



Health and Social Care Bill

Bill 132 of 2010-11

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This briefing on the *Health and Social Care Bill* has been prepared for the Second Reading debate on the Bill in the House of Commons on 31 January 2011.

The Bill is intended to give effect to the reforms requiring primary legislation that were proposed in the NHS White Paper *Equity and excellence: Liberating the NHS*. This White Paper set out the Government's aims to reduce central control of the NHS, to engage doctors in the commissioning of health services, and to give patients greater choice.

Measures in the Bill would give consortia of General Practitioners responsibility for commissioning the majority of health services, and create an independent NHS Commissioning Board. It would abolish Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) and transfer local health improvement functions from PCTs to local authorities. It would also give local authorities responsibilities for coordinating the commissioning of local NHS services, social care and health improvement

The Bill would introduce measures to promote competition between providers of NHS-funded services and would provide for all remaining NHS trusts to become foundation trusts.

Other parts of the Bill deal with the functions of several 'arm's length bodies', and the regulation of health and social care workers. There are also a number of consequential amendments and miscellaneous provisions.

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Contents

| | | |
|----------|---|-----------|
| | Summary | 1 |
| 1 | Introduction | 3 |
| 2 | Background to NHS reform | 3 |
| 3 | The Government's health service reforms | 6 |
| | 3.1 The NHS White Paper | 6 |
| | 3.2 Reactions to the White Paper and the Government's response | 8 |
| | 3.3 Timetable for implementation | 11 |
| 4 | Functions of the Secretary of State, the NHS Commissioning Board and GP consortia (Part 1 of the Bill) | 13 |
| | 4.1 Duties of the Secretary of State | 13 |
| | 4.2 The Secretary of State's annual mandate to the NHS Commissioning Board | 14 |
| | 4.3 Exceptional powers to direct the NHS Commissioning Board and GP consortia | 15 |
| | 4.4 The Secretary of State's annual report | 16 |
| | 4.5 The NHS Commissioning Board | 16 |
| | 4.6 GP commissioning consortia | 18 |
| | 4.7 Abolition of Primary Care Trusts and Strategic Health Authorities | 22 |
| | 4.8 The transition from PCT to GP commissioning | 23 |
| | 4.9 GP commissioning: other issues | 25 |
| 5 | Public health | 27 |
| | 5.1 The public health White Paper | 27 |
| | 5.2 Public health functions of local authorities and the Secretary of State (Part 1 of the Bill) | 27 |
| | 5.3 Abolishing the Health Protection Agency and further provisions about public health (Part 2 of the Bill) | 29 |
| 6 | Economic regulation (Part 3) | 29 |
| | 6.1 The role of Monitor | 29 |
| | 6.2 Competition | 30 |
| | 6.3 Designated services | 32 |
| | 6.4 Licensing arrangements | 33 |
| | 6.5 Tariff prices paid to providers of NHS services | 34 |
| | 6.6 Insolvency and special administration | 35 |
| | 6.7 Financial assistance in special administration cases | 35 |

| | | |
|-----------|--|-----------|
| 7 | NHS foundation trusts and NHS Trusts (Part 4) | 36 |
| 7.1 | Governance and management | 37 |
| 7.2 | Foundation trust finance: financial assistance, borrowing and the independent banking function | 37 |
| 7.3 | Mergers, acquisitions, separations and dissolution | 38 |
| 7.4 | Repeal of de-authorisation provisions | 38 |
| 7.5 | Trust special administrators | 38 |
| 7.6 | Abolition of NHS trusts in England | 39 |
| 8 | Patient involvement and local authorities (Part 5 of the Bill) | 39 |
| 8.1 | HealthWatch | 39 |
| 8.2 | Local authorities and democratic accountability in health and social care | 40 |
| 8.3 | The Health Service Commissioner for England: information sharing | 42 |
| 9 | Amendments to primary care service legislation (Part 6) | 42 |
| 10 | Regulation of health and social care workers (Part 7) | 42 |
| 10.1 | Changes to the regulation of social work | 43 |
| 10.2 | Professional Standards Authority for Health and Social Care | 47 |
| 10.3 | Abolition of the Office of the Health Professions Adjudicator (OHPA) | 49 |
| 11 | National Institute for Health and Clinical Excellence (NICE) (Part 8) | 49 |
| 12 | Health and Social Care Information Centre (Part 9) | 51 |
| 13 | Abolition of certain public bodies (Part 10) | 51 |
| 14 | Miscellaneous provisions | 52 |
| | Appendix 1 – Key Department of Health publications on the reform proposals | 53 |
| | Appendix 2 – Reactions to the <i>Health and Social Care Bill</i> | 54 |
| | Appendix 3 - Responses to the NHS White Paper | 57 |
| | Appendix 4 – Statistical Annex | 59 |

Summary

The Bill is intended to give effect to the reforms proposed in the NHS White Paper that require primary legislation. The White Paper *Equity and excellence: Liberating the NHS*, published in July 2010, set out the Government's aims to reduce the central direction of the NHS, to engage doctors in the commissioning of health services, and to give patients greater choice.

The Bill would devolve responsibility for commissioning services to groups of GPs, create an independent NHS board to oversee day to day running of the NHS, and introduce a system of economic regulation to promote competition in the delivery of health services. Although the Bill deals primarily with health services, its title refers to social care because a number of measures would apply to bodies with joint functions and responsibilities; the Government intends to introduce legislation on social care reform later in the Parliament.

The Bill is the largest piece of health legislation since the creation of the NHS and would fundamentally alter the landscape of healthcare in England: abolishing several NHS bodies and layers of management, changing the way NHS services are commissioned and establishing local government powers to scrutinise services and promote public health. However, it also extends earlier reforms to hospitals and commissioning. Opinion is divided as to whether the Bill marks a radical and risky departure or a logical and sensible extension of earlier policies.

Part 1 of the Bill covers the health service in England and would:

- Make provisions for the Secretary of State's duties to improve and protect public health, improve the quality of services, and to reduce inequalities;
- establish a framework for a comprehensive system of GP consortia, with responsibility for commissioning the majority of health services, and paving the way for the abolition of Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs);
- create an independent NHS Commissioning Board, accountable to the Secretary of State, to allocate NHS resources to GP consortia, provide national leadership in commissioning, and promote patient choice; and
- place clear limits on the role of the Secretary of State in relation to the NHS Commissioning Board, and local NHS organisations, including a duty to promote the autonomy of health service bodies.

Part 1 of the Bill would also underpin the creation of a new public health service, Public Health England, within the Department of Health, and transfer local health improvement functions from PCTs to local authorities. It also contains a number of miscellaneous measures including amendments to the *Mental Health Act 1983*.

Part 2 of the Bill would make further provisions about public health, including the abolition of the Health Protection Agency.

Part 3 of the Bill covers the economic regulation of health care services and would:

- develop and expand the role of Monitor, currently the regulator of NHS foundation trusts, transforming it into the economic regulator for health (and possibly social care);
- introduce measures to promote competition between service providers;

- establish powers to ensure the continuity of certain designated health services;
- enable Monitor to promote competition and safeguard the continuity of services by creating a licensing system for all providers of NHS-funded services;
- establish a joint process (involving Monitor and the NHS Commissioning Board) for setting the tariff prices paid to providers of NHS services; and
- introduce insolvency arrangements for failing organisations and a special administration regime to protect designated health services.

Part 4 of the Bill would provide for all remaining NHS trusts to become foundation trusts by repealing the legislation on NHS trusts, and the powers to 'de-authorise' foundation trusts. The Bill would also reform the foundation trust model, introducing new governance arrangements and removing restrictions on how they operate (including lifting the restrictions on borrowing and private work).

Part 5 of the Bill relates to public involvement and includes measures intended to increase local democratic legitimacy in health and social care. It would give local authorities the function of coordinating the commissioning of local NHS services, social care and health improvement. In particular, the Bill would:

- establish HealthWatch England as a statutory part of the Care Quality Commission, to 'champion' service users across health and social care, and create a network of local HealthWatch organisations;
- introduce a statutory duty for all upper-tier local authorities to: create a health and wellbeing board (HWB), and develop a new joint health and wellbeing strategy (JHWS); and
- change the legislation governing the Health Services Ombudsman to strengthen the arrangements for her to share information more widely.

Part 6 of the Bill makes consequential amendments to provisions on primary care services.

Part 7 of the Bill covers the regulation of health and social care workers.

Part 8 of the Bill reforms the functions of the National Institute for Health and Clinical Excellence (NICE), making it a non-departmental public body, reforming its role, and extending its remit to social care (and changing its name to the 'National Institute for Health and Care Excellence')

Part 9 of the Bill changes the functions of the Health and Social Care Information Centre.

Part 10 of the Bill would abolish a number of arm's length bodies and advisory committees.

Part 11 of the Bill covers miscellaneous provisions, including: duties for key public bodies to co-operate with each other in performing their functions; and arrangements between the NHS Commissioning Board and the devolved authorities.

Part 12 of the Bill contains the final provisions of the Bill, such as details of commencement and territorial extent.

1 Introduction

The Bill was introduced in the House of Commons on 19 January 2011.¹ It is scheduled to have its Second Reading on 31 January 2011. This research paper provides background to the Government's proposals to reform the NHS and covers the most significant changes outlined in the Bill. Rather than dealing with every clause in order (the *Explanatory Notes to the Bill* provide a comprehensive explanation of individual clauses) this paper follows the general outline of the Bill as set out below, with the relevant parts of the Bill shown in brackets:

- The functions of the Secretary of State, NHS Commissioning Board and GP commissioning consortia (Part 1 of the Bill)
- Public health (Parts 1 and 2)
- Economic regulation (Part 3)
- NHS Foundation Trusts (Part 4)
- Public involvement and local authorities (Part 5)

The subsequent parts of the Bill, which mainly deal with the functions of several arm's length bodies, and with consequential amendments, are covered in less detail:

- Amendments to primary care service legislation (Part 6)
- Regulation of health and social care workers (Part 7)
- National Institute for Health and Clinical Excellence (NICE) (Part 8)
- Health and Social Care Information Centre (Part 9)
- Abolition of certain public bodies (Part 10)
- Miscellaneous provisions

The Bill would amend a number of Acts, primarily the *National Health Service Act 2006*,² although it does also contain some free-standing provisions. Most of the provisions contained in the Bill extend to England and Wales only, but in practice apply only to England as health is devolved to Wales.

2 Background to NHS reform

Since its creation in 1948, the National Health Service has provided healthcare that is comprehensive, universal and free at the point of use.³ However, the constituent parts of the service have not always been organised in the same way. There have been a number of

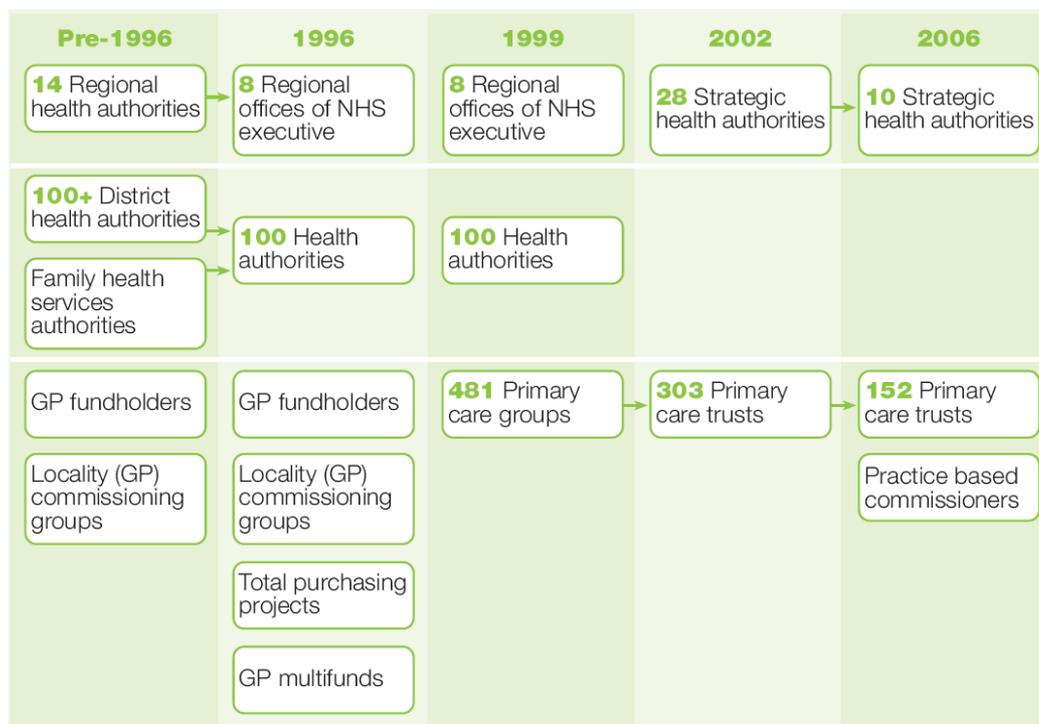
¹ *The Health and Social Care Bill* [Bill 132 2010-11], 19 January 2011

² The NHS Act 2006 consolidated much of the pre-existing legislation relating to the NHS.

³ The NHS is funded almost entirely from general taxation. Some patient charges (such as prescription charges) have existed in the NHS since the early 1950s, but they have never contributed more than a very small proportion of the service's overall budget.

substantial reorganisations of the NHS and the pace of reform has accelerated over the last 20 years, following the introduction of ‘internal market’ policies in 1991.⁴

The following table sets out the changing management and commissioning structure of the NHS from the mid 1990s to today:



From: Audit Commission, *Is the treatment working? Progress with the NHS system reform programme*, 2008

The NHS White Paper, *Equity and excellence: Liberating the NHS*, published on 12 July 2010, outlined the Government’s ambitious programme of reforms in the NHS.⁵ These reforms entail further reorganisation of the structure of the NHS, including the abolition of Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) and are likely to lead to the creation of around 300 GP commissioning consortia of varying sizes.

NHS funding and performance

There has been significant real growth in the resources going into healthcare, with NHS expenditure increasing by over two thirds over the last ten years (with real-terms growth averaging around 5.5% per annum).

This relatively high level of NHS investment has been associated with improvements in hospital waiting times, life expectancy and some health outcomes in absolute terms (see statistical annex at appendix 4). However, the Government has argued that despite this investment, the NHS has achieved relatively poor health outcomes compared to other countries.⁶

⁴ The Library Standard Note *NHS commissioning* (SN/SP/5607) includes an annex setting out the history of structural reform in the NHS.

⁵ DoH, *Equity and excellence: Liberating the NHS* (Cm 7881) 12 July 2010

⁶ *Ibid.* para

1.8; see also the Prime Minister’s speech on modern public service, 17 January 2011

Official estimates point to falling NHS productivity during the period of increased spending,⁷ although, productivity is rather a crude measure of value for money in the NHS, calculated by comparing inputs and outputs. There are questions about what is and is not measured, and about how to place a value on the outputs of healthcare and patient experience.

In October 2010, the Government spending review for the period 2011/12 to 2014/15 confirmed that the total NHS budget for England would increase by £10.6 billion over four years. This reflected the Government's commitment to protect the NHS and increase health spending in real terms. Planned expenditure on the NHS in England for the current financial year (2010/11) is £103.8 billion. This figure is set to increase to £114.4 billion by 2014/15.⁸ Using inflation figures published in the June 2010 Budget this represents around 0.1% of annual real terms change growth. However, the Office for Budget Responsibility published a revised GDP deflator in November 2010⁹ and if this is applied the NHS funding settlement no longer represents a real terms increase.¹⁰

Efficiency savings

The Government aims to deliver up to £20 billion of efficiency savings in the NHS by the end of 2014/15, to be reinvested in front-line services. This challenge, which equates to savings of 4% each year, was first articulated by the chief executive of the NHS, Sir David Nicholson, in 2009. The NHS is expected to achieve this under its Quality, Innovation, Productivity and Prevention (QIPP) programme through a combination of quality and productivity improvements and efficiency savings.

The Secretary of State for Health, Andrew Lansley, has stated that the one-off cost of implementing his NHS reforms would be £1.4 billion, although others have estimated the reorganisation could cost up to £3 billion.¹¹ The *Impact Assessments* published with the Bill estimate the Government's reforms will save the NHS more than £5 billion by the end of 2014/15, achieved by a 33% saving in administrative costs.¹² For administrative and managerial staff, the estimated staff reduction figure is 24,500, which comprises 20,900 predicted redundancies and 3,600 staff leaving through natural wastage. The predicted redundancy cost from the proposed restructuring is £1 billion.¹³

Public attitudes towards the NHS and NHS reform

In December 2010 the National Centre for Social Research released its latest British Social Attitudes report. This found that public satisfaction with the NHS is at an all time high. When Labour gained power in 1997, only a third of people (34%) were satisfied with the NHS, the lowest levels since our survey began in 1983. By 2009, satisfaction had nearly doubled, and stood at two thirds (64%).¹⁴

A poll published in *The Sunday Times* on 23 January 2011 reported that the Government's plans for the NHS were supported by 25% and opposed by 39%, with 36% unsure. Asked

⁷ The Office for National Statistics found that NHS productivity in the UK fell by 3.3 per cent between 1995 and 2008, or 0.3 per cent a year on average.

⁸ HM Treasury Spending Review 2010, Cm 7924, October 2010

⁹ Office for Budget Responsibility, *Economic and Fiscal Outlook, November 2010*

¹⁰ Further information is available from Library Standard Note, *NHS funding and expenditure* (SN/SG/724)

¹¹ Walshe, K (2010), Reorganisation of the NHS in England. *BMJ* 2010; 341:c3843

¹² This is estimated to equate to a £5.4 billion saving by the close of the 2014/15 financial year and a £1.3 billion annual saving thereafter. DoH, *Combined impact assessments*, 19 January 2011

¹³ DoH, *Health and Social Care Bill 2011: Coordinating document for the Impact Assessments and Equality Impact Assessments*, 19 January 2011, para. 51

¹⁴ <http://www.natcen.ac.uk/media-centre/press-releases/2010-press-releases/bsa-27th-report>

how well they understood the Government's NHS policy 43% said they understood it well (37% fairly well, 6% very well), 48% either not very well (39%) or not at all (9%).¹⁵

Among opinion polls, healthcare and the NHS is consistently ranked in the top five most important issues facing the country (IPSOS Mori Research Archive).

3 The Government's health service reforms

3.1 The NHS White Paper

The Government's NHS White Paper, *Equity and excellence: Liberating the NHS*, published on 12 July 2010,¹⁶ set out the Government's three key objectives for healthcare in England: to create a patient-led NHS; to improve healthcare outcomes; and to increase autonomy and accountability within the NHS

Specific proposals are intended to give patients more choice and control over services and information, based on the principle of 'no decisions about me without me'. Under the plans, patients would be able to choose which GP practice they register with, regardless of where they live, and choose between consultant-led teams. Additional information will be published to help patients make these choices together with healthcare professionals.

The White Paper announced that 'improvement in quality and healthcare outcomes' will be established 'as the primary purpose of all NHS-funded care' and the Government will remove targets which have 'no clinical justification'.¹⁷ The Secretary of State for Health will hold the NHS Commissioning Board to account for delivering better health outcomes through a national NHS Outcomes Framework.¹⁸

Under plans for commissioning, the White Paper proposed giving 'consortia' of GPs responsibility for commissioning health services for their local communities, and setting up a national NHS Commissioning Board to support this. The Board would also be responsible for commissioning those services not commissioned by GP consortia, such as specialist services currently commissioned at a national or regional level, and primary care services (including primary medical services provided by GPs).

There would be greater competition between providers, including the private and voluntary sector and staff-led social enterprises, so that in most sectors of care 'any willing provider' can provide services. NHS trusts are expected to become foundation trusts by April 2014.¹⁹

The White Paper also proposed to give local authorities greater responsibilities for public health and to support integration across health and social care; new health and wellbeing boards are intended to bring democratic accountability to health services.

Following the establishment of the NHS Commissioning Board and GP consortia, PCTs and SHAs will no longer have NHS commissioning functions, and PCT responsibility for health improvement will be transferred to local authorities. As a result of these changes SHAs will be abolished from April 2012, and PCTs by April 2013. Community services currently provided by PCTs will be provided by NHS foundation trusts or other types of provider.

¹⁵ <http://today.yougov.co.uk/sites/today.yougov.co.uk/files/YG-Archives-Pol-ST-results-21-230111.pdf>

¹⁶ DoH, *Equity and excellence: Liberating the NHS* (Cm 7881) 12 July 2010. The White Paper referred to the need for further consultation and links to these consultation documents are provided in Appendix 1. The NHS Evidence website also provides links to a range of relevant documents.

