



**RCN Policy and International Department**

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# **The Independent Sector: History and Role in England**

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## Introduction

With a membership of over 410,000 registered nurses, midwives, health visitors, nursing students and health care assistants, 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.

This document is split into key parts:

- **Part one** sets out the overarching view of the RCN on the independent sector (IS)
- **Part two** sets out a historical overview of some of the ways that the independent sector has worked with the NHS in England.<sup>1,2</sup> This briefing also details RCN views on specific policies which have enabled IS provision of care funded by the public sector
- **Part three** sets out more detail on the scope and scale of the IS as it was during 2011-12 or the latest available statistics<sup>3</sup>
- Final sections provide **contact details** so you can tell us what you think of the issues raised as well as provide **further reading**.

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<sup>1</sup> Many of the details and dates of NHS history in this briefing are sourced from:  
<http://www.nhshistory.net/index.htm>

<sup>2</sup> There are differences across the UK and this briefing only looks at the role of the independent sector in England.

<sup>3</sup> The most recent year for which data relates, although not all data is consistently available for 2012.

## Part One: RCN Position on the Independent Sector (IS)

### RCN definition of the Independent Sector

The independent sector is diverse and complex, and ranges from single care home organisations to large acute care providers in health, as well as social care providers. This includes privately owned companies, charitable institutions and social enterprises.<sup>4</sup> The RCN defines the IS as: *“encompassing individuals, employers, and organisations contributing to needs assessment, design, planning, commissioning and delivery of a broad spectrum of health and social care, who are wholly or partially independent of the public sector.”*<sup>5</sup>

### Overarching position

Whilst the RCN passionately supports the NHS model, we recognise that the history of the NHS includes IS activity; General Practice being a critical case in point. Our members work both within and outside the NHS. The independent sector forms part of a comprehensive provision of health and social care services in England. The RCN estimates that there are around 200,000 to 300,000 nurses across the UK who work outside the NHS. Around a third of RCN members work outside the NHS (over 100,000). This does not account for members who may hold second jobs within the IS.

RCN policy position in relation to the involvement of the independent sector within the NHS is based on the [RCN principles](#). These principles inform RCN policy on all developments around the partnership between the NHS and the IS. The principles are:

- Quality – which includes themes of safety, dignity and effectiveness
- Accountability – including transparency and trust
- Equality – which includes universality, equity and diversity
- Partnership – including representation and collaborative decision making.

There has been greater role for the independent sector given the direction of travel of a number of policy initiatives over time. The pace of change now will depend upon the dynamics of decisions made by commissioners and providers. It may well differ according to the type of service and type of providers (for example, a slow-down in growth for more ‘traditional’ commercial sector hospitals but growth in community services delivered by the IS).

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<sup>4</sup> Note that non NHS hospitals can be referred to as both private hospitals and independent hospitals.

<sup>5</sup> RCN, RCN Policy Briefing: [The Independent Section in Health and Social Care in England in 2009 and Prospects for the Future](#), 2010

The RCN is concerned about the implications of a more fragmented NHS and the potential for higher transactions costs. The RCN has also been concerned that the pursuit of competition could endanger much needed integration of services. The RCN is also aware of when things have not gone as planned when care has been provided outside the NHS. We also recognise that there can also be problems in the NHS.

The greater role of the IS has implications for nursing and for patients.

- Greater diversity of providers in both primary and secondary care settings, offering a range of employers for nurses to work for.
- Different providers may offer a range of roles, with varying pros and cons (for example, terms and conditions, etc).
- There is a challenge to workforce planning and the provision of training as the number of providers increases.
- Greater diversity of providers for patients to choose from. This choice will need transparent and comparable information.
- Some patients may look to nurses to help them navigate the system and make choices.
- There may be issues around the provision of seamless or integrated care with an increasing number of different providers involved with care provision.

The RCN believes, and there is much evidence outlined in the [Boorman Review](#), that good employers who support their staff are also likely to deliver high quality and safe health and social care. The RCN has argued that all providers delivering NHS services should meet both employment and clinical standards in a well regulated, sustainable and effectively scrutinised system. We are also aware of changes being made across system regulation to improve checks and balances for all types of providers of NHS care. In part, this is a response to high profile failures in both NHS care (such as Mid Staffordshire NHS Foundation Trust) and IS care (such as Winterborne View).

## Part Two: History of Use of the IS in England

### The independent sector: a timeline of key events

**Pre 1948:** The UK had a 'private', patchwork health system, which included:

- a national insurance system (where entitlement depended on contributions), mostly benefiting working men
- a range of financially unstable, voluntary hospitals
- the Poor Law and its workhouses provided medical assistance to the most impoverished individuals
- a public health system run by local authorities.

### 1948: The establishment of the NHS

Founded on the 5 July 1948, the NHS was based on the principle that health care should be available to everyone - regardless of wealth – from cradle to grave. It became the first health system in the world to be paid from taxation, offering free health care to the entire population at the point of need.

Today it remains almost entirely funded by general taxation, although in 1952 prescription charges were implemented owing to escalating demand and costs. Other small pockets of money come from sources such as research and development funds. Being 'cash-limited', the pressure on NHS funding – in light of continued demand, new treatments and potential areas of growth for health (ie public health) – has remained throughout the life of the NHS. Undoubtedly, it is one of the reasons why using, learning from and working in partnership with the IS continues to be considered by governments in England.

