



Royal College  
of Nursing

*RCN Response to the*

# **Open Public Services White Paper**

# Introduction

With a membership of 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.

We welcome the opportunity to respond to the Cabinet Office's *Open Public Services White Paper*. The RCN used a number of methods to engage with its members and other stakeholders on the White Paper during the UK Government's consultation process that started on 11 July and closed on 30 September 2011. This included the following:

- a dedicated section on the RCN website providing a series of resources for members to engage with the consultation
- a factual briefing of the key themes in the *Open Public Services White Paper* highlighting some of the key questions for nurses and nursing for members to consider
- an online member survey on the White Paper. The results of which are included throughout this response document
- highlighting the consultation and the online member survey through RCN member communications channels.

## Executive summary

The RCN believes that some of the principles driving the *Open Public Services White Paper*, such as ensuring 'fair access to public services' and public services being 'accountable to users and taxpayers', are commendable. However, we have concerns that some of the proposals contained in the document could potentially have a negative impact on these aims. The White Paper does not currently go far enough in providing a sufficient evidence base for its proposals or provide enough detail as to how they would work in practice. The RCN also believes that many of the proposals contained in the White Paper need to undergo rigorous piloting and evaluation before they could begin to be rolled out.

For example, the RCN welcomes the Government's commitment to enabling individuals to have more choice and control over the services they use. However, with regard to health and social care, although we recognise that patient choice is vital to driving up standards, within a limited budget, patient choice is inevitably finite and there must be a balance between choice, equity and managing individuals' expectations.

A key issue for the RCN regarding equity and the promotion of choice is the necessity of support being provided for those individuals unable to make informed choices for themselves. The White Paper does not make it clear how the Government will ensure that vulnerable people in society will not be disadvantaged and how it will prevent the most articulate from benefiting the most. We believe that there is a lack of evidence to support the assertions in the document that opening public service provision will help reduce inequalities. In order for reforms to be successful and evidence-based, the "choice agenda" should be properly piloted and evaluated before being rolled out nationally. We strongly believe that this is also the case for other proposals in the White Paper, including personal budgets and neighbourhood councils.

In addition, the White Paper does not acknowledge the implications the current financial climate will have on opening public services up to a wider variety of providers to ensure individuals have real choice and control. For example, the Government's proposals signify an increased role for charity and voluntary organisations in delivering services in health and social care. However, recent reports have highlighted that these organisations are experiencing significant cuts in their funding owing to the financial pressures currently faced by local authorities seeking to make efficiency savings over the next four years. The Government has not provided enough detail as to how they will ensure that charity and voluntary organisations will be financially able to capitalise on the opportunities outlined in the White Paper.

The RCN recognises that there is a role for the voluntary sector, the commercial sector, and social enterprise in delivering NHS funded services. The RCN represents 100,000 members delivering care outside of NHS organisations. However, the NHS has made significant improvements in recent years and the UK ranks highly in international comparisons of health care systems. This has been evidenced by the sustained rise in patient satisfaction levels and positive patient outcomes. The RCN accepts that there are areas in which the NHS must strive to improve, however, where NHS organisations and staff are performing well, this should be acknowledged and built on.

A significant amount of our activity on the *Health and Social Care Bill* has focused on the provisions in the bill regarding competition and a move to a more diverse market to deliver NHS funded services. We believe that there may be a role for competition as a lever to improve quality but safeguards must be in place, such as effective regulation from Monitor and the Care Quality Commission to assure minimum standards of quality and patient care.

We have ongoing concerns about the implementation of the Any Qualified Provider (AQP) policy<sup>1</sup> and the effect of this policy upon existing providers, and NHS providers in the main. Our concerns include the process for setting tariffs and the level at which tariffs will be set. We believe that independent sector providers may be in a better position to operate and deliver a low tariff, as they may have lower margins related to staffing costs and overheads. We are also concerned that existing providers could be squeezed out of the AQP market and as such lead to staff redundancies. There is a real danger that if AQP policy is not carefully managed and if tariffs do not reflect the true cost of delivering services, existing NHS providers will be left to deliver critical services. These include accident and emergency or intensive care, which are the most expensive, essential and challenging services to deliver.

As part of our work on the *Health and Social Care Bill*, we have been vocal in calling for more detail on the Government's proposed failure regime and this is just as important with regard to the proposals outlined in this White Paper. The RCN believes that it is essential that a robust failure regime, which covers all types of providers in the new market, is established. As the failure of the care provider Southern Cross has shown, the Government must seek to put mechanisms in place to try to prevent failure where possible and to protect patients where it is not. The RCN is currently looking in further detail at the Government's recent document *Securing continued access to NHS services*<sup>2</sup>, which sets out the processes for dealing with failures in NHS organisations.

Finally, although this White Paper is driven by the desire to decentralise and decrease the size of the State, the RCN believes that there is still a legitimate role for the State in delivering services. There are services that only the State can provide owing to the risks involved, such as emergency health care. It must be recognised that there are local and national services that cannot be devolved to individuals or communities.

<sup>1</sup> Department of Health (2011) <http://healthandcare.dh.gov.uk/any-qualified-provider/> (Accessed 9 August 2011) (Internet)

<sup>2</sup> Department of Health (2011) *Securing continued access to NHS services: Technical annex*, London: DH

# Individual services

## Choice agenda

The RCN welcomes the Government's commitment to enabling individuals to have more choice and control over the services they use. In health care, we support the improved involvement of patients and the public in the planning and delivery of health and social care services.

This objective can best be achieved by all offers of individual services being premised on the principle of choice; that is, any interaction about state commissioned services should be undertaken using the principles of 'shared decision making'. This is currently primarily used in health care, whereby patients and service-users play an active and equal role in deciding the choice of treatments and health care interventions to be used. This principle is being promoted across the NHS as the default position for treatment provision under 'no decision about me without me'.

A key issue regarding the promotion of choice is the necessity of support being provided for those individuals unable (for instance by virtue of physical or mental capacity) to make informed choices for themselves. The RCN would want to see commissioners ensuring that provision is made for support and brokerage services, to enable people who need assistance in making choices about their services, and where necessary, in managing those services as and when they are provided.

Several times throughout the Health and Social Care Bill 'patient choice' is mentioned. The NHS Commissioning Board, Clinical Commissioning Groups and Monitor all have specific guidance to ensure patient choice is at the heart of their functions. Although we welcome and recognise that patient choice is vital to driving up standards and providing an NHS fit for the future, within a limited budget, patient choice is inevitably finite and there must be a balance between choice and equity.