¹⁷ *Ibid.* pages 17-18 and 21-26. The Government has already issued a revised NHS Operating Framework for 2010/11, setting out how existing targets should be treated in 2010.

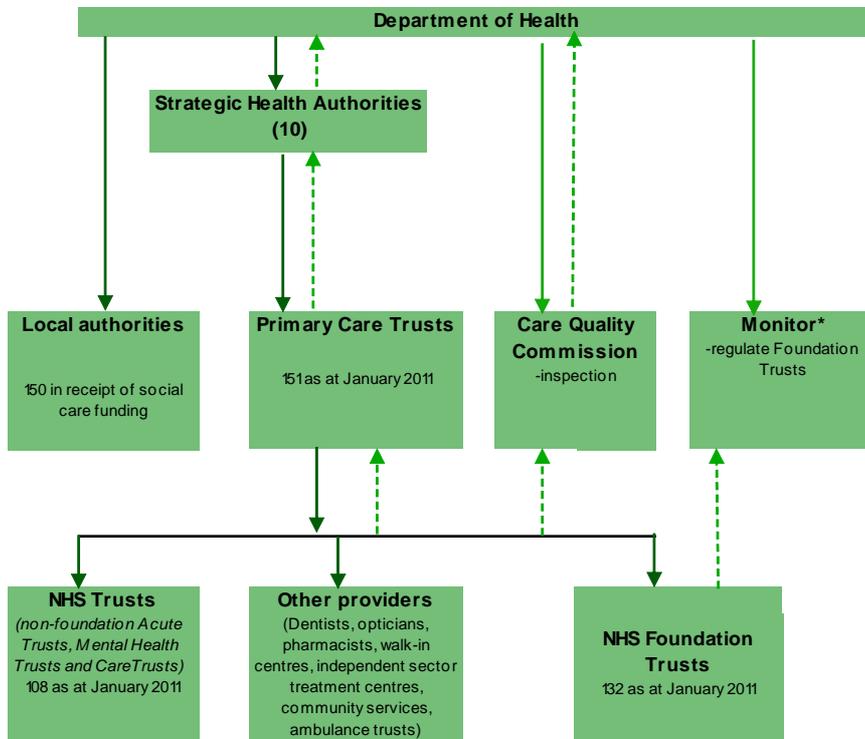
¹⁸ DoH, NHS Outcomes Framework, 20 December 2010 (there will be separate outcomes frameworks for public health and social care)

¹⁹ Foundation trusts are "public interest companies" and have greater freedoms than NHS trusts.

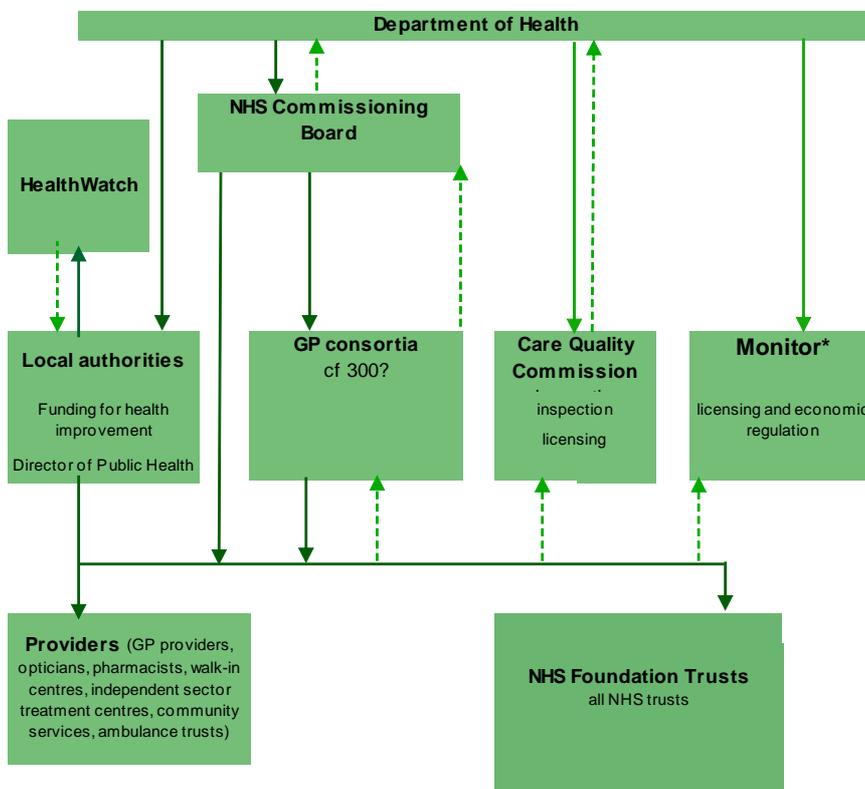
Current and proposed structure of the NHS

---> Accountability
 —> Funding

Current Structure



Proposed Structure



* Monitor are directly accountable to parliament

Adapted from National Audit Office, *National Health Service Landscape Review, 2011*, Figure 2

3.2 Reactions to the White Paper and the Government's response

Although initial reactions were broadly positive about the White Paper's objectives to increase patient choice and give GPs control of commissioning, there were widespread concerns about the scale and pace of reforms. Consultation responses from the main professional bodies and unions representing NHS staff warned that the timescale for the abolition of primary care trusts and the transfer of commissioning to GPs was too short, and called for further piloting (see Appendix 2 and 3 for a summary of reactions to the Bill and the White Paper).

There were also concerns that structural reorganisation of the NHS risked undermining the delivery of efficiency savings under the Quality, Innovation, Productivity and Prevention (QIPP) programme. The Health Select Committee, chaired by Stephen Dorrell (a former Health Secretary in the Major Government), raised concerns that 'institutional upheaval' announced by the White Paper may distract from the 'key priority' for the NHS to make efficiency savings.²⁰

The Royal College of General Practitioners' (RCGPs) initial response to the White Paper was generally positive about the aims of the reforms, although qualifying its support for greater GP leadership and influence with the warning that training, time and resources will be necessary to make it a success. However, the new chair of the RCGP, appointed in November 2010, has highlighted her serious concerns about the potential risks of the reforms.²¹

Some relatively small surveys of doctors by the King's Fund and by the BBC found that there was scepticism from many GPs about their proposed new commissioning responsibilities, and about the Government's NHS reforms in general.²² However, the Government recently announced that over 140 'pathfinder' groups of GPs have now formed consortia, covering around half the population of England, in order to pilot GP commissioning arrangements.²³

Some respondents, particularly trade unions representing NHS staff, argued that the White Paper reforms threatened the core principles of the NHS and that they would open the door to much greater private sector involvement in the NHS.

A number of commentators noted their surprise at the apparent disparity between the White Paper's proposals and the commitment in the *Coalition Programme for Government*, published less than two months before, that:

We will stop the top-down reorganisations of the NHS that have got in the way of patient care.²⁴

However, the *Coalition Programme for Government*, and Conservative Party documents published in

Health Select Committee report on commissioning

The Health Committee, published the report of their inquiry on *Commissioning* on 18 January 2011. This evaluated the changes proposed by the NHS White Paper and highlighted some of the risks. Although the report noted that the Committee "broadly shares the Government's policy objectives" it also had concerns about the Government's approach. The Committee intend to review the proposed arrangements for NHS commissioning as the Bill progresses through Parliament.

²⁰ Health Select Committee, *Commissioning*, 18 January 2011, HC 513-I 2010–11, page 3. See also: "Dorrell: the 'main game' is delivering efficiency", *Health Service Journal*, 18 November 2010

²¹ "Doctors warned to expect unrest over NHS reforms", *the Guardian*, 19 November 2010

²² "GPs 'uncertain if NHS shake-up will benefit patients'", BBC News website, 7 October 2010; and "Doctors' scepticism means rocky road for NHS reform", *Guardian* website, 24 October 2010

²³ DoH, "Second wave of pathfinders announced", Pathfinder Learning Network website, 17 January 2011

²⁴ *The Coalition: our programme for government*, 20 May 2010, p 24

opposition, had foreshadowed some of the proposals later developed in the White Paper.²⁵ Section 3 of the Library Standard Note *NHS commissioning* provides an account of how the Government's commissioning reforms developed from proposals made in opposition.²⁶

In November 2010 a number of newspapers reported that Oliver Letwin, the Minister for Government Policy at the Cabinet Office, had been charged with scrutinising the Department of Health's plans for NHS reform, reflecting what were reported to be Cabinet and Treasury reservations about the policy. In an interview with the *Financial Times* Andrew Lansley addressed these reports, noting:

"Oliver [Letwin] is the minister for government policy, so I don't think anybody should be terribly surprised if he spends his time getting involved in government policy. The bigger the policy, the more important it is for him to be involved."²⁷

The opposition

The Shadow Health Secretary, John Healey, set out Labour's response to the Bill in a speech at the King's Fund on Friday 21 January 2011. Although he noted that he agreed with the overall aims of reform, the Government's plans to achieve them were "high cost and high risk." He stated that the true intents of what he described as the "Conservative plan for the NHS" was "opening up all parts of the NHS to private health companies, and taking what remains of NHS out of the public sector."²⁸

There was an Opposition-day debate in the House of Commons on the 17 November 2010, on the following Labour motion:

That this House believes that the Government is pursuing a reform agenda in health that represents an ideological gamble with successful services and has failed to honour the pledges made in the Coalition Agreement to provide real-terms increases each year to health funding; further believes that the Government is failing to honour its pledge in the Coalition Agreement by forcing the NHS in England through a high-cost, high-risk internal reorganisation as set out in the health White Paper; is concerned that the combination of a real cut to funding for NHS healthcare and the £3 billion reorganisation planned by the Secretary of State for Health will put the NHS under great pressure and that services to patients will suffer; supports the aims of increasing clinician involvement and improving patient care, but is concerned that the Government's plans will lead to a less consistent, reliable and responsive health service for patients which is also more inefficient, secretive and fragmented; and calls on the Secretary of State for Health to listen to the warnings from patients' groups, health professionals and NHS experts and to rethink and put the White Paper reforms on hold, so that in this period of financial constraint the efforts of all in the NHS can be dedicated to improving patient care and making sound efficiency savings that are reused for frontline NHS services.²⁹

The debate included contributions from Andrew Lansley, John Healey and a large number of backbench Members, the full text of the debate is available on the Parliamentary website [HC Deb 17 November 2010 cc904-954].³⁰

²⁵ See, for example, the Conservative Party policy paper, *NHS Autonomy and Accountability* (2007).

²⁶ Library Standard Note *NHS commissioning* (SN/SP/5607), 25 January 2011

²⁷ Nicholas Timmins, "Lansley to press on with NHS reforms", *Financial Times*, 7 December 2010

²⁸ <http://www2.labour.org.uk/john-healeys-speech-to-the-kings-fund,2011-01-21>

²⁹ HC Deb 17 November 2010 c904; The House rejected the motion on division: Ayes 239, Noes 317

³⁰ There was also a debate on healthcare in the House of Lords on 28 October 2010 (HL Deb 721 c1355-93)

Revolution or Evolution?

Many organisations and commentators have referred to the radical or revolutionary nature of the Government's reforms, with some respondents describing them as the greatest change to the NHS since its foundation. The Chief Executive of the NHS, Sir David Nicholson, has been quoted as saying the programme of reforms and efficiency savings in the NHS is "the only one so large that you can actually see it from space".³¹ However, in an interview with the *Financial Times* on 7 December 2010 the Secretary of State for Health, Andrew Lansley, said people "woefully overestimate the scale of the change", and noted that practice based commissioning, choice of provider, NHS price lists and foundation trusts already exist. He also emphasised the continuity with the earlier reforms under Labour that "were never completed or in some cases virtually abandoned."³²

Julian Le Grand, Professor of Social Policy at the London School of Economics and former senior health policy adviser to Tony Blair has described the Government's proposals as "a logical extension of the reforms put in place by Tony Blair's government."³³ The Government has also stressed the continuity with previous reforms:

Our proposals build on an extensive evidence base from the reforms of the previous administration and NHS reforms in the 1990s. GP-led commissioning is a development of the principles established over 20 years through GP fundholding and practice-based commissioning. We are strengthening and seeing through to fruition the previous government's ambitions for patient choice and for freeing NHS providers through the introduction of foundation trusts.³⁴

The Shadow Health Secretary, John Healey, has strongly contested the claim that the Government's reforms are a logical extension of earlier Labour policies, saying: "this is a revolution for the NHS not an evolution".³⁵

A summary of some of the responses to the White Paper and the *Health and Social Care Bill* can be found in Appendix 2 and 3.

The Government's response: a legislative framework and next steps

In December 2010 the Government published *Liberating the NHS: Legislative framework and next steps*, its response to the consultations on the White Paper, and associated documents (see Appendix 1). *Liberating the NHS: Legislative framework and next steps* (hereafter referred to as the *Legislative Framework*) summarises some of the over 6000 consultation responses and sets out more detail about how the Government intends to legislate for and implements its reforms. It also sets out some areas in which the Government has refined its proposals, in response to suggestions received during the consultation. In particular, the changes included:

- Strengthening the role of health and wellbeing boards in local authorities, and a new responsibility to develop a joint health and wellbeing strategy, spanning the NHS, social care and public health.
- A more distinct identity for Healthwatch England, led by a statutory committee within the CQC.

³¹ Nicholas Timmins, "Risks and rewards of NHS reforms", 19 January 2011

³² Nicholas Timmins, "Lansley to press on with NHS reforms", *Financial Times*, 7 December 2010

³³ Julian Le Grand, letter to the *Financial Times* on 29 October 2010 and article in the *Financial Times* on 20 January 2011

³⁴ DoH, *Liberating the NHS: Legislative framework and next steps* (Cm 7993) 15 December 2010

³⁵ <http://www2.labour.org.uk/john-healeys-speech-to-the-kings-fund,2011-01-21>

- Requiring all GP consortia to have a published constitution.
- Changing the Government's proposal that maternity services should be commissioned by the NHS Commissioning Board.
- Extending councils formal scrutiny powers to cover all NHS-funded services.
- Giving GP consortia a stronger role in supporting the NHS Commissioning Board to improve quality in primary care.
- Creating a duty for all arm's length bodies to cooperate in carrying out their functions, backed by a new mechanism for resolving disputes.

The Government also refined its schedule for implementation to create a more phased transition, including:

- A longer period for completing reforms to providers and for introducing economic regulation.
- Confirming the setting up of GP consortia pathfinders.
- The introduction of a programme of early implementers for health and wellbeing boards.
- Phasing the timetable for giving local authorities responsibility for commissioning NHS complaints advocacy.

In reply to the criticisms that their reforms were too fast and would distract the NHS from making efficiency gains, the Government's response argued that rapid progress on reform is essential to delivering the required productivity improvements:

There is no way to make a step change in the quality of commissioning without better engaging the GPs who already make the decisions that commit most NHS resources – as our reforms will do. Meanwhile, driving efficiency in provision depends on having the right incentives, which our reforms to pricing and regulation will create, coupled with a relentless focus on the most financially challenged organisations – which we are determined to provide.³⁶

3.3 Timetable for implementation

The NHS White Paper stated that legislation to implement its reforms, would be published by the end of 2010.³⁷ However, publication of the *Health and Social Care Bill* was delayed until 19 January 2011.

Although the Government has announced it is pushing back the deadline for implementation of some measures,³⁸ the overall timetable for implementation has remained unchanged, with the majority of reforms coming into effect by 2012:

³⁶ DoH, *Liberating the NHS: Legislative framework and next steps* (Cm 7993) 15 December 2010, para 1.23

³⁷ DoH, *Equity and excellence: Liberating the NHS* (Cm 7881) 12 July 2010, pages 49-50

³⁸ DoH, *Liberating the NHS: Legislative framework and next steps* (Cm 7993) 15 December 2010

Timetable for implementation of NHS reforms:

| | |
|---|---------------|
| Shadow NHS Commissioning Board established as a special health authority | April 2011 |
| Arrangements to support shadow health and wellbeing partnerships begin to be put in place | |
| GP consortia established in shadow form | 2011/12 |
| NHS Outcomes Framework fully implemented | By April 2012 |
| Majority of reforms come into effect: <ul style="list-style-type: none"> • NHS Commissioning Board fully established • New local authority health and wellbeing boards in place • Limits on the ability of the Secretary of State to intervene • Public record of all meetings between the Board and the Secretary of State • The public health service, Public Health England, in place • NICE put on a firmer statutory footing • HealthWatch established • Monitor established as economic regulator | April 2012 |
| NHS Commissioning Board makes allocations for 2013/14 direct to GP consortia | Autumn 2012 |
| Formal establishment of all GP consortia | 2012 |
| SHAs are abolished | 2012/13 |
| <ul style="list-style-type: none"> • GP consortia hold contracts with providers • Health and wellbeing boards assume full powers • Local authorities start to receive ring-fenced public health budget • PCTs are abolished | April 2013 |
| All NHS trusts become, or are part of, foundation trusts | By April 2014 |
| All providers subject to Monitor regulation | From 2014/15 |

Adapted from NHS White Paper, *Equity and excellence: Liberating the NHS* (Cm 7881) 12 July 2010

4 Functions of the Secretary of State, the NHS Commissioning Board and GP consortia (Part 1 of the Bill)

4.1 Duties of the Secretary of State

Currently, the Secretary of State is directly responsible for providing or securing the provision of all health services as set out in the *NHS Act 2006*, a function which is largely delegated to Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) under section 7 of the *NHS Act 2006*.

Part 1 of the Bill sets out a framework in which functions in relation to the health service are conferred directly on the organisations responsible for exercising them, with the intention that the Secretary of State retains only those controls necessary to discharge core functions.

The Secretary of State would continue to be under a duty to promote the comprehensive health service but direct responsibility for securing the provision of health services would be conferred on the NHS Commissioning Board and GP commissioning consortia. Under the new commissioning arrangements the Secretary of State will be responsible for setting a formal mandate for the NHS Commissioning Board and holding the Board to account. The Secretary of State would continue to be accountable to Parliament for health service expenditure but his, and the Department's, role in directly managing and intervening in the NHS would be reduced.

The Government intends that the focus of the role of Secretary of State should shift to tackling health inequalities and (together with local authorities) protecting and improving public health. The Department would also focus on these objectives and on reforming adult social care.

Quality improvement

Clause 2 of the Bill introduces a new duty for the Secretary of State to act with a view to securing continuous quality improvement in services provided by the NHS; in discharging this duty the Secretary of State must also act with a view to securing 'continuous improvement' in outcomes. The outcomes include the three 'dimensions of quality' (first established by the Darzi review in 2008³⁹): the effectiveness and safety of the services provided to patients, and the quality of the experience undergone by patients. **Clauses 19 and 22** impose similar duties on the NHS Commissioning Board and GP consortia.

Reduction of inequalities

Clause 3 would impose a duty on the Secretary of State to consider the need to reduce inequalities in respect of the benefits that may be obtained from the health service. **Clauses 19(section 13 (F)) and 22** impose similar duties on the NHS Commissioning Board and GP consortia.

Duty to promote autonomy

The *Legislative Framework* stated the Government's intention to restrict central control by enshrining 'the principle of autonomy at the heart of the NHS' by:

maximising the autonomy of individual commissioners and providers and minimising the obligations placed upon them, in a way that is consistent with the effective operation of a comprehensive health service.⁴⁰

³⁹ DoH, *High quality care for all: NHS Next Stage Review final report*, Professor the Lord Darzi of Denham KBE, (Cm 7432), 30 June 2008

⁴⁰ DoH, *Liberating the NHS: Legislative framework and next steps* (Cm 7993) 15 December 2010

Clause 4 seeks to establish this overarching principle, by stating that the Secretary of State should act with a view to promoting autonomy in the health service. It identifies two constituent elements of autonomy: freedom for health service bodies (such as commissioning consortia) to exercise their functions in a manner they consider most appropriate (by inserting section 1C(a) in the *NHS Act 2006*), and not imposing unnecessary burdens on those bodies (section 1C(b)). **Clause 19(section 13(E))** imposes a similar duty on the NHS Commissioning Board.