The NHS took over thousands of existing, voluntary and municipal hospitals. Some private hospitals remained, mainly in London, as they were religious or belonged to a particular group.<sup>6</sup> However, GPs successfully won a contract for services, rather than a contract of services. In doing so, they have remained independent or private, self-employed practitioners and continue to do so today. There are also a significant number of practice nurses who work in and are employed by the IS.

A pay system for consultants also developed, which has enabled them – and which they have fiercely guarded – to undertake either limited, private practice

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<sup>6</sup> For example, Professions and charities

if employed full-time, or unlimited, private practice if employed part-time by the NHS. Hence, from its creation pay-beds have been accepted in NHS hospitals stemming from the idea that it was better for NHS patients if consultants were based in NHS hospitals, not private hospitals.

Nonetheless, the existence of pay-beds has not been without political opposition and in the 1970s, the Labour Government sought to outlaw them,<sup>7</sup> arguing that they were unfair and challenged the principle of the NHS by fast-tracking those able to pay. The Government's efforts were unsuccessful and ultimately were said to have incited the further demand for private insurance and increase in the number of private hospitals. However, private health care was more common in some surgical specialities where the NHS waiting lists were long, and often the surgeons with the longest NHS waiting lists also undertook high amounts of private work. Paying for the operation was a way to beat the waiting list. Whatever the cause, health care in England slowly, though haphazardly, edged towards mixed economy provision as more people took out and more employers offered private insurance and the increasing, private work of NHS consultants became no longer limited to evenings or the weekend.

It is worth noting that when the NHS was established, an arbitrary dividing line between health and social care services was drawn, with need for the latter falling into a different, means-tested funding system and increasingly being paid for privately by individuals. Social care services have and continue to be provided by a wider range of providers, which has included independent providers and less public provision.

### **1990: NHS and Community Care Act – the Internal Market**

The size of the NHS budget depends on a combination of the economic context and political priorities. On coming to power in 1979 and in light of economic austerity, the Conservatives widely discussed plans for reforming NHS funding; the NHS was struggling to meet rising demand with less funding, and waiting lists rose as staffing numbers fell. However, perhaps in view of the general public's attachment to the core principles of the NHS - including its funding system – funding reform plans were abandoned. On becoming Secretary of State for Health in 1989, Ken Clarke instead argued that the NHS should be made more efficient by the introduction of the internal market, as per the NHS and Community Care Act 1990, and the incentives of internal NHS choice and competition.

The key element to the internal market was the separation of purchasing (or commissioning) and the provision of services. Health authorities no longer

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<sup>7</sup> The National Union Public Employees led industrial action on this issue

managed services and were instead handed commissioning responsibilities and received weighted capitation funds according to the demographics of the local population. On the other hand, the providers – NHS hospitals and community services - could apply for self-governing status as NHS trusts. The aim was for commissioning decisions to affect the quality and efficiency of providers as ‘money would follow the patient’ and good performance would be rewarded.

On becoming NHS trusts, providers were offered more freedom to manage their organisations. It was felt this would enable them to be more innovative, efficient and respond to patients’ needs and choices. Local support was a precondition for trust status, but this was reversed when support was not forthcoming. Many health care professions – and the Labour Party - felt that the internal market was the precursor to full-blown privatisation of the NHS and campaigned against it. However, between 1991 and 1995 NHS hospitals and community organisations transformed into publicly owned self-governing bodies.

At the same time, the commercial sector in England continued to slowly increase – income from pay beds increased as did the private health care market. In addition, private hospitals began to treat NHS patients referred to them by GP fundholders<sup>8</sup> and to alleviate waiting lists, further moving health care in England to a mixed economy. In 1995 Virginia Bottomley, the then Secretary of State, described the NHS as the provision of care on the basis of clinical need regardless of the ability to pay, not by who provided the service.<sup>9</sup>

### **1997: the New Labour Government**

Labour had been opposed to the Conservative NHS reforms, and although lacking a blueprint for an alternative path for the health service in England, they began to plan the end of the internal market. However, the NHS was not in a healthy state in 1997 – waiting lists were soaring, operations were postponed and services were being cut as funding ran out in the face of continued rising demand. The purchaser/provider split was shedding more light on how money was being spent but change in provider behaviour was still being impeded by lengthy, block contracts. Extra contractual referrals permitted from the 1990 reforms were also causing some difficulties including delays or refusals for treatment. Hence, after two years in power New Labour devised plans which incorporated the familiar principles of choice and competition, supported the purchaser/provider split and indeed that went

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<sup>8</sup> GP fundholders were introduced by the 1990 NHS and Community Act. Initially GPs with 11,000 or more patients (but later much less due to lack of demand) could apply for their own NHS budgets to cover their staff costs, prescribing, outpatient care, and a specified range of hospital services, mainly elective surgery.