The patient choice agenda has recently been extended, equating to £1 billion of NHS procurement. The RCN believes that in order for reforms to be successful and evidence-based, this policy should be properly piloted and evaluated before being rolled out.

## Informed decision making and the role of nurses

Nurses are integral to enabling patients and their carers to understand, and thus make best use of, data and information through initiatives such as care planning. Additionally, nurses have a specific and important role to play in assisting patients and the general public to interpret and use information to make choices about their health care that best fit their individual needs. This is evidenced by the nursing workforce already employed in this capacity by NHS Direct, as well as within general practice and primary care. Nurses also play an important advocacy role for their patients.

In a system with increasing emphasis on individual patient choice, appropriate support for health care staff in advocacy and support roles will be needed, including further programmes such as the Health Foundations' *Co-creating health*<sup>3</sup>.

The majority of respondents to our survey on the White Paper's proposals agreed that nursing staff should have a role in helping patients to exercise their rights in choosing between different providers. One RCN member stated that "nursing care has always been about advocating for patients and so enabling your patient to have a louder voice should be positive".

However, RCN members also expressed a number of concerns about how this would work in practice. For example, one respondent was concerned that although patients should have more choice, in practice this is not always possible, which "creates an expectation that cannot be met". Another RCN member stated that they did not feel that they were in a position to be able to "discuss the pros and cons of several different providers". Other concerns raised included current pressures on nursing staff's time and resources would mean that that they may struggle to spend enough time with patients to help them to make informed choices.

Another issue raised by respondents to the survey was that the proposals could also impact on the day-to-day work of nursing staff. Staff will need to interact with a greater number of providers to

<sup>3</sup> Health Foundations (1998) *Co-Creating Health Briefing Paper*, London: The Health Foundation

coordinate care for their patients who wish to exercise their right to choose. This could result in more administrative tasks and place burdens on staff already under significant pressure. For example, an RCN member responded that there is a risk that “patients may fall through the gaps between organisations contributing to what might become an extremely complex care package”.

The RCN would want to see plans to ensure the sufficient training of nurses in supporting people to self manage, understand and navigate the systems in order to access timely and appropriate care.

## Data and information for patients

The RCN welcomes the Government’s proposals to promote greater transparency of satisfaction data and information for patients and carers to facilitate individual choice of providers. However, the White Paper does not make it clear how the Government will address the following issues to achieve universal access to reliable, evidence-based information:

- the need to remove the digital divide experienced by certain groups in society (i.e. those with low income, low literacy and those in remote geographical locations)
- the need to ensure that information content is good quality, non-biased and evidence based
- the need to ensure that information is presented in a form suitable for people with poor literacy skills, those with visual or hearing impairment, in plain English, and where necessary, in other languages.

For example, vulnerable patients, such as older people or those with learning disabilities should not be disadvantaged by lack of access to sources of information and or by the need for support to understand the information. Respondents to the RCN survey raised their own experiences with patients, with one member arguing that not all patients “want to make complex decisions about their care, they want good care provided as a matter of course”.

One of the most important factors for patients when using information to make choices, for example about hospital services, is how the information is presented<sup>4</sup>. The RCN believes that work needs to be done to understand how people make health related decisions and what information is needed and the best ways to present it.

The RCN agrees with the principle of all providers who are delivering individual services in health and social care collecting satisfaction data in a standardised form to enable comparison. We believe that obtaining the views of the patients, service users and those who support them should be an integral part of the treatment and care management process. However, it will not be an easy task to standardise information, ensure reliable data, and make sure there is compliance across an increased number of providers in the market. The Government needs to provide greater detail on how it plans to ensure that data is standardised and reliable, and clinical staff are trained on the importance of maintaining good quality records.

In addition, the RCN believes that ‘satisfaction data’ is not the same as ‘experience data’. Any data collected on whether a recipient of a service is satisfied is liable to distortion by virtue of being subjective, unless attached to some form of meaningful reference scale. The Government has previously released consultations on three scales for measuring outcomes (in health care, public health and social care), which are to form the basis for measuring the difference (positive and negative) made by specific forms of intervention. This is on the premise that providers of these services will be contracted in such a way that they are remunerated (or penalised) according to their ability to meet the targets of agreed measurable outcomes. For instance in public health this might mean a reduction in teenage obesity for a given population within a given area over a given timescale.

The RCN believes that it would therefore be sensible to ensure that where providers are providing individual services, that the same approach be used, and that data be collected on the outcomes of interventions, rather than purely on the perceived notion of the recipient as to whether they are satisfied with the service. That is not to say that some objective measures will not translate into satisfaction measures. For example, the use of Patient Reported Outcome Measures (PROMs) in measuring health care outcomes following an intervention is able to reflect both the needs of the health care commissioners to ensure best use of resources, and the desire of patients to experience improved health.

<sup>4</sup> Boyce T, Dixon A, Fasolo B. & Reutskaja, E (2010) *Choosing a high quality hospital*, London: King’s Fund Publications

The RCN is a partner in the Health Quality Improvement Partnership (HQIP)<sup>5</sup>, a body contracted by the Department of Health to oversee, and develop, clinical audits. This contract, and the manner by which clinical audit data is used, would provide an excellent example of creating data that is related to experience, but equally related to outcomes.

The RCN is currently in the process of responding to the Cabinet Office consultation on *Making Open Data Real*<sup>6</sup>, where we will consider issues regarding the standardisation of data in more detail.

## Health inequalities

We are concerned that the Government's proposals could have a potential impact on disadvantaged or disengaged individuals or communities. This is especially important in relation to the increased use of information to inform patient choice and decision making, as well as to the more well acknowledged issues relating to involvement and engagement by the health services with disenfranchised communities.

The RCN is committed to eliminating health inequalities – the gap in health outcomes between the wealthiest and the most deprived communities and individuals. In our responses to the *Liberating the NHS*<sup>7</sup> and *Healthy Lives, Healthy People*<sup>8</sup> White Papers, we raised concerns that current plans to reform the NHS and public health services may contribute to the development of unacceptable variations in both access to services and the quality of those services. We asked for assurances as to how this would be monitored and how it would be addressed should the risk be borne out.