4.2 The Secretary of State's annual mandate to the NHS Commissioning Board

Under the current system the Chief Executive of the NHS publishes an NHS Operating Framework setting out the key objectives and financial allocations for the coming year, usually in December.⁴¹ The Secretary of State also has wide powers to direct PCTs and SHAs at any other time. The *Legislative Framework* stated that in order to provide for greater stability and planning certainty, the Secretary of State's direction for the NHS should be restricted to a yearly process of setting a mandate for the Board. It is intended that this mandate should include the totality of the Government's requirements and expectations for the NHS over what is likely to be a three-year period but updated annually. The *Legislative Framework* states that the mandate will be the key mechanism for the Secretary of State to meet his duties to promote improvement in health service quality and outcomes:

For the first time the Secretary of State will be under specific duties to promote improvement in quality and outcomes, and reduce inequality in healthcare provision, and will set out objectives for the NHS Commissioning Board in these areas including specific levels of improvement. The mandate will also include financial allocations to the NHS Commissioning Board. The Board will be under a duty to seek to achieve the objectives set for it in the mandate, and will have a duty to comply with any requirements imposed on it for that purpose.⁴²

Clause 19 of the Bill makes further provisions relating to the Board, inserting Chapter A1 into Part 2 of the *NHS Act 2006*. New section 13A, which requires the Secretary of State to publish and lay before Parliament a document to be known as 'the mandate' before the start of each financial year. Section (13A(2)(a)) state that the mandate must specify the objectives that the Board should seek to achieve, and any other requirements that the Secretary of State considers necessary to ensure those objectives are met (13A(2)(b)). The objectives may relate to the current financial year or subsequent financial years (as set out in 13A(4)(a) and 13A(4)(b)). This is to allow the Secretary of State to set longer-term objectives for the Board, not necessarily tied to one particular year's funding (e.g. enabling an objective to improve health outcomes over a number of years).

Subsections 13A(3) and (4) indicate that the Secretary of State must specify in the mandate the Board's financial allotment and resource allocation for the financial year, and may also do so for subsequent financial years.

Before specifying any objectives or requirements in the mandate, the Secretary of State would be under a duty to consult the Board and such other persons that he considers appropriate to ensure that the mandate would be effective (13A(8)).

New section 13B establishes the rules around in-year changes to the mandate. The Secretary of State may only make changes to the mandate, or the resources allocated to the Board, if the Board agrees to the revision or if the Secretary of State feels that there are exceptional circumstances that make the revision necessary (subsection (3)). The Secretary of State may also revise the mandate following a parliamentary general election (subsection

⁴¹ DoH, *NHS Operating Framework for 2011/12*, 15 December 2010, para 5.16

⁴² DoH, *Liberating the NHS: Legislative framework and next steps* (Cm 7993) 15 December 2010

(3)(b)). After altering the mandate, the Secretary of State must publish the revised document, and lay the new version before Parliament with an explanation of the reasons for making the changes, as specified in subsection(4).

4.3 Exceptional powers to direct the NHS Commissioning Board and GP consortia

Regulations relating to EU obligations

Under the current system, the Secretary of State has the power to delegate certain aspects of his functions relating to EU obligations to PCTs and SHAs, and to direct them in the exercise of these and other functions to ensure compliance with EU law. In view of the abolition of PCTs and Strategic Health Authorities, **clause 15** gives the Secretary of State similar powers with regard to the Board and consortia. For example, the Secretary of State might delegate to consortia the function of authorising patients in England to go to another EU state for their treatment.

Standing rules

Clause 16 makes provision for the Secretary of State to establish 'standing rules' which would impose requirements on the NHS Commissioning Board and commissioning consortia in the exercise of their functions. The requirements in the standing rules would be imposed by means of regulations, as outlined in subsection(1). These will, for example, provide the basis for the legal rights in the NHS Constitution that currently depend on directions to PCTs, and will also give power for ministers to ensure compliance with EU obligations (and is complementary to the powers in **clause 15**). Other subsections of this clause confer powers to direct the Board or consortia with regard to the drafting of commissioning contracts, and to require information to be provided to patients and the public. Subsection(7)(c) also allows for a general power for the Secretary of State to require the Board or consortia 'to do such other things as the Secretary of State considers necessary for the purposes of the health service'. Given the broad scope of this power regulations brought forward under subsection(7)(c) would be subject to the affirmative procedure in Parliament.

The expectation is that the Secretary of State would make changes to the standing rules only at the same time as the mandate is set, on 1 April each year; where that is not the case, the Bill requires the Secretary of State to lay a statement before Parliament explaining why.

Standing rules created by this clause must apply generically and cannot apply only to individual consortia.

Power to confer additional functions on the Board

Clause 19(section 13U) gives the Secretary of State the power to confer additional functions relating to the health service on the NHS Commissioning Board through regulations. These regulations would be subject to the affirmative procedure, and could only be conferred on the Board if it connected to another function of the Board.

Power to intervene: failure by Board to discharge functions

Clause 19(section 13V) confers powers on Secretary of State to intervene in cases of serious failure of the NHS Commissioning Board to carry out any of its functions.

Emergency powers

Clauses 38 and 39 would amend the *NHS Act 2006* to make provision in relation to emergencies affecting the health service.⁴³

⁴³ The provisions are in addition to the provisions of the Civil Contingencies Act 2004 relating to emergencies and civil contingency planning by health service and other public bodies.

Clause 38 sets out the role and responsibilities of the NHS Commissioning Board and commissioning consortia in relation to assuring NHS emergency preparedness, resilience and response.

Clause 39 would extend the Secretary of State's emergency powers. Currently section 253 of the *NHS Act 2006* confers on the Secretary of State the power to give directions to any body or person exercising functions under the Act, other than NHS foundation trusts, where he considers it necessary by reason of an emergency to do so. The clause also amends section 253 so that the Secretary of State can give a direction where he considers it is 'appropriate', not just necessary, to do so by reason of an emergency. In addition, the effect of the amendment is that the power is not limited to giving directions to ensure that a service is provided, rather it provides that the Secretary of State's power to direct applies to all NHS bodies except Local Health Boards (which are Welsh NHS bodies) – i.e. it covers the NHS Commissioning Board, commissioning consortia, Special Health Authorities, NHS trusts and NHS foundation trusts. The power would also apply to the National Institute for Health and Care Excellence (NICE), the Health and Social Care Information Centre and any provider of NHS services.

4.4 The Secretary of State's annual report

Clause 44 would require the Secretary of State to publish an annual report relating to the performance of the health service in England, which is to be laid before Parliament. The *Explanatory Notes* to the Bill state that this is the first time that a specific requirement for an annual report of this kind has been proposed, and it is intended to ensure that the performance of the comprehensive health service is subject to the appropriate Parliamentary scrutiny. This report would cover both those aspects of the health service commissioned by the NHS Commissioning Board and commissioning consortia, as well as those public health services for which the Secretary of State and local authorities are responsible. It may, for example, include an assessment as to the extent to which the comprehensive health service had achieved progress in the outcomes set out in the Outcomes Framework.⁴⁴

4.5 The NHS Commissioning Board

The NHS Commissioning Board is meant to hold commissioning consortia to account for the quality of services they commission, the outcomes they achieve and for their financial performance. The Board would provide national leadership in commissioning, promote patient choice and allocate NHS resources to GP consortia. In addition it would be responsible for commissioning primary care services and specialist services currently commissioned at a national level.

In December 2010 the Secretary of State, Andrew Lansley, announced the appointment of Sir David Nicholson, current Chief Executive of the NHS, to be the new Chief Executive of the NHS Commissioning Board. In an interview with the *Health Service Journal* Sir David is quoted as saying:

“The Health Bill will set out exactly how many executives and non-executives [the board will have] but that's it... [The make-up] is something I've got to think about and work through over the next few months.”⁴⁵

The NHS Commissioning Board would initially be established in shadow form as a Special Health Authority. **Clause 5** of the Bill would establish the Board as a new non-departmental public body, accountable to the Secretary of State. This clause inserts Schedule 1 of the Bill, which makes provision for the membership of the Board to comprise of:

⁴⁴ *Explanatory Notes to the Bill* [Bill 132-EN], paras. 412-3

⁴⁵ “Board will step in if consortia falter”, *Hsj*, 20 January 2011

- a chair appointed by the Secretary of State,
- at least five other members also appointed by the Secretary of State, and
- the chief executive and other members.

Paragraph 3 of Schedule 1 provides that the executive members be appointed by the non-executive Members and that the appointment of the Chief Executive receives the approval of the Secretary of State. It also requires that the Secretary of State appoint the first Chief Executive of the NHS Commissioning Board.

The NHS Commissioning Board would have broad overarching duties to promote a comprehensive health service (other than in relation to public health) and to exercise its functions with a view to securing the provision of services for that purpose. It would also be responsible for commissioning those services not commissioned by GP consortia, such as specialist services commissioned at a national or regional level, and primary care services (including primary medical services provided by GPs). The Board would also have the power to intervene where there is evidence that consortia are failing or are likely to fail to fulfil their functions.

As well as containing provisions regarding the annual mandate to the Board, **clause 19** also sets out the general duties of the Board, these would include the following general duties (subsections 13A to 13K):

- to exercise its functions effectively, efficiently and economically;
- to improve the quality of services and outcomes (this is similar to the duty imposed on the Secretary of State by **clause 2** although the Board must also have regard to any document published by the Secretary of State (such as the Outcomes Framework) and to quality standards prepared by NICE);
- to promote autonomy (this mirrors the duty imposed on the Secretary of State in **clause 4**);
- to reduce inequalities and promote patient involvement;
- to obtain appropriate advice from other health professionals;
- to promote innovation in the provision of health services;
- to have regard to the need to promote research and the use of evidence;
- to encourage integrated working; and
- to have regard to the impact of services on the provision of health services to people living in areas of Wales or Scotland close to the border with England.

Clause 19(sections 13L to 13P) set out additional functions of the Board including arrangements for public involvement, for collecting and processing information, for publishing a business plan, and for producing an annual report (to be laid before Parliament). Sections 13Q to 13S provide additional powers to share commissioning funds with one or more consortia to create a 'risk pool', and for the Board to generate income in certain circumstances.

Funding of the Board

Clause 20 covers the funding of the Board (section 223B), its use of resources (223C), and its financial duties (223E to 223G). Broadly, this clause outlines how the Secretary of State would fund the Board and set limits on the amount of resource it can use, and outlines the way in which the Board would make use of its funds.

Services commissioned by the NHS Commissioning Board:

The Board would commission those services not commissioned by GP consortia, including primary medical, dental, ophthalmic and community pharmaceutical services as set out in Part 6 of the Bill. The Board would commission these primary care services to avoid any potential conflict of interests for GP consortia.⁴⁶

The Board may also be required to commission other services as outlined in new section 3B of the *NHS Act 2006* (inserted by **clause 11**). These include “specialised services” for rare conditions, which are currently commissioned nationally by SHAs because of their low volume and high cost.

Clause 12 would transfer the duty to arrange for provision of high security psychiatric services (such as Broadmoor Hospital) from the Secretary of State to the NHS Commissioning Board. The clause would enable the Secretary of State to give directions to the Board about the way it exercises its functions in relation to high security services.

4.6 GP commissioning consortia

The NHS White Paper proposed to give responsibility for commissioning the majority of health services to GPs and their practice teams, working in consortia. It is expected that by 2013 these GP consortia will be responsible for around 70-80% of the NHS budget.

The White Paper stated that GPs are ‘best placed to coordinate the commissioning of care for their patients’, and that GP commissioning will ‘bring together responsibility for clinical decisions and for the financial consequences of these decisions’.⁴⁷ The Government’s *Legislative Framework* explains that the purpose of establishing GP commissioning consortia as statutory bodies:

...is to ensure that they have an identity that is separate from that of their member practices, with clarity between the commissioning responsibilities of the consortium as a whole and the specific responsibilities of individual practices. Being a statutory body means that consortia can have clear powers and duties. Compared to current practice-based commissioning, statutory arrangements will afford a more transparent framework for how consortia operate, including what happens when a consortium is unable to fulfil its functions.⁴⁸

Clause 6 of the Bill would establish GP commissioning consortia as corporate statutory bodies, authorised to act by the NHS Commissioning Board. These consortia will be responsible for commissioning the majority of health services.

Duties and powers of consortia

Clauses 9 and 10 would amend section 3 of the *NHS Act 2006* to provide for the duties and powers of consortia as to commissioning certain health services. **Clause 10** would insert a new section 3A into the *NHS Act 2006* which provides a power for consortia to commission the services or facilities that it considers appropriate to securing improvement in the physical

⁴⁶ DoH, *Equity and excellence: Liberating the NHS* (Cm 7881) 12 July 2010, para 4.10-4.11, pages 30-33

⁴⁷ *Ibid.* para 4.2-4.9, pages 27-30

⁴⁸ DoH, *Liberating the NHS: Legislative framework and next steps* (Cm 7993) 15 December 2010, para 4.15

and mental health of persons for whom it has responsibility, and the prevention, diagnosis and treatment of illness in these people. Commissioning consortia will be the appropriate commissioner unless there is a duty on the Board to commission that service.

The establishment of GP commissioning consortia

Clause 21 would insert Chapter A2 into Part 2 of the *NHS Act 2006*, which makes further provision about the establishment of consortia and the requirement that they have a constitution (sections 14A to 14D and 14J), variations to their constitution (14E and 14F) and their merger and dissolution (14G to 14I).

Subsection 14A(1) requires the Board to ensure that, at any time after the date specified by the Secretary of State, all providers of primary medical services (typically GP practices) in England are members of a consortium. Subsection(2) requires the Board also to ensure that, from this date, the areas specified in each consortium's constitution cover the whole of England and do not coincide or overlap. This is intended to ensure that there is no ambiguity as to which consortium is responsible for a person that is not registered with a GP practice or who needs access to emergency healthcare. Together, these and all the other subsections to 14A have the effect that all GP practices must be members of a consortium.

Applications for the establishment of commissioning consortia

New section 14B makes provision for applications to be established as a consortium to be made to the Board (subsection(1)). Under subsection(2), an application may be made by two or more persons, provided that each of them is either a provider of primary medical services (i.e. a GP contract holder) or wishes to be so. Under subsection(3), applications must include a copy of the consortium's proposed constitution, the name of the person whom the consortium wishes the Board to appoint as its accountable officer and such other information that the Board may specify.

Determination of applications

Section 14C provides for the approval of the applications, subject to the Board being satisfied that the applicants have made appropriate arrangements to discharge the consortium's functions, including being satisfied that the geographic area covered by the consortium is appropriate (subsection14C(2)(c)).

GP consortia: constitution

Subsection 14B(6) and Section 14D have the effect of introducing Schedule 2 of the Bill which makes provision about consortia and what must be included in their constitution.

- Paragraphs 1 to 3 of this schedule state that a consortium must have a constitution, and that it must specify the name and members of the consortium, the geographical area that they cover, and must specify functions in relation to determining remuneration and terms and conditions of its employees. Arrangements may also include the appointment of committees, the membership of which may include members of the public.
- Paragraph 4 provides that the constitution must include the procedures for dealing with consortium members' conflicts of interest.
- Paragraph 5 provides that the provisions made under paragraphs 3 and 4 must ensure that there is effective participation by each member of the consortium.
- Paragraph 7 provides that each consortium is to be a body corporate.

- Paragraph 8 provides that consortium may appoint employees on such terms and conditions (including remuneration) as they determine. The *Explanatory Notes* to the Bill state that consortia are to be granted the status of 'Employing Authorities' by amending the *NHS Pension Scheme Regulations* (after the passage of the Bill). This means that (like other NHS bodies such as foundation trusts) consortia would be required to offer the NHS pension scheme to their employees.
- Paragraph 9 sets out that each consortium must have an accountable officer, who may be either a member of the consortium or an employee. They may be the accountable officer for more than one consortium. The accountable officer is responsible for ensuring the consortium complies with its financial obligations (under new sections 223I to 223K of the *NHS Act 2006*). The accountable officer is responsible for ensuring that the consortium fulfils its duties to exercise its functions effectively, efficiently and economically under new section 14K, and its duties under new section 14L in relation to improvement in the quality of services. The accountable officer must also ensure that the consortium exercises its functions in a way which provides good value for money. Other obligations may be specified by the Board.
- Paragraphs 11 to 15 of Schedule 2 would enable a consortium to enter into externally financed development agreements, the keeping of accounts and the provision of audited accounts to the Board. These paragraphs also cover the provision of additional information required by the Board or Secretary of State, and the incidental powers of consortia.

Sections 14E and 14F cover arrangements for a consortium to vary its constitution, or for the Board to do so, in order for the Board to ensure that every GP contract holder is a member of a consortium or to ensure that the areas specified in the constitutions of consortia together cover the whole of England.

Sections 14G and 14H cover arrangements for the merger and dissolution of consortia. Section 14I covers staff and property transfers in connection with variation, merger and dissolution. Section 14I also introduces Part 3 of Schedule 2 of the Bill, paragraphs 16 to 20 of which set out further details in respect of property and staff transfer schemes which may be made under section 14I.

General duties of consortia

Clause 22 would insert new sections 14K to 14Z9 into the *NHS Act 2006*.

Under section 14K each consortium must exercise its functions effectively, efficiently and economically. Section 14L places commissioning consortia under a duty to exercise their functions with a view to securing continuous improvements in the quality of services provided to individuals, particularly in relation to the outcomes from that care (the duties set out in 14K and 14L mirror those duties on the Board in **clause 19**).

The Government's intention, as set out in the Bill, is that NHS Commissioning Board will be responsible for commissioning GP services and holding GP contracts. However, following consultation on its proposals the Government was persuaded to introduce an explicit duty for all GP consortia to support the Board in improving the quality of primary medical care services provided by other consortium members.⁴⁹ Section 14M specifies that each consortia must assist and support the Board in discharging its duty under 13D as to improvement in the quality of primary medical services.

⁴⁹ DoH, *Liberating the NHS: Legislative framework and next steps* (Cm 7993) 15 December 2010, para 4.82

Sections 14N to 14P cover duties in relation to reducing inequalities, promoting patient involvement, obtaining appropriate advice and consulting and involving the public.

Sections 14Q and 14R enable consortia to collaborate with each other, and with local health boards in particular circumstances.

Additional powers for consortia to raise additional income and to make grants are set out in sections 14S and 14T.

Sections 14U, 14V, 14W and 14X make provision for the Board to have functions in relation to assisting consortia. For example 14U states that the Board may publish a document specifying the circumstances in which a consortium is liable to make payments to a provider to pay for services provided under arrangements commissioned by another consortium. This provision would, for instance, enable the Board to specify that, where a person uses an urgent care service commissioned by a consortium other than the consortium that is ordinarily responsible for that person's healthcare, the cost of that service is charged to the latter consortium.

Section 14V provides that the Board must publish guidance for consortia on the discharge of their commissioning functions. Section 14W provides that the Board may, at the request of a consortium, exercise commissioning functions on behalf of the consortium. Section 14X states that the Board may provide assistance or support.

Commissioning plans

Section 14Y provides that consortium must prepare a plan setting out how it proposes to exercise its functions, particularly with regard to discharging its duties to ensure continuous improvement in health outcomes (under section 14L) and its financial duties (under sections 223I and 223K). The consortium must send its plan to the Board and to any local authority health and wellbeing boards (HWBs) that cover its area. GP consortia will also be under an obligation to include a statement as to whether the relevant HWB agrees that their plans have due regard to their joint health and wellbeing strategy (JHWS).

Sections 14Z to 14Z5 cover annual reporting, the Board's performance assessment of consortia and the Board's powers to require information from consortia.

The NHS Commissioning Board's powers to intervene

Under section 14Z6, if the Board is satisfied that a consortium is failing or has failed to discharge any of its functions, or there is a significant risk that it will fail to do so, the Board has powers to direct the consortium as to the discharge of its functions, terminate the accountable officer's appointment and appoint another person, to vary a consortium's constitution or, ultimately to dissolve that consortium.

Section 14Z7 sets out the procedural requirements in connection with these intervention powers.

Financial arrangements for consortia

Clause 23 sets out the financial arrangements for commissioning consortia, inserting new sections 223H to 223L into the *NHS Act 2006*. The *Explanatory Notes* to the Bill provides an overview of the arrangements:

The Secretary of State will remain accountable to the Treasury for the Department of Health's Departmental Expenditure Limit (DEL), the annual spending limit for a government department arising from its agreed, long term financial settlement with HM Treasury. The Department will allocate resources for NHS commissioning to the Board and hold the Board to account for living within its spending and resource limits. The

Board will in turn allocate resources to consortia and hold them to account for living within their spending and resource limits.⁵⁰

Section 223I sets out the duty for consortia to break even on their commissioning budget, in other words to ensure that their expenditure in a financial year does not exceed the allotment given to them by the Board, together with any other sums received by the consortium.

Resource allocation

Funds for commissioning would be calculated as 'practice-level budgets', to be allocated directly to consortia. Payments could be made in respect of good performance (under section 223L) and it is expected that a 'Quality Premium' would be top-sliced from existing GP practice income streams and withheld if a consortium failed to achieve good enough outcomes and financial control in its commissioning. GP consortia spending on management and administration is expected to be capped by a 'maximum management allowance'.