<sup>9</sup> [http://www.nhshistory.net/chapter\\_6.html](http://www.nhshistory.net/chapter_6.html)

further including payment by results, plurality of providers, increased contribution of private providers and the creation of foundation trusts.<sup>10</sup>

Perhaps the most influential Secretary of State in this period was Alan Milburn, who set out his vision of the health service in a number of papers.<sup>11</sup> Like Bottomley, the type of provider – public or private - was less important than the quality of services they provided. Devolving power to local organisations was seen as an important part of raising quality through enabling innovation. His ideas included foundation trusts, payment by results, patient choice and enabling primary care trusts to purchase care from the most appropriate provider – be they public, private or voluntary.<sup>12</sup>

### **NHS foundation trusts**

The concept of foundation trusts is said to have emerged in 2001 after Alan Milburn visited the Alcoron hospital in Madrid, whose private management had been 'freed' from centralised, bureaucratic control and who could borrow money from banks, rather than solely depending on public funds.<sup>13</sup> However, Milburn's initial plans for foundation trusts received widespread opposition from within the Labour Party and beyond, with many feeling they represented 'privatisation through the back door'. Even watered down, many opposed the creation of foundation trusts in the 2003 Health and Social Care (Community Health and Standards) Bill. Many were concerned that a two-tiered system of hospitals would develop, since foundation trusts though still part of the NHS, had greater freedoms over their finances and management.

Foundation trusts were different as they:

- were accountable to local people, who could become members and governors of the trust and its Board (the Secretary of State would not have the power to be involved in or appoint Board members)
- were authorised, monitored and regulated by Monitor (a separate regulator of foundation trusts)
- made decisions locally about how to provide their services
- could retain surplus finances and invest in the delivery of new services
- could locally manage and reward their staff (though within Agenda for Change<sup>14</sup>)

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<sup>10</sup> However, they did end GP fundholding.

<sup>11</sup> The NHS Plan, Redefining the NHS, Delivering the NHS Plan

<sup>12</sup> Although much of this was implemented by the following Secretary of State, John Reid.

<sup>13</sup> [http://www.nhshistory.net/chapter\\_6.html](http://www.nhshistory.net/chapter_6.html)

<sup>14</sup> Implemented in 2004, Agenda for Change was the biggest overhaul of NHS-wide pay, terms and conditions. It was created to deliver a fairer pay system for non medical staff by using the Knowledge and Skills Framework as a link between pay and career progression and harmonise terms and conditions (ie annual leave, sick pay, etc) across the NHS.



- raise money for capital development (though it remained on the Government's balance sheet and limits are agreed).
- could undertake private practice (though again within set limits).

### **The RCN view on foundations trusts**

The RCN developed a [scorecard](#) through which an assessment of the merits of a trust's application to become a foundation trust could be made.

The RCN supports the principle of local accountability and involvement that foundation trusts aspire to put into practice through its members and governors. However, an [RCN survey](#) of nurses working at foundation trusts in England found that nearly half (49 per cent) reported that most or all board meetings are held behind closed doors. Nearly half (47 per cent) of the nurses surveyed did not feel that being a member of the foundation trust made any difference to how it is run, indicating a failure to engage with members.

The RCN continues to support the introduction of foundation trusts on a case by case basis.

### **Private Finance Initiative (PFI)**

PFI had been a Conservative policy initiative dating back to 1991 when funding was scarce but hospitals were in need of capital investment. PFI funds were more expensive as interest was paid over a set period, but it was a solution to the shortage of finances. It was also meant to diminish the risks associated with builds, by shifting them to the private contractor. The Labour Government started a major building programme of hospitals using PFI or public-private partnership schemes, and PFI became the "only game in town".<sup>15</sup>

In PFI a private organisation or consortium designed, built, financed and operated the new hospital building. The trust pay an annual fee covering the interest, capital cost, maintenance and associated costs over a period of 25 to 35 years. However, whilst it was a way of injecting capital funds, PFI repayments - which were more expensive than schemes financed through the government (although each PFI application was compared to a public sector comparator) - quickly began to take their toll on trusts' budgets. Locked into PFI commitments, some trusts have found it very difficult to make their books balance whilst paying off PFI in today's economic climate. Some have been

<sup>15</sup> Reportedly Alan Milburn: <http://www.publicfinance.co.uk/news/2010/11/hospitals-should-cut-pfi-costs-before-staff-mps-say/>

'bailed' out by additional funding from the Department of Health.<sup>16</sup> Some have however re-negotiated and/or bought back the PFI.<sup>17</sup>

### RCN view on PFI

PFI has seen significant variability in success. Some NHS staff were actively included in the process of helping to design their hospitals, facilitating better layouts and planning, higher standards of patient care in new PFI hospitals and better consideration of health and safety.<sup>18</sup>

On the other hand, there have been some schemes which not only delivered dubious results and quality<sup>19</sup>, but that were expensive to maintain (one school reportedly paid £300 to change a light bulb under the PFI contract).<sup>20</sup>

Furthermore, as is being increasingly seen today – with over 60 trusts in serious financial trouble owing to PFI<sup>21</sup> although that PFI is the cause is debated<sup>22</sup> - during an economic crisis PFI places enormous and arguably unsustainable pressure on trusts' budgets. As more and more savings must be met, trusts can only turn to costs directly related to care delivery – such as staffing numbers (see RCN campaign on [Frontline First](#)). The most notable example of the pressure PFI can place on a trust is South London Healthcare Trust, which is now in administration.<sup>23</sup> Whilst it may have been a short term fix to the need for capital investment, PFI is proving to be a long term and costly burden on the budgets of trusts already under significant pressure.

