visits and demands for information from these and other bodies because of the current fragmentation in the structure of NHS inspection. Fragmentation not only makes for unnecessary bureaucracy, it weakens the system of inspection. It makes for confusion about how well the NHS is performing for those working in the NHS, for patients who use it and for taxpayers who fund it. We now propose radical change.
>
> 10.7 We are proposing to establish an independent, single new Commission for Healthcare Audit and Inspection (CHAI) which will bring together the health value for money work of the Audit Commission, the work of the Commission for Health Improvement and the private healthcare role of the National Care Standards Commission. The new single Commission will have responsibility for inspecting both the public and private health care sectors. Its principal roles will include:
>
> - inspecting all NHS hospitals;
> - licensing private health care provision;
> - conducting NHS value for money audits on a national basis;

[13] Statement of purpose, as above, paragraph 1.12

- validating published performance assessment statistics on the NHS, including waiting list information;
- publishing star ratings for all NHS organisations with the ability to recommend special measures where there are persistent problems;
- publishing reports on the performance of NHS organisations both individually and collectively;
- independent scrutiny of patient complaints;
- publishing an annual report to Parliament on national progress on health care and how resources have been used.

10.8 New legislation will be needed to establish the Commission. The new Commission will be more independent of Government than the Audit Commission, CHI or the NCSC. Commissioners will be appointed by the Independent Appointments Commission, rather than by Ministers, and in accordance with Nolan rules. The Commissioners, rather than Ministers, will appoint a Chief Inspector of Healthcare.

10.9 The Commission will have the key role in particular in explaining to the public how NHS resources have been deployed and the impact they have had in improving services, raising standards and improving the health of the nation. For the first time the NHS – and indeed private health care – will have a single rigorous inspectorate armed with the ability to expose poor practice and highlight goodpractice. The new Commission will help strengthen accountability and transparency between the health service and the public who pay for it.

10.10 Similar changes are needed in social services ….

10.13 There will be a legal requirement placed on the two new Commissions to co-operate with one another. We have considered the option of establishing a single Commission to cover both services but believe that the organisational upheaval and the extended scope would not be justified. We will, however, keep the situation under review.[14]

In January 2003, the Government announced further details of its proposals in a document called ***Statement of Purpose: The Commission for Healthcare Audit and Inspection (CHAI) and the Commission for Social Care Inspection (CSCI)***.[15] The document said that the Government was committed to establishing these bodies as independent bodies at arm's length from government: they would be non-departmental public bodies, whose chair would be appointed by means of an independent process and not directly by the Secretary of State who would delegate his powers of appointment; the Chief Executives would in turn be appointed by the Commissioners; and they would have a duty to report annually directly to Parliament. They would also be set up in shadow form as soon as possible. In relation to their functions, the document said:

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14 *Delivering the NHS Plan: next steps on investment, next steps on reform*, Cm 5503, April 2002

15 Statement of Purpose, as above

2.7. CHAI and CSCI will both encourage improvement in the quality and effectiveness and in the economy and efficiency of health and social care provision as well as the promotion and protection of public health.

2.8 In pursuit of these goals, CHAI and CSCI will have a number of key functions:

2.8.1. In accordance with national standards and service priorities, CHAI and CSCI will inspect the management, provision and quality of health and social care. For the first time, the inspection of both public and private health care will be carried out by a
single body. CHAI and CSCI will also track where, and how well, public resources are being used so that not only the quality but also the value for money of services will be examined by a single inspectorate.

2.8.2. CHAI and CSCI will carry out investigations into serious service failures, reporting to the public on what has happened, why, and how a repetition might be avoided. People are understandably concerned when major service failures take place. CHAI and CSCI will play a key role in identifying lessons to be learnt in these cases whenever and wherever they occur.

2.8.3. Whenever they have serious concerns about the quality of public services or the way in which they are being run, CHAI and CSCI will also be obliged to report this to the Secretary of State. They will also have the ability to recommend that special measures are taken to secure improvements in services.

2.8.4. Taking account of national priorities, CHAI and CSCI will publish annual performance ratings for all NHS organisations in England (Wales will determine its own assessment regime) and for all local councils with social services responsibilities and other information on the performance of local service providers to help inform local patients and service users. CHAI and CSCI will also produce annual reports to Parliament on the state of health and social care. These independent assessments will play a key role in strengthening public accountability. They will provide an annual benchmark of the quality of health and social care provision and of the effectiveness of investment in public services.

2.8.5. CHAI and CSCI will collaborate with each other to ensure joint approaches to integrated services. They will also help to coordinate the activity of other relevant review and inspection bodies. This will be particularly important in relation to health
care where it has been recognised for some time that there is a need for better co-ordination between the variety of bodies with distinct inspection roles.