This White Paper does not provide evidence to support its assertions about the role that opening public service provision will play in reducing inequalities. For example, it is claimed that the reforms will “make opportunity more equal” and make “sure the poorest are at the front of the queue” without providing adequate detail about how this will be achieved, or of the safeguards and oversight measures that will be necessary to ensure that the Government's vision can become reality.

In response to the RCN survey on the White Paper, members expressed concerns about the potential for these proposals to impact on the most vulnerable patients. For example, one respondent argued that those “who are least likely to be able to articulate their needs will lose out”.

The ‘right’ to do something does not necessarily translate into the desire or means to do so. Individuals and communities will need varying levels of support and resources in order to make good on the rights set out in this document, and the ‘personalisation agenda’ will not be appropriate for everyone. There is a risk of ‘middle class’ capture, whereby the better off in society benefit from the ‘opening of the market’ policy disproportionately. It is widely accepted that health inequalities are the result of wider inequalities and unfairness in society. Therefore, if public services across the board increase social inequalities, the gap in health outcomes will continue to increase as well. The RCN would be deeply concerned about any policy which even risks such an outcome.

Whilst the White Paper acknowledges the need for oversight measures and safeguards to prevent inequalities worsening, the RCN is concerned at the lack of detail about what these will be, and how they will operate. For example, the Health Premium is cited as a way in which to ensure that local authorities prioritise reducing health inequalities. The RCN raised concerns in our response to the *Public Health White Paper* that a health premium may not work as intended. For example, local authorities may opt for the ‘low hanging fruits’ and be rewarded for focusing on areas of work which do not tackle the most deep rooted of problems. The Public Health Minister, Anne Milton, has admitted that there is always the possibility of local authorities attempting to ‘game’ the system<sup>9</sup>. Equally, some historically deprived areas with consistently transient populations will find it difficult to maintain progress in improving outcomes.

Furthermore, to date, there is still no publicly available formula for the health premium, meaning that it is impossible to calculate whether it is appropriately weighted to act (as intended) as a lever for reducing inequalities.

We are also concerned that at a time of cuts in public expenditure – most especially to the budgets of local authorities – any premium which is granted as a financial lever to ensure health and/or wider

<sup>5</sup> Healthcare Care Quality Improvement Partnership website, [www.hqip.org.uk/](http://www.hqip.org.uk/) (Accessed 9 August 2011) (Internet)

<sup>6</sup> Cabinet Office (2011) *Making Open Data Real: A Public Consultation*, London: (HMG)

<sup>7</sup> Royal College of Nursing (2010), *Response to the NHS White Paper: ‘Equity and Excellence: Liberating the NHS*, London (RCN)

<sup>8</sup> Royal College of Nursing (2011), *RCN response to Healthy lives, healthy people: our strategy for public health in England*, London (RCN)

<sup>9</sup> The King's Fund (2011) *Public Health System Reform Summit: getting the balance right*, London: King's Fund Publications

social inequalities do not widen, may be ‘eaten up’ and simply used to maintain the status quo rather than improve outcomes for disadvantaged communities.

The RCN is clear that whilst there are opportunities for improving services at local level, local services do not operate in a vacuum. Central government policy is the largest influence upon peoples’ economic and social circumstances, and the links between low incomes, both amongst the employed and unemployed, and poor physical and mental health, must be recognised in the development and implementation of any policy instruments. For example, the RCN has signalled concern in responses to other consultations that proposed welfare reforms, such as cuts to housing benefit and incapacity benefit, may be counterproductive for the health and wellbeing of vulnerable members of society, especially those who are dependent on the welfare system to maintain a minimum standard of life and ensure a minimum standard of health.

## Local government budgets

The RCN supports the principles of allowing individuals to have greater choice and control over the services they use. However, we are acutely aware that the current economic climate of severe financial cutbacks to local authority budgets and the £20billion efficiency savings sought from the NHS budget, may impact on the effective establishment of open public services in health and social care.

For example, with regard to public health, the RCN welcomes the commitment to ring-fence public health spending. However, we also recognise that all public sector bodies currently have to make financial savings. To ensure the development of an effective public health service, it is imperative to have financial protection. The RCN wishes to see more detail of how the ring-fenced public health budget will operate, including information on the degree of freedom that staff will have to use budgets to meet local health needs by commissioning a variety of providers to deliver a variety of services.

The RCN also has concerns about how cuts to the local government budgets will impact on social care. For example, we are aware that charitable and voluntary organisations are experiencing cuts to their funding and services. Further cuts to social care budgets would be to the detriment of social care and NHS users, and limit the contracts available in the market. Inadequate funding of social care results in higher unmet social care needs and a greater burden on NHS services as a result.

## Personal budgets

Personal budgets have proved successful in improving the sense of control that some groups of people who require social care support have over their lives, particularly younger physically disabled people<sup>10</sup>. On the other hand, older groups found them to be an “additional burden”, whilst differences between control groups and budget holders around outcomes were not significant<sup>11</sup>. In a recent National Audit Office report<sup>12</sup> on personal budgets, around two-thirds of budget holders reported a positive impact on aspects of their well-being, but 3-8 per cent reported being worse-off. Thirty one per cent of budget holders found it difficult to cope with being an employer, with some instances of employment tribunals being made against budget holders.

Personal health budgets (PHBs) are currently being piloted, although the Government is also concurrently drawing up plans for their roll-out following the end of the pilot in 2012. Given the present financial and policy context, the RCN has serious doubts about the impact of PHBs and feels they pose many risks.

## PHBs and choice and control

In a RCN social care survey of members this year, 58 per cent of respondents agreed that PHBs improve choice and control, 24 per cent neither agreed nor disagreed, whilst 18 per cent disagreed. Almost the same percentages were reflected in members’ responses to whether everyone should be entitled to a personal health budget (57 per cent, 24 per cent and 19 per cent respectively).

Members’ mixed views may have stemmed from the mixed findings of the evaluation of personal budgets set out above. In light of these varying results in social care but also in view of the complex nature of some health conditions, the RCN believes that for some people – especially the vulnerable – personal health budgets simply do not represent a viable solution to their care needs. There are issues around

<sup>10</sup> Individual Budgets Evaluation Network (2008), Evaluation of the Individual Budgets Pilot Programme: Final Report, London (IBEN)

<sup>11</sup> Individual Budgets Evaluation Network (2008), Evaluation of the Individual Budgets Pilot Programme: Final Report, London (IBEN)

<sup>12</sup> National Audit Office (2011), Oversight of user choice and provider competition in care markets, London: (NAO)

safeguarding (discussed in section below) a patient's cognitive ability and the skills and degree of support needed to make appropriate decisions, become an employer and manage the processes involved. Research carried out by the NHS Confederation has confirmed that these fears are shared by GPs, psychiatrists and psychologists too<sup>13</sup>. The RCN believes that patients should have the choice not to have a PHB.