### Payment by results (PbR) - 2002

Prior to the introduction of PbR, hospitals were paid in lump sums for the services they delivered ('block contracts'). PbR was a mechanism intended to drive up activity – and thereby help ease waiting lists but also ensure that money followed the patient (as the Conservatives had previously intended). In other words, it can be seen as an extra dimension of competition designed to strengthen the internal market. PbR does not cover all hospital activities but is applied to certain services (for example, elective services), so that trusts increasingly receive payments depending on the number of elective procedures they deliver, paid for on the basis of a national tariff. PbR intended to:

- pay providers on a fair basis and thereby support patient choice of provider

<sup>16</sup> Bidgood, E PFI, [Still the Only Game in Town?](#) Civitas, December 2012

<sup>17</sup> HSJ, [NHS Trust Buys Back Its PFI Debt](#), 1 February 2011

<sup>18</sup> Bidgood, E PFI, [Still the Only Game in Town?](#) Civitas, December 2012

<sup>19</sup> BBC News, [Nurses Highlight PFI Pitfalls](#), 23 April 2002

<sup>20</sup> Channel 4 Fact Check, [Does PFI Offer the Taxpayer Value for Money?](#) 15 February 2011

<sup>21</sup> Telegraph, [PFI Hospital Crisis: 20 More NHS Trusts 'At Risk'](#) 26 June 2012

<sup>22</sup> Bidgood, E PFI, [Still the Only Game in Town?](#) Civitas, December 2012

<sup>23</sup> RCN Statement, ['Worrying State of Affairs' at London Trust](#) 26 June 2012

- reward efficiency and quality and help tackle rising and unmet demand.

Today, PbR continues to be developed and expanded.

### **The RCN view on PbR**

The RCN has been concerned that tariff has failed to reflect the complexities of care and quality in nursing. Without a more complete understanding of nursing costs and their contribution to the overall process of patient care within the tariff, the RCN is concerned that nursing workforce numbers and skill mix may be subject to inappropriate cuts as was seen during the 'NHS deficits crisis' of 2006-7.<sup>24</sup>

### **Treatment Centres**

Treatment Centres were created to help address waiting lists (or meet waiting time targets), improve value for money and innovation. They were centres designed to accommodate planned day and short-stay surgery and diagnostic procedures for which there were long waiting times (such as ophthalmology and orthopaedics). Some treatment centres were NHS but a number of independent sector treatment centres (ISTCs) were also built.

The ISTC programme was different to the previous use of the commercial sector by the NHS as it was a deliberate central policy, providing care only to NHS patients and not to a mix of both public and private patients. ISTCs (along with NHS treatment Centres) were able to provide dedicated facilities for planned activity (for example, hip and cataract operations). These facilities did not need to cancel operations due to emergencies, which in other NHS hospitals can reduce capacity to treat less urgent cases. They could be fixed sites or mobile and able to deliver services to different geographical locations. ISTCs were initially guaranteed volumes of patients and payment some 15 per cent above NHS tariff costs to recognise the start-up costs. There were two waves of ISTCs. Wave one included 25 fixed site centres and two chains of mobile units. Wave two included 10 schemes (which were more comprehensive in service provision, some covering multiple sites). Some ISTCs included multiple specialities and outpatient care, diagnostics and day surgery.<sup>25</sup>

Whilst ISTCs did bring additional capacity<sup>26</sup>, some trusts resented them in view of the higher tariffs offered to the commercial sector but also as some NHS trust services ran below capacity. Furthermore, there were concerns about quality of the services in some ISTCs and the fact that for the most part

<sup>24</sup> RCN Policy Unit Policy Briefing 11/2009 [Nursing and Payment by Results: Understanding the Cost of Care](#), 2009

<sup>25</sup> The Kings Fund [Independent sector treatment centres](#), 2009

<sup>26</sup> The Kings Fund [Independent sector treatment centres](#), 2009

ISTCs were poorly integrated into the NHS. There were also questions raised in relation to the guaranteed contracts signed with wave one ISTCs and the DH did not see the expected referrals being made to ISTCs (a number of wave one ISTCS were underperforming). However, no full evaluation of ISTCs or NHS treatment centres was ever made<sup>27</sup> (partly because so many details are not in the public domain), hence no robust verdict of their impact can be made. Politically the idea lost support, and the third wave was abandoned. Some second wave contracts were cancelled and compensation was given to private companies.<sup>28</sup>

### **RCN view on ISTCs**

At the time, the RCN accepted that there was sufficient evidence to demonstrate that separating elective surgery from emergency surgery provided a more efficient service by reducing the risk of cancellation for non-clinical reasons. However, we noted that providing a service in this way is not unique to an ISTC programme and that alternative ways of achieving this included NHS treatment centres, day surgery units and five-day wards. The RCN was also concerned about the lack of transparency in relation to key information such as capacity, criteria for selection and financial implications, which made it impossible for the college to hold an informed position in relation to this procurement. We therefore raised many issues, particularly around the workforce but also on the lack of evaluation including the following.

