

RCN briefing: Health and Social Care Bill 2011

In summary the RCN is seeking changes to the Bill that would ensure:

- Care is not fragmented, leading to inequalities in provision and an inability for clinicians and health providers to collaborate
- the quality of patient care is not detrimentally affected by forced price competition
- nurses are represented at commissioning consortia board level and on the National Commissioning Board
- nationally agreed pay, terms and conditions are not threatened by moves to localised pay structures and negotiating.

Introduction

With a membership of over 410,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

The Health & Social Care Bill 2011 signifies a dramatic shift in health policy and maps out a huge reorganisation of the NHS. This is something RCN members were not expecting, particularly following the Secretary of State's speech to the 2010 RCN Congress, pledging to end the continual cycle of NHS reorganisation¹.

The RCN welcomes the general premise of the Bill to place patients at the centre of care; to reduce inefficiency in the NHS; to involve clinicians in the commissioning of services; and to improve standards across all aspects of the health service. However, the RCN has repeatedly expressed major reservations that the policies set out in the Bill will actually deliver on these underlying principles.

The RCN also believes that implementing these changes now, at a time of financial constraint within the NHS and during a £20bn efficiency drive, will add to the burden of an already overworked workforce and service. The RCN's Frontline First campaign has already found that almost 27,000 posts have been earmarked for removal from the NHS. This dual challenge of reform and efficiency savings could result in adverse affects on the quality of care. The RCN believes the proposals within this Bill are essentially too much, too soon. This is why the RCN called for a comprehensive programme of pilots and phasing of these complex structural reforms with a subsequent public evaluation. The RCN was, therefore, disappointed to see that the 'Pathfinder' projects that have been implemented will not but subjected to any evaluation process.

The RCN submitted a full and comprehensive response to the NHS White Paper consultation last year. Within that submission the RCN set out a list of 18 key concerns which must be addressed to avoid the proposed reforms having a negative impact upon the NHS. Full details of that response can be found at www.rcn.org.uk/whitepaper.

This briefing is issued to Members of Parliament in advance of the Health and Social Care Bill's Second Reading on Monday 31st January; it will highlight how RCN concerns within the White Paper have been addressed and point out specific areas of concern.



[www.rcn.org.uk/
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¹Rt. Hon. Andrew Lansley MP, speech to RCN Congress, 28th April 2010



NHS Principles

The RCN believes in the founding principles of the NHS, namely that services should be universal, provided free at the point of delivery, based on clinical need and not the ability to pay, and financed through taxation. In the recently published *NHS Operating Framework*, the RCN was pleased to see a commitment to these principles. However, with a move to a much more locally centred, less collaborative, commissioning system the RCN is worried that a more fragmented approach to commissioning of services may appear, increasing the potential for a ‘postcode lottery’ in service delivery.

The RCN believes that the NHS is currently well placed to take a strategic overview of health inequalities and identify need across a wide area. The RCN has concerns that the proposals as they stand will not allow for this strategic oversight.

Quality and Competition

The 2011/12 operating framework for the NHS revealed that providers will be able to offer services to commissioners at less than the published mandatory tariff price. There is clear evidence that price competition in healthcare is damaging. Enforced competition will also make it harder for GPs and nursing staff, as part of a multi-disciplinary team with responsibility for commissioning care, to work with colleagues in hospital and community settings to create the integrated care pathways that patients want and need, and that help make services more efficient.

The Bill does not reassure the RCN about how the quality and sustainability of providers under Any Willing Provider (AWP) would be monitored over time. There remains a lack of detail on the way in which the CQC and Monitor, the economic regulator, will oversee providers and how they will be required to work together. In essence, principles of safety, quality, and sustainability must underpin the choice of provider. This applies whatever the size, sector, or service they provide.

Despite assurances from the Government in recent weeks, the RCN is concerned that AWP could still result in a ‘race to the bottom’; essentially that the lack of national prices in some service areas will result in local pricing (which we acknowledge occurs to some degree anyway). However, these local prices could be pushed below the threshold where providers can deliver safe and sufficient quality services.

Lessons from previous NHS failures, where the focus upon quality care was lost, must be learnt and applied to any future reform. Quality of care and patient safety depend upon safe staffing levels and a climate of openness and transparency.

The RCN opposes the introduction of a maximum national tariff (price) for the provision of some services. Giving Monitor and the NHS Commissioning Board the power (Clause 103) to set a maximum price, with flexibility to negotiate below that price, provides a very significant risk that the quality of patient care will be compromised. In order to drive up and maintain standards it is essential that the tariff moves towards a system that instead rewards and incentivises improvements in the quality of care patients receive. In addition, the RCN wishes to highlight that it remains concerned that the tariff allows for sufficient nursing resources. The RCN has evidence that in some instances the tariff is not sufficient to cover nursing input and that implies a degree of cross subsidy. Any changes to the tariff need to ensure that it does not inappropriately incentivise reductions in nursing input which could threaten safety for patients for which there is increasing evidence.