In light of the fact that PHBs will not be suitable for all patients who are eligible, there will be an increasing need to deliver and manage existing 'traditional' services alongside additional services that personal budget-holders commission.

## PHBs and cost implications

Mixed support for PHBs also stems from concern over views that they will save money<sup>14</sup>. The RCN is concerned that this could be a motive for policy implementation and has identified the following reasons why significant, not fewer, resources will be needed:

- demand on the NHS is increasing – in particular numbers of those patients suitable for PHBs, such as those with long term conditions, are increasing as they live longer
- since PHBs must be optional and to realise its goal of maximising patient choice, the Government will have to deliver 'traditional' services alongside this initiative, and to therefore consider the cost of and critical mass required to maintain them.
- budget-holders will continue to require considerable clinical support in the assessment and review of their care needs. Such competencies cannot be delegated to less experienced members of staff
- budget-holders will require a range of different support to help them manage their PHB and make appropriate choices, including both staff and suitable information resources and diverse formats. In some cases this will be extensive support, and whilst it may be in the best interest of the patient, it will have significant cost implications (as was found in the personal budget pilot evaluation, with older people requiring significant support from their care coordinator). Without this support, there will be legitimate concerns warged about PHBs increasing health inequalities, if the lack of support available prevents some from having a PHB
- health care staff will require training and support to be able to deliver PHBs. Nursing is the biggest professional group delivering frontline care in the NHS and as such is the backbone upon which new services and ways of working are delivered. Adequate investment into their training and education will be essential in the successful implementation of this policy
- economies of scale that are currently realised in NHS provision will be lost if delivering PHBs does mean budget-holders choose from a much more diverse and plural market. In the personal budget evaluation this was described as "potentially a major tension between volume discounts and delivering individualised services"
- in light of the different funding mechanisms, in social care, personal budgets can be 'topped up', an option that is likely to become more prevalent as personal budgets are reduced and restricted to meet budget cuts<sup>15</sup>. The RCN does not support the introduction of top up payments in the NHS, and would be extremely concerned if this policy took a similar direction, particularly given the £20 billion 'efficiency' savings the NHS has to make, in addition to paying for a costly, wholesale reform.

In the Netherlands the belief that costs would be reduced by PHBs was not realised and the Dutch Secretary of State for Health said recently the programme's expenditure had "risen immensely over the last few years and this growth cannot be sustained". Indeed, increased demand for PHBs amongst younger patient groups in the Netherlands has seen an escalation in costs, resulting in the tightening of eligibility criteria<sup>16</sup>.

At the beginning of 2011, the RCN carried out specific research with its members about PHBs, which has helped inform the RCN's perspective on PHBs as set out below. We believe these to be important

<sup>13</sup> NHS Confederation, (2011) [www.nhsconfed.org/Publications/reports/Pages/Facing-up-to-the-challenge-of-personal-health-budgets.aspx](http://www.nhsconfed.org/Publications/reports/Pages/Facing-up-to-the-challenge-of-personal-health-budgets.aspx) (accessed August 2011) (Internet)

<sup>14</sup> In Control (2011), Quality, Innovation, Productivity and Prevention (QIPP) and Personal Health Budgets. Available: [www.in-control.org.uk/media/6115/qipp%20and%20personal%20health%20budgets.pdf](http://www.in-control.org.uk/media/6115/qipp%20and%20personal%20health%20budgets.pdf)

<sup>15</sup> The Guardian (2011), Scale of cuts has 'no bearing' on services for disabled people. Available: [www.guardian.co.uk/society/2011/sep/13/coping-with-cuts-councils-disabled-services](http://www.guardian.co.uk/society/2011/sep/13/coping-with-cuts-councils-disabled-services) (Accessed September 2011) (Internet)

<sup>16</sup> The Health Foundation (2011), *The Dutch experience of personal health budgets*, London: The Health Foundation

considerations in the development of the Government's thinking and approach to extending the policy into health, whilst there will be transferable lessons for other areas also.

Given the current financial context the RCN does not believe appropriate resources will be forthcoming to ensure PHBs are able to preserve NHS principles, respect the choice of individuals, and tackle rather than exacerbate inequalities.

## PHBs and safe guarding

Budget holders will be responsible for purchasing their care and will become employers, raising the following legitimate concerns to consider around safeguarding:

### For the budget holder:

- Appropriate mechanisms and support will be needed to safeguard budget holders whose mental capacity may fluctuate against:
  - potential financial exploitation of the budget-holder by their family, carers or employees
  - potential abuse of the budget-holder by their family, carers or employees.
- The care plan will be a key element of the safeguarding process. The influence of clinicians who are involved in agreeing and reviewing the care plan will be an important way to monitor the budget holder's health outcomes, and their general wellbeing. It will also be important that all clinicians involved in delivering care to the budget holder are able to feed back to the clinician in charge of coordinating the care plan. Such relationships will help manage the risk of abuse, exploitation and fraud for instance.
- Criminal Record Bureau checks offer another means to help safeguard. However the new system will be voluntary for personal care assistants and whether this will be adequate protection for risk remains to be seen.
- The RCN has been calling for mandatory regulation of health care assistants for some time, and recently endorsed the Nursing and Midwifery Council's (NMC) recommendation for a system of mandatory, not voluntary, regulation of health care assistants. The RCN believes there is a public protection issue, particularly around care of older people and as witnessed in recent cases such as Winterbourne View. The RCN is committed to working with the NMC about how to make this a reality.
- There will be issues around the sustainability of new providers entering the market. The National Audit Office's report on personal budgets<sup>17</sup> in social care discussed how disruptive and costly provider failures can be, where alternative providers may need to be found which are lower in quality, higher in cost, or both – at short notice. It discussed the case of Southern Cross and highlighted how it fell on local authorities, in light of their duty to ensure continuity of care, to react to the crisis. How the NHS would be affected by and whether it could have the capacity to deal with such provider failures in the future is a significant risk, and would have huge implications for patients.
- There will also be issues around the credentials of new providers and how budget-holders are given information about their services to ensure that they make informed decisions. It will be important that they are not 'sold' services through the result of, for instance, a provider's superior advertising and marketing techniques.
- Fraudulent use – there may be some cases where budgets are misused and again appropriate mechanisms will need to be in place to mitigate against this.