- ‘Additionality’, the RCN was concerned that ISTCs would ‘poach’ NHS staff, and ultimately shift scarce staffing resources from NHS services. The college was clear that ISTCs must be additional resources (ISTCs were contractually restricted from employing anyone who was employed within the NHS at anytime in the previous six months – this included bank and agency staff).
- As ISTC contracts were for a limited period of time, it was agreed between the unions and the Department of Health that a Retention of Employment (RoE) model would be used if NHS staff transferred to work in ISTCs (so in effect putting the legal breaks on a TUPE transfer). This Government has subsequently put a break on the use of RoE.
- To avoid the development of a two tiered workforce whereby those transferred from the NHS would have different terms and conditions than the rest of the workforce, the RCN argued that all staff working within an ISTC should have access to Agenda for Change. We were unsuccessful in getting any contractual requirement for ISTCs to pay AfC rates.
- The lack of evaluation of ISTCs and NHS treatment centres meant that their impact on the NHS, costs, capacity gaps, training and

<sup>27</sup> However, some audit work has been conducted. See RCS, [Patient Outcomes in Survey, A report comparing Independent Sector Treatment Centres and NHS providers](#), October 2011

<sup>28</sup> Bureau of Investigative Journalism, [NHS spent £60 million on cancelled healthcare contracts](#) 25 May 2011

development, and the overall approach cannot be assessed. However, from the evidence available, the RCN believes key lessons from this programme include:

- Centrally procured contracts may be cheaper than ad hoc purchasing. However, the structure of the contracts can lead to payment when not all the capacity is actually used. The structure of contracts is therefore a crucial part of considering the overall value for money from use of the IS.
- Contracting should include comparable indicators on quality so that the IS and the NHS can be compared on a like for like basis. Delivery models should also be compared to the NHS to determine if they are innovative and if so, how best to import this back into the NHS.<sup>29</sup>

### Patient choice and competition

Choice of elective activity was progressively opened up, which includes the choice of both NHS and private providers.<sup>30</sup>

- In 2002, patients were offered choice for cardiac services in a pilot of patient choice.
- By 2006, patients were offered a choice of four providers when referred to hospital, including foundation trusts, ISTCs, and other independent sector providers in the Extended Choice Network.
- From 2008, the free choice policy was introduced allowing patients to choose from any hospital or clinic that meets NHS standards, and according to what matters to them most (performance, location, etc.).

However, the NHS 'privatisation' agenda was still a hotly contested issue, with many concerned that the role of the commercial sector in the health service was evolving into full scale privatisation of the NHS. In 2009, the then Secretary of State Andy Burnham stated that the NHS – not the independent sector – was 'the preferred provider', and DH acted on his intent.<sup>31</sup> Following potential legal challenges by independent organisations the 'policy' quickly had to be reversed.<sup>32</sup>

Another dimension to patient choice was implementation of personal budgets in social care, and the three-year pilot programme of **personal health budgets** in 2009. Personal health budgets according to DH, "*makes it clear to you and the people who support you how much money is available for your*

<sup>29</sup> RCN, RCN Policy Briefing: [The Independent Section in Health and Social Care in England in 2009 and Prospects for the Future](#), 2010

<sup>30</sup> [http://en.wikipedia.org/wiki/Hospital\\_choice\\_in\\_the\\_NHS](http://en.wikipedia.org/wiki/Hospital_choice_in_the_NHS)

<sup>31</sup> HSJ, [Andy Burnham Extends Preferred provider Vow](#), 22 October 2009

<sup>32</sup> HSJ, [Preferred Provider Policy Unravels](#), 11 March 2010

*NHS care so you can discuss and agree the best way to spend it. This gives you more say over the care you get.”<sup>33</sup>*

There are three ways an individual's resources or money can be allocated: a notional budget held by the commissioner; a budget managed on the individual's behalf by a third party; and a cash payment to the individual (a 'healthcare direct payment'). The budget is held by the budget holder to directly employ any services or individual to meet an agreed need as per the care plan. Hence, a range of providers can be purchased by the budget holder and DH believes people will have more choice, flexibility and control over the health services and care they receive – ie they will be able to have a greater say over which services they access, which may differ from those traditionally accessed. Under the current government, this policy sits neatly with their proposal to diversify providers in the healthcare market and is being rolled out next year.

#### **RCN view on personal health budgets**

- Given the present financial and policy context, the RCN has serious doubts about the impact of PHBs and feels they pose the following risks:<sup>34</sup>
  - Erosion of 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.
  - Exacerbation of 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.
  - Endanger the delivery 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.
  - Prevent PHB budget holders from becoming best practice employers, and deliver pay, terms and conditions in line with Agenda for Change.
  - Potentially, negative impacts on pay terms and conditions of those employed by current providers.

#### **2010: Coalition Government and the Health and Social Care Act**

In 2010, the Conservative-Liberal Democrat Coalition came to power. Despite pre-election promises to the contrary, the Coalition parties quickly agreed the

<sup>33</sup> Department of Health, [Understanding Personal Health Budgets](#), 2009

<sup>34</sup> RCN Policy Briefing 6/11, [Personal Health Budgets: An Overview of Policy in England So Far](#), 2011



largest wholesale reform of the NHS to date, and with it came a further signal that the mixed health economy is set to expand in England.