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Part 3, Economic Regulation of Health and Adult Social Care Services Chapter 1, Monitor

Monitor, currently the economic regulator of Foundation Trusts, is to have its remit vastly widened to cover all health and adult social care services in England. Monitor will now also have the duty, set out in Clause 52, to promote “competition where appropriate”. This along with other clauses in Chapter 2, reinforces the emphasis on Monitor’s role in encouraging competition between providers and for commissioners to embrace this in their procurement of services.

The RCN is concerned that in focusing on competition, particularly price competition, then quality standards will become of secondary consequence. The issue of promoting and regulating competition must not hinder Monitor from the most important issue of regulating a national health service which delivers integrated, collaborative and comprehensive care.

Monitor will be responsible for ensuring that any willing providers, including NHS and voluntary organisations, and commercial companies, are able to compete to provide all NHS services. Monitor will be actively encouraging price competition.

Research carried out by economists at Imperial College² shows that following the introduction of competition in the NHS in the 1990s, where hospitals were encouraged to negotiate prices, a fall in clinical quality ensued. With the NHS facing £20bn of efficiency savings, there is a real danger that the commissioners and providers focus will be on cost, not quality.

The RCN sees a crucial role for Monitor and other regulators in the NHS as part of an effective system of checks and balances to ensure quality. With an increased emphasis being placed upon competition, the relationship between Monitor and the Care Quality Commission will be vital to maintain quality.

The proposed changes in this section of the Bill will give greater freedoms, and potentially more involvement from a plurality of providers, and will necessitate a very clear set of standards and credible checks and balances. The regulators will need to respond to a more diverse range of providers and plan for the longer term. If the number and type of providers increases, it is important to ensure that they operate in ways that deliver high quality, safe care.

The RCN also notes that the efficiency of the NHS is not just about finance, but about allocating scarce resources and in the health care sector this affects quality of care. Monitor, as the economic regulator, must ensure that it does not emphasise the financial considerations too heavily.

Nursing Leadership and Commissioning

Clause 21, Commissioning Consortia: establishment etc.

Clause 22, Commissioning Consortia: general duties

Schedule 1, Schedule 2

The RCN is concerned that the proposals to replace Primary Care Trusts (PCTs) with commissioning consortia, as set out by the Bill, do not make sufficient provisions for the role of nurse leadership within the commissioning framework. This omission sends out a powerful message to nurses, the largest professional group providing care, that they are not integral to the decision making process of the NHS. The RCN also believes this will be to the detriment of care and quality across the service.

Nurses have fought hard to ensure that they are represented at director level and by the Chief Nursing Officer (CNO) in England at the Department of Health. Nurses that sit on Primary Care Trusts, Strategic Health Authorities and provider organisation boards,

²Carol Propper, Simon Burgess and Denise Gossage (2008) ‘Competition and Quality: Evidence from the NHS Internal Market 1991-9’, *Economic Journal* 118(525): 138-70



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provide an invaluable insight into the practical issues of service delivery, including advice on value for money, efficient practice, and effective and quality care provision. They have a pivotal role in being able to stand back and view the whole care pathway, take a holistic perspective to look above the day to day clinical issues and effectively support commissioners in the decision making process.

Some solutions to commissioning will inevitably be nurse-led; modern healthcare services are increasingly nurse-led as a response to changing healthcare needs. These include specialist services, such as cancer services, and many public health initiatives. The profession must therefore be involved at every stage and level of the design, commissioning and implementation of services.

The Chief Executive of the NHS Commissioning Board, Sir David Nicholson, recently stated in the *Nursing Times* that the boards of commissioning clusters, which will take charge of strategic direction during the transition, should have “a doctor and a nurse because we want clusters to be clinician led”. Ensuring nurse participation on consortia boards through legislation is a natural progression of this policy. The RCN therefore calls for provision to be made in the Bill for nurses to be formally represented at a senior level in commissioning consortia and on the NHS Commissioning Board. The RCN believes the CNO should hold a prominent position in regard to national commissioning and oversight of this process.

The RCN believes that in order to avoid failure in commissioning and provision of services, the Department of Health, National Commissioning Board and local commissioning consortia must all have nurse representatives and leadership at a senior level.

Clause 22, Subsection 14O states that:

“commissioning consortium must make arrangements with a view to securing that it obtains advice appropriate for enabling it effectively to discharge its functions from persons with professional expertise relating to the physical or mental health of individuals.”