The *NHS Operating Framework for 2011/12* set out how resources will be released from the infrastructure and running costs of SHAs and PCTs in order to provide a running cost allowance for GP consortia. The expectation is that GP consortia will have an allowance for running costs that could be in the range of £25 to £35 per head of population by 2014/15. The Government will not determine the exact amount until further work has been undertaken with pathfinders.⁵¹

Clause 24 would enable the introduction of a new requirement in the terms of the General Medical Services (GMS) contracts for the GMS contract holder to be a member of a commissioning consortium and to nominate an individual to act on behalf of the contract holder in its dealings with the consortium.

4.7 Abolition of Primary Care Trusts and Strategic Health Authorities

Commissioning in the NHS takes place in the context of the 'purchaser / provider split' introduced in 1991, whereby one part of the NHS is responsible for contracting with NHS (and independent-sector) providers for the supplying of services for patients. The commissioning function currently resides with Primary Care Trusts (PCTs), which are run by appointed (executive and non-executive) Board members. Some 80% of the NHS annual budget is spent by PCTs, which receive average annual funding of around £500 million each.⁵²

Clauses 28 and 29 of the Bill provide for the abolition of Strategic Health Authorities (SHAs), which act as regional offices of the Department of Health, and PCTs. Following the establishment of the NHS Commissioning Board and GP consortia, PCTs would no longer have NHS commissioning functions, and PCT responsibility for health improvement would be transferred to local authorities. It is expected that PCTs are to be abolished from April 2013, and SHAs by April 2012. Community services currently provided by PCTs would be provided by NHS foundation trusts or other types of provider.

A number of the Schedules to the Bill would make consequential amendments to other Acts, removing references to 'Primary Care Trusts' and 'Strategic Health Authorities', and replacing

⁵⁰ *Explanatory Notes to the Bill* [Bill 132-EN]

⁵¹ DoH, *NHS Operating Framework for 2011/12*, 15 December 2010, para 5.16

⁵² PCTs also receive some capital funding. The remaining fifth of the NHS budget is accounted for by other items of capital spending, funding for SHAs and centrally-managed revenue budgets. The last of these includes funding for pharmacy (dispensing) and ophthalmology services, as well as areas such as research and development, training, arm's length bodies, litigation and Connecting for Health (which is responsible for delivering the National Programme for IT).

them with references to commissioning consortia, the NHS Commissioning board and local authorities as necessary.

4.8 The transition from PCT to GP commissioning

The timetable for transition

The Government intends that a comprehensive system of GP consortia should be in place by April 2012, with authorised GP consortia taking on full statutory and financial responsibilities from April 2013.

There are already moves to lay the basis for the new consortia, building on existing arrangements such as Practice Based Commissioning. In October 2010 Andrew Lansley announced a 'Pathfinder' programme, to enable 'trailblazing' groups of GPs to take on budgets before 2013 (see the section on pathfinder areas below). The *NHS Operating Framework for 2011/12*⁵³ published on 15 December 2010 set out the following 'road map' for the introduction of GP consortia and the abolition of PCTs in April 2013:

| | |
|---------------------------|---|
| Now – March 2011 | PCTs to involve GP practices and emerging consortia, with other clinicians, in the 2011/12 contracting round and the broader commissioning cycle from 2011/12 onwards |
| December 2010 | Initial GP consortia pathfinders identified |
| January – March 2011 | Delegated responsibilities of pathfinder consortia confirmed with PCTs |
| January 2011 – March 2012 | Further pathfinders identified and emerging consortia encouraged to become increasingly involved in commissioning and take on increasing delegated responsibilities |
| In 2011/12 | NHS Commissioning Board set up in shadow form as special health authority |
| June 2011 | PCT clustering arrangements in place |
| April 2012 | All GP practices in GP consortia and start of NHS Commissioning Board authorisation of consortia |
| April 2012 | NHS Commissioning Board established, takes over relevant responsibilities |
| April 2012 | SHAs abolished and responsibilities allocated to bodies in the 2012/13 architecture |
| April 2012 – March 2013 | NHS Commissioning Board to work with GP consortia that need further support to be ready to take on full statutory responsibilities |
| April 2013 | Authorised GP consortia take on full statutory responsibilities |
| April 2013 | PCTs abolished |

From DoH, *NHS Operating Framework for 2011/12*, 15 December 2010

⁵³ DoH, *NHS Operating Framework for 2011/12*, 15 December 2010

Concerns about the transition

The British Medical Association has said it is 'extremely alarmed' at the 'potential vacuum' that could open up in the transition from PCTs to consortia – with 'a real risk of PCT implosion'.⁵⁴ However, other commentators have highlighted the risk of slowing down. The National Association of Primary Care (NAPC) has defended the Government's timetable. Its President, Dr Johnny Marshall, recently told the NAPC's conference that:

Developing this over two and a half years is quite long enough to deliver significant change without prejudicing the safety of patients or financial control. Any longer and I fear all life will be strangled out of these reforms.⁵⁵

Speaking at a meeting of NHS medical directors in November 2010, Sir David Nicholson commented on the timetable for the abolition of PCTs:

There is a lot of talk about pace and that it should somehow be slowed down. I think it is unlikely we will be able to slow it down ... if anything it needs to be speeded up rather than slowed down.⁵⁶

The NHS Alliance has advocated what might be called a multi-speed approach, quicker than planned in some areas but slower in others, according to local circumstances. It urges that 'there should be sufficient flexibility within the proposed timetable to accommodate both the fast movers and those who require a more considered timescale'.⁵⁷ A survey for the NHS Alliance of more than 200 GPs, PCT managers and practice managers found that, whilst 78% of them supported GP commissioning, only 35% believed the planned timetable was achievable. More than 54% of those surveyed believed the handover from PCTs to consortia would take longer to achieve than the planned date of 2013.⁵⁸

Piloting GP Commissioning: pathfinder areas

On 21 October 2010 the Secretary of State announced a new pathfinder programme⁵⁹ to identify and support groups of GP practices who want to make faster progress in taking on the new roles set out in the NHS White Paper. This is intended to let GPs test different consortia designs and to identify any issues and areas of learning that can be shared across the GP community.

The Department of Health has released details of the first two cohorts of pathfinder consortia, making a total of 141 consortia, covering around 28 million people across England (over 50% of the population).⁶⁰ The consortia in the first cohort range in size from a single practice with fewer than 19,000 patients in Radlett, Hertfordshire, to one covering more than 600,000 patients in Durham.⁶¹

Clustering of PCTs

To support the transition to GP commissioning the Government has stated that it expects PCTs to form into regional 'clusters', under the control of a single executive team. These

⁵⁴ Nicholas Timmins, "BMA warns of primary care trust 'implosion'", *Financial Times*, 1 October 2010

⁵⁵ "Slow down will 'strangle' reforms, warns NAPC", *Health Service Journal* website, 21 October 2010

⁵⁶ David Nicholson, reported in HSJ, "DH maps end of PCTs and SHAs", 2 December 2010

⁵⁷ NHS Alliance response to White Paper, p. 16

⁵⁸ "GP commissioning timetable 'unrealistic', NHS Alliance poll finds", *Pulse* magazine website, 28 September 2010

⁵⁹ DoH press release, "GPs can take control in new pathfinder Consortia", 21 October 2010

⁶⁰ DoH, "Second wave of pathfinders announced", Pathfinder Learning Network website, 17 January 2011. The Prime Minister referred to the "over 140 GP-led consortia" pathfinders in his speech on modern public service on 17 January 2011

⁶¹ A full list of the GP Pathfinders included in the first wave of the Pathfinder Programme can be found at: www.dh.gov.uk/pathfinderlearningnetwork

clusters will be responsible for overseeing the delivery of PCT's statutory functions during the transition and supporting emerging GP consortia.

The *NHS Operating Framework for 2011/12* states that:

While PCTs will have a critical role up to April 2013, we do not expect to maintain 151 fully functional separate organisations up to that time, particularly if we want to offer capacity to emerging GP consortia. Because of this, and because of the broader drive to reduce running costs across the system, some regions of the NHS have already developed clusters of PCTs. In order to secure the capacity and flexibility needed for the transition period, we shall undertake a managed consolidation of PCT capacity to create such clusters across all regions of the NHS. Alongside this, staff will be increasingly assigned to emerging GP consortia to support their development.⁶²

Financial legacies of PCTs

Concerns have been raised about possible financial legacies which consortia may inherit from PCTs, including deficits and uneconomic contracts (e.g. for GP-led health centres). Professor Steve Field, former Chair of Council of the Royal College of General Practitioners (RCGPs), warned of "an inherited flock of financial albatrosses for the new GP consortia, which would be unfair".⁶³

In a question-and-answer session at the conference of the RCGP in October 2010, the Secretary of State was asked by a GP whether he could prevent consortia being "drowned at birth by the debts and mistakes" of PCTs. He responded that existing contracts would have to be honoured: "a contract is a contract and for the continuing life of that contract you will have a responsibility to get the best value out of that facility". He also indicated it was unlikely that PCT debts would be paid off. However, he insisted that:

"consortia will not be set up to fail. They will be set up to succeed and we have an obligation to ensure that consortia start with as few inherited problems as possible."⁶⁴

The *NHS Operating Framework for 2011/12* stated that GP consortia will not be responsible for resolving PCT legacy debt that arose prior to 2011/12 and that PCTs must ensure that through planning in 2011/12 and 2012/13, all existing legacy issues are dealt with. The framework explains that GP consortia will be expected to work closely to ensure financial control and balance is maintained to avoid responsibility for any unresolved post 2010/11 PCT deficits.⁶⁵

4.9 GP commissioning: other issues

GP consortia size

The Government says it has no preconceptions about the size of individual GP consortia, or the overall number of consortia that there should be. The *Analytical Strategy* accompanying the NHS White Paper states that 'most GP consortia will be smaller organisations than PCTs are at present'⁶⁶ – indicating that there will be more consortia than the current 152

Information on the development of NHS commissioning under previous governments, and the development of the Government's proposals for reform are provided in the Library Standard Note, *NHS commissioning*.

⁶² DoH, *NHS Operating Framework for 2011/12*, 15 December 2010, para 2.11

⁶³ "NHS white paper proposals backed by only one in four doctors", *Guardian* website, 24 October 2010

⁶⁴ "Lansley to protect GPs from rationing", *healthcarerepublic* website (*GP* newspaper), 14 October 2010

⁶⁵ DoH, *NHS Operating Framework for 2011/12*, 15 December 2010, para. 5.10

⁶⁶ DoH, *Analytical Strategy for the White Paper and associated documents*, July 2010, para. 33

PCTs. Given that the 141 pathfinder consortia cover about 50% of the population it suggests the final number of consortia may be around 300.⁶⁷

The NHS White Paper noted that consortia will need to have ‘sufficient geographic focus’ to allow them to commission locality-based services (such as emergency care), and services commissioned jointly with local authorities.⁶⁸

The *Legislative Framework* confirmed the Government’s intention to allow GP practices to decide how they configure consortia. The duty of consortia to discharge certain functions (for example, ensuring access to accident and emergency services in that area and commissioning care for people living in that area who are not registered with a GP practice) would mean they had to serve a ‘defined geographic area’.⁶⁹

The Bill would enable membership and geographic boundaries of consortia to change, allowing members to leave and join another consortium, and letting consortia merge or dissolve. However, all GP practices (as holders of primary medical contracts) will have a duty to be a member of a consortium.

Commissioning support for GP consortia

The NHS White Paper proposes that GP consortia will be able to decide what commissioning activities they undertake for themselves and for what activities (such as demographic analysis, contract negotiation, performance monitoring and aspects of financial management) they choose to buy in support from external organisations, including local authorities, private companies and voluntary sector bodies.⁷⁰

Potential conflicts of interest?

In its report on Commissioning published on 18 January 2011 the Health Select Committee highlights the potential conflict between the principle of patient choice and the ability of GPs commissioners to deliver the consortium’s clinical and financial priorities — particularly at a time when resource pressures within the NHS are bound to intensify. The Committee intend to review the arrangements proposed in the Bill for enabling consortia to reconcile this potential conflict.⁷¹

A report by the Nuffield Trust,⁷² has warned that offering financial incentives to GPs to improve the delivery of patient care could damage relationships with patients. The report says the NHS needs to learn important lessons from the US, where groups of doctors have been working in a similar way to how the GP consortia are expected to operate, and where income incentives are routinely used. Similar concerns about the potential damage to the patient-GP relationship have been raised by Dr Clare Gerada, chair of the Royal College of General Practitioners, and the Patients Association.⁷³

The evidence for GP commissioning

The question of the evidence base for giving responsibility for commissioning to GP consortia has come up in a number of PQs⁷⁴ and was also addressed during the Health Select Committee’s inquiry into Commissioning. The Health Committee questioned a number of

⁶⁷ DoH, “Second wave of pathfinders announced”, Pathfinder Learning Network website, 17 January 2011

⁶⁸ DoH, *Equity and excellence: Liberating the NHS*, July 2010, page 29

⁶⁹ DoH, *Liberating the NHS: Legislative framework and next steps* (Cm 7993) 15 December 2010, paras. 4.20-4.21

⁷⁰ DoH, *Equity and excellence: Liberating the NHS*, July 2010, page 29

⁷¹ Health Select Committee, *Commissioning*, 18 January 2011, HC 513-I 2010–11, para 115

⁷² “GP commissioning: insights from medical groups in the United States”, *The Nuffield Trust*, January 2011

⁷³ “NHS shakeup could set patients against their GPs, warns report”, *the Guardian*, 19 January 2011

⁷⁴ HC Deb 22 July 2010 c575W

witnesses on the evidence for the Government's commissioning reforms, on 19 October 2010⁷⁵ and 16 November 2010.

In the evidence session on 16 November 2010 Julian Le Grand, professor of social policy at LSE, emphasised evidence from GP fundholding to Practice Based Commissioning that supported the Government's approach. However, Lancaster University professor of sociology and public health, Jennie Popay, and Manchester University professor of social policy, Steve Harrison, said that past evidence was anecdotal, small-scale and difficult to transfer to the Government's large scale commissioning proposals.⁷⁶

5 Public health

5.1 The public health White Paper

The public health White Paper, *Healthy Lives, Healthy People*,⁷⁷ published on 30 November 2010, set out the Government's long-term vision for the future of public health in England. In the public health White Paper, the Government took the view that the balance of responsibility and action should shift from central government to local communities, and that people should be 'nudged' towards taking on more responsibility for their health.

The Government proposes to transfer local health improvement functions from PCTs to local authorities and to create a new body, Public Health England (the latter does not require legislation as it is likely to be created as a directorate within the Department of Health). Public Health England is expected to take on full responsibilities oversee the local delivery of public health services and deal with national issues like flu pandemics and other population-wide health threats from 2012. The majority of public health services will be commissioned by local authorities from a ring-fenced budget. The first such grant will be made for 2013-14, under section 31 of the *Local Government Act 2003*. Early estimates suggest that current spend on areas that are likely to be the responsibility of Public Health England and local authorities could be in the range of £4 billion. This figure of £4 billion, referred to in the public health White Paper, appears to be based on a 2009 estimate by Health England that public health spending equated to roughly 4 per cent of the NHS budget in 2006-07. The Department has made an initial assessment of baseline spend on the areas for which Public Health England will become responsible. This is the first step in determining the size of the future ring-fenced public health budget. Following *Healthy Lives, Healthy People*, the Department has published a consultation paper on the scope, funding and commissioning responsibilities in the new public health system, including the role of local authorities.⁷⁸

Public Health England is expected to assume the functions and powers of the Health Protection Agency (HPA) and the National Treatment Agency for Substance Misuse (NTA) from April 2012, once these bodies have been abolished.

5.2 Public health functions of local authorities and the Secretary of State (Part 1 of the Bill)

Duty to protect public health

The Bill is intended to underpin these reforms by setting out the public health duties of the Secretary of State (which it is expected will be fulfilled by Public Health England), transferring

⁷⁵ See Q.11-13 and Q.14-17 of transcript of evidence session held on 19 October 2010, Health Select Committee, *Commissioning*, 18 January 2011, HC 513-II 2010-11,

⁷⁶ *Ibid.* Transcript of evidence session held on 16 November 2010. See also Margaret Whitehead, Barbara Hanratty, Jennie Popay, "NHS reform: untried remedies for misdiagnosed problems?", *The Lancet*, Volume 376, Issue 9750, Pages 1373 - 1375, 23 October 2010

⁷⁷ DoH, *Healthy Lives, Healthy People*, (Cm 7985) 30 November 2010.

⁷⁸ DoH, *Healthy lives, healthy people: consultation on the funding and commissioning routes for public health*, 21 December 2010

local health improvement functions from PCTs to upper-tier local government, and abolishing the HPA and other bodies with public health functions.

Part 1 of the Bill sets out the detail of the respective roles of the Secretary of State and local authorities. **Clause 7** places a new duty on the Secretary of State for Health to protect public health through the insertion of a new section 2A into the *NHS Act 2006*. Subsection (2) of new section 2A lists some of the steps that the Secretary of State might take to protect public health. These include carrying out research into disease, providing laboratory services, providing information and advice to the public about health dangers and providing national vaccination and screening programmes. Many of these activities falling within this provision are currently carried out by the HPA, which would be abolished by **clause 46**.

Duty to improve public health

Clause 8 would place duties on the Secretary of State and local authorities in relation to the improvement of public health, inserting new section 2B in the *NHS Act 2006*. Subsection (3) of new section 2B lists the steps that could be taken to improve public health. These include carrying out research into health improvement, providing information and advice, providing facilities for the prevention or treatment of illness, and providing financial incentives to encourage individuals to adopt healthier lifestyles (examples of measures to improve health could include smoking cessation or weight loss services).

The Secretary of State's powers to direct local authorities

Clause 14 enables the Secretary of State to make regulations (subject to affirmative procedure) requiring a local authority to exercise any of the public health protection and improvement functions under section 2A and 2B (inserted by clauses 7 and 8 of the Bill). **Clause 18** would also allow the Secretary of State to delegate any of his functions under section 2A and 2B to the NHS Commissioning Board, GP consortia or local authority.

Transferring public health functions from PCTs to local authorities and GP consortia

Following the abolition of PCTs, their responsibilities for local health improvement (usually duties delegated from the Secretary of State), would transfer to local authorities or GP consortia. A ring-fenced grant, weighted for inequalities, would be made to upper tier and unitary local authorities for this purpose.

For example, **clause 13** would transfer responsibility for a number of public health activities in relation to school children from the Secretary of State (and currently delegated to PCTs) to local authorities. These include school nursing services. Subsections(11) and (12) of clause 13 transfer to GP consortia the Secretary of State's existing responsibility for the supply of wheelchairs and other vehicles to people with a physical disability; in practice PCTs currently arrange these services.

Clause 25 would enable the transfer to local authorities of PCTs existing functions around dental public health, and extend to local authorities a duty to help deliver and sustain good health among the prison population.

Appointment of directors of public health

PCTs are currently required to appoint directors of public health (DsPH) to provide local leadership and co-ordination of public health activity. **Clause 26** would transfer this requirement to local authorities, acting jointly with the Secretary of State.

Exercise of public health functions of local authorities

Clause 27 would require local authorities to have regard to documents that the Secretary of State publishes when exercising their public health functions. In particular this power is

intended to be used to require local authorities to have regard to the Department's proposed public health outcomes framework.⁷⁹

5.3 Abolishing the Health Protection Agency and further provisions about public health (Part 2 of the Bill)

Clause 46 would repeal the *Health Protection Agency Act 2004*. Abolishing the Health Protection Agency (HPA) is part of the Government's policy of creating a new system for the protection and improvement of public health. **Clauses 47 and 48** follow from this and confer new UK-wide functions in relation to biological substances and radiation protection. These are functions currently carried out by the HPA.

Clause 50 would require co-operation between the Secretary of State and other people or organisations engaged in public health protection activity.

6 Economic regulation (Part 3)

6.1 The role of Monitor

Under the proposals for the regulation of healthcare providers, Monitor, the body that currently regulates NHS foundation trusts, would become the economic regulator for the whole of the health and adult social care sectors. In this expanded role, Monitor would have three core functions: to promote competition where appropriate, to regulate prices for NHS funded services, and support the continuity of services.

To support its functions, Monitor would have the power to license providers of NHS-funded care. The *Legislative Framework* compared Monitor's new role in regulating healthcare, to that of Ofcom or Ofgem in regulating the communication and energy markets.⁸⁰ The *Explanatory Notes* to the Bill state that the legislation 'draws upon lessons from the utilities, rail and telecoms industries, borrowing provisions where applicable, but tailoring others to the particular circumstances of the health sector.'⁸¹

The Department of Health and the Department for Communities and Local Government are in discussion about whether to extend the system of economic regulation to the social care sector. The Bill contains provisions to extend the remit of Monitor to social care if this is considered to be appropriate in the future.