The NHS white paper *Equity and Excellence: Liberating the NHS*<sup>35</sup> detailed the reforms and inspired a raft of widespread protest and opposition from Labour, Royal Colleges and other stakeholders concerned not only by the pace, timing and scale of reform but also by its 'pro-market' clauses on competition and the risks it posed in relation to the fragmentation of the NHS, increasing inequalities, variation and red tape whilst diminishing the mechanisms for accountability.<sup>36</sup>

Although the Government paused the legislative process to 'Listen' and briefly consult with stakeholders on their areas of concern, the Health and Social Care Act was passed in 2012. Despite some concessions, such as the requirement for a nurse on every Clinical Commissioning Group Board, the RCN ultimately rejected the Health and Social Care Bill.<sup>37</sup>

Key elements of Health and Social Care Act relating to the role of the independent sector include:

- **Extension of patient choice.** Patients would get more choice and control, backed by more information, again so that services are more responsive to patients and designed around them. This includes Any Qualified Provider (see section below).

The RCN has supported the provision of more information for patients to make informed choices about their care. However, the RCN raised concerns that 'plurality of care providers involved in a single patient's care could lead to increased disjointed, incomplete records resulting in issues with patient safety and continuity of care. Small independent care provider organisations could struggle to support the IT requirements to maintain electronic information flows. The current situation with information held in disparate systems and locations (paper as well as electronic) cannot sustain safe, effective patient care.

- **New role for Monitor.** Prior to April 2013 Monitor authorised and regulated NHS foundation trusts, monitoring their compliance against their terms of authorisation. In April 2013, Monitor became the sector regulator of all providers of NHS services<sup>38</sup> and is responsible for

<sup>35</sup> Department of Health, [Liberating the NHS White Paper](#), July 2010

<sup>36</sup> RCN, [Response to the NHS White Paper: Equity and Excellence: Liberating the NHS \(England\)](#), 2010

<sup>37</sup> RCN Parliamentary Briefing, [Why the RCN is Opposing the Health and Social Care Bill](#), January 2012

<sup>38</sup> From April 2013 this covers foundation trusts, from April 2014 this will cover all providers of NHS care with the exception of small providers (with turnover of less than £10 million). See RCN Policy and International Department Briefing Policy Briefing 16/12 [Monitor and the NHS Provider License](#), May 2013

protecting and promoting patients interests, including tackling 'anti-competitive behaviour' (changed from 'promoting competition' in the 'Listening' exercise due to fears about privatisation), 'enabling integrated care' (again this was introduced during the 'Listening' exercise due to concerns about competition causing fragmentation) and in conjunction with NHS England, setting prices.

The RCN has said that the Government must demonstrate that there will be adequate regulation to safeguard the quality and safety of patient care.

- **Section 75 of regulations relating to competition.** These regulations concerned the implementation of the Health and Social Care Act. These have been controversial and revised over time, but now passed into legislation.

The RCN sought clarification and raised its concern about how this regulation would be interpreted in practice. Like other stakeholders, our fear was that the regulation's wording would make commissioners feel they had to tender for every service.

- **Extension of foundation trusts and their freedoms.** Foundation trusts will be rolled out (though more cautiously than first planned by this Government), so that every trust will become a foundation trust. Foundation trusts are also now able to partner with the commercial sector (or anyone else) and can earn up to 49 per cent of their income from private sources (the so-called private income cap).

The RCN was opposed to removing the private income cap. We felt that this was not appropriate until foundation trusts can credibly demonstrate that private income is not at the expense of NHS patients. The RCN does not believe that there has been sufficient analysis to justify the changes made in this area.

There is a fear that competition will be based on price, not quality, with additional detrimental impacts on the delivery of integrated care. There are new large, corporations such as Virgin and Serco who are increasingly moving into delivering large NHS community contracts and a new franchising approach has been tested using Circle in Hinchingsbrooke hospital. The RCN has set up a monitoring system to ensure that these providers do not infringe core NHS principles.

### **Any qualified provider (AQP)**



Details about AQP were set out in the consultation *Liberating the NHS: greater choice and control: Extending patient choice of provider (Any qualified provider)* published in 2010.<sup>39</sup> AQP focuses on community services set within a national framework, but allows local determination of specific services to be offered. The underlying rationale is to increase quality through provider competition, and again enable the money to follow patients' choices.