2.8.6. CHAI and CSCI will carry out an independent review function for NHS and social services complaints in England, strengthening current arrangements. Placing this responsibility with CHAI and CSCI will provide the necessary independence and speedier resolution of complaints, as well as a direct link into quality improvement processes. In Wales, existing arrangements for reviewing

NHS and social care complaints will be strengthened, resulting in more independent systems, co-ordinated investigations of complaints containing NHS and social care aspects, and stronger links between NHS complaints and clinical governance arrangements.

2.8.7. CHAI and CSCI will register, inspect and regulate care providers in the independent sector and local authority providers against national minimum standards. Where they find that the quality of provision falls substantially below these standards, particularly where the safety or welfare of service users is at risk, they will
be able to take enforcement action and, if serious concerns persist, to remove providers' registration.

2.9. CHAI will also:

- inspect clinical governance arrangements that local NHS organisations have in place to ensure effective quality assurance and quality improvement. (This will be a HIUW function in Wales, except where this comprises a part of a thematic review across England and Wales bodies.)
- ensure appropriate arrangements are in place to promote public health
- carry out any national healthcare studies covering both England and Wales (local reviews and investigations of NHS bodies and service providers in Wales will be carried out by a new Healthcare Inspection Unit for Wales)
- inspect NHS Foundation Trusts3 (which will be established subject to Parliamentary approval) and report on its findings, to an Independent Regulator, who will be responsible for their regulation. CHAI may also recommend that the Independent Regulator takes special measures where it has serious concerns about the quality of services provided.
- replace the Mental Health Act Commission in providing enhanced scrutiny of the operation of compulsion under the new Mental Health Bill (which will be introduced as soon as Parliamentary time allows).[16]

2. Complaints

The current NHS complaints procedure was introduced in 1996. The same system applies to NHS Trusts and to Primary Care Trusts, which means both complaints about hospital treatment and complaints about GPs. It basically consists of three levels, that is a first local, relatively informal resolution stage, a second "independent" panel stage (to which there is no automatic progression) and then the Health Service Ombusdman.[17] The system has been widely criticised outside government by bodies such as the Association for

[16] *Statement of Purpose*, as above parapgraph 2.8.6

[17] The Department of Health's website: http://www.doh.gov.uk/complaints/index.htm describes the procedures and contains the leaflet distributed to patients.

Community Health Councils and the Consumers Association for for being neither fair nor independent and for being dauting, distressing and inadequate to meet their concerns. [18]

The Government has for several years been concerned to introduce reforms. The complaints procedure was evaluated during 1999/2000. The report of the evaluation, *NHS Complaints Procedure National Evaluation,* and another document, *Reforming the NHS Complaints Procedure – a listening document* were published on 3 September 2001.[19]

The Chancellor's Budget Statement in April 2002 said that there would be independent scrutiny of complaints about the NHS. The Government's document on the future of the NHS, *Delivering the NHS Plan*, published in April 2002, proposed the establishment of CHAI (see above) and said that among its responsibilities would be the independent scrutiny of complaints. The document setting out the details of CHAI and CSCI (the body responsible for social services) published in Janaury 2003 said:

> CHAI and CSCI will carry out an indpendent review function for NHS and social services complaints in England, strengthening current arrangements. Placing this responsibility with CHAI and CSCI will provide the necessary independence and speedier resolution of compalints, as well as a direct link into quality improvement processes. In Wales, existing arrangements for reviewing NHS and social care complaints will be strengthened, resulting in more independent system, co-ordinated investigations of complaints containing NHS and social care aspects, and stronger links between NHS complaints and clinical governance arrangements.[20]

On 28 March 2003, a couple of weeks after the Bill that is the subject of this Paper was published, the Department of Health published a document that set out the Government's plans for reforming the NHS complaints procedure, *NHS Complaints Reform: making things right.* [21] This reaffirmed that CHAI would take over responsibility from NHS Trusts and Primary Care Trusts for independent reviews of complaints. The Government press statement accompanying the document said that research had shown that complainants did not perceive the independent review stage of the procedure as being impartial.

In Parliament, David Lammy, the Health Minister with responsibility for this issued said:

> The programme builds on the existing NHS complaint procedure, as well as wider initiative, to introduce operational improvements focused on:

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[18] See, for example, chapter 5 of *New Life For Health, The Commission on the NHS* chaired by Will Hutton, 2000; "NHS Complaints Overhauled" *BBC News Online*, 28 March 2003

[19] The Department of Health's website also contains a sub page on the history of reform proposals: http://www.doh.gov.uk/complaints/reform.htm

[20] Statement of Purpose, as above

[21] http://www.doh.gov.uk/complaints/makingthingsright.pdf

- making the system more flexible so that there are a range of ways in which people can express concerns about the services they have received
- improving the local resolution stage so that formal complaints are more likely to be resolved, reducng the need for them to escalate unnecessarily
- radical reform to the independent review stage, subject to primary legislation- by placing responsibility for it with te new Commission for Healthcare Audit and Inspection
- making sure information about complaints and their causes are an integral part of the system that assures safe, high quality care, which is constantly improving.[22]