Establishing Monitor as economic regulator

Clause 51 states that Monitor continues to exist, but ceases to be known as the Independent Regulator of NHS Foundation Trusts. Instead, its formal name would be 'Monitor'. The clause also gives effect to the Schedule 7 which provides details of the membership of Monitor and the process for appointments. The chief executive and other executive members would be appointed by the non-executive members with the consent of the Secretary of State. The Secretary of State could suspend or remove a non-executive member from office on the grounds of incapacity, misbehaviour or failure to carry out duties. Schedule 7 also states that Monitor would have to respond in writing to any recommendations from a Committee of either House of Parliament about the exercise of its functions.

Clause 52 stipulates Monitor's principal overarching duty: to exercise its functions so as to protect and promote the interests of people who use health care services, by promoting competition where appropriate and through regulation where necessary.

⁷⁹ http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_122962

⁸⁰ DoH, *Equity and excellence: Liberating the NHS* (Cm 7881) 12 July 2010, para 4.26-4.30, pages 37-39

⁸¹ *Explanatory Notes to the Bill* [Bill 132-EN], para. 491

Power to give Monitor functions relating to adult social care services

The Government is considering the proposed role for Monitor in regulating adult social care with respect to potential anti-competitive behaviour and/or provider failure, ensuring that such a role does not duplicate existing functions. **Clause 53** would allow for Monitor's remit to be extended to include adult social care through regulations should this be required.

Clause 54 provides a list of the considerations to which Monitor must have regard when carrying out its specific functions.

Conflicts between functions

As the current regulator of foundation trusts Monitor has intervention powers to remove board members and governors, and issue 'directions' when necessary. In its future role as economic regulator, Monitor would need to treat all providers of NHS services equally and so these powers would be removed. The Department proposed in the White Paper to remove these controls from April 2012 onwards, but it has since been decided that it should retain intervention powers temporarily for new foundation trusts (authorised after April 2012 and for a defined subset of existing foundation trusts), until March 2014 or two years after the individual foundation trusts authorisation date, whichever is later.

In order to deal with potential conflicts of interest during this transitional period, **clause 55** places requirements of transparency upon Monitor in the case of conflict between its general duties. For example, subsection(3) of this clause states that in exercising its functions around competition, licensing and in respect of pricing, Monitor must ignore its functions in respect of foundation trusts as subject to transitional measures. Subsection (5) states that for cases of particular significance Monitor would have to publish a statement about the particular conflict that arose, and how it decided to resolve it.

Failure to perform functions

Clause 59 would give power to the Secretary of State to direct Monitor when he considers that it is failing to perform its functions. The *Explanatory Notes* to the Bill state that it is intended that this would only be used in exceptional circumstances and that other arm's-length bodies, including the Care Quality Commission, have similar powers of intervention.⁸²

6.2 Competition

Any willing provider

The NHS White Paper explained that the Government sees competition as an important means for driving up the quality and efficiency of health services, and for promoting patient choice and control over the care. It stated that:

Our aim is to free up provision of healthcare, so that in most sectors of care, any willing provider can provide services, giving patients greater choice and ensuring effective competition stimulates innovation and improvements, and increases productivity within a social market.⁸³

The Government's proposals in this area have attracted strong opposition from a number of respondents but the principle of 'any willing provider' is not new within the NHS. The development of policies to increase patient choice from the early 2000s, supported by a new system for paying for hospital services known as 'Payment by Results' in 2003, provided new incentives for commissioners and providers in the NHS.

⁸² *Ibid.* para. 547

⁸³ DoH, *Equity and excellence: Liberating the NHS* (Cm 7881) 12 July 2010, para 4.26

NHS commissioning frameworks have set out how commissioners are able to use open tendering where provision is either unavailable or not to the required standard, and allowing ‘any willing provider’ to compete in this process. Patients have been given increasing freedom to choose from a range of providers for most types of elective acute care, including independent-sector providers (subject to quality standards and price limits).

On 17 September 2009 Andy Burnham, who was then Secretary of State for Health, gave a speech to the King’s Fund which focused on putting quality at the core of the NHS, and in which he referred to the NHS as ‘our preferred provider’.⁸⁴

Following publication of a revised procurement guide in March 2010⁸⁵ there was some press comment about whether this represented a ‘watered down’ version of the ‘preferred provider’ policy.⁸⁶ The current Government’s competition proposals clearly state their commitment to ‘level the playing field’ for all providers.⁸⁷

Monitor’s role in ensuring effective competition and patient choice:

This section of the Bill is intended to provide Monitor with powers intended to ensure that competition and patient choice operate effectively. **Clause 60** would give Monitor concurrent powers with the Office of Fair Trading (OFT) to apply the *Competition Act 1998* in relation to the provision of healthcare in England (Chapter I of Part I of this Act prohibits undertakings from reaching agreements that prevent, restrict or distort competition; Chapter II prohibits undertakings from abusing a dominant position in a market. There are similar provisions under EU law). This would allow Monitor to investigate practices by individual providers or groups of providers if it were suspected that these might restrict competition, such as actions to exclude competitors or agreements to restrict patient choice.

Monitor would also have concurrent powers to impose remedies for breaches of the prohibitions, as stipulated in sections 32 to 41 of Part I of the *Competition Act 1998*. These remedies include the issuing of directions to undertakings to bring an infringement to an end, or fines following an infringement.

Functions under Part 4 of the Enterprise Act 2002

Clause 61 would give Monitor concurrent powers with the OFT under Part 4 of the *Enterprise Act 2002*, in respect of the provision of health care services in England.

These powers would enable Monitor to carry out market studies and to make market references to the Competition Commission, if it has reasonable grounds for suspecting that any features of a market prevent, restrict or distort competition. Under section 134 of the 2002 Act, after receiving a market reference the Competition Commission must investigate it and publish a report within two years. If it decides that there is an adverse effect on competition, it also decides upon the action to be taken to remedy this.

⁸⁴ A letter from the NHS Chief Executive, David Nicholson, to SHA and PCT Chief Executives, dated 13 October 2009, highlighted the potential implications of this policy for commissioners and others:

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_107127.pdf

The speech itself is available on the Department of Health’s website:

http://www.dh.gov.uk/en/MediaCentre/Speeches/DH_105366

⁸⁵ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113745
This document has now been superseded by the procurement guide published in July 2010:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_118218

⁸⁶ “Private healthcare hails end of ‘preferred provider’”, by Nicholas Timmins, *Financial Times*, 25 March 2010

⁸⁷ DoH, *Liberating the NHS: Legislative framework and next steps* (Cm 7993) 15 December 2010, para. 6.9

Requirements as to good procurement practice

Following consultation on its competition proposals the Government decided to ensure NHS commissioners were subject to comparable prohibitions of anti-competitive conduct as those for providers.⁸⁸ **Clauses 63 and 64** are intended to ensure good procurement practice by the NHS Commissioning Board and by GP consortia.

Clause 63 would enable the Secretary of State to make regulations setting rules for the Board and GP consortia to ensure good procurement practice and protect choice and competition with regard to healthcare services.

Clause 64 sets out Monitor's powers to investigate and remedy breaches of the regulations. Monitor would have the power to investigate following a complaint by an interested party. The *Explanatory Notes* to the Bill suggest that regulations might confer on Monitor powers to declare, in specified circumstances, that an arrangement for the provision of services was ineffective and to direct the Board, or a consortium, to put the provision of services out to tender.⁸⁹

Review of competition

Clause 66 would require the Competition Commission to carry out a review of the development of competition and regulation in public healthcare services every seven years, with the first review to be completed no later than 2019.

6.3 Designated services

The Government has acknowledged that there is need for regulation to help protect essential healthcare services.⁹⁰ One of Monitor's new core functions under this Bill would be to support commissioner's duties with regards to the continuity of certain specified services in the event of provider failure, by means of a special administration regime. These services would be known as 'designated services'. It is intended that local commissioners would lead the process of defining which services would be designated for each provider.

Clause 69 provides for commissioners (GP consortia and the NHS Commissioning Board) to make an application to Monitor for services to be designated.

Subsection(3) would require that a commissioner may only apply for a service to be designated if, in the absence of alternative provision of that service, ceasing to provide the service would have a 'significant adverse impact' on the health of patients (or cause a failure to prevent or ameliorate such an impact).

Subsection(4) would require that commissioners, in designating services, also have regard to (i) the current and future need for the provision of the service, (ii) whether the removal of the service would significantly reduce equality of access to the service and (iii) anything else that may be specified in Monitor's guidance.

Clauses 70 and 71 relate to procedures for providers or potential providers of a service to make an appeal to a tribunal against a decision by Monitor to designate or not designate that service, and for Monitor to review and remove designations.

⁸⁸ *Ibid.*, para. 6.87-6.89

⁸⁹ *Explanatory Notes to the Bill* [Bill 132-EN], para 570

⁹⁰ DoH, *Liberating the NHS: Legislative framework and next steps* (Cm 7993) 15 December 2010, para. 6.112-6.114

6.4 Licensing arrangements

The Bill would establish powers for Monitor to run a licensing regime for providers of NHS care (including NHS foundation trusts, social enterprises, and private and voluntary sector providers). The licence would be the main mechanism which would enable Monitor to carry out its regulatory functions, giving it the ability to collect information to set prices, promote competition and support the continuity of designated services.

Monitor would determine the licence conditions that it would be necessary to impose on providers to enable effective regulation of the health sector, and would have a set of enforcement powers so that providers complied with the requirements of the licence.

The Care Quality Commission (CQC) currently registers providers of health and adult social care services to provide assurance that they meet essential levels of quality and safety. They will continue to exercise this role. Monitor on the other hand would license providers of NHS services as a mechanism for delivering its economic regulatory functions such as setting efficient prices, promoting competition and supporting continuity of services.

Monitor and the CQC would be expected to work closely together and the two organisations would be under a duty to co-operate, with an equal duty to share information and provide for a joint licensing process. However, their remits would remain distinct.

Requirement for health service providers to be licensed

Clause 74 specifies that any person who provides a healthcare service for the purposes of the NHS would be required to hold a Monitor licence.

Exemption regulations

Clause 76 would provide the power for the Secretary of State to make regulations subject to the negative resolution procedure, exempting providers of NHS services from the requirement to hold a licence. The intention is to ensure that a regulatory burden would not be imposed where it was not needed.

Clauses 78 to 85 relate to licensing procedures and cover the criteria for the application for a licence, for the grant or refusal of licences, and arrangements for appeals.

Register of licence holders

Clause 86 requires Monitor to keep and publish a register of licence holders, as the CQC is currently required to do under the *Health and Social Care Act 2008*. It is intended that the information would be available to the public although the clause also allows regulations to be made setting out what information should not be accessible.

Licence conditions

Clauses 87 to 93 specify the different licence conditions that Monitor can set. Standard conditions would apply to all providers, or to all providers of a certain type (either those providing a particular service, or those in a particular geographic area).

Enforcement of licence conditions

While it is intended that there will be a joint licensing regime overseen by both Monitor and the CQC, the two organisations would have separate responsibilities regarding enforcement (although they would be obliged to share information about relevant enforcement actions taken). **Clauses 94 to 100** would provide Monitor with the necessary powers to enforce its licensing requirements.

These clauses provide enforcement powers for Monitor modelled on the powers available to other economic regulators and set out in the *Regulatory Enforcement and Sanctions Act 2008*. Specifically, if licence conditions are breached, Monitor will be able to order a provider to remedy the breach (or commit to do so) or issue fines of up to 10% of turnover.

6.5 Tariff prices paid to providers of NHS services

The second of Monitor's new core functions would be to regulate the prices commissioners pay to providers for NHS services under the Payment by Results system. Chapter 5 of Part 3 of the Bill provides the NHS Commissioning Board and Monitor with powers to set the tariff prices paid to providers. This would be a joint process, with the Board responsible for the design of the structure of pricing (deciding the types of services for which the national tariff would apply), while Monitor would be responsible for setting prices, in order to promote fair competition and drive-up productivity.

The Bill states that Monitor would also need to have regard to the overall funding allocation within which the NHS must operate.

Price payable by commissioners for NHS services

Clause 103 sets out how prices would be specified and used for the payment of health services. It would allow for services to be covered by:

- a standard price;
- a maximum price, with flexibility to negotiate below that price;
- a locally agreed pricing, for other services not covered by the standard or maximum prices.

Clause 104 would require Monitor to publish a national tariff which would include the following:

- the range of services (in line with the structure agreed with the NHS Commissioning Board) for which prices would apply;
- the methodology that had been employed by Monitor to produce a price level;
- the resultant price levels; and
- guidance on the process for determining local prices for services not specified as being covered by a national tariff.

Clauses 105 to 109 (and Schedule 10) of the Bill would cover procedures for consultation on proposals for the national tariff, which include allowing a reference to be made to the Competition Commission where a sufficient number of commissioners or providers challenge the methodology used to set prices.

Local modifications of prices of designated services: agreements

The *Legislative Framework* stated that the Bill should allow Monitor to modify prices for designated services, in order to protect essential services. **Clause 110** specifies the process for a provider of a designated service and the commissioner to agree an exceptional subsidy

to the price level if the national or maximum price did not allow it to cover costs, even with an efficient service.⁹¹

Concerns about price competition

The NHS Operating Framework for 2011/12, published on 20 December 2010, signalled that providers of NHS services would, with the agreement of commissioners, be able to offer services at less than the published mandatory tariff price:

One new flexibility being introduced in 2011/12 is the opportunity for providers to offer services to commissioners at less than the published mandatory tariff price, where both commissioner and provider agree. Commissioners will want to be sure that there is no detrimental impact on quality, choice or competition as a result of any such agreement.⁹²

Concerns have been expressed that the introduction of competition on price under the Payment by Results system could undermine the quality of services.⁹³

6.6 Insolvency and special administration

The Government has stated that foundation trusts should be brought within the scope of ordinary corporate insolvency procedures to ensure a level playing field across different types of provider, and that there should be a special administration regime ensuring the continuity of essential 'designated services' where a provider fails.

Application of insolvency law to NHS foundation trusts

Clause 113 would remove the existing (and non-operational) failure arrangements for foundation trusts set out in sections 53 to 55 of the *NHS Act 2006* and would oblige the Secretary of State to make secondary legislation as soon as is practical to apply existing corporate insolvency procedures to foundation trusts (foundation trusts are public benefit corporations which are currently outside of the scope of the *Insolvency Act 1986*). The *Explanatory Notes* state that applying insolvency law in this way could facilitate the rescue of a failed foundation trust (for example, through administration or a voluntary arrangement with creditors) and would also allow for orderly market exit.⁹⁴

Clauses 114 to 119 would provide Monitor with powers to ensure the continuity of designated services through the operation of a distress regime and, as a last resort, a health 'special administration' regime.

6.7 Financial assistance in special administration cases

The consultation on the regulation of providers proposed the development of a funding facility to support the continuity of services when providers are placed into special administration. The *Legislative Framework* stated that the Bill would establish a 'risk pool', giving Monitor the power to collect levies from providers and commissioners of designated services. The intention was that any financial assistance for designated services would be pre-funded by the providers and commissioners of such services, rather than, as under current failure arrangements, by the Secretary of State.

Clauses 120 to 132 would require Monitor to set up effective mechanisms for providing financial assistance to health special administrators, who may be appointed to protect the continued provision of designated services in the event of a provider failing.

⁹¹ DoH, *Liberating the NHS: Legislative framework and next steps* (Cm 7993) 15 December 2010, para. 6.110

⁹² See NHS Operating Framework for 2011/12, 20 December 2010, para 5.43

⁹³ Nick Timmins, "Hospital price competition 'a retrogradestep'", *Financial Times*, 7 January 2011

⁹⁴ *Explanatory Notes to the Bill* [Bill 132-EN], para. 737

Monitor would have the power to decide which financial mechanisms would best fit the risks of failure and to establish such financial mechanisms. As specified by subsection(2) of **clause 121**, these mechanisms could include, but not be limited to:

- providers and commissioners of designated services being required to contribute to a collective insurance scheme or 'risk pool'; or
- providers being required to purchase their own insurance to cover such liabilities on failure as are specified by Monitor.

7 NHS foundation trusts and NHS Trusts (Part 4)

The NHS White Paper, *Equity and excellence: Liberating the NHS*,⁹⁵ stated that all NHS trusts should become self-governing foundation trusts (or become part of an existing foundation trusts) by 2013/14. It also set out plans to give foundation trusts more freedom, including abolishing the cap on the amount of income they may generate from other sources, such as private patients.⁹⁶

The *Legislative Framework* acknowledged that the ambition for all NHS trusts to become, or be part of, a foundation trust within three years is a considerable challenge. At present there are 120 organisations, or 48% of NHS statutory providers, that have yet to become foundation trusts. The Government has also recognised that a minority of trusts – the analysis suggests around 20 – face very significant challenges and will not be able to achieve foundation trust status in their current organisational form. This may be because they have services that are not currently clinically sustainable; or because of financial problems, for example as a result of Private Finance Initiative (PFI) and legacy debts, or falling levels of acute sector income.⁹⁷

The *NHS Operating Framework for 2011/12* set out measures to support the implementation of an all foundation trust sector by 1 April 2014. These included the establishment of a Provider Development Authority, to be established as a Special Health Authority by April 2012. The Authority is intended to 'performance manage' NHS trusts until they become foundation trusts. It is expected that the Authority will be wound down once there is an all foundation trust sector by 1 April 2014.⁹⁸

Part 4 of the Bill would amend Chapter 5 of Part 2 of the *NHS Act 2006*, which makes provision for NHS foundation trusts. It would remove various restrictions on foundation trusts and regulation specific to them and make changes to the authorisation of foundation trusts, in light of the proposals in Part 3 for Monitor to become an economic regulator and to license all providers of NHS services. As the Government intends all NHS trusts to become foundation trusts the Bill would repeal NHS trust legislation, and Monitor's power to authorise new foundation trusts, from 1 April 2014. It would clarify the duties on governors and directors and introduces new powers for governors. It would make amendments to the financing and accounting arrangements of foundation trusts. In addition, it would make amendments to the process of foundation trust mergers and enables acquisitions, separations and dissolution of foundation trusts. It repeals provision about de-authorisation, preventing foundation trusts being returned to NHS trust status, and allows Monitor to operate the failure arrangements for foundation trusts, ahead of their replacement by the new failure arrangements set out in Part 3 of the Bill. In the longer-term, when most of Monitor's specific functions in relation to foundation trusts would be repealed, there would be a specific role for Monitor in maintaining

⁹⁵ DoH, *Equity and excellence: Liberating the NHS* (Cm 7881) 12 July 2010

⁹⁶ *Ibid.*, para 4.20-4.25 pages 35-37

⁹⁷ DoH, *Liberating the NHS: Legislative framework and next steps* (Cm 7993) 15 December 2010, para. 6.37

⁹⁸ DoH, *NHS Operating Framework for 2011/12*, 15 December 2010, paras 2.23-2.26

an adapted register of foundation trusts, and in establishing a panel to advise foundation trust governors.⁹⁹

Mergers between foundation trusts

Clause 65 would ensure that mergers between foundation trusts should be subject to the Office of Fair Trading (OFT) and the Competition Commission's merger controls.

7.1 Governance and management

As the reform of the role of Monitor would reduce its specific oversight of foundation trusts the Bill includes measures intended to strengthen foundation trusts' internal governance and to increase the accountability of governors and directors.

Clauses 136 to 141 would cover the duties of the governors and directors of foundation trusts, making explicit the duty of governors to hold the board of directors to account, and the duty of directors to promote the success of the organisation (similar to the duty imposed on company directors under company law). **Clause 136** would also give governors the power to require the trust's directors to attend meetings, while **clause 141** would require foundation trusts to hold an annual meeting of the trust's membership.

Clause 143 would give the Secretary of State, in light of new decision-making powers for foundation trusts in subsequent clauses, a regulation-making power to alter the voting arrangements for directors, governors and members of foundation trusts relating to matters provided for in this Bill (such as the amendments of foundation trust constitutions). Regulations made under this clause would be subject to the affirmative resolution procedure.

The Bill would retain the existing requirement on foundation trusts to have a constitution and continues to require trusts' constitutions to include certain information. **Clause 146** would transfer responsibility for approving changes to a foundation trust's constitution from Monitor to the council of governors and board of directors. Foundation trusts would be required to inform Monitor of any amendments they decide to make to their constitutions as Monitor would continue to act as the registrar of foundation trusts under the new arrangements.