### For the workforce:

- there will be safeguarding issues to consider for the employee too, and ways to ensure they are not abused or exploited by the budget holder. Budget holders and new providers will have to uphold, and where necessary be supported to do so, the best practice in employment and HR management
- these safeguarding issues include pay, terms and conditions and the RCN would like to see new providers and employers align contracts with Agenda for Change terms and conditions
- there may be conflict of interest for those either responsible for the care plan assessment or for coordinating care if the budget-holder wants to discuss choice of provider.

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<sup>17</sup> National Audit Office (2011), *Oversight of user choice and provider competition in care markets*, London: (NAO)

**For both budget holder and the workforce:**

- delegated responsibility – the RCN has been working with key stakeholders to consider delegated responsibility and the personalisation agenda. There currently appears to be confusion amongst some providers over what can and cannot be delegated to unregistered staff or carers, and an unreasonable fear of prosecution and being reported to regulators for poor delegation. The essential issue is that Registered Nurses should not be delegating assessments or decision-making outside of protocols. In other words, tasks can be delegated to competent people; clinical judgement cannot. Guidance to reduce anxiety around delegation issues may be required
- the RCN has developed a tool about accountability and delegating responsibility<sup>18</sup>.

**PHBs and integration with personal budgets**

The Government has proposed the integration of social care personal budgets and personal health budgets. Such integration could be a fix to the problems that RCN members identified last autumn around working with social care including confusion over who pays, ‘bed blocking’, the ‘revolving door’, eligibility assessments and duplicative paperwork<sup>19</sup>. Budget integration for people with disabilities or with long term conditions could help improve the quality of patient care and the patient journey across the two systems.

However, the desperate underfunding of social care and the imminent cuts the sector is facing is a cause for serious concern. When determining the integrated budget for care, transparent mechanisms will need to be in place to calculate costs of a budget-holders’ social and health care needs. NHS care is free on the point of delivery and must remain so. Moreover, the NHS should also not be asked to pick up the cost for any social care shortfall in a personal budget.

**RCN position**

When implementing PHB pilots and policy, the Department of Health stated that personal health budgets should:

- uphold NHS values
- support safeguarding and improve quality
- support tackling inequalities
- be voluntary
- support working in partnership
- support decision-making as close to the patient possible.

These are principles that the RCN wholeheartedly support. However, the RCN is not convinced that these same principles are driving the policy currently. Given the present financial context and other challenges outlined above, the RCN has serious concerns that the Government will be able to deliver optional, appropriately resourced and supported PHBs within an appropriate system of safeguards. The RCN fears that the current context and challenges pose many risks for PHBs, budget holders and the NHS, namely that the policy will:

- erode the principles of the NHS, namely being free at the point of delivery. The RCN opposes any move towards a top-up system in health care, as in social care
- exacerbate inequalities. To ensure that all eligible patients can access a budget holder, a range of different support and resources will need to be in place, which will have significant cost implications
- affect the running of ‘traditional’ or existing services, which provide choice to those who are unable to manage or who choose not to manage their own budget
- place vulnerable patients at risk. Currently the RCN does not believe there are adequate safeguarding mechanisms in place to guarantee the safety of budget holders. The RCN sees the mandatory regulation of health care assistants, alongside regular clinical review of PHBs, as a part of the solution

<sup>18</sup> The Royal College of Nursing (2011), Accountability and Delegation Film. Available: [www.rcn.org.uk/development/health\\_care\\_support\\_workers/accountability\\_and\\_delegation\\_film](http://www.rcn.org.uk/development/health_care_support_workers/accountability_and_delegation_film)

<sup>19</sup> The Royal College of Nursing (2011), *RCN response to the call for evidence on the Future Funding of Care and Support in England*. Available: [www.rcn.org.uk/\\_data/assets/pdf\\_file/0011/359993/Future\\_funding\\_of\\_care\\_and\\_support\\_in\\_England.pdf](http://www.rcn.org.uk/_data/assets/pdf_file/0011/359993/Future_funding_of_care_and_support_in_England.pdf)

- prevent budget holders from becoming best practice employers, and deliver pay, terms and conditions in alignment with Agenda for Change
- of particular concern for the RCN is safeguarding, and we ask the Government to lay out how it intends to ensure budget holders are appropriately protected and supported as employers and commissioners of their own care.

In addition, whilst the RCN can see merits in PHBs it believes it is important to note the distinction between personalised care, care tailored to the needs and preferences of individuals and PHBs. They are not one and the same. PHBs are one tool to help deliver personalised care and the RCN would like to see the Government acknowledge this distinction. The RCN strongly supports the delivery of personalised care, 88 per cent of RCN respondents in a survey this year felt that individuals should be able to tailor their care to their own preferences and needs.

Even with appropriate resourcing and safeguarding in place, the RCN does not believe that PHBs will be an appropriate way to deliver personalised care for all patient groups and individuals. Different methods to personalise the care of some patient groups and individuals will be required, and this will mean using existing services. Therefore, the RCN believes that patients should have the choice not to have a PHB and that they must be optional. To maximise choice and personalisation, the Government will have to look to resource and deliver existing ‘traditional’ services alongside additional services that personal budget-holders commission.

These issues should be understood in the context of the need for a huge cultural shift for both patients and the workforce to make PHBs work and should not be under-estimated – people have been engaging with the NHS on current terms since its inception. This again demonstrates the need for optional PHBs and the maintenance of existing services.

Finally, the RCN continues to call for the Government to follow a best practice process and learn from and fully review the findings of the personal health budget evaluation before implementing the initiative nation-wide. In light of the scale of the challenges and issues that PHB implementation will need to overcome, a timely and carefully planned approach is essential.

## Role for Ombudsman services

The proposal in the White Paper for the Ombudsman services to encompass choice as part of the new approach would seem in keeping with the principle of choice being the default position for the provision of public services across the spectrum.