Eight priority areas for the implementation of AQP were identified by the Department of Health and local NHS commissioners were asked to select three (or more) services from their priority list to offer under AQP. Commissioners then chose providers who met agreed conditions including registration with the Care Quality Commission (to provide reassurance on quality of services).<sup>40</sup> They also agreed the price of services: where a tariff already exists, this is used but where a tariff does not exist, then a tariff is locally agreed.<sup>41</sup>

AQP was implemented in April 2012.<sup>42</sup> There are now over 500 services listed for patients to choose from including services such as hearing, eye, musculoskeletal and wheelchair. Further services may well be added as AQP is extended.<sup>43</sup> Media reports suggest that some 100 or so new providers could be from the commercial sector.<sup>44</sup> They include InHealth, Specsavers and Virgin Care. Over 140 providers are from the NHS. There is no expectation that commissioners must open up services to tender and decisions are expected to be locally determined.<sup>45</sup> However, some have commented that AQP is not locally driven but instead is a top-down process.<sup>46</sup>

There is an evaluation planned of the first wave of AQP<sup>47</sup>, but further details on how it is to be evaluated and when the results will be available are unclear. Concerns have been raised by some, including a concern of fragmenting services,<sup>48</sup> and confusing choices for patients.<sup>49</sup>

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<sup>39</sup> Department of Health, [Liberating the NHS: Greater Choice and Control- Government Response, Extending Patient Choice of Provider \(Any Qualified Provider\)](#), July 2011

<sup>40</sup> The Care Quality Commission is the quality and safety inspectorate and regulator of the health care system in England.

<sup>41</sup> Supply2health [AQP FAQs](#)

<sup>42</sup> NHS Choices, [Any Qualified Provider](#)

<sup>43</sup> GPOnline, Viewpoint: [What any qualified provider means for GPs](#), November 2012

<sup>44</sup> Guardian, [NHS being 'atomised' by expansion of private sector's role, say doctors](#), 6 January 2013

<sup>45</sup> Ibid.

<sup>46</sup> GPonline, [Services open to 'any qualified provider' revealed by DH](#), September 2012

<sup>47</sup> Supply2health [AQP FAQs](#)

<sup>48</sup> GPOnline, Viewpoint: [What any qualified provider means for GPs](#), November 2012

<sup>49</sup> Guardian, [NHS being 'atomised' by expansion of private sector's role, say doctors](#), 6 January 2013

## RCN view on AQP

The RCN will use the same principles it uses to assess the suitability of any provider of NHS services<sup>50</sup>:

- Quality – which includes themes of safety, dignity and effectiveness
- Accountability – including transparency and trust
- Equality – which includes universality, equity and diversity
- Partnership – including representation and collaborative decision making.

The RCN has consistently argued that introducing non-NHS providers into the NHS market should not result in a drive to the bottom for staff terms and conditions. As part of this strategy, the RCN, alongside other NHS trade unions (through the Staff Passport Group), is negotiating with DH, NHS and IS providers a framework agreement for staff working on clinical contracts to have access to the NHS pension.

RCN members have also been involved in developing and evaluating AQP service specifications.

In addition, the RCN has also worked with the Social Partnership Forum (which brings together NHS Employers, NHS trade unions and the Department of Health) on the [Staff Passport](#). This is a tool with a range of guidance, designed to support staff and employers, where an independent sector and NHS interface is developing.

## Failures in the IS

The RCN doesn't generalise about the whole of the IS from examples of failure of some organisations, however the RCN wants to ensure that lessons are learned from failure (whether in the IS or NHS) in order to avoid the same mistakes happening again. These failures also relate to broader issues in how the system as a whole provides checks and balances on providers.

### *Serco out of hours provision in Cornwall*

Out of hours care delivered by Serco in Cornwall was investigated by the Public Accounts Committee, culminating in their 11 July 2013 report.<sup>51</sup> Their report found that whistleblowers had raised concerns about short staffing and that performance data was changed by Serco in early 2012. The contract is worth £32 million over five years. The committee found that the concerns were substantially true. They also found that Serco responded in a way that inhibited whistleblowers from being open in the patients' best interest. In addition, the quality of the service was falling below a level that should be

<sup>50</sup> RCN, [Principles to Inform Decision Making: What Do I Need to Know?](#), 2008

<sup>51</sup> Public Accounts Committee, <http://www.parliament.uk/business/committees/committees-a-z/commons-select/public-accounts-committee/news/out-of-hours-gp-service-in-cornwall/>

expected.

The committee also said that the PCT and SHA hadn't demonstrated that they had the appropriate skills to negotiate effectively, nor to effectively hold Serco to account. They also highlighted that only two organisations were willing to bid to provide services at the cost set out by the PCT, and that Serco says that they are running the service at a loss.

### **Winterbourne View**

In May 2011 BBC Panorama "Undercover Care: The Abuse Exposed" was transmitted, and revealed staff in Winterbourne View Hospital mistreating and assaulting adults in their care. The footage was obtained from an undercover reporter who was employed as a support worker in the hospital for five weeks.

As a result of this programme, South Gloucestershire Safeguarding Adults Board commissioned a Serious Case Review into the events that occurred in Winterbourne View Hospital between January 2008 and May 2011.<sup>52</sup> The Serious Case Review pulled together evidence from a range of stakeholders.<sup>53</sup> They found that:

- The hospital depended on its learning disability nursing and psychiatry for its knowledge and professional base. However, over time Winterbourne View Hospital was said to have become 'a support worker led hospital'
- There were two occasions when Winterbourne View Hospital operated without a Registered Manager, for seven months in 2008 and for the final 18 months of the hospital (there was an acting manager but he was not registered)
- The use of restraint by untrained personnel, the limited ways in which staff worked with patients, the underoccupation of patients and the discontinuity or absence of internal and external support, professional challenge or patient advocacy
- During 2010 'on the job' training and inadequate staffing levels persisted with poor recruitment practices and further instances of unprofessional behaviour in an increasingly non-therapeutic hospital
- There were high levels of staff sickness and staff turnover at the hospital