Panel for advising governors

Clause 147 gives Monitor the power to establish an independent panel to provide non-binding advice to governors who have concerns about the appropriateness of actions taken by their foundation trust. This measure is a response to some respondents to the Government's consultation who thought there should be a source of independent advice to governors.¹⁰⁰

7.2 Foundation trust finance: financial assistance, borrowing and the independent banking function

Clause 148 would amend powers relating to the financial matters of foundation trusts in a number of areas. The Secretary of State's powers to give financial assistance to foundation trusts would be replaced by a power to make loans on commercial principles and governed by guidance required under legislation.

As part of the move away from statutory controls on foundation trusts, the borrowing code currently produced by Monitor, and the borrowing limits that are calculated using that code, would no longer be required. Subsection(4) would therefore remove the powers for the

⁹⁹ *Explanatory Notes to the Bill* [Bill 132-EN], para 809

¹⁰⁰ DoH, *Liberating the NHS: Legislative framework and next steps* (Cm 7993) 15 December 2010, para. 6.50

regulator to revise the prudential borrowing code and subsection(10) would remove the limit imposed on foundation trust borrowing by the code.

This clause would also enable the Department of Health's existing £24 billion investment in foundation trusts to be managed by an 'operationally independent banking function' within the Department of Health. This is intended to protect the taxpayer's interest in foundation trusts.

The current chief executive of Monitor, David Bennett, has warned that by being based within the Department, rather than an arm's-length body, this banking function may not be sufficiently independent.¹⁰¹

Private health care: removal of the cap on private income

Clause 150 would repeal the restriction on the amount of income a foundation trust can earn from private charges, otherwise known as the 'private patient income cap'.

The cap, which was introduced in 2003, has the effect that a foundation trust cannot earn in any financial year a higher proportion of its total income from private charges than it derived from private charges in the financial year 2002-03 (the year before the first foundation trusts were authorised).

The role of income from private patients in the NHS has long been a controversial issue; it has been alleged that the cap on private patient income was introduced to prevent a backbench rebellion by Labour MPs when the legislation introducing foundation trusts was going through parliament. As the Government's *Legislative Framework* acknowledges, the proposal to lift the cap also provoked strong views. Some respondents to the Government's consultation, such as Unison, thought this would lead to foundation trust's prioritising fee-paying patients. The Government also highlighted other more positive responses that argued that removing the cap would not obstruct foundation trust's principle purpose to provide goods and services for the health service.¹⁰²

7.3 Mergers, acquisitions, separations and dissolution

Clauses 153 to 157 cover the mergers, acquisitions, separations and dissolution of foundation trusts and would restrict Monitor's current powers to approve or refuse these changes.

7.4 Repeal of de-authorisation provisions

The effect of de-authorisation is for a foundation trust to revert to being an NHS trust, this would no longer be appropriate given the repeal of the NHS trust model by **clause 164** of this Bill. **Clause 158** would repeal the de-authorisation provisions as a consequence of the Government's intention that all NHS Trusts are to become foundation trusts.

7.5 Trust special administrators

Clause 159 and subsequent clauses would amend existing provisions on foundation trust failure which have not yet been used. It would also adapt the failure regime for foundation trusts to create a transitional failure regime which would be consistent with the final special health administration regime proposed by Chapter 6 of Part 3 of this Bill.

¹⁰¹ Nicholas Timmins, "Monitor warns on perils of NHS plans", *Financial Times*, 6 January 2011

¹⁰² DoH, *Liberating the NHS: Legislative framework and next steps* (Cm 7993) 15 December 2010, paras. 6.31 to 6.34

7.6 Abolition of NHS trusts in England

Clause 164 would make provision to abolish NHS trusts in England, and the legislative framework that provides for them, and would come into force on 1 April 2014. This reflects the Government's intention, set out in *Liberating the NHS: Legislative Framework and Next Steps*, to support all NHS trusts to become foundation trusts within three years.¹⁰³

Clause 165 would repeal the provisions on authorisation for NHS foundation trusts which would no longer be needed once all NHS trusts have become foundation trusts.

8 Patient involvement and local authorities (Part 5 of the Bill)

Part 5 of the Bill contains provisions about the duties of the NHS Commissioning Board and GP consortia in relation to patient engagement and choice, the creation of HealthWatch, and changes to the role of the Health Service Ombudsman.

The Bill would place the NHS Commissioning Board and GP consortia under a duty to have regard to the need to promote the involvement of patients and their carers, and to enable patients to make choices about the health services provided to them. The NHS Commissioning Board will also be under a duty to issue guidance on commissioning to GP consortia, which could include guidance about how to fulfil their duties in relation to public and patient involvement.

The Government launched two consultations in December 2010: *Liberating the NHS: Greater choice and control*,¹⁰⁴ on its proposals for patient choice and engagement, and *Liberating the NHS: An Information Revolution*, which included details of its proposals to use information to support people to be involved in decisions about their care. Both consultations closed on 14 January 2010 and the Government has yet to publish its formal response to these.

Personal health budgets

Clause 45 of Bill would retain current legal provisions for piloting direct payments in healthcare as one of the ways to offer a personal budget. The evaluation of the personal health budgets pilot programme is due to report in October 2012.

8.1 HealthWatch

Establishment of HealthWatch England

The NHS White Paper proposed that a national organisation, HealthWatch England be established to provide leadership and advice to local HealthWatch and to escalate concerns to the Care Quality Commission (CQC), of which it would be a part. Following consultation the Government refined its proposal so that HealthWatch England would be established as a statutory committee within the CQC, in order to support its independence and give it a 'distinctive identity'.¹⁰⁵

The HealthWatch England Committee would carry out the work of CQC related to HealthWatch England and would have powers to provide advice to the NHS Commissioning Board, Secretary of State for Health, CQC and Monitor.

Clause 166 would amend Schedule 1 to the *Health and Social Care Act 2008* and establishes Healthwatch England as a statutory committee of the Care Quality Commission (CQC); and would make provision about Healthwatch England's purpose, its exercise of

¹⁰³ *Ibid.* Para 6.36

¹⁰⁴ DoH, *Liberating the NHS: Greater choice and control*, 18 October 2010

¹⁰⁵ DoH, *Liberating the NHS: Legislative framework and next steps* (Cm 7993) 15 December 2010, para 2.59

functions and other related matters. The clause includes a power for the Government to set out in regulations how the HealthWatch Committee should be appointed.

Establishment and constitution of Local HealthWatch

The NHS White Paper proposed to transform Local Involvement Networks (LiNs) into local HealthWatch. Local HealthWatch would be supported and led by HealthWatch England but funded by local authorities and based in local authority areas.

Clause 167 provides for the establishment and form of local Healthwatch organisations. Local Involvement Networks (LiNs) would cease to exist and local HealthWatch organisations would take over their functions in promoting and supporting public involvement in the commissioning, provision and scrutiny of local health and social care services.

Local authority arrangements to commission local HealthWatch

The Bill would enable local authorities to commission HealthWatch to provide advice and information to enable people to make choices about health and social care. The Government's *Legislative Framework* states that this could include helping people to access and understand information about provider performance and safety, and the NHS Constitution.¹⁰⁶

During the Government's consultation some concerns were expressed about proposals for HealthWatch to provide advocacy services for NHS complaints, these related to potential conflicts of interest with the role of HealthWatch in the commissioning decision making process, and its potential to undermine existing advocacy services. The Government's *Legislative Framework* responded to these concerns by stating it will 'provide flexibility concerning whom local authorities will commission NHS complaints advocacy services from...'.¹⁰⁷

The Bill would also give local HealthWatch the power to escalate concerns about the quality of services, by making recommendations to the HealthWatch England committee of CQC for CQC to carry out investigations into health and care services.

The Bill would provide for regulations to be made setting out what local HealthWatch membership should be.

Responsibility for commissioning independent mental health advocacy under the *Mental Health Act 2007* will move from PCTs to local authorities, together with the role of the supervisory body in respect of hospitals under the *Mental Capacity Act 2005* deprivation of liberty safeguards. However, owing to its highly specialised nature, mental health advocacy would not be a part of the NHS complaints advocacy services that local authorities will be able to commission from HealthWatch.¹⁰⁸

8.2 Local authorities and democratic accountability in health and social care

The NHS White Paper included proposals to 'increase local democratic legitimacy in health' by giving local authorities the function of coordinating the commissioning of local NHS services, social care and health improvement.¹⁰⁹ The Government published a consultation document, *Liberating the NHS: Increasing democratic legitimacy in health*, setting out its proposals in more detail.

¹⁰⁶ *Ibid.* para 2.40

¹⁰⁷ *Ibid.* para 2.42-2.43

¹⁰⁸ *Ibid.* para 2.53

¹⁰⁹ DoH, *Equity and excellence: Liberating the NHS* (Cm 7881) 12 July 2010, para 4.16-4.19

Local authority overview and scrutiny functions

Clause 175 would give local authorities flexibility, from April 2013, to discharge their health scrutiny powers in the way they deem to be most suitable – whether through continuing to have a specific health Overview and Scrutiny Committee (OSC), or through a suitable alternative arrangement. To enable this flexibility, this clause would confer the health overview and scrutiny functions directly on the local authority.

Current scrutiny powers enable local authorities to request NHS bodies to attend before them to answer questions and to provide information. Subsection(2) of this clause would extend the powers of local authorities to enable scrutiny of any provider of any NHS-funded service, and any NHS commissioner. This would include will include scrutiny of private sector providers and local public health services.

The clause would also enable regulations to be made requiring a decision by a local authority to refer a substantial service change proposal to the Secretary of State to be triggered by a meeting of the full council.

Joint strategic needs assessments (JSNA)

The production of Joint Strategic Needs Assessments (JSNAs) is currently a statutory duty for PCTs and local authorities. **Clause 176** would provide for the PCT responsibility to transfer to GP consortia, which together with local authorities will develop JSNAs through health and wellbeing boards (HWBs).

Responsibility for pharmaceutical needs assessments would also be transferred from PCTs to local councils, to be discharged through HWBs (**clause 190**).

Joint health and wellbeing strategy (JHWS)

Clause 177 inserts new sections 116A and 116B into the *Local Government and Public Involvement in Health Act 2007*. New section 116A imposes a duty on local authorities and commissioning consortia to produce a joint health and well-being strategy (JHWS) to meet the needs identified in the JSNA.

This would give local authorities and GP consortia a ‘comprehensive suite’ of duties and powers relating to the JHWS, spanning NHS, social care and public health services. Both GP consortia and local councils would be under a statutory duty to have regard to JHWS and both would have a duty to consider how to best utilise flexibilities such as pooled budgets.

Health and wellbeing boards

The NHS White Paper included a proposal for ‘health and wellbeing boards’ (HWBs) to be established within local authorities, to allow local authorities to take a strategic approach and promote integration across health and adult social care.¹¹⁰ The Government’s *Legislative Framework* states that HWBs should be in place from April 2013, with shadow boards expected to be in place from 2012.

Clause 178 would introduce a statutory duty for all upper-tier local authorities to establish a HWB. The clause would require HWBs to be made up of at least one elected representative, the director of adult services, director of children’s services, director of public health and a representative from the local branch of HealthWatch. GP commissioning consortia would also be required to send a representative.

Clauses 179 and 180 cover the functions of HWBs. **Clause 179** imposes a duty on the HWB to encourage integrated working between commissioners of NHS, public health and social

¹¹⁰ *Ibid.* page 34

care. **Clause 180** requires HWBs to lead on the joint strategic needs assessment (JSNA) and joint health and wellbeing strategy (JHWS).

As provided for in **clause 22** of the Bill, GP consortia would be required to confirm whether HWBs endorse their commissioning plans.

Care Trusts: integration of health and adult social care

The NHS White Paper set out Government's plans for closer integration of healthcare and adult social care services and to pool funding to encourage preventative action.¹¹¹ Care Trusts provide opportunities for close integrated working across health and social care services, provisions for which are made through section 77 of the *NHS Act 2006*.

Clause 184 would amend section 77 of the *NHS Act 2006* to make it possible for NHS foundation trusts or commissioning consortia and local authorities to form care trusts, and to abolish the direct role of the Secretary of State in the process of forming or disbanding a care trust.

8.3 The Health Service Commissioner for England: information sharing

The Government's *Legislative Framework* proposed to change the legislation governing the Health Service Commissioner for England (more commonly known as the Health Services Ombudsman) to strengthen the arrangements for the Ombudsman to share more widely investigation reports and complaints information. The Ombudsman is currently subject to some significant legislative constraints in relation to sharing and publishing information about the complaints she receives. This proposal was not set out in the NHS White Paper but follows a consultation on sharing information by the Ombudsman in December 2009.

Clause 185 would amend section 14 of the *Health Service Commissioners Act 1993* to allow the Health Service Ombudsman, to share her complaints investigation reports and statements of reasons with such persons as she thinks appropriate.

9 Amendments to primary care service legislation (Part 6)

The Bill would make changes to the *NHS Act 2006* that are mainly required to revise, but not substantially change, the existing provisions with relation to medical, dental, ophthalmic and pharmaceutical services. This is as a consequence of the structural changes elsewhere in this Bill that create the NHS Commissioning Board, commissioning consortia and the public health service, and abolish PCTs and SHAs.

10 Regulation of health and social care workers (Part 7)¹¹²

As part of a cross-Government strategy to increase accountability and transparency, and to reduce the number and cost of quangos, in July 2010, the Government conducted a review of arm's-length bodies in health and social care, including the General Social Care Council (GSCC), and the Council for Healthcare Regulatory Excellence (CHRE).¹¹³ In addition, the Government launched a consultation on the case for proceeding with the implementation of the Office of the Health Professions Adjudicator (OHPA).¹¹⁴

The GSCC regulates the social work profession and social work education in England. It also approves courses for those who wish to be approved as mental health professionals in

¹¹¹ *Ibid.* para 1.17

¹¹² By Manjit Gheera, Social Policy Section

¹¹³ DoH, *Liberating the NHS: Report of the arms-length bodies review*, 26 July 2010

¹¹⁴ DoH, *Fitness to practise adjudication for health professionals: assessing different mechanisms for delivery. A paper for consultation*, 9 August 2010

England under the *Mental Health Act 1983*. Established under the *Care Standards Act 2000*, the GSCC is an executive non-departmental public body funded partly by the Department of Health. It is the only professional regulator answerable directly to the Secretary of State for Health.¹¹⁵

The CHRE was established by the *National Health Service Reform and Health Care Professions Act 2002* as non-departmental public body (NDPB). It is currently responsible for the scrutiny and quality assurance of the nine health professions regulatory bodies in the UK. It is funded by the Department of Health and the devolved administrations.

The OHPA was established as a new independent body under the *Health and Social Care Act 2008* to adjudicate on fitness to practice cases. Initially, the OHPA was to take up this role in relation to General Medical Council registrants in 2011 and then subsequently for General Optical Council registrants.

Part 7 of the Bill would make changes to the three health and social care arm's-length bodies. It would:

- abolish the GSCC and transfer its functions to the Health Professions Council;
- make changes to the governance and functions of the CHRE; and
- abolish the OHPE.

Consequential amendments to the proposals are set out in Schedule 14 of the Bill.

This section of the Research Paper provides an overview of the key provisions in Part 7 of the Bill. A detailed explanation of the proposals and consequential amendments is available in the *Explanatory Notes* to the Bill.¹¹⁶

10.1 Changes to the regulation of social work

In *Liberating the NHS: Report of the arm's-length bodies review*,¹¹⁷ published as part of the proposals in the White Paper on NHS reform, the Government claimed that there were potentially significant benefits to be gained from putting social work regulation on a similar footing to the health professions, which are regulated by the Health Professions Council (HPC). The HPC is a body independent of Government and was set-up to safeguard the health and well-being of users of its professional registrants.

In contrast to the HPC, the social work regulator - the GSCC - is funded by and answerable to the Department for Health. The Government view, stated in the arm's-length bodies report, was that an independent regulator, able to set its own standards and fees would serve as an incentive to members to ensure that those standards were upheld by the profession. The current functions and the remit of the GSCC and the HPC are compared in the table below:

¹¹⁵ DoH, *Impact assessments for Health and Social Care Bill 2011*, p137

¹¹⁶ *Explanatory Notes to the Bill* [Bill 132-EN],

¹¹⁷ DoH, *Liberating the NHS: Report of the arm's-length bodies review*, 26 July 2010

| | GSCC | HPC |
|--------------------------------------|--|--|
| Governance and accountability | <p>Arm's-length body, answerable to the Department of Health.</p> <p>Council board, with a majority of lay members, determines strategic direction.</p> | <p>Independent of government; answerable to Parliament through the Privy Council.</p> <p>Council board of lay and registrant members, assisted by statutory and non-statutory committees. Develops policy to protect the health and well-being of those using or needing the services of registrants.</p> |
| Funding | Government subsidy and registration fees | Financially independent of government. Funding is solely from registration fees |
| Registrants | Over 83,000 social workers and 17,000 social work student registrants | <p>20,000 registrants from the following professions:</p> <p>Arts therapists, biomedical scientists, chiropractors / podiatrists, clinical scientists, dietitians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists / orthotists, radiographers, and speech and language therapists.</p> |
| Standard setting | Set by the Secretary of State for social workers and issued by the GSCC as codes of practice | Sets its own fitness to practice standards for all its registrants. |
| Students | Registers social work students | Does not register students |
| Annual registration fees | £30 for UK qualified social workers; £10 for student social workers | £76 |
| Other functions | <p>Investigates cases of misconduct. A conduct panel hears evidence in cases. In appropriate cases GSCC can take enforcement action.</p> <p>Administers social work education support grants to higher education institutions.</p> <p>Approves courses for mental health professionals</p> | Hears fitness to practise cases. |

*The Bill**Powers to regulate social workers in England*

The Bill would amend section 60 of the *Health Act 1999* – the current provision which provides for the regulation of health professionals, including the Health Professions Council under the *Health Professions Order 2001*. The existing section 60 power is a Henry VIII power allowing changes to primary legislation and secondary legislation to be made by of Orders in Council. **Clauses 193 and 194** would extend the powers under section 60 to include the making of orders regulating social work and social care workers and in relation to the education and training of approved mental health professionals. Orders made under section 60, as amended by the Bill, would continue to be subject to the affirmative resolution procedure.

The Government states that the rationale for the use of the Henry VIII power is that there ‘is a need to be able to amend primary and secondary legislation to take account of the changing needs and practices of these professionals and workers, without needing to await and appropriate opportunity to introduce parliamentary legislation.’¹¹⁸ Currently a similar Henry VIII power exists enabling the Secretary of State to regulate social workers.¹¹⁹ The Bill would revoke those provisions¹²⁰ along with the provisions in the *Care Standards Act 2000* relating to the Secretary of State’s powers to regulate social worker training.¹²¹

The abolition of the GSCC

Clause 196 would abolish the GSCC and transfer its functions relating to social work regulation and the approval of mental health professional courses to the HPC. To reflect the new remit of the HPC, its name would be changed to the Health and Care Professions Council (the Council).

The HPC currently regulates 15 professions by maintaining a register of those professional that meet its fitness to practice standards. In order to extend the remit of the HPC to social work regulation, **clauses 197 to 199** would amend the *Health Professions Order 2001* which provides the legislative framework for the HPC. Social workers in England would be included as a ‘relevant profession’ that the Council would regulate.