By leaving this option open for commissioning bodies, the RCN does not believe this goes far enough in prescribing for the needs of patients as a whole. No single profession can have sole responsibility for commissioning services and if the appropriate range and mix of health and social care professionals are not involved in the commissioning process, the proposed new models will fail.

Clause 23, Subsection 223L, Payments in respect of performance

The RCN is concerned that this section of the Bill makes provision for the National Commissioning Board to offer one-off bonus payments to commissioning consortia following a period of perceived good performance. The recipient commissioning consortia is then free to distribute payment that it receives “in such proportions as it considers appropriate”. The RCN believes that in a period of financial constraint where frontline staff are facing increasing pressures due to budgetary cuts, any additional monies must be earmarked for reinvestment into services, not as bonus payments.

National Pay

NHS staff pay, terms and conditions are currently negotiated through a national negotiating structure (the NHS Staff Council). Pay awards are determined by the NHS Pay Review Body. The current NHS pay system is underpinned by a comprehensive job evaluation framework and a national pay scale (Agenda for Change). This structure is a fair and effective arrangement, which meets equal pay legislation and is supported by NHS employers, NHS Trade Unions and NHS staff. The RCN has concerns that in addition to the removal of the two tier code, the provisions to encourage local commissioning consortia and Foundation Trusts to enter local pay bargaining will break down this agreement, resulting in fragmented, inconsistent systems, which would be costly to develop and result in industrial unrest.

³Nursing Times – 18 January 2011 – *Nurses to sit on commissioning cluster boards* – <http://www.nursingtimes.net/nursing-practice/clinical-specialisms/management/nurses-to-sit-on-commissioning-cluster-boards/5023987.article>



The implications of the Bill for NHS staff terms and conditions and employment relations are substantial. The encouragement of NHS organisations and particularly Foundation Trusts in England, to determine their own pay and reward structures will be highly damaging to recruitment, retention and morale and lead to unequal pay problems across the NHS. It would lead to leapfrogging of pay rates and NHS organisations competing against each other for staff. While Agenda for Change delivers an equality-proofed pay and grading scheme, the development of a plethora of local schemes could undermine the stability produced by the current system, leading to a surge of equal pay litigation cases and a challenge to workplace relations. It would also have a knock on impact on pay negotiation in the devolved administrations.

In regard to NHS pensions, the RCN has submitted evidence to Lord Hutton's review on Public Sector Pensions and eagerly awaits its findings. The RCN welcomes the reference within the Bill to the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE), and firmly believes this must be upheld. The RCN, alongside staff side colleagues, will continue to work with employers to guarantee fair terms and conditions.

Clause 150 Private healthcare

As the RCN's response to the NHS White Paper stated, the RCN cannot support the removal of the private income cap, as proposed by Clause 150, until healthcare providers can demonstrate that private income is not taken at the expense of NHS patients. The RCN believes that the current arrangements for the cap should remain in place and does not believe that there has been sufficient analysis to justify the proposed change in this area.

Part 5, Public involvement and local government

Since the publication of the NHS White Paper, the Government has repeated the mantra of placing patients at the centre of care, however, the RCN does not believe this is a consistent message throughout the Bill. For example, there is no requirement for the NHS Commissioning Board, commissioning consortia or HealthWatch England (which will replace the current Local Involvement Networks), to have a public representative.

Clause 170, instructs Local Authorities of their duty to provide a channel for patients and individuals to lodge a complaint about a health care service. However, it clearly states that it is up to Local Authorities to "make such arrangements as it considers appropriate". The RCN fears that this open ended clause will lead to an even further fragmented coverage of services, and in some areas will make it far more difficult for serious concerns to be aired.

A Local Authority's duty to host a Health Overview and Scrutiny Committee is amended by Clause 176, which shifts the scrutiny responsibility directly to the Local Authority. The Local Authority will have the option to form an Overview and Scrutiny Committee but will no longer be required by law. The RCN has concerns that in the current climate, with extreme pressures being placed upon Local Authorities through budgetary cutbacks, the opportunity not to run a service will be seized upon due to financial necessity. Health Overview and Scrutiny Committees carry out an important role at a local level, bringing to light areas of concern affecting local communities' health care services, and encouraging joined up working between health and social care services.

The RCN welcomes the intent by sections of the Bill such as Clause 19, subsection 13L, and Clause 21, subsection 14P, which state the need for the NHS Commissioning Board and commissioning consortia to ensure that service users are consulted on changes to the commissioning of services which affect them. It is important that this consultation and supplying of information is sufficiently robust to satisfy the needs of service users and provide the service which they require.