However, this new role may entail an increase in both the amount of complaints and their complexity and these services will need to be resourced in a manner appropriate to the increased demand on workloads. It may therefore well be necessary for the Government to increase the resource allocations for the three identified services to enable them to fully and adequately cover their new responsibilities. The RCN would like to see greater detail as to how the Ombudsman services will be supported in fulfilling its new remit.

## Role of elected and unelected officials

The *Health and Social Care Bill* will see the creation of a number of the new bodies (which will be comprised of both elected and unelected officials) that will be charged with the provision of health care with detailed responsibilities for promoting patient choice, and patient and public involvement. The RCN believes that the extension of these responsibilities across the wider public services structures would ensure a consistent approach.

The RCN believes that a further consideration in respect of elected officials must be that of transparency. We would want to see provisions put in place to ensure that they must fully disclose any and all relationships that they have to any organisations, public, private, or not-for-profit, when responding to service-users or members of the public, or representing them in case of concern or complaint.

# Neighbourhood services

## Neighbourhood councils

The RCN is concerned that the White Paper does not contain a concrete definition of what “neighbourhoods” and “communities” are in the context of the proposals to open up public services and devolve control to a local level. As the White Paper recognises itself, not every area of England has functioning parish or town authorities at present.

We would like to see further detail from the Government on how these neighbourhood councils will be able and incentivised to gain the views of the community of which they are charged with representing. In addition, in the process of creating new public bodies, or reinvigorating existing ones, the Government needs to ensure that it does not create new borders of poverty falling between neighbourhood councils.

In order for these new bodies to succeed, they will need to be adequately resourced, and training and support provided. For example members will need to be trained to ensure that are able to manage involvement and engagement activities with the public they represent in an inclusive way.

In addition, the RCN is concerned that by moving towards a level of governance that is more reflective of the principles of proportionality and subsidiary, the Government must be careful not to remove opportunities to be gained from economies of scale, which may occur if resource use is placed at too low a structural level.

# Commissioned services

## Role of the State

Although this Public Services White Paper is driven by the desire to decentralise and decrease the size of the State, the RCN believes that there is still a legitimate role for the State in delivering some services.

It is important to guard against the danger of systems becoming more disjointed and fragmented as the numbers of organisations providing services increase. Each service is different and choice and contestability will look very different in each setting. There are also question marks over how accountability will work for specific or complex services if they are not universally available. Increasing choice for individuals will only be beneficial if the choice is between quality providers. There are services that only the State can provide owing to the risks involved, such as emergency services. It must be recognised that there are local and national services that cannot be devolved to individuals or communities.

## Principles of commissioning

We believe that good commissioning seeks to understand the needs of communities by talking both to existing providers of services in order to capitalise on existing expert knowledge, as well as the public to gain an insight into the lived experience of being a member of the community.

The RCN would want to see “open commissioning” putting preferred public outcomes at the heart of the commissioning plans, not just financial constraints, despite the current difficult climate. The Government should also ensure that commissioners are encouraged to invest in developing services for difficult issues or seldom heard groups by actively listening and reaching out to the community.

There must be clear mechanisms by which the tax payer can hold ministers as well as those responsible for commissioning, delivering and overseeing care, accountable for the NHS funded health and social care services. This also includes ensuring contracting processes are publicly accountable, transparent and fair. At present, the Government’s proposals do not make it clear how it will ensure accountability across all providers of publicly funded services. The RCN also believes that mechanisms need to be put

in place which ensure that the performance management of commissioned services is based equally on the views of service users, communities and those providing services as well as financial performance.

The RCN would want to see further information as to how the Government will build in high quality employment standards, ambitious environmental sustainability standards, and best practice equality measures into service specifications. Providers must not be allowed to deliver savings on the back of low pay, poor employment practices or cheap goods.

## Ensuring diversity of provision

### Competition and Any Qualified Provider (AQP)

The RCN notes that the current NHS White Paper, the *Health and Social Care Bill* and this White Paper encourages an increase in the level of competition in the NHS, as well as the number and range of different providers delivering health and social care. The independent sector, which encompasses a wide range of providers from not-for-profit organisations right across to commercial organisations, has always had some part in providing some key NHS services. The RCN recognises that there is a role for the independent sector including the voluntary sector, the commercial sector, and social enterprise in delivering NHS funded services.

While the RCN recognises that within the NHS, the Government is creating a system of competition based on quality rather than price, we do want to be clear that, the RCN is fundamentally opposed to any competition amongst providers based on price. We believe that this risks a “race to the bottom” and places patients at risk. Research 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<sup>20</sup>.

We have been extremely vocal in raising our concerns in relation to this in our activity on the *Health and Social Care Bill*. We were pleased to see that following the House of Commons committee stage the bill was amended to remove reference of setting a maximum national tariff. We also welcomed the change in the duty placed on Monitor from actively promoting competition to promoting integration.

We believe that there may be a role for competition as a lever to improve quality but safeguards must be in place, such as effective regulation from Monitor and the Care Quality Commission to assure minimum standards of quality and patient care. The RCN is currently examining the amendments to the *Health and Social Care Bill* to see if they have fully addressed our concerns around choice and competition. We remain concerned that local prices may be pushed below the threshold where providers are able to deliver safe and quality services.

We are apprehensive about the potential negatives of the AQP policy, particularly in light of the direction given to Clinical Commissioning Groups to increase choice and the number of providers. It is unclear whether the effect of this policy upon existing providers, NHS providers in the main, has been taken into account. For example, private providers’ ability to meet locally set service tariffs, while operating outside of the Agenda for Change pay scales, could place them in a more competitive position than existing providers. There is the potential for the AQP policy to destabilise existing providers and therefore threaten the future of a whole range of local services. We would want to see tariffs being set, which demonstrate an understanding of NHS staffing costs to ensure there is no unfair disadvantage.

There is also a real danger that existing NHS providers will be left to deliver critical services, such as accident & emergency or intensive care, which are the most expensive, essential and challenging services to deliver. This is the reality which will enable the ‘cherry picking’ of NHS services by private providers with a serious, potentially irreversible, impact upon the highly skilled NHS workforce. With more and more NHS services being passed to independent sector providers, NHS staff could find themselves being made redundant.