The abolition of the GSCC and the consequential amendments would affect arrangements in England. **Clause 199** would require all social workers in England to register with the Council. The requirement would not extend to social workers practising in England but already registered with the requisite councils in Wales, Scotland and Northern Ireland.¹²² The regulation of social workers in Wales, provision for which is also currently set out in the *Care Standards Act 2000*, would continue to be regulated by the Care Council of Wales.¹²³

The Equality Impact Assessment to the Bill states that users of social work services are unlikely to be affected negatively by the changes as regulatory functions in relation to social workers would continue. It adds:

¹¹⁸ DoH, *Memorandum for the House of Lords Delegated Powers and Regulatory Reform Committee*, para 737

¹¹⁹ Sections 124 and 126, *Health and Social Care Act 2008*

¹²⁰ Schedule 14 to the Bill

¹²¹ Clause 205

¹²² Clause 199/section 13B

¹²³ Schedule 14 of the Bill sets out the amendments to the *Care Standards Act 2000* and the *Health and Social Care Act 2008* to reflect the consequential changes from the abolition of the GSCC

Service users are in fact likely to benefit from the transfer; for instance, the HPC's fitness to practice system is expected to deal more effectively with competence issues than the GSCC's current conduct system.¹²⁴

The GSCC functions administering the Department of Health's social work education support grants would not assumed by the Council. A final decision on the 'appropriate body' that would assume the responsibility has yet to be taken'.¹²⁵

Reaction

Following the announcement that the GSCC was to be abolished, its chief executive, Penny Thompson, sought to address the concerns of registered members by stating on the GSCC website that, in the short to medium term, there would be no impact on dealings with the regulator, since the new arrangements would not come into effect before 2012 at the earliest.¹²⁶ However the chair of the GSCC, Rosie Varley, expressed her surprise at the timing of the decisions and added:

We recognise the economic imperative behind the proposal. However discussions have yet to take place about how this will work, including the costs, benefits and wider consequences. We are seeking an early meeting with the Health Professions Council and the government.¹²⁷

Members of the Social Work Reform Board¹²⁸ expressed their disappointment at the decision of the arms-length review. In a letter to Ministers in the Departments for Education; for Universities and Science; and of Health, the chair of the reform board, Moira Gibb wrote:

While we note the rationale for such a change we were disappointed that the contribution GSCC has recently been making to our work was not recognised. We would advocate for the GSCC changes to be timed to maximise their contribution to the speedy delivery of the Task Force's recommendations. In particular the GSCC has been working to deliver the Task Force recommendation on more transparent and effective regulation of social work education, to assure greater consistency and quality. It would be unhelpful to lose this improvement because organisational change is required.¹²⁹

Other social work and social care organisations were also critical of the move. Des Kelly, executive director of the National Care Forum, warned that there was a real risk that merging improvement bodies would damage the distinctive contribution of social care to support services. He accused the Government of dismissing the benefits of the existing system and using the budget deficit to justify the abolition despite the significant risk that resources would be wasted in rearranging structures.¹³⁰ His views were shared by Peter Beresford, Professor of social work policy at Brunel University and David Hones, previous general secretary of the British Association of Social Workers. Both warned that the changes risked social work's distinct role and contribution being lost if it became dominated by other professions.¹³¹

The HPC however, welcomed the news, claiming that it was well-placed to manage the change. Its chief executive registrar, Marc Searle was reported as saying:

¹²⁴ DoH, *Equality impact assessments for the Health and Social Care Bill 2011*, para E61

¹²⁵ DoH, *Impact assessment for the Health and Social Care Bill 2011*, para E70

¹²⁶ GSCC, *Transfer of GSCC's functions to the Health Professions Council*

¹²⁷ GSCC press release: *GSCC response to ALB review*, 23 July 2010

¹²⁸ Social Work Reform Board was set up by the previous Government to implement recommendations made by the Social Work Taskforce in *Building a safe, confident future, to reform social work*

¹²⁹ Letter to Ministers, from the Moira Gibb, Social Work Reform Board, 17 August 2010.

¹³⁰ Community Care, *GSCC abolition: Is there anything to fear?* 5 August 2010

¹³¹ *Ibid.*

HPC recognised the importance of the social work profession and we look forward to working collaboratively with the profession to deliver enhanced public protection and cost effective professional regulation across the health and social sectors. We will work closely with the government departments, stakeholders and the GSCC to ensure a smooth transition and to welcome social workers into a multi professional regulatory body.¹³²

10.2 Professional Standards Authority for Health and Social Care

The Council for Healthcare Regulatory Excellence (CHRE) was established by the *National Health Service Reform and Health Care Professions Act 2002*. Funded by the Department of Health and the devolved administrations, it is currently responsible for scrutiny and quality assurance of the following health professions regulatory bodies:

- General Chiropractic Council
- General Dental Council
- General Medical Council
- General Optical Council
- General Osteopathic Council
- General Pharmaceutical Council
- Health Professions Council¹³³
- Nursing and Midwifery Council
- Pharmaceutical Society of Northern Ireland.

The Government's arm's-length bodies review examined whether it was necessary to have a regulator of health profession regulators. The review concluded that the CHRE did 'currently fulfill an ongoing need to quality assure professional regulation'¹³⁴ but that the matter would be kept under review. Going forward, the review announced that the CHRE would no longer be an executive NDPB but would become self-funding and would have its remit extended to regulate and set quality standards for voluntary registers held by health and social care providers and professional regulators.¹³⁵

The Bill makes provision for changes to the CHRE's constitution and remit. A summary of the main changes is set out below. A detailed clause by clause explanation of the Bill provisions relating to the CHRE is available in the *Explanatory Notes* to the Bill

The Bill

Changes to the CHRE functions

Since the Bill would extend the HPC's remit to cover social workers, **clause 207** would extend the CHRE's remit to cover regulators of social care and social work services in England.

Clause 212 would make provision for regulatory bodies to establish, in appropriate cases, a voluntary register for unregulated health professionals, health care workers, social care workers and students within those fields. A voluntary register is defined in **clause 212(section 25E)** as a 'register of persons who are not required by any enactment to be on that register in order to use a title, practise a profession, engage in health care work in the UK or social care work in England or undertake certain studies'. The *Explanatory Notes* to the Bill provide that the register is defined so that:

¹³² Community Care Market News, Bureaucracy bonfire lit, August/September 2010; vol 17, issue 5

¹³³ The Bill would rename the Health Professions Council the Health and Care Professions Council

¹³⁴ DoH *Liberating the NHS: Report of the arms-length bodies review*, 26 July 2010, para. 3.35

¹³⁵ *Ibid.* paras. 3.34-35

...should one or more of the administrations in England, Scotland, Wales or Northern Ireland decide to make it compulsory for persons in that part of the UK to be on a particular register in order to do one or more of these things, that register would still be regarded as a voluntary register in so far as it registers persons in other parts of the UK (in relation to which no requirement to be on that register exists). It is also defined in such a way that if an enactment makes it compulsory for a person to be on a particular register in order to carry out work or practice of a particular kind but only for a specific purpose, that register will remain a voluntary register. An example would be if a statutory instrument required a person to be on a particular register in order to work as a health care support assistant in the NHS in England (but not in order to work as a health care support assistant outside the NHS in England).¹³⁶

The voluntary register provisions would not apply to the new Health and Care Professions Council whose members would have to be registered in order to practise under their professional titles.¹³⁷

The Bill would also make provision for the following further functions of the CHRE:

- To accredit voluntary registers maintained by regulatory bodies and others (**clause 213**).
- Extend its current powers to refer to the courts, final fitness to practise decisions taken in relation to registered professionals by the regulatory bodies,¹³⁸ to cover decisions in relation social workers (**clause 207**).
- Allow it to provide, for a fee, advice or auditing services to the regulatory bodies, or to bodies with functions that correspond to those of the regulatory bodies.
- Require it to publish a strategic plan for the coming financial year (and for such subsequent years as it may determine) and lay its strategic reports before the four UK parliaments and assemblies as soon as possible after the end of the financial year. The current requirement to send copies of its annual report to the Secretary of State would be revoked.

To reflect its new remit, the CHRE would be known as the Professional Standards Authority for Health and Social Care (**clause 206**).

Governance

The Bill would make changes to the governance and accountability of the new Authority. Currently the Secretary of State, as a member of a council board, appoints members of the CHRE. The Secretary of State's power to appoint non-executive members of the Authority would be transferred to the Privy Council, although the Authority would be able to determine its remuneration and allowance to members. The Secretary of State would, however, be able to request advice from the Authority on matters connected with the social work profession, or social care workers, in England (**clause 207**). A fee would be payable for any such request which the Authority would have to comply with.

Clauses 208 to 211 provide that the Privy Council's new functions would include:

¹³⁶ *Explanatory Notes to the Bill* [Bill 132-EN], para 1109

¹³⁷ Clause 212/section 25D(4)

¹³⁸ Section 29 of the *National Health Service Reform and Health Care Professions Act 2002*

- Regulation making powers relating to the payment and the level of fees paid to the Authority by regulatory bodies for the performance of its functions. The power would be subject to the negative resolution procedure.
- Powers to make regulations about the investigation by the Authority of complaints made to it about the regulatory bodies. The Secretary of State's current power regulatory in relation complaints would be revoked. As now, the provision would be subject to the affirmative resolution procedure.
- Powers to determine arrangements in relation to the Authority's annual accounts.
- Powers to make appointments to the regulatory bodies (with the exception of the Pharmaceutical Society of Northern Ireland). Appointments are currently made the Appointments Commission which would be abolished by **clause 259** of the Bill.

10.3 Abolition of the Office of the Health Professions Adjudicator (OHPA)

A new Office of the Health Professions Adjudicator (OHPA), to adjudicate on fitness to practice cases brought before it by the General Medical Council (GMC) and the General Optical Council (GOC) was proposed in the *Trust, Assurance and Safety* White Paper.¹³⁹

The OHPA was established by the Labour Government under Part 2 of the *Health and Social Care Act 2008* as an independent body. It was expected to take up its role in relation to GMC cases from April 2011¹⁴⁰ and then, in due course, to take on the adjudication role in relation to health professionals from the other health regulators. However, following a consultation exercise, the current Government announced it was not persuaded that the creation of OHPA was the most appropriate and proportionate way forward in terms of adjudication and had decided not to proceed with setting up the OHPA.¹⁴¹ **Clause 215** would repeal Part 2 of the 2008 Act and abolish the OHPA.

An article in the *BMJ* in September 2010 noted that in the light of the Government's decision not to proceed with the OHPA a new disciplinary tribunal for doctors may be set up by the GMC, possible on a statutory basis.¹⁴²

11 National Institute for Health and Clinical Excellence (NICE) (Part 8)

The National Institute for Health and Clinical Excellence (NICE) provides evidence-based information for the NHS on the effectiveness and cost-effectiveness of healthcare interventions. It publishes mandatory technology appraisal guidance (stipulating clinical interventions – mainly medicines – which must be funded by PCTs, as well as advisory clinical guidelines and public health guidance (which PCTs are not obliged to implement). PCTs are legally required to make funding available for drugs and treatments recommended by NICE as part of a technology appraisal within three months of NICE's final guidance being published.¹⁴³

The *Legislative Framework* states that the Bill will establish NICE on a firmer statutory footing, clarify its role and functions, secure its independence, and extend its remit to social care:

¹³⁹ DoH, *Trust, assurance and safety: The regulation of health professionals*, 21 February 2007

¹⁴⁰ Department of Health press notice, 18 February 2010

¹⁴¹ HC Deb 26 July 2010 c65-6WS

¹⁴² "GMC supports government plans to keep role as doctors' adjudicator" (7 September 2010), *BMJ* 2010; 341:c4919

¹⁴³ http://www.nice.org.uk/aboutnice/whatwedo/niceandthenhs/nice_and_the_nhs.jsp

In future, NICE will be a non-departmental public body. Its primary purpose and function will be to provide advice to both the NHS Commissioning Board and the Secretary of State to enable them to discharge their respective quality improvement functions effectively.¹⁴⁴

Part 8 of the Bill would re-establish the National Institute for Health and Clinical Excellence (NICE) as a non-departmental public body (it is currently a Special Health Authority) and re-name it the 'National Institute for Health and Care Excellence', reflecting the extension of its remit to social care (it will still be known as NICE).

The Government has tasked NICE with developing a suite of quality standards to support the NHS Commissioning Board, GP commissioning consortia and those providing NHS care to deliver the outcomes set out in the framework. The first three standards, on stroke, dementia and prevention of venous thromboembolism, were published in June 2010. Within the next five years, NICE will be expected to produce 150 standards.

The Bill also sets out how NICE will develop quality standards, give advice, guidance or provide information, and make recommendations on areas including medicines and treatment.

The future role of NICE and value-based pricing

Following speculation in the media about the future role of NICE,¹⁴⁵ Lord Crisp, a former Chief Executive of the NHS, asked a series of parliamentary questions about NICE and the new arrangements for GP commissioning:

To ask Her Majesty's Government what plans they have to replace the single clinically led and scientifically based national assessment of drugs and therapies currently undertaken by the National Institute for Health and Clinical Excellence with local arrangements.[HL3664]

To ask Her Majesty's Government whether, and to what extent, they expect general practitioners to follow the assessments of drugs and therapies made by the National Institute for Health and Clinical Excellence and local arrangements.[HL3665]

The Parliamentary Under-Secretary of State, Department of Health (Earl Howe):

As set out in our White Paper, *Equity and Excellence: Liberating the NHS*, we plan to reform the way that drug companies are paid for National Health Service medicines by moving to a system of value-based pricing from 2014. This will ensure licensed and effective drugs are available to NHS patients and clinicians at a price to the NHS that reflects the value they bring. The National Institute for Health and Clinical Excellence (NICE) is recognised as an international leader in the evaluation of drugs and health technologies, and it will continue to have an important advisory role, including in assessing the incremental therapeutic benefits of new medicines. However, as we implement our plans for value-based drug pricing from 2014, NICE's role will inevitably evolve.

Prior to the introduction of value-based pricing, we will continue to ensure that the NHS funds drugs that have been positively appraised by NICE.

To ask Her Majesty's Government whether they have plans to issue a statement clarifying their expectation of the future relationship between GP consortia and the National Institute for Health and Clinical Excellence.[HL3666]

¹⁴⁴ DoH, *Liberating the NHS: Legislative framework and next steps* (Cm 7993) 15 December 2010, para. 3.36

¹⁴⁵ <http://www.bbc.co.uk/news/health-11664684>

Earl Howe: As we have made clear in our White Paper, *Equity and Excellence: Liberating the NHS*, general practitioner (GP) consortia will be responsible for making decisions about the range and nature of services to commission in order best to respond to the needs of their local population. Individual GPs will continue to be responsible for their referral and prescribing decisions. The National Institute for Health and Clinical Excellence will continue to have an important role in providing advice to both commissioners and clinicians.¹⁴⁶

The Government is currently consulting on its proposals for a new value-based approach to the pricing of branded medicines (closing 17 March 2011).¹⁴⁷

12 Health and Social Care Information Centre (Part 9)

This part of the Bill would establish the Health and Social Care Information Centre (HSCIC), which is currently a Special Health Authority, as a non-departmental public body. In its role collecting data to support central bodies in discharging their statutory functions, it will have powers to require data to be provided to it when it is working on behalf of the Secretary of State or the NHS Commissioning Board. The HSCIC will also be able to consider additional requests from other arm's-length bodies, and carry out those data collections if specific criteria are met. It will have a duty to seek to reduce the administrative burden of data collections on the NHS, with powers to support this.

This part of the Bill also sets out how the Secretary of State or the NHS Commissioning Board may prepare and publish information standards

13 Abolition of certain public bodies (Part 10)

The Department of Health's review of its arm's length bodies (ALBs), published in July 2010,¹⁴⁸ recommended an overall reduction of ALBs in the health sector from eighteen to between eight and ten bodies. In particular, the review announced plans to abolish the NHS Institute for Innovation and Improvement, the Appointments Commission, National Patient Safety Agency and Alcohol Education Research Council.

The Cabinet Office list of quangos published on 14 October 2010 confirmed the decisions reached by the Department of Health's review of ALBs and also set out plans for the Department's 31 non-executive advisory committees, panels, groups and commissions. Some of these, such as the NHS pay review body, are to be retained on grounds of impartiality while others are having their functions transferred. Most will be reconstituted as 'committees of experts' within the Department of Health, the proposed Public Health Service, or the Medicines and Healthcare products Regulatory Agency (MHRA) (an executive agency of the Department of Health).

This part of the Bill contains provisions that would abolish the following arm's length bodies:

- Alcohol Education and Research Council (**clause 258**)
- The Appointments Commission (**clause 259**)
- The National Information Governance Board for Health and Social Care (**clause 260**)
- The National Patient Safety Agency (**clause 261**)

¹⁴⁶ HL Deb 15 November 2010 cWA157-8

¹⁴⁷ DoH, *A new value-based approach to the pricing of branded medicines - a consultation*, 16 December 2010

¹⁴⁸ DoH, *Report of the arms-length bodies review*, July 2010

- The NHS Institute for Innovation and Improvement (**clause 262**).

Clause 263 would repeal section 250 of the *NHS Act 2006*, which provides for the establishment of standing advisory committees. There would be will be a saving provision for the continuation of the Joint Committee on Vaccination and Immunisation as a statutory body.

14 Miscellaneous provisions

Clauses 30 to 37: Amendments to the Mental Health Act 1983

Clauses 30 to 37 would make a number of changes to the *Mental Health Act 1983* (the 1983 Act) in the light of the abolition of PCTs and Strategic Health Authorities (SHAs). For example, SHAs currently carry out the Secretary of State's functions with regard to approving doctors who can take decisions about detained patients under the 1983 Act. **Clause 30** of the Bill would enable the Secretary of State to appoint others to undertake this approval function on his behalf.

A letter from Bruce Calderwood, Director of Mental Health and Disability at the Department of Health, outlines these changes.¹⁴⁹

Clause 40: New Special Health Authorities

This clause, which relates to the establishment of Special Health Authorities, would allow the Secretary of State to establish a Special Health Authority for a specific function, but only for a time-limited period. The time limit is intended to ensure that when a Special Health Authority is required for a specific purpose, it does not continue to exist once that purpose has been met.

Part 11 of the Bill: miscellaneous provisions

This part of the Bill contains a number of miscellaneous provisions, including duties for bodies to co-operate, arrangements with devolved authorities, supervised community treatment and transfer schemes.

¹⁴⁹ Letter from Bruce Calderwood, Director of Mental Health and Disability, 19 January 2011

Appendix 1 – Key Department of Health publications on the reform proposals

The Department has published a number of documents on its proposals:

The NHS White Paper: Department of Health, *Equity and excellence: Liberating the NHS* (Cm 7881) 12 July 2010

The White Paper referred to the need for further consultation and the Department of Health published the following four individual consultation papers, later in July 2010:

- *Transparency on outcomes - a framework for the NHS* (19 July 2010) sought views on how to develop an NHS Outcomes Framework.
- *Liberating the NHS: Increasing democratic legitimacy in health* (22 July 2010) consulted on proposals for local authorities to i) support patient choice ii) take on local public health improvement functions, and iii) promoting more effective commissioning arrangements and integration of services.
- *Liberating the NHS: commissioning for patients* (22 July 2010) sought views on how GP consortia, the NHS Commissioning Board and others can best work together
- *Liberating the NHS: regulating healthcare providers* (26 July 2010) sought views on proposals for economic regulation and the reform of foundation trusts.

Two further consultation papers were published by the Department on 18 October 2010 setting out proposals to give people more information and choice about their care:

- *Liberating the NHS: An Information Revolution*
- *Liberating the NHS: Greater choice and control*

Department of Health, *Liberating the NHS: Legislative framework and next steps* (Cm 7993) 15 December 2010

The Health and Social Care Bill [Bill 132 2010-11], 19 January 2011

Explanatory Notes and an impact assessment of the proposals were published alongside the Bill

Additional detail, particularly on the transition to the new model, can be gained from: Department of Health, *The Operating Framework for the NHS in England 2011/12*, 15 December 2010

Department of Health, *NHS Outcomes Framework*, 20 December 2010

Letter from the Chief Executive of the NHS, Sir David Nicholson, to all NHS chief executives: *Equity and excellence: Liberating the NHS – Managing the transition and the 2011/12 Operating Framework*, Department of Health, 15 December 2010

The Department of Health has also published a public health White Paper, *Healthy Lives, Healthy People*, (Cm 7985) on 30 November 2010.

Appendix 2 – Reactions to the *Health and Social Care Bill*

The Labour Party

John Healey, Shadow Health Secretary, set out Labour's response to the Bill in a speech at the King's Fund on Friday 21 January 2011. Although he noted that he agreed with the overall aims of reform, the Government's plans to achieve them were "high cost and high risk." He stated that the true intents of what he described as the "Conservative plan for the NHS" was "opening up all parts of the NHS to private health companies, and taking what remains of NHS out of the public sector."¹⁵⁰

Mr Healey also contested the claim that the Government's reforms were a logical extension of earlier Labour policies:

On GP commissioning, we as a Labour Government certainly fostered the early involvement and leadership of GPs and those cited in Cumbria and Nottingham as models are working within the current system. But we ensured these developments always had the proper public openness, and scrutiny and accountability which will not be required in the new system, and we always recognised the important role other clinicians, professions and specialists need to play alongside GPs.