3. Shadow CHAI

The Government has said that, subject to the passage of the necessary legislation through Parliament (the current Bill), CHAI will be operational from April 2004. The new complaints system would therefore also have to wait until then before it could be fully introduced.[23]

Meanwhile the Government has started to set up CHAI in shadow form. Professor Sir Ian Kennedy, former chair of the Bristol enquiry, whose report recommended a tougher regulatory regime for healthcare (see above) was appointed shadow chair of the Commission–to-be, with effect from 2 December 2002. In February 2003 he announced the appointment of Peter Homa, currently Chief Executive of CHI, as the shadow Chief Inspector, to lead the work of establishing the new body. The announcement said that until Royal Assent he would remain as Chief Executive of CHAI and act as advisor to Sir Ian Kennedy on a part-time basis. However, in mid April Peter Homa left, according to some press reports, because he and Sir Ian could not agree about the way that the new body should be created although some reports concentrated more on "personality differences". [24]

C. The Bill in outline

The Bill was published on 13 March 2003. The press notice accompanying it paid most attention to the provisions on NHS Foundation Trusts but Alan Milburn, Secretary of State for Health, also commented on CHAI:

> The Commission for Healthcare Audit and Inspection will report to the public on the extra services, improved quality and better care they can expect from the

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22 HC Deb 28 April 2003 c279W

23 See, for example, "Shadow Chief Inspector of the new health inspectorate is appointed," *Department of Health Press Notice* 13 February 2003; HL Deb 31 March 2003 WA107

24 see, for example, "Policy clash behind shock exit of Homa, *Health Service Journal*, 17 April 2003; and "Shock resignation at NHS inspectorate," *BBC News Online* 11 April 2003.

> rising levels of investment now going in. For the first time private sector health care will also be subject to the same inspection regime as NHS hospitals.
>
> This Bill takes forward the NHS Plan commitment for an NHS where standards are national but control is local…[25]

Before setting out the specific functions that CHAI is to perform, the Bill makes three general provisions. Chapter I sets up CHAI and abolishes CHI. Chapter 2 replaces the existing duty of quality of NHS bodies contained in section 18 of the *Health Act 1999* with a new duty to monitor and seek to improve the quality of healthcare. It also provides for the Secretary of State and the Welsh Assembly to be able to issue standards in relation to NHS bodies. However, Clause 43 in chapter 3 also enables CHAI to advise the Secretary of State or the Welsh Assembly of any changes that it considers necessary to these standards. (Standards in relation to the independent sector are already issued by the Secretary of State under the *Care Standards Act 2000*.)

The Explanatory Notes to the Bill say that it is expected that CHAI will develop several teams with appropriate expertise, such as ex-employees of CHI, the NCSC and the Audit Commission. These teams might also include others, such as patients and carers who make use of NHS and independent services.[26] A separate chapter of the Bill, chapter 7, provides for the transfer of NCSC independent sector healthcare functions to CHAI while most of the existing functions of CHI and the Audit Commission are provided for afresh. (For example, clause 56 provides for CHAI to carry out studies of economy, efficiency etc of a type that used to be carried out by the Audit Commission.)

1. NHS Functions of CHAI

Chapter 3 Clauses 43-65

The Bill covers the functions of CHAI in relation to healthcare provided by NHS bodies themselves and by other bodies for the NHS. The functions are divided into the following categories: general functions, functions specific to Foundation Trusts, healthcare provided by and for NHS bodies other than Foundation Trusts, and other functions. Chapter 3 then covers the way that the functions are to be exercised. The Bill provides that:

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[25] "Health and Social Care (Community Health and Standards) Bill Published", Department of Health Press Notice 2003/011, 13 March 2003

[26] Bill 70 of 2002/3, Explanatory Notes, paragraph 136

a. General

- CHAI is required to keep the Secretary of State and the Welsh Assembly informed about the provision of healthcare by and for any NHS body. (Clause 43) It may also give advice, including advice about changes to standards.

- CHAI may review the quality of healthcare data obtained by others, the method used in the collection and analysis of the data and the validity of conclusions drawn. Where it does so, it must publish such report as it considers appropriate. (Clause 44)

b. NHS Foundation Trusts

The Explanatory Notes say that separate provisions are necessary in relation to NHS Foundation Trusts because they are licensed (authorised) bodies and have to be reviewed against the terms of their licence (authorisation) rather than against the general criteria applicable to other NHS bodies (see below). CHAI's functions relating specifically to NHS Foundation Trusts are listed in Library Research Paper 03/38. (Clauses 45-48)

c. NHS bodies (other than NHS Foundation Trusts)

The functions that apply only to England apply also to cross-border Strategic Health Authorities.

