October 2011

Health and Social Care Bill: Briefing ahead of Second Reading in the Lords

This briefing summarises the Royal College of Surgeons views on the amended Health and Social Care Bill ahead of its Second Reading in the House of Lords in October 2011. The College supports the aims of the reforms to modernise the healthcare system by cutting bureaucracy and giving patients and their clinicians the right to decide the best treatment on an individual basis. We believe that commissioning should be based around the patient, supported by the relevant clinicians and healthcare staff.

The College has recommended that the plans laid out in the Health and Social Care Bill should now be implemented without any unnecessary delays, otherwise we believe that delays to this process will ultimately be to the detriment of patients. Below are our clause-specific comments on the Bill focussing on the areas of: commissioning, clinical advice and leadership; competition; patient choice and involvement; education and training; and research and innovation.

Commissioning, Clinical Advice and Leadership

- ***Commissioning***

The College welcomes clauses **13C** and **14O** of the Bill – the duty of the NHS Commissioning Board and Clinical Commissioning Groups (CCGs) to promote the NHS Constitution – and believes that the Constitution preserves the rights of patients to be able to access treatments and services. Furthermore, given the significance of the NHS Constitution, we welcome the initiative in this clause to further promote an awareness of the Constitution amongst NHS staff, patients and the public.

The College believes that greater integration amongst health and social care professionals along the care pathway is a positive move for patients and clinicians. As such, the College has called for this to be a central element of the reforms and welcomes clauses **13M** and **14Y** and the focus on integration. We look forward to seeing more detail on these plans, and in particular how the RCS will be able to use its established regional network of surgeons across the surgical specialties to engage in these processes. Furthermore we would seek assurances that this pledge does not contradict with clause **13F** on the duty of the NHS Commissioning Board on the promotion of autonomy. We believe that more detail is needed on clause **13F** to ensure that fragmentation of services does not occur as a result of an interpretation of what constitutes greater autonomy.

The College is supportive of efforts to improve transparency and accountability in the health service. We welcome clauses **13S, 13T, 14Z13** and **14Z14** which stipulate forms of reporting on the NHS Commissioning Board and CCGs through business plans and annual reports.

Clause **3B** describes how the NHS Commissioning Board will be responsible for making arrangements for the provision of rare conditions – however we would like to see more detail on how the recommendations and advice of clinical networks and the Clinical Senates are taken into account

and acted upon. We believe these groups will provide vital clinical advice for the provision of these services.

- ***Clinical advice***

Clinical senates, RCS regional networks and clinical networks represent a depth of clinical expertise available to the NHS Commissioning Board and CCGs. The College welcomes clauses **13J** and **14V** – the duties for NHS Commissioning Boards and CCGs to obtain appropriate advice. However the College would like to see further detail on the membership of the Clinical Senates; how they will be involved in advising the NHS Commissioning Board and CCGs; how they will engage with other healthcare professionals, including the Medical Royal Colleges and what precisely the responsibilities of these clinicians are. Furthermore the College would like to know whether details of the advice sought will be made public. Similarly the RCS awaits further information on the embedding of clinical networks, how these networks will be involved in advising the Commissioning Board and how the clinical issue of focus for each network will be decided.

In particular the College believes that more detail is necessary on how these various new structures will engage with each other with regard to 'sub-national' (regional) commissioning. We therefore believe that there is a case for expanding clause **12** – *Power to require the Board to commission certain health services* – for the Board to consider a wider range of services such as those that need to be commissioned regionally.

The College supports the amendments that the CCG membership must have a doctor with secondary care experience, however we believe that it is unnecessary that this membership should also be contingent on the doctor being from outside the local area or retired. This policy could lead to candidates with a strong understanding of local systems and patient populations being overlooked.