In private health providers, we used the private sector when it could add to established NHS care, either to offer patients something new the NHS was not doing or increase capacity to clear waiting lists and reduce waiting times for patients. But this was always competition within the planned and managed development of services, and was never competition based on undercutting through price.¹⁵¹

British Medical Association

The BMA described the Bill as a "massive gamble". Dr Hamish Meldrum, Chairman of Council at the BMA, said that "Ploughing ahead with these changes as they stand, at such speed, at a time of huge financial pressures, and when NHS staff and experts have so many concerns, is a massive gamble." The BMA believes that potentially positive elements of the reforms - giving clinicians greater responsibility for commissioning and shaping local health services, increasing public and patient involvement, and putting a greater focus on improving public health - are threatened by other aspects, particularly those that seek to increase competition. The BMA has issued a briefing paper for the Second Reading of the Bill, which sets out their position in detail; it also calls on the Government to halt implementation of the reforms while the legislation is going through Parliament.¹⁵²

The King's Fund:

Chris Ham, Chief Executive of The King's Fund, said the publication of the Bill signals "the biggest shake-up of the NHS since its inception," and that:

"The last decade has seen significant progress in the performance of the NHS. While ministers are right to stress the need for reform to make it truly world class, these gains are at risk from the combination of the funding squeeze and the speed and scale of the reforms as currently planned."¹⁵³

¹⁵⁰ <http://www2.labour.org.uk/john-healeys-speech-to-the-kings-fund,2011-01-21>

¹⁵¹ <http://www2.labour.org.uk/john-healeys-speech-to-the-kings-fund,2011-01-21>

¹⁵² BMA Parliamentary Brief, *Health and Social Care Bill - Second Reading*, 26 January 2011

¹⁵³ The King's Fund comments on the publication of the Health and Social Care Bill. (19 January 2011)

NHS Confederation

The NHS Confederation supports the objectives of these reforms and the report argues that there are potential benefits from GPs being moved closer to decision making and extending the range of providers in order to drive up efficiency and innovation. However, it says there are significant risks in the transition to the new system, which the government will need to address. On 27 January 2011 the NHS Confederation published a parliamentary briefing for the Second Reading of the Bill.

Patients Association

The Patients Association noted that it was deeply concerned by the lack of detail in the Bill and in particular about some aspects of GP commissioning and the proposals for HealthWatch.¹⁵⁴

The Royal College of General Practitioners (RCGP)

The RCGP stated its support for the overall principles of a NHS, led by clinicians with patients at its centre. It referred to its continued concerns about how the Government plans to implement its proposals, and in particular that some of the types of choice outlined in the Government's proposals run a risk of destabilising the NHS and causing long-term harm to patient outcomes (particularly in cases of children with disabilities, those with multiple co-morbidities and the frail and elderly).¹⁵⁵

Royal College of Nursing

The Royal College of Nursing has said that major reform of the NHS in England must not jeopardise recent improvements to patient care. RCN Chief Executive & General Secretary Dr Peter Carter expressed particular concern at the scale and pace of change at a time when the NHS is being tasked with saving £20 billion over the next four years. The RCN is also concerned that fragmentation across the NHS could result in unexplained variations in service, a reduction in collaboration and less sharing of good practice.¹⁵⁶

Other reactions to the Health and Social Care Bill:

A letter to the *The Times* signed by the heads of the Royal College of Nursing, the British Medical Association, the Royal College of Midwives and the Chartered Society of Physiotherapy, and officials representing the health service membership of Unison and Unite, stated that the: "sheer scale of the ambitious and costly reform programme, and the pace of change, while at the same time being expected to make £20 billion of savings, is extremely risky and potentially disastrous."¹⁵⁷

Confederation of British Industry, CBI comments on Health and Social Care Bill (19 January 2011)

Council for Healthcare Regulatory Excellence, 2011 Health & Social Care Bill proposes more independence and new powers for CHRE (19 January 2011)

Foundation Trust Network, FTN statement on Health Bill (19 January 2011)

Joseph Rowntree Foundation, Health and Social Care Bill 2011 - a lot to get right (21 January 2011)

¹⁵⁴ Patient's Association response to the Health and Social Care Bill. (20 January 2011)

¹⁵⁵ RCGP responds to the Health and Social Care Bill. (19 January 2011)

¹⁵⁶ RCN response to the Health and Social Care Bill (19 January 2011)

¹⁵⁷ Letter to *the Times*, 17 January 2011

The Nuffield Trust, Response to the publication of the Health and Social Care Bill (19 January 2011)

Royal College of Midwives, NHS Bill ushers in prolonged period of instability say midwives. (19 January 2011)

The NHS Evidence website also provides links to reactions from key stakeholders.

Appendix 3 - Responses to the NHS White Paper

British Medical Association

The BMA noted that there were positive elements of the Government's plans for the NHS in England – such as devolving more control to patients and frontline clinicians, and a stronger focus on public health – but that these were at risk from other aspects that seek to accelerate a market-based approach.

The BMA warned that proposals to encourage further competition in the NHS – such as extending choice to 'any willing provider' and giving the foundation trust regulator Monitor a duty to promote competition – would risk shifting the focus onto cost rather than quality, and would undermine opportunities to work more collaboratively across primary and secondary care. It also said that forcing all hospital trusts to become semi-independent foundation trusts would prove damaging. The BMA response stated "There are aspects of the white paper's proposals which have the potential to undermine the stability and long-term future of the NHS".

Foundation Trust Network

The Foundation Trust Network welcomed the proposals, stating that "the vision for the NHS articulated in the White Paper is the right one - putting patients and carers at the centre". In particular it supported the proposals to extend the freedoms of foundation trusts, and the fact they would no longer be constrained by the cap on earning income from non-NHS sources. However, the response also identified risks associated with the reforms which could be detrimental to healthcare services for patients.

The King's Fund:

The health think tank the King's Fund agreed there was a need for change and supported the aims of the White Paper to improve clinical engagement and patient choice. However, they asked ministers to reconsider the pace and scale of the reforms. The Fund also questioned the need for a fundamental reorganisation of the NHS when "evidence shows that health outcomes and public satisfaction have improved in recent years".

Local authorities:

In general local authorities, responding in their own right and through representative bodies such as the Local Government Association, supported the transfer of public health functions. However, specific representations were made concerning the ring-fencing of public health resources, and the need for the public health outcomes framework to be produced in partnership with local government.

The National Association of Primary Care

The NAPC described the White Paper as "a unique opportunity to raise the bar in the commissioning and delivery of care for patients."

NHS Alliance:

The NHS Alliance, which represents doctors and managers,¹⁵⁸ welcomed the proposals towards clinical commissioning and highlighted that, "if the changes are going ahead, then GP practices and PCTs should start working together immediately to accelerate the pace and implement the changes sooner rather than later." The Chief Executive of the NHS Alliance said, "The direction of travel is right. For years the NHS Alliance has been advocating that the balance of power for planning and delivery of health services should tip towards primary care clinicians, their patients and communities."

¹⁵⁸ Formerly the National Association of Commissioning GPs

NHS Confederation:

The NHS Confederation, which represents NHS employers and managers, supported the Government's objectives but called for the Government to reduce the risks associated with the design and implementation of the reforms. The response also noted that the transition period will be the time of greatest risk as it will be difficult to "deliver major structural change and make £20 billion worth of efficiency savings at the same time." The NHS Confederation response also stated that PCTs have built up a wealth of expertise that will be important to the success of the new consortia. It advised that urgent action was needed to retain good staff and preserve organisational memory. It published a report on the reforms, *Liberating the NHS: What might happen?*, on 17 January 2011.

Royal College of General Practitioners (RCGP)

The RCGP's initial response to the White Paper, under its former chair Professor Steve Field was generally positive about the aims of the reforms, although qualifying its support for greater GP leadership and influence with the warning that training, time and resources will be necessary to make it a success. However, the new chair of the RCGP appointed in November 2010, Dr Clare Gerada, has highlighted her serious concerns about the potential risks of reform.¹⁵⁹

Royal College of Nursing

The RCN agreed with the principles on which the proposed reforms are based but asked if they were "Too much, too soon, and too little evidence?"

The NHS Evidence website provides links to a number of other White Paper consultation responses from key stakeholders.

¹⁵⁹ "Doctors warned to expect unrest over NHS reforms", *the Guardian*, 19 November 2010

Appendix 4 – Statistical Annex

Health outcomes

In absolute terms, improvements have been observed in a range of health outcome indicators since 1995-97.

Improvements in selected health outcomes 1995-97 to 2006-08

| | 1995-97 | 2006-08 | % change |
|--|---------|---------|----------|
| All cause mortality rate (deaths per 100,000 population) | 141.21 | 113.96 | -19.3% |
| Cancer mortality (deaths per 100,000 population aged under 75) | 743.79 | 581.94 | -21.8% |
| Stroke mortality (deaths per 100,000 population aged under 75) | 26.33 | 13.74 | -47.8% |
| Male life expectancy | 74.61 | 77.93 | 4.4% |
| Female life expectancy | 79.69 | 82.02 | 2.9% |

Source: NHS national Clinical Health Outcomes Database

Hospital waiting lists

In England, the average (median) waiting time for inpatient hospital treatment in March 2010 was 4 weeks and 2 days; for outpatient treatment it was 2 weeks 5 days. In March 1997, average waits were 13 weeks for inpatients and 6 weeks for outpatients. The Department of Health no longer publish waiting times data (the final publication was March 2010).

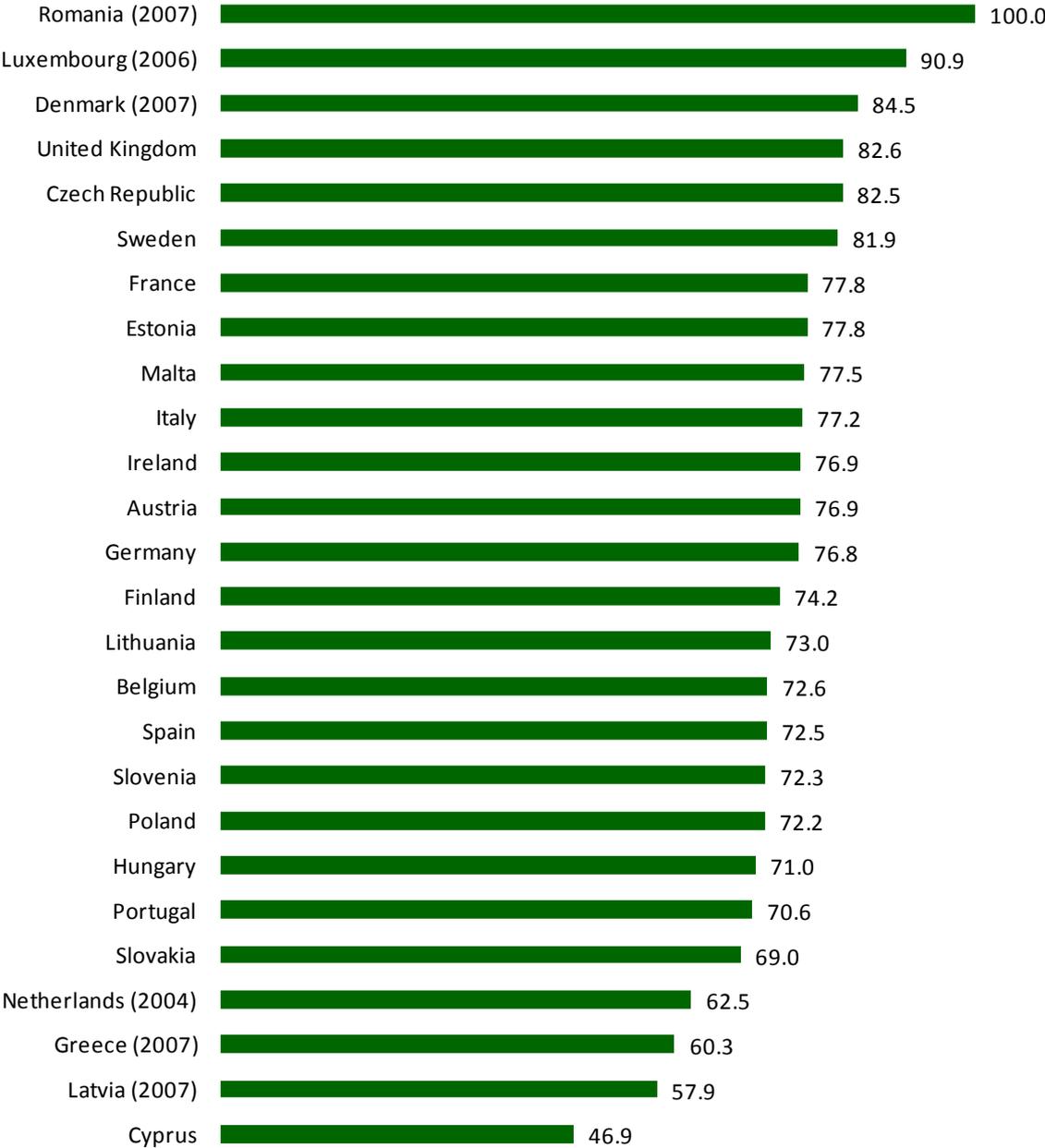
| Inpatient waiting lists: 1997-2009 | | | | | |
|--------------------------------------|---------|--------------------------------|-------|------|-------|
| England (provider based) at 31 March | | | | | |
| | 000s | % of patients waiting (months) | | | |
| | Waiting | <3 | 3-5 | 6-11 | 12-17 |
| 1997 | 1,157.9 | 50.8 | 24.2 | 22.3 | 2.7 |
| 1998 | 1,297.7 | 46.7 | 23.9 | 24.2 | 5.2 |
| 1999 | 1,072.9 | 50.6 | 23.3 | 21.7 | 4.4 |
| 2000 | 1,037.1 | 50.6 | 23.6 | 21.1 | 4.7 |
| 2001 | 1,006.5 | 51.8 | 23.8 | 20.3 | 4.2 |
| 2002 | 1,034.7 | 51.4 | 25.3 | 21.2 | 2.1 |
| 2003 | 992.0 | 54.6 | 26.0 | 19.4 | 0.0 |
| 2004 | 905.6 | 63.7 | 27.2 | 9.0 | 0.0 |
| 2005 | 821.7 | 68.0 | 26.9 | 5.0 | 0.0 |
| 2006 | 784.5 | 75.2 | 24.7 | 0.1 | 0.0 |
| | | % of patients waiting (weeks) | | | |
| | | 0-13 | 13-26 | 26+ | |
| 2007 | 700.6 | 83.5 | 16.4 | 0.1 | |
| 2008 | 531.5 | 92.7 | 7.3 | 0.0 | |
| 2009 | 566.0 | 93.0 | 7.0 | 0.0 | |
| 2010 | 614.8 | 91.0 | 9.0 | 0.0 | |

Source: DH, *Hospital Waiting Lists in England, Green Book*

Public expenditure on health, international comparisons

There is considerable variation across European countries in the public/private breakdown of health expenditure. The chart below shows World Health Organisation (WHO) data on the proportion of public expenditure on health. In 2008, 82.6 per cent of UK health expenditure was public, the fourth highest of EU27 countries for which data was available¹⁶⁰.

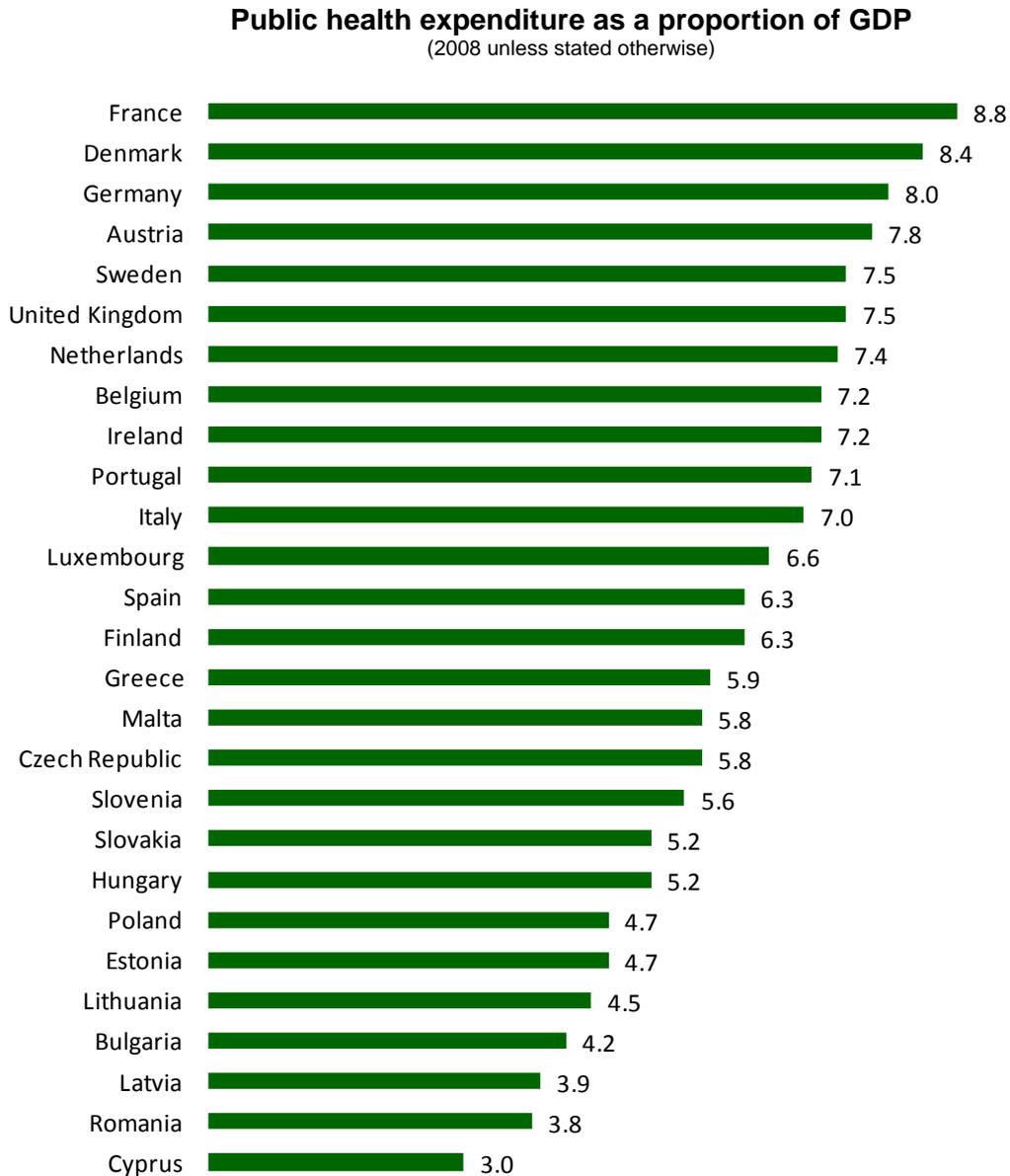
Public expenditure on health as a percentage of total health expenditure
(2008 unless stated otherwise)



¹⁶⁰ Data for Bulgaria is not available

Health expenditure as a proportion of GDP, international comparisons

In 2008, WHO data indicated that public health expenditure in the UK amounted to 7.5 per cent of GDP. The UK was ranked 6th of the EU27 countries in terms of the proportion of GDP represented by public health expenditure.



Cancer Survival Rates

The EUROCARE study (EUROpean CAnCer REgistry-based study on survival and CARE of cancer patients) is a cancer epidemiology research project on survival of European cancer patients. The most recent study EUROCARE-4 includes data on more than 13 million cancer diagnoses provided by 93 population based cancer registries in 23 European countries.

The EUROCARE-4 data follows up those diagnosed with cancer between 1995 and 1999 to determine their survival five years later. The tables below show five year survival rates for men and women in the 23 EUROCARE countries. The five year relative survival rates for all cancers tend to be lower in countries of the UK than other nations.

Five year relative survival rate (all cancers) for men diagnosed 1995-1999

| Country | Relative survival rate (%) | Rank |
|---------------------|----------------------------|------|
| Iceland | 55.99 | 1 |
| Sweden | 55.57 | 2 |
| Austria | 54.59 | 3 |
| Finland | 51.84 | 4 |
| Switzerland | 51.79 | 5 |
| Norway | 50.41 | 6 |
| Belgium | 50.15 | 7 |
| Portugal | 49.26 | 8 |
| Germany | 48.32 | 9 |
| France | 46.34 | 10 |
| Italy | 46.33 | 11 |
| Netherlands | 45.75 | 12 |
| Spain | 44.78 | 13 |
| UK Wales | 43.71 | 14 |
| Ireland | 42.47 | 15 |
| Malta | 41.37 | 16 |
| UK England | 41.26 | 17 |
| UK Northern Ireland | 38.95 | 18 |
| UK Scotland | 38.69 | 19 |
| Czech Republic | 36.76 | 20 |
| Slovenia | 35.41 | 21 |
| Poland | 32.81 | 22 |
| Slovakia | 31.22 | 23 |

Source: EUROCARE-4