- CHAI has the function of encouraging improvement in the provision of healthcare. (Clause 49, England and Wales) When publishing performance data or exercising its functions in relation to failing bodies, CHAI must, in particular, take into account :

    a) the availability of, and access to, the healthcare
    b) the quality and effectiveness of healthcare
    c) the financial or other management of the healthcare and the economy and efficiency of its provision
    d) the need to safeguard and promote the rights and welfare of children
    e) the effectiveness of measures taken for the purposes of d) by the body in question, and the people within it providing the healthcare

- CHAI has the function of publishing data relating to the provision of healthcare (clause 50, England and Wales) CHAI must conduct annual reviews of each body and must award a performance rating to each body. CHAI has the function of devising the criteria, which have to be approved by the Secretary of State (clause 51, England)

- CHAI has the function of conducting national reviews of particular services (eg cancer services) or of particular aspects of healthcare and has the power to carry out inspections for this purpose (Clause 51, England and Wales)

- CHAI has the function of conducting other reviews, including reviews into the way bodies are carrying out their duty to monitor and improve the quality of healthcare. It has power to conduct inspection for this purpose and must publish such report as it thinks appropriate.(Clause 53, England)

- Where CHAI has conducted a review, it must make a report to the Secretary of State if it is of the view that there are significant failings in the provision of healthcare, the running of a body, or by an individual providing healthcare, it must make a report to the Secretary of State, which may recommend that the Secretary of State or the Welsh Assembly, as appropriate, take special measures. The Explanatory Notes say that these may include practical assistance or organisational support. In more serious cases, they could replace all or part of an NHS body's board.(Clause 54, England and Wales)

d. Other functions (England)

- CHAI may promote the effective co-ordination of reviews or assessments carried out by public bodies in relation to healthcare. (Clause 55)

- CHAI has the function of promoting or undertaking studies, including comparative studies in order to enable it to make recommendations about improving the economy, efficiency and effectiveness of a Primary Care Trust, a Strategic Health Authority or an NHS Trust, or for improving the financial or other management or operations of such a body. (Clause 56)

  The Explanatory Notes say that such studies were previously carried out by the Audit Commission under section 33 (1) of the Audit Commission Act 1998. (The Notes also say that studies of this type with respect to NHS Foundation Trusts are to be undertaken by the National Audit Office under its powers in the *National Audit Act 1983* – provided for by schedule 4 paragraph 57 of the Bill)

- The Secretary of State may by Regulations provide for CHAI to have additional functions. These may relate to any of the three broad areas already covered, that is, the provision of healthcare by or for NHS bodies, the improvement of economy, efficiency and effectiveness in the exercise of the functions of English NHS bodies, and the improvement of the financial or other management, or operations, of English NHS bodies. The Secretary of State must obtain the consent of the Regulator in relation to NHS Foundation Trusts and of the Welsh Assembly in relation to healthcare provided by a Welsh NHS body. (Clause 57)

  How the functions are to be discharged

- CHAI must have regard to such aspects of government policy as the Secretary of State may direct in writing and the Secretary of State may, after consulting CHAI, make Regulations requiring CHAI to devise and publish criteria for use in the exercise of any of its functions under chapter 3. (Clause 58)

- Where the Secretary of State consider that CHAI is to a significant extent failing to discharge its functions, or failing to do so properly, he may issue a direction writing with which CHAI must comply.(Clause 59)

- CHAI may charge fees from the persons or bodies that it reviews or investigates. (Clause 60)

- CHAI must make copies of any report that it publishes under chapter 3 of the Bill available for inspection at its offices at any reasonable time and make copies available for people to keep subject to any fee that it considers appropriate. (Clause 61)

- Individuals authorised by CHAI have various powers to enter and inspect premises. It is an offence to obstruct, without reasonable excuse, such individuals. (Clauses 62 and 63)

- CHAI is given certain powers to require documents. (Clause 64)

Regulations may make provision for CHAI to require an explanation of any documents or information that it is entitled to obtain. (Clause 65)

2. Independent Healthcare Functions of CHAI

Chapter 7

The Bill deals (among other things) with the transfer to CHAI of the functions of the National Care Standards Commission relating to independent healthcare. (Clauses 99, 100, 102, 103 and 105.) The healthcare functions being transferred cover independent hospitals, independent clinics and independent medical agencies. The *Care Standards Act 2000* is amended to make provision CHAI. There is also a change in relation to charging fees. They are currently set out Regulations under the 2000 Act. Clause102 would amend it so that CHAI could determine the fees instead of the Secretary of State.

3. Complaints

Chapter 9

The Bill provides for complaints procedures relating to heathcare. It leaves most of the detail of the new complaints system to be set out in Regulations, including provision for CHAI to be able to consider complaints. Clause 109 makes provision for Regulations relating to complaints to English NHS bodies or cross-border Strategic Health Authorities

and Clause 110 makes provision for the Welsh Assembly to issue Regulations where a compalint is made to a Welsh NHS body.