In short, NHS providers will not be able to compete fairly with private providers. This will also be compounded by removal of the NHS as the preferred provider of NHS services. The Government has already announced how the first phase of its AQP policy will be implemented, opening up a number of additional services to competition between a wide range of organisations. This timing of this policy implementation is worrying as it is occurring at a time of significant structural change

<sup>20</sup> Cooper Z, Gibbons S, McGuire A (2009) *Does Hospital Competition Save Lives? Evidence From The Recent English NHS Reforms*, London: LSE

within commissioning. The RCN would like reassurances from the Government that it will put in place mechanisms to monitor the impact AQP has on the health care market.

The RCN has additional concerns that the AQP policy will not necessarily lead to increased choice for service users. For example, three providers taking on an NHS funded service might offer the same type of service to users in their area with little real variation. We feel that AQP is not the only mechanism to promote choice and that negotiations with only one provider delivering a service in the area with the aim of better meeting patient's needs (such as increasing opening hours) could deliver greater choice.

The impact of competition and the AQP model crucially depends on how the market works in practice. We believe that the emphasis on choice for individual services must be balanced by the imperative to encourage the development of integrated care pathways that involve good collaboration between the, often, many different organisations involved.

## Pay terms and conditions

It is fundamental to the stability of the NHS-funded workforce, and to patient outcomes, that there is confidence in relation to pay and pensions. The RCN believes that pension security and a national pay system provides staff with the required confidence during periods of transition and fiscal challenge. The key drivers for introducing the national pay framework remain: equal pay (the NHS in the period proceeding the implementation of Agenda for Change faced the prospect of substantial claims); recruitment and retention of staff; improving local flexibility; and removing barriers to change. A drive to local pay will prove to be expensive in terms of transactional costs and it is very unlikely to deliver any greater benefits to individual employers. Indeed, a drive towards local pay will not only reintroduce the risk of equal pay claims, but it is likely to take financial and management resources away from a focus on improving frontline clinical services.

## Failure regime

With regards to health and social care services, the RCN believes that it is essential that the Government provides further detail about how it will establish a robust failure regime, which covers all types of providers in the new market. As Southern Cross has shown, the Government must seek to put mechanisms in place to try to prevent failure where possible and to protect patients where it is not. The RCN is currently looking in further detail at the Government's recent document Securing continued access to NHS services, which sets out the processes for dealing with failures in NHS organisations.

## Independent sector

The independent sector has always had a part in providing publicly funded NHS services – these services include general practice, mental health, palliative care, and acute elective services. These services are delivered through a range of different organisational forms from social enterprises to organisations owned by private equity companies to charities.

From an employment relations perspective, a growing number of RCN members are finding, and will increasingly find, their employment transferred to a new business, owing to private contractors successfully tendering for NHS services. TUPE regulations apply when there is a transfer from the public to the private sector, however, there is no specific obligation for employers to continue to provide transferred employees with continued access to the NHS pension scheme. The RCN continues to argue that any staff delivering NHS funded services should have access to the NHS pension scheme.

## Social Enterprises

The Government has signalled its commitment to the development of social enterprises to deliver health and social care in both its ongoing reforms outlined in the *Health and Social Care Bill* and in this White Paper. At present, 25,000 staff delivering NHS services work in the social enterprise sector, which accounts for £900 million of services. These services include community care for the vulnerable and homeless, sexual health services, and support for bereaved children and families. Many of these services involved a transfer of NHS community services into social enterprises as part of the Transforming Community Services process, which saw the separation of PCT commissioning functions from its provider functions.

While the RCN recognises that social enterprises can bring benefits to their members and patients, this is not a trait, which is exclusive to social enterprises. Social enterprises have been promoted as a mechanism to improve staff engagement, which research shows can lead to improved patient outcomes, but again this is not exclusive to social enterprises. There is a wealth of evidence on the benefits of staff engagement within a health care environment. A report by the Nuffield Trust in 2009<sup>21</sup> indicates that these benefits include lower sickness absence, lower patient mortality, lower patient complaints and higher levels of innovation. Research projects undertaken by Aston University clearly demonstrate the link between staff and patient satisfaction (2003), the link between people management and organisational performance in the NHS (1999-2001), and between staff involvement and organisational performance in the NHS (2002-2005)<sup>22</sup>.

The social enterprise model is not a panacea. Social enterprise organisations will only be appropriate in certain circumstances. For example, when staff are fully consulted on the proposals; when it is guaranteed that the new organisation will be sustainable in the long term; and when existing staff delivering NHS services have access to the NHS pension scheme, and when NHS pay, terms and conditions for staff are guaranteed.

The White Paper raises a number of concerns for the RCN regarding the potential for NHS staff to find their employer has changed and they have been transferred to a social enterprise. Social enterprises and mutual organisations are free to establish their own pay terms and conditions frameworks. The NHS Staff Passport developed by the NHS Social Partnership Forum sets out the employment standards and rights, which employees undertaking NHS funded work have the right to expect when their employment is transferred. Although this may mean pay terms and conditions at the point of transfer are maintained, any further changes in NHS terms and conditions would need to be negotiated. This process of changing pay, terms of conditions can impact negatively on staff morale and motivation (impacting on staff recruitment and retention) and take organisational resources and focus away from care delivery.

A more pluralistic market and increased short term contracts with commissioners will mean that social enterprises (along with other providers) must develop sustainable business models to function in this type of environment. This will include looking at how viable they will be in the long term and how the business can adapt if contracts are lost and the impact this may have on employees. The practical challenges to increasing the social enterprise sector's contribution to public services also include the vulnerability of small organisations in a competitive market, where larger providers may be able to meet the tariff more successfully.

The need for a robust business model and to ensure that long term sustainability of service providers, such as social enterprises, is highlighted by the failure of Secure Healthcare<sup>23</sup>. Secure Healthcare was a staff-owned social enterprise delivering NHS services to prisoners in Wandsworth, which failed due to a lack of capital and the banks' unwillingness to provide a loan. The local PCT had to step in to protect the jobs of the employees and to ensure the prisoners continued to receive care. The failure of the social enterprise resulted in an increased cost to the public purse.

In August 2011, The King's Fund report on 'Social enterprise in health care'<sup>24</sup> argued that "in order to survive in the long term and meet the changing needs of commissioners and the local populations they serve, social enterprises will need to demonstrate the necessary business orientation and ability to innovate". The report goes on to state that the "leaders of these social enterprises will require support and skills to enable his development and lead their organisation through this process". The RCN believes that it is important to ensure that individuals and managers setting up a social enterprise have the right skills and competencies and to manage the risks involved in operating in an increasingly competitive market.