Education and training

The RCN will be submitting a response to the Department of Health's *Liberating the NHS: developing the healthcare workforce* consultation in due course. The consultation is seeking responses to proposals to establish a new framework for developing the healthcare workforce and seeks views on the systems and processes that will be needed to support it.

Nevertheless, workforce planning and education remains a significant concern for the RCN. For example, workforce planning has not generally been carried out well. Changes in the type of demand with regards to care (moving care into the community) and changes in supply (difficulties around an ageing nursing workforce) are not currently well reflected in workforce plans.

The RCN will be keen to see that the Government's proposals will ensure sufficient resources and infrastructure to provide national and regional oversight, as well as a multi-professional approach to workforce planning and education.

Abolition of Public Bodies

The RCN is concerned about the demise of several public bodies which it believes fulfil a vital role in health policy formation and the health of the nation. The RCN has issued briefings in regard to those public bodies affected by the Public Bodies Bill. Those affected by the Health Bill, which the RCN holds concerns about, are detailed here.

Clause 46, Abolition of Health Protection Agency

The Health Protection Agency (HPA) is to be abolished as a statutory organisation and functions transferred to the Secretary of State as part of the new Public Health Service.

The RCN would like further information about how the proposals would work in practice. The HPA oversees a number of important functions and if the Department of Health is to be streamlined, it is not clear how it would cope with its new responsibilities. The HPA is a largely service driven and customer facing organisation, but the DH is not. In addition, the RCN is concerned that the role the HPA currently performs will become lost in the general view of 'Public Health'. The RCN is also seeking further clarification around how the UK-wide functions of the HPA will be transferred with regards to the devolved countries.

The RCN is currently consulting with its members and will be setting out its views on the abolition of the HPA in more detail in its response to the Government's consultation on *Healthy Lives, Healthy People: Our strategy for public health in England*. However, the RCN calls for the HPA to speak with staff regarding concerns around potential site closures, relocations and timetables for change.

Clause 261, The National Patient Safety Agency

The National Patient Safety Agency (NPSA) promotes patient safety and manages the National Clinical Assessment Service, the National Research Ethics Service and confidential enquiries. Clause 261 of the Health and Social Care Bill would see the NPSA abolished as an Arms Length Body and its safety functions to be retained and transferred to the NHS Commissioning Board. This Bill does not deal with the National Clinical Assessment Service and the National Research Ethics Service.

The RCN believes that the agency has a critical role in collecting data on patient safety problems, and identifying trends and patterns of avoidable incidents as well as supporting ongoing education and learning. For example, the National Reporting and Learning System (NRLS) enables patient safety incident reports to be submitted to a national database and the data is then analysed to identify risks and opportunities to improve the safety of patient care. Since the NRLS was established, over four million incident reports have been submitted by healthcare staff.



The RCN calls for reassurances that important safety functions, such as the NRLS, will continue to be sufficiently resourced and provided for at the same level (For example, the NRLS currently covers England and Wales and the NHS Commissioning Board, which will oversee it, will be England-only). This is particularly important as the NPSA is not funded to exist after the end of the current financial year and the RCN believes that the patient safety function is likely to become considerably smaller (most recent estimate 120 staff reduced to 40). This causes some concern regarding retention of expertise and a potential loss of “organisational memory” around quality and safety in the NHS.

The RCN also calls for the NPSA to engage in discussions with trades unions and staff about the impact the proposed changes will have, for example, regarding where services will be located going forward.

Clause 262, The NHS Institute for Innovation and Improvement

Clause 262 of the Bill provides for the abolition of the NHS Institute for Innovation and Improvement, which supports the NHS by spreading new ways of working, new technology and leadership. The Bill proposes to move the functions, which will support the NHS Commissioning Board in leading for quality improvement, to the Board. The Government will review the potential for its remaining functions to be delivered through alternative commercial delivery models, but this will not be dealt with by the Bill.

In the RCN’s response to the NHS White Paper, the RCN stated that the decision to close the NHS Institute for Innovation appears to be a backward step given the strong focus on health prevention within the White Paper and associated consultation documents. The RCN is concerned about how collaboration and the sharing of information, knowledge and best practice across an increasingly competitive health and social care market will be supported. We will be seeking assurances that this collaboration will continue.

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

The Institute does an important and sometimes unpopular job in difficult circumstances and remains widely respected within the UK and abroad. Health care funding for medicines in England, as in other countries, is inevitably constrained within wider Government spending priorities. Demand has always been greater than available resources and priorities have to be determined fairly and transparently. NICE has demonstrated the ability to respond positively to criticism and adapt to new challenges, and should not be separated from the Cancer Drugs Fund approval process.

Royal College of Nursing
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