4. Regulation, Inspection, and Complaints in Wales

Chapter 4 and chapter 9

There will be different arrangements in Wales in line with the Welsh Assembly's desire to develop an NHS policy suitable for the needs of that country. The Bill covers NHS care in Wales only but this note attempts to clarify the overall comparative position.

- Some of the work of the existing Commission for Health Inspection relating to Wales will transfer to CHAI (see above) and some will be devolved to the Welsh Assembly.

- The work of the Audit Commission relating to Wales will stay with the Audit Commission. (The English work will transfer to CHAI). However, there are proposals for a single audit body for Wales,[27] and it is therefore possible that at some later date, if an audit body for Wales were created, that the functions of the Audit Commission could transfer to such a new body. (Since 1999, the Audit Commission has had a separate office in Wales, known as the Audit Commission in Wales.)

- The Bill does not directly alter the current private health regulation functions of the Care Standards Inspectorate for Wales. (In England the private healthcare functions of the National Care Standards Commission are transferring to CHAI.) But it leaves open various options, including leaving the function where it is, transferring it to the the Healthcare Inspectorate for Wales, the body which is likely to be created subject if the Bill becomes law, or, through co-operative arrangements, having it carried out by CHAI.

- Complaints – As for England, the Bill makes provision for the complaints procedure to be set out in Regulations (Clause 110)

- There are various other specific provisions relating to Wales that parallel those relating to CHAI. For example, the Welsh Assembly is required to make an annual report of the way in which it has exercised its healthcare (and social care) functions in the Bill), and its functions under the *Care Standards Act 2000* in relation to independent health services (clause 129) and there is provision relating to inquiries conducted by the Welsh Assembly (Clause 131), and both the Assembly and CHAI are required to co-operate with one another.

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[27] See Draft Public Audit (Wales) Bill, 3 April 2003

5. Supplementary

Chapter 10 covers:

Joint working: The Bill places a duty on both the CHAI and CSCI to co-operate with one another and enables them to conduct joint reviews and investigations with one another (eg joint inspections of Care Trusts[28]); it provides for CHAI and CSCI to assist other UK public bodies with the exercise of their functions (for example, OSTED, the Audit Commission or the Probation Service[29]); it enables a Minister to arrange for CHAI to carry out functions in relation to health schemes for which the Minister is responsible (eg the Secretary of State for Defence might arrange for CHAI to inspect healthcare provided to the armed forces[30]).

Annual reports: The Bill places a duty on CHAI to produce an annual report, lay it before Parliament and send a copy to the Secretary of State and the Welsh Assembly.

Public enquiries: The Bill provides for the Secretary of State or the Assembly to initiate a public or private inquiry into any matter concerning the exercise of any of CHAI's functions.

Disclosure of information obtained by CHAI: The Bill makes it a criminal offence for any person, including a member or employee of CHAI to knowingly or recklessly disclose confidential information which relates to or identifies an individual. It also provides for defences in realtion to this offence, for example where the information is disclosed for sepcified purposes.

Miscellaneous measures: There is also a variety of miscellaneous measures such as provision for offences, minor and consequential amendments etc.

D. Comment

Although the reaction to the provisions on CHAI and related measures in the Bill has been overshadowed by those relating to NHS Foundation Trusts, there has been some earlier commentary, which provide an indication of current attitudes. In particular, at the birth, and during the life of, the existing bodies there has been some debate about their proper role.

In relation to CHI, for example, there has been some debate about whether the balance of its functions should tip towards a more Ofsted-like, critical inspectorate role or whether it

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28 EN paragraph 285
29 EN paragraph 287
30 EN paragraph 288

should provide more of a helping hand. Nick Timmins, writing in the Financial Times in December 2002, said that this was an issue that was still unresolved.[31] When the Care Standards Bill that provided for the National Care Standards Commission was making it way through Parliament, issues raised included the question whether it was appropriate for NHS healthcare and private healthcare to be regulated by separate bodies and whether it was appropriate for the private hospital sector to be regulated by a body primarily concerned with social care.[32]

The proposal of creating a new independent Commission for Healthcare Audit and Inspection (CHAI), responsible for inspecting both the NHS and the private sector, and with a remit covering both quality standards and financial management, was generally welcomed. The BMA singled it out for praise, commenting:

> We support the decision to create the Commission for Healthcare Audit and Inspection which we hope will strike the right balance between accountability and hyper-regulation. Currently we have a confusing patchwork of 17 or more regulatory and inspection bodies. We want to see a much more streamlined system which sets common standards for both NHS and private care and which does not pull doctors away from the central task of treating their patients.[33]

The Commission for Health Improvement issued a press release welcoming the Secretary of State's statement and stating:

> The bringing together of inspection of the NHS and independent healthcare is eminently sensible and is something we have called for for some time. This announcement is a vote of confidence in what CHI has achieved.[34]