Additionally these new structures will require the involvement of clinicians who are already facing constraints on their working time for the wider NHS. The College reiterates the need for recognition that clinicians need to be afforded time by their employers to participate in activity outside their own organisation on behalf of the wider NHS, whether this is through Royal Colleges, arms-length Government bodies, the Department of Health or any of these new structures. The active engagement and leadership of clinicians is at the core of these reforms and it is essential that they are given the appropriate time to perform any new functions accordingly. In addition the College believes that in establishing these structures they should be created to function in the most efficient and streamlined way possible.

Competition

The College welcomes clause **58** and the change to the role of Monitor to enable health care services to be provided in an integrated way, with regard to the quality or efficiency of a service being improved without any detriment to the service's quality. The College supports clause **58** – in particular sub-section 2 – which says that long-term demands and expectations on the health service must be taken into account when considering the provision of any aspect of the health service. The College highlights its guidance on *Commissioning a competent surgical service* (Appendix A) which we believe should serve as a blueprint for the future commissioning of surgical services.

These guidelines highlight the need for providers to avoid 'cherry-picking' services without making full arrangements for full emergency provision or the follow-up of patients after their treatment. The College welcomes the strengthening of the legislation in Part 3, Chapter 5 of the Bill, in particular clauses **118** and **119** around ensuring the fair reimbursement to a provider for a service, taking into account clinical complexity and the range of services offered.

Regarding the composition of Monitor in clause **58**, the College would like assurance that the proposed board of Monitor has clinical and patient representation given that it will have extensive powers to decide what is anti-competitive, set the national tariff and define quality - all of which require clinical input. We would also like to ensure that when producing its annual report, Monitor reports on how patients and clinicians have been represented in their work. Clause **58** stipulates that Monitor has a duty to protect and promote the interests of people who use health care services however there is no mention of how quality and effectiveness links to the responsibilities of NICE, something we believe should be addressed.

Subsection (8) of clause **58** requires Monitor to secure professional clinical and public health advice. It is for Monitor to decide what degree of involvement there should be in particular aspects of its work and how to secure that involvement. The RCS would like assurance that rather than letting Monitor decide how to secure professional clinical and public health advice to help it to discharge its functions effectively, that Monitor should be required to obtain professional clinical, public health, patient and the wider public advice in its work and publish the source of this advice.

Clause **93** states that there might be occasions when it is not appropriate for Monitor to release certain information to the public on the register of licence holders. We believe that Monitor needs to be transparent and state why information should not be released.

We welcome clause **144** which inserts new section 12E into the NHS Act which is intended to ensure that the Secretary of State does not favour any particular sector, such as the public, private or voluntary sector and that the Secretary of State is prohibited from seeking to increase or decrease the share of the market for the provision of health care services held by a particular group of providers. We also welcome within clause **114** the requirement that Monitor will publish "the national tariff" and that it will need to specify the methodology that had been employed to produce the national price levels.

Patient choice and involvement

As the College has consistently stated during the legislative process, a crucial part of the Health and Social Care Bill is its intention to ensure and promote patient involvement and choice. As such we welcome clauses **13H, 13I, 13P** and **14Z** which stipulate these responsibilities on the NHS Commissioning Board and CCGs and await additional detail. Furthermore we reiterate our belief that this principle must not be tokenistic.

We welcome clause **178** that Healthwatch England will advise and provide information to the Secretary of State, NHS Commissioning Board, Monitor, English local authorities and the Care Quality Commission on the views of users of health and social care services and their experience of such services. The College also welcomes clauses **192** and **194** which give health and wellbeing boards the duty to provide advice across the health service and for the Commissioning Board to send a representative to the health and wellbeing boards to discuss local commissioning responsibilities. We also welcome clause **198** that allows the Health Service Ombudsman 'to share her complaints investigation report and statements of reasons with such persons as she thinks appropriate'.

The College remains concerned about the future of the National Reporting and Learning Service (NRLS) and clinical analysis of the information. Clause **275** provides for the abolition of the National Patient Safety Agency but only makes a commitment to responsibilities being transferred to the Commissioning Board but not to the NRLS system of report and learning.

