Care Bill: House of Lords Committee stage briefing (10 June)
Briefing from the Royal College of Surgeons

This briefing from the Royal College of Surgeons (RCS) sets out our views on Part 2 of the Care Bill to be debated on 10/12 June. This complements the more general briefing we provided at second reading.

Our overall view
We support many of the proposals in the Bill to help raise standards of care following the Francis Inquiry. However, we have concerns about the proposal to split enforcement powers between CQC, Monitor, and the NHS Trust Development Authority. This needs urgent clarification. As Robert Francis QC made clear, complex regulation can contribute to failings in patient care.

We also believe the House of Lords should give consideration to the regulation of healthcare support workers and managers as part of efforts to drive up standards.

1. DIVISION OF RESPONSIBILITIES BETWEEN MONITOR AND CQC (THE 'FAILURE REGIME') (clauses 74-77)

We agree with the Government that the NHS needs to place an equal emphasis on addressing both failures of quality and financial failures. It does not make sense that the NHS currently has a clear 'regime' for dealing with financial failings, but not quality failings.

In essence, to help tackle this, the Bill proposes that the CQC should now lead on exposing problems and requiring remedial action. At the same time, it will delegate its current enforcement powers (those beyond issuing warnings) to Monitor for Foundation Trusts, and the NHS Trust Development Authority for non-FTs. However, to confuse matters, the CQC will retain enforcement powers for social care, general practice, and independent sector providers.

As well as being confusing to the public, there are a number of risks associated with these changes and **this part of the Bill requires serious scrutiny from the House of Lords.** As Robert Francis QC made clear, regulatory complexity can contribute to system failings so it is important to get this right.

We believe Peers should consider the following issues:

- How will Monitor, the CQC, and the NHS Trust Development Authority work together to ensure problems are acted upon quickly?
- Will Monitor and the NHS TDA be able to question the CQC's findings and recommendations? What happens if they disagree about whether action is needed?
- Will this additional level of complexity slow down action required to address failings?

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- What will the Government and the regulators do to help patients understand who is responsible for enforcement action in the NHS and social care?
- Does such a division of responsibility happen in other sectors outside of healthcare?

We appreciate trying to create a single failure regime for quality and finance is difficult while working within existing organisations. Nevertheless, we are concerned about these risks and we look forward to further clarification from the Government.

2. ROLE OF THE CQC AND OFSTED-STYLE RATINGS (clause 80)

The Bill provides the CQC with new powers relating to reviews and performance assessments and the publication of these in the form of ratings (clause 80) although much of the detail will be set out in regulations.

The RCS believes any ratings system should be clear about what is being assessed. It is difficult to directly compare, for example, a foundation trust hospital which treats a large number of patients through A&E with an independent sector provider that has no A&E service. Equally, an overall rating for a trust could be misleading as the disparity between the performances of different services within a trust may be marked. These are important issues given the Government has said a ratings system is necessary so that 'patients and the public can compare organisations or services in a fair and balanced way'.

The RCS believes there is value in having ratings broken down to service level, ideally for individual surgical specialties or, where that is not possible, for the overall surgical service. This will help to drive improvements in performance and provide clear information for patients. However, close attention must be paid to risk adjusting ratings otherwise the information may be misrepresentative. The Government and the CQC should also consider how they will take into account surgeons' outcomes data, due to be published this summer.

It is vital that the CQC's inspections and performance assessments make use of clinical advice and clinicians, especially when they are inspecting the quality of a specific service. We are therefore pleased to note that the CQC's recently published strategy indicates it will use greater clinical expertise in its inspection teams. The expertise necessary for inspecting and monitoring clinical services, combined with increasing public confidence in the service will come as a result of clinician involvement. For similar reasons, it is important to make use of royal college and clinical expertise when designing any new ratings system.

3. REGULATION AND TRAINING OF HEALTHCARE SUPPORT WORKERS AND MANAGERS

In **our response** to the Mid-Staffordshire Hospitals Public Inquiry, the RCS was clear in its support for an improved regulatory system for managers and healthcare support workers to ensure any leaders, managers or healthcare assistants that are found not to be fit and proper persons are prevented from holding such positions in the future. Within surgery, nurses and operating department practitioners are currently regulated but there are a

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number of healthcare support workers who we believe should also be regulated, such as surgical care practitioners and healthcare assistants.

Regulation is also important for improving the status and support for managers and healthcare support workers. Although the Inquiry said 'there was a failure of the NHS system at every level', a recent poll suggests more than half the public blame NHS managers for the disaster of poor care at the Mid Staffordshire NHS Foundation Trust[1]. It is clear that managers in particular need to earn the trust of the public.

It is disappointing such measures are not included in the Care Bill although we look forward to such issues being debated through tabled amendments.

4. DUTY OF CANDOUR

We are aware a number of Peers intend to support amendments to place a statutory duty of candour on individuals in the NHS. We remain to be convinced this will improve transparency and patient safety. Any legislative proposal must avoid: dissuading reporting of any kind, deterring clinicians from undertaking complex medical cases, or discouraging innovation. Emphasis should be placed on encouraging openness, recognising deficiencies and seeking quality improvement.

The Government has said they will create a duty of candour for organisations registered with the CQC, but not individuals, through regulations. While it remains to be seen how this would operate in practice, we believe this approach poses fewer problems than one which puts a duty on individuals.

[1] http://www.hsj.co.uk/5055127.article

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