Amendments to the *National Health Service Reform and Health Care Professions Bill*, tabled in March 2002 during the Lords Committee stage, had in fact sought to bring the private health sector within CHI's remit, with similar proposals being made during the passage of the *Health Bill in 1999* when CHI was first created.[35] In response to the most recent attempt to extend CHI's role, the Health Minister Lord Hunt expressed "great sympathy" with the principle, but felt it was premature.[36] Some concern was also expressed that separate Commissions were being established for health and social care, given the increasing importance of providing "seamless" care across the health and social care divide.[37]

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31 "Watchdog with more than NHS in its sights", by Nicholas Timmins, *Financial Times*, 24 December 2002

32 See Library Research Paper 00/52

33 BMA Press Notice, 21 April 2002

34 CHI Press Notice, 18 April 2002

35 eg. Standing Committee A, 13 May 1999 cc7110724 and 18 May 1999 cc727-734

36 HL Deb 21 March 2002 c1564

37 "Separate checks", *Guardian Society*, 24 April 2002, p23

III Other Measures In The Bill

1. Recovery of NHS Treatment and Ambulance Costs Where People Claim and Receive Personal Injury Compensation

Part 3 and schedule 9 (clauses 137-156)- applies to England, Scotland and Wales (except clause 150(3).

The aim of this Part of the Bill is to enable the NHS to recover treatment and ambulance costs from organisations making compensation payments to people suffering personal injury. This issue is covered in detail in the Department of Health's full Regulatory Impact Assessment on the Bill,[38] published on 14 March 2003, and in the Explanatory Notes to the Bill. The issue is not covered in detail here.

The provisions in the Bill can be traced back to recommendations of the Law Commission Report published in 1999[39] although these have been adapted since then. In September 2002, the Government issued a consultation document, *The recovery of NHS costs in cases involving personal injury compensation*,[40] which closed on 8 November 2002, responses to which have also fed into the current proposals.

For over 70 years hospitals have had the right to recover costs from raod traffic accidents. The *Road Traffic (NHS Charges) Act 1999* tightened this provision for NHS costs to be recovered. These schemes raises around £100 million a year for hospitals in England, Scotland and Wales and is administered by the Compensation Recovery Unit of the Department for Work and Pensions.[41]

However, at present, except for cases involving compulsory motor vehicle insurance, where a person has agreed to pay compensation for an injury suffered by another person the compensator does not meet the costs of any NHS hospital treatment, or ambulance transport, which has been necessary. The estimated cost to the taxpayer of meeting these costs is approximately £150m in Great Britain per year.

The Government's objective in introducing such a charge is for people to be more aware of their responsibilities and to take active steps to reduce the risk of causing injury to third

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38 Department of Health, Full Regulatory Impact Assessment, Health and Social Care (Community Health and Standards) Bill, 14 March 2003, Annex E
http://www.doh.gov.uk/regulatoryimpact/healthsoccarecommhealth.PDF

39 Law Commission, *Damages for Personal Injury, Medical, Nursing and Other Expenses; Collateral Benefits*,Law Com No 262, HC 806, Novmeber 1999

40 http://www.doh.gov.uk/nhscosts/recoverycosts.pdf

41 Source: "NHS to recover costs in personaly injury cases" Department of Health Press Notice, 12 September 2002

parties, as well as to reduce the cost to the taxpayer of subsidising the wrongdoer by meetng part of the costs of his or her wrongdoing.[42] According to press reports, the Association of British Insurers is concerned about the proposal because it thinks that this will raise costs at a time when businesses are under pressure. it also predicts that liability insurance premiums will have to go up.[43]

2. Dental Services

Part 4 and schedule 10

The Bill would bring the provision of NHS dentistry, including General Dental Services, in England and Wales under the aegis of Primary Care Trusts in England and Local Health Boards in Wales. These bodies will take responsibility for commissioning NHS dental services. The Bill will also modify Personal Dental Services arrangements and abolish the Dental Practice Board (which pays NHS dentists).

There have been well-publicised concerns for over a decade about the difficulties experienced by some patients in finding a dentist willing to provide them with NHS treatment. General dental practitioners ("high street" dentists) are independent contractors, able to provide dental services to the general public both on the NHS and on a private basis. There have been fears that dentists have chosen to focus more on their private work, in some cases withdrawing altogether from NHS provision. A Health Select Committee report published in March 2001, *Access to NHS dentistry*, provides the following history:

> Prior to 1990 General Dental Services dentists, working as independent practitioners, contracted to provide NHS dental care on a fee-per-item basis for all their patients. There were no formal arrangements for continuing care. Each course of treatment represented a short-term contract between dentist and patient. In practice, however, practitioners built up lists of regular patients to whom they had an on-going commitment.
>
> A new dental contract in 1990 introduced capitation payments for children, and the registration of adult patients – whose treatment continued to be remunerated on a fee-per-item basis. The declared intention was to shift the emphasis from individual dental treatments to the purchase of continuing dental care. The underlying *principles* of the 1990 contract, essentially a move away from remunerating dentists for the amount of work they did to a more preventative approach, were broadly welcomed by the profession. But its *implementation* was widely opposed because of fears among dentists that its net effect would depress their incomes. To protect their incomes they worked harder (by a factor of 8.5%),

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[42] Regulatory Impact Assessment, as above.