The Social Enterprise Pathfinder Programme<sup>25</sup> was launched in 2006 to support the early development of 26 social enterprises and evaluate their success. The evaluation showed that additional barriers to success included:

<sup>21</sup> Nuffield Trust (2009) *NHS Mutual: engaging staff and aligning incentives to achieve higher levels of performance*, London: Nuffield Trust.

<sup>22</sup> Aston Business School: Research Projects. Available: [www1.aston.ac.uk/aston-business-school/research/structure/centres/ihse/research-projects/](http://www1.aston.ac.uk/aston-business-school/research/structure/centres/ihse/research-projects/)(Internet)

<sup>23</sup> The Guardian (2009), An ill wind blows for social enterprise. Available: <http://www.guardian.co.uk/society/2009/nov/18/prison-healthcare-nhs-social-enterprise> (Internet)<sup>17</sup> [http://www.kingsfund.org.uk/publications/social\\_enterprise\\_in.html](http://www.kingsfund.org.uk/publications/social_enterprise_in.html)

<sup>24</sup> The King's Fund, (2011), *Social enterprise in health care: Promoting organisational autonomy and staff engagement*, London: King's Fund Publications

- risks, such as a lack of secure contracts or revenue, which have a “severe impact on the ability of pathfinders to establish themselves and develop” and social enterprises’ vulnerability due to competition owing to the “relatively low engagement in marketing activities and competitive analysis”
- pensions as the most common issue of concern, with NHS staff transferring wanting to maintain access to the NHS pensions scheme
- timescale is often underestimated, as it can take between 3–5 years before a social enterprise is established and begins to trade. This allows for time to develop, plan, secure funding and contracts, and negotiate liabilities.

The evaluation also identified elements which are important to the success of social enterprise organisations, such as:

- sufficient revenue for 2–3 years and capital funding
- strong leadership and management
- the ability to cope with risks, uncertainty and challenges.

Responses to our survey on the proposals contained in the White Paper highlighted that there are some specific barriers to nursing staff taking up the opportunities to set up a social enterprise. Respondents raised concerns that nursing staff may not feel that they have sufficient business expertise or management experience. One respondent stated that nursing staff would not, for example, have the “expertise to win tenders”.

The RCN is calling for further detailed information from the Government on how it proposes to support those interested in setting up social enterprises to overcome these barriers, including provision of guidance and advice, as well as providing certainty around commissioning priorities. For example, we would like more detail about the recently set up Enterprise Incubator Unit within the Cabinet Office which has a remit to “provide advice, challenge and resources for public service providers from central government departments and their agencies who want to move from the public sector to the independent sector”<sup>26</sup>.

## Charitable and voluntary organisations

The Government’s proposals also signify an increased role for charity and voluntary organisations in delivering services in health and social care. Charity and voluntary sector agencies are already involved in delivering a range of services within health and social care – including palliative care, learning disabilities, and drug and alcohol services (to name a few). We have significant concerns, however, regarding the ability of the sector to be able to capitalise on this opportunity, when many are facing cuts to their funding by Local Authorities and the NHS. The Government’s Comprehensive Spending Review in 2010 signalled that Local Authorities face cuts of 28 per cent of funding over four years.

The RCN’s *Frontline First* campaign has received information from members that staffing and service cuts are taking place in charitable and voluntary organisations. *Frontline First* has been running for over a year and encourages members to report where they see cuts to services and posts, which impact negatively on patients. The RCN carefully validates this information.

On 2nd August 2011, the False Economy campaign<sup>27</sup> conducted research based on Freedom of Information Act (FOI) requests, which revealed that more than 2000 charities and community groups are facing budget cuts as local authorities reduce their funding. The list of charities facing these cuts includes: 112 adult care charities; 142 elderly-related charities; 382 children’s and young people-related charities; and 151 disability-related charities.

These cuts will affect essential core services, which some of the most vulnerable people on society rely on. There is also a great danger that the consequences of these cuts could create gaps in provision and increase pressure on the NHS. The RCN knows firsthand that when care needs are not addressed quickly close to home, it is the NHS that picks up these needs. With this evidence that services are being further scaled back in the community, more pressure will be put on health care services, at more expense.

<sup>25</sup> Department of Health (2009) *Leading the way through social enterprise*, London: DH

<sup>26</sup> Cabinet Office (2011) *Open Public Services White Paper*, London: HMSO

<sup>27</sup> False Economy (2011) *Exclusive: More than 2,000 charities and community groups face cuts*. Available: <http://falseeconomy.org.uk/blog/exclusive-more-than-2000-charities-and-community-groups-face-cuts> (Internet)

We believe that cuts to organisations like these will prevent the Government from achieving their aim of a diverse range of providers for publicly funded services. It is unclear how a diverse range of quality providers could flourish in this economic environment if public services were made more open.

## Southern Cross

The recent case of Southern Cross Healthcare has highlighted the need for the Government to consider the future regulation of care providers and review their business models, as it has shown that some models are likely to be too high risk for care provision. It has also led to concerns by RCN members raised in our survey on this White Paper. One respondent argued that “Southern Cross should be a warning as to what can happen when private companies have involvement in care and then fail”.

Southern Cross’ business failure put at risk services for 31,000 residents in around 760 care homes when its rent bills became unsustainable, given falls in revenue from councils. About 70 per cent of placements in the organisation’s care homes were funded by local authorities. This has also caused great uncertainty for its 43,000 staff, which includes 22,000 care staff and 5,000 nurses. The RCN is currently working hard to support members who may be affected by potential job losses and changes to pay terms and conditions.

We have a number of concerns regarding the consequences of when a provider, such as Southern Cross fails. This includes the impact on vulnerable patients who are dependent on services. There is evidence that moving frail and elderly residents from one home to another can be the cause of increased stress-related behaviour, morbidity and mortality. It has also caused a significant amount of worry for residents, who could suffer damage to their health and well-being if they are forced to move. We believe that robust and responsible planning must take place with the residents, and their families, to help comply with their personal wishes and reduce distress and harm to their health.

We would want to see sufficient safeguards put in place to ensure that situations like Southern Cross do not become increasingly frequent following the Government reforms to public services and the provision of health and social care. Currently, no body oversees the financial structure of providers. The *Health and Social Care Bill*, as it stands, would give NHS regulator Monitor the power to license providers of NHS-funded care and support the continuity of services, should one become insolvent. However, this would not apply to social care.



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