Education and Training

The College welcomes the commitment from Government in its response to the Future Forum report to *'introduce a duty on the Secretary of State to maintain a system for professional education and training as part of the comprehensive health service.'* We would welcome the inclusion of this duty and would strongly urge that it is included in the Bill in line with the Government's commitment.

Education and training of surgeons is a key area of work for the College and it is essential that the funding and standards of surgical education are maintained effectively. As part of this process, the College believes that it should be involved at the centre of the governance and quality assurance processes for surgical education and training, and that similar arrangements should be made concerning the other medical Royal Colleges for others areas of medical education and training.

Research and Innovation

Surgery differs from many other medical specialties in that the research and assessment of new innovations often requires the teaching of new manual skills. Therefore there needs to be the development of infrastructure to create dedicated surgical research and assessment networks that will also aid innovation.

The College welcomes the series of commitments made towards supporting research and innovation across all levels of the new structure of the health service (Secretary of State, NHS Commissioning Board and CCG) in clauses **5**, **13K**, **13L**, **14W** and **14X** of the legislation. We look forward to seeing further detail in the secondary legislation and to the implementation of the legislation with regard to embedding of research across the system, incentivising surgical research and innovation in the NHS and supporting surgeons in the development of innovation and research in the health service.

Additionally the College has long called for the wider uptake of clinical audits in the health service and particularly in surgery. As such we welcome the principles set down around information systems in clauses **253-263** and believe that there is great scope for the wide involvement of the College and the surgical profession with these principles. In particular the College believes that with infrastructure and resource there is potential to expand the range clinical audits and the subsequent transparent publication of this information by surgeons, as part of the implementation of these reforms.

The College is a member of the Association of Medical Research Charities (AMRC) and fully supports the AMRC's briefing *Embedding Research into the Health System*, which contains more detail on the broader aspects of medical research and the Health and Social Care Bill.

October 2011

For further information

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Appendix A

Commissioning a competent surgical service
College position statement

The Royal College of Surgeons believes that a defined standard of treatment and care set by the profession should drive commissioning and not the commercial interests or convenience of the provider. Standards of care and outcome requirements should be incorporated into the decision-making process for commissioning services in order to achieve the best care and outcomes for patients. Within the proposed arrangements for the delivery of healthcare, commissioners will be able to exercise clinical judgement and have the power to safeguard and ensure the quality and standard of care.

The College believes that in order to ensure the delivery of comprehensive and competent services commissioners should adhere to the following principles and standards when taking commissioning decisions:

1. Training the healthcare workforce – a contractual commitment to training and the ability to deliver the standards and outcomes agreed and published by the profession.

2. Educating the healthcare workforce – a contractual commitment to provide appropriate education and continuing professional development opportunities for all health professionals.

3. Clinical audit – contractual agreements to ensure participation in clinical audit and publication of audit outcomes.

4. Research and development – contractual agreements to ensure participation in high quality research which is essential for advancing and improving patient care and outcomes.

5. Commissioning a complete service – ensuring the service includes arrangements for full emergency provision at the appropriate level to manage the follow-up of patients, including complications.

6. Measuring outcomes – outcomes to be measured coherently to enable comprehensive benchmarking across the NHS, with the data made available to the profession and used to inform practise and improve patient safety.

7. Appropriate impact on the local healthcare economy – when commissioning a service, a full assessment must be made of the impact of the decision on the patients' pathway of care (i.e. ensuring that the patient will experience a seamless pathway across different providers) and the impact of the commissioning decision on related services (e.g. clinical

interdependencies) in order to safeguard patients' access. Such assessments should include a consideration of the best available evidence used to support the decisions.

The College further believes that in order to maintain these standards for quality, commissioners of healthcare should ensure providers are able to make sufficient time available in the form of Supporting Professional Activities (SPA) within the consultant contract to allow consultants wishing to be involved in training, education, audit, research etc to do so. By acting in this way commissioners will demonstrate a high degree of senior level commitment to all the elements of a clinician's role which contribute significantly to an increasingly safe and high quality health service.