[43] "NHS set to claim more costs from insurance companies, Financial times, 14 March 2002.

> increasing the payments due to them and leading to an overspend on the GDS[44] in 1991-92 of £190 million. As a result the DoH made unilateral cuts in the fee scale for 1992-93 of 23%, later reduced after negotiation to 7%. This furore led to a breakdown in relations between the DoH and dentists, and compounded existing dissatisfactions among the profession about remuneration and the problems of providing high quality care. GDPs [general dental practitioners] continued to reduce their commitment to the NHS and the DoH acknowledges in *Modernising NHS Dentistry* that the access problem stems from the reduction of GDPs' time spent working for the NHS.
>
> Examining this situation in 1993, we concluded that the difficulties some people were having in gaining access to NHS dental care were not the transient effects of the dispute over pay but the results of inherent contradictions within the system of remuneration that had been highlighted by, but not caused by, the dispute:
>
> > "the present system of remuneration for dentists seems to have an inherent leaning towards instability which threatens to undermine the commitment of dental practitioners to the NHS."
>
> This situation has not improved. John Renshaw, Chairman of the Executive Board of the BDA [British Dental Association] told us that the 1992 fee cut is still seen as a "scar running through the profession that has never been put right".[45]

In its report, the Health Committee concluded:

> We have received extensive written evidence and are quite clear that urgent action is required. We consider that dentistry has never been fully integrated into the NHS and as a result major health inequalities exist. We believe that the present arrangements for accessing NHS dentistry are inequitable, uncertain and getting worse; patients do not know where they stand. Unregistered patients find it hard to get any form of care. Registered patients can lose that status without redress and often without knowing they have done so. Patients do not always get the advanced conservative treatment they need (crowns, bridges, implants etc) through the NHS even when they are registered. Certain very vulnerable groups of patients, such as elderly people and those with dementia, face particular problems. We agree with the Eastman Hospital that "there should be greater clarity and honesty regarding availability of NHS treatment". *Modernising NHS Dentistry* aims to address immediate problems of access. But these are, as the BDA told us, multi-faceted long-standing problems to which solutions will not be found overnight. There are widespread concerns that the proposals in the document merely provide a quick fix and do not go to the root of the problems. There are also concerns about current workforce levels and distribution, about

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[44] The general dental service, ie dental services provided by high street dentists (general dental practitioners)

[45] Health Committee, *Access to NHS dentistry*, March 2001, HC 247 2000-2001,vii, paras 12-14

> which at present we have little detailed information. We believe these are serious concerns and that *Modernising NHS Dentistry* lacks the weight to alter fundamentally what is a deteriorating situation. We would suggest that a longer term strategy for dentistry within the NHS is still badly needed.[46]

Following on from the Health Committee's report, the Department of Health established a working group, *NHS Dentistry: Options for Change*, chaired by the Chief Dental Officer and with a remit of proposing standards for NHS dentistry which meet patients' needs and wishes, a range of models for delivering NHS dentistry (including possible changes to the remuneration system) and proposals for the education and training needs of the dental team.[47] The Working Group's report was published in August 2002 and was welcomed by the Health Minister, David Lammy. It included the following recommendations:

- Primary Care Trusts should be responsible for commissioning NHS dental services in the same way as they currently commission hospital services, with funding devolved for this purpose;
- a variety of forms of remuneration should be tested on a pilot basis, including salary, capitation (ie payment per patient, regardless of how much treatment they need) and a simplified modernised fee scale;
- the patient's gateway to NHS dental services should be via an oral health assessment, focusing on prevention of disease and lifestyle advice as well as the discussion of any necessary treatment;
- the direct association between payment to dentists and the type of treatment provided should be removed where possible;
- in future services should be provided through larger practices, using the skills of a wider range of professionals complementary to dentistry;
- national standards should be developed so that patients know what they can expect.

The Regulatory Impact Assessment on the Bill says that NHS dentistry can at present be commissioned only within a contractual framework providing very limited options for both NHS and dentists.

> The legal framework does not allow significant departure from a uniform national contract and at a local level it has not been possible to integrate NHS dentistry with other NHS services, which have developed greatly in recent years. This means that funds cannot be targeted effectively and that services to patients are increasingly irrelevant to health needs in the population. Neither does the existing framework enable any contractual certainty for the PCT beyond the short term, because dentists can change their NHS commitment without reference to the PCT. The net effect has been that although dentist numbers have increased to 18,400 in 2002 (England), from 16,728 in 1997, activity in the General Dental

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46 *ibid*, xvii, para 48

47 Department of Health, *NHS dentistry: options for change*, August 2002

> Services remains at about the same level. In addition, the existing charging arrangements are bureaucratic and unclear to patients.

It argues that the key benefit of the proposals in the Bill will be to enable the NHS local, through Primary Care Trusts, to make contracts which meet the need and wishes of the public who use the service:

> This has the potential to make better use of funds which are currently spent on treatments, assessed as providing questionable health gain. There should also be benefits to dentists through practice based contracts, encouraging development of the dental team and enabling them to work in larger groups than currently, allowing a reduction in overheads and enhanced profitability for dentists generally. Across NHS dentistry this could release substantial efficiency savings for recycling into improved services.[48]

The proposals in the Bill have been welcomed by the British Dental Association

> "The Bill represents a once in a generation opportunity to save NHS dentistry after decades of neglect by successive governments. The British Dental Association welcomes the Government's move to secure a strong NHS dental service with improved access for patients. But the British Dental Association has serious concerns that unless NHS dentistry is properly resourced, the Bill's promised reforms will not be delivered. There is an urgent need to make the NHS a good place to work for dentists and other dental professionals. Better funding and steps to make NHS dentistry an attractive career must go hand-in-hand with the measures proposed in the Bill."[49]

The Explanatory Notes to the Bill explain the provisions in detail.[50]

3. Welfare Foods

Part 5 Clause 167 (England, Wales and Scotland)

The Welfare Food Scheme was introduced in 1940 as a wartime measure to protect the health of mothers and children at a time of shortages and rising prices. Originally benefits were universal, but in more recent years, eligibility has been primarily restricted to those in receipt of Income Support and Income Based Job Seekers' Allowance. The nature of foods provided has been only slightly modified over the last 60 years. Cod liver oil and orange juice have been substituted for vitamin drops and infant formula has replaced 'national dried' milk.

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48 Regulatory Impact Assesment, as above, Annex D.

49 John Renshaw, Chair of the Executive Board of British Dental Association, BDA website: http://www.bda-dentistry.org.uk/

50 EN, as above; http://pubs1.tso.parliament.uk/pa/cm200203/cmbills/070/en/03070x--.htm

The current Scheme provides tokens for milk (liquid and formula) and vitamins to expectant and nursing mothers, and to babies and infants under 5, in low income families. It also provides non-means tested milk to those in day care and a very few disabled children. An estimated total of 40,000 pregnant women and 713,000 mothers and young children benefit from the Scheme in Great Britain. The total current annual cost (GB) is £142m, comprised of £125m of programme expenditure and £17m administration (£7m of which is a block allocation to the NHS).

A consultation document, *Healthy Start*, was issued by the Department of Health in October 2002, with a closing date of 13 December 2002.[51] The document proposed that there should be a choice of a wider range of 'healthy' foods than is available under the present scheme; and that advice, support and guidance on nutrition would be available from NHS health professionals for mothers-to-be and new mothers and carers as an integral part of the scheme. The reason given for the proposals was that milk and vitamins were both important elements in the diets of mothers and young children but that according to the latest scientific evidence they were not sufficient on their own to meet the nutritional needs of these groups.

The Bill would replace section 13 of the *Social Security Act 1988*, which provided powers for a scheme or schemes to be set up to distribute welfare food.The new section 13 provides powers for regulations to be made setting up a new scheme or schemes, linked more closely with health services, designed to help certain pregnant women, mothers and children to have access to, and incorporate into their diets, certain prescribed foods.

The Explanatory Notes to the Bill say that it is intended that the nutritional basis of the current scheme will be extended under the first new scheme to include a broader range of foods in addition to milk such as fruit, vegetables, cereal-based foods and other foods suitable for weaning. The aim is to use a voucher bearing a fixed value to enable beneficiaries to access these foods. It is also intended that the new scheme should be integrated with the NHS and health policies so that beneficiaries can receive appropriate advice on nutrition to accompany the prescribed food benefit.[52]

4. Miscellaneous

Part 5 of the Bill would include a number of other measures. For example:

- It will enable the Health Secretary to devolve his powers of appointment to the boards of the health professionals regulatory bodies and many of the Department of Health's key advisory bodies to the NHS Appointments Commission. (Part 5 clause 168 –169 and schedule 11)

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51 The consultation document is on the Department's website at: http://www.doh.gov.uk/healthystart/

52 EN, as above.

- It will remove the requirement to carry out an annual check of the Protection of Children Act List and Vulnerable Adults List for those staff in permanent NHS positions. (Part 5 and clause 170)
- It will remove the requirement for the consent of the Treasury to be given when the Secretary of State makes loans to NHS Trusts. (Part 5 clause 171)

Part 6 of the Bill makes provision for Orders, Regulations, Money, Interpretation etc.