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<sup>52</sup> <http://hosted.southglos.gov.uk/wv/report.pdf>

<sup>53</sup> The Review is based on information provided by Castlebeck Care (Teeside) Ltd, the NHS South of England, NHS South Gloucestershire PCT (Commissioning), South Gloucestershire Council Adult Safeguarding, Avon and Somerset Constabulary and the Care Quality Commission; correspondence with agency managers; contact with some former patients and their relatives; and discussions with a Serious Case Review Panel (representatives from the NHS, South Gloucestershire Council, Avon and Somerset Constabulary and the Care Quality Commission).

- Occasions when two families recalled clear progress in the lives of their relatives were characterised by hospital staff seeking to understand and getting to know patients as individuals and offering valued continuity. More typically, however, families recalled the high turnover of young, untrained and inexperienced staff and inattentive managers
- The salary of a support worker is around £16,000 a year
- Castlebeck refused to respond to the review's request for a financial breakdown of the £3.5K charge per patient each week because of its 'commercial sensitivity'.

In relation to commissioners, the review found that:

- NHS organisations, making 'spot' purchases, were responsible for commissioning placements for the majority of Winterbourne View Hospital patients. They did not press for, nor receive, detailed accounts of how Winterbourne View was spending weekly fees on behalf of its patients. Even though the hospital was not meeting its contractual requirements in terms of the levels of supervision provided to individual patients, commissioners continued to place people there. Although some commissioners funded advocacy services, Winterbourne View controlled patients' access to these
- Commissioners did not specify the performance targets required of Winterbourne View or even key milestones – the critical points that assure everyone that the hospital is achieving all that it has promised concerning a patient; and they did not seek information about the accomplishments and achievements of the hospital with regards to its patients; for example, in terms of money invested and the results achieved in the short and medium terms. In turn, Castlebeck Ltd benefitted financially to a substantial degree.

In the case of Winterbourne View, there were also significant issues raised about how the Care Quality Commission dealt with Whistleblowers as they had been informed of concerns but had not acted upon them.

## **Concluding remarks on history of use of IS in England**

This briefing has tried to set out some of the key developments in the role of the private and independent sector in the NHS in England. The involvement of the commercial sector remains controversial in view of the mass support for the NHS and its principles. Increasing the diversity of providers does pose some important questions about the health service in England, as well as challenges to the NHS model including equality of access and quality, and enabling companies to profit from delivering NHS services.

The NHS model was created in the 1940s for a population with different needs and has continued to evolve throughout its history. Today, it must respond to the challenges of delivering for generations with higher expectations and who are more informed 'consumers', with access to a range of information technology channels and ways to obtain and share information. At the same time, it is clear that the NHS will not enjoy any significant rise in its budget for some time in the future in light of the economic context, whilst tasked with delivering the current reforms, meeting the demands of reviews and recommendations of care scandals and continuing to deliver advanced health care. The NHS will need to be innovative to ensure that it can continue to meet the needs of the people it cares for and treats. Whether IS organisations can help achieve this remains to be seen, and there are some real concerns about how more providers will not impede the delivery of integrated care with an increasing number of systems, processes and working cultures to overcome. What we do know is that the new NHS architecture and its key players – the commissioners, regulators, governance boards and workforce - will have to be fully supported and resourced to play their role in ensuring the delivery of high quality and safe care by all providers, that can continue to deliver services for everyone in England that are free at the point of need.

## **Part Three: Current Use of Independent Sector in England**

### **Use of the IS**

There are a number of ways that public funds are currently being used in the IS. A summary is provided in the table below and covers separately:

- Delivery of health care (both primary and secondary care)
- Delivery of social and domiciliary care
- Financing of physical capacity (buildings and equipment)
- Strategy and commissioning support to the NHS.

We also include the scale from 2008-9 when we last produced a [briefing](#) on the independent sector in England.

It is also worth noting that it is difficult to assess the full scale of IS activity because local provision varies and statistics are not always centrally collated. It is also difficult to separate out funding according to the specific type of IS; voluntary, local authority and commercial sector.

**Table 1: Overview of use of IS by the public sector/NHS (latest available statistics)**

Activity and sector	Type of IS	Public sector use of IS	Rationale for public sector use	Scale 2008-9	Scale 2011-12 <sup>54</sup>
<b><i>Delivery of health care</i></b>					
Secondary care (e.g. hip operations)	Independent sector hospitals	Spot purchasing and some DH central procurement of activity from existing IS hospitals <sup>55</sup>	1. To overcome short term capacity constraints  2. To deliver 18 week target using readily available capacity	1. £305m in 2007 <sup>56</sup>  2. Unknown share of £270m in 2007 <sup>57</sup>	£957m in 2011-12 <sup>58</sup>
Secondary care (e.g. hip operations)	Independent Sector Treatment Centres (ISTCs)	DH central procurement of activity	1. To increase the capacity available to treat NHS	Unknown share of £270m in	£357m in 2011-12 <sup>60</sup>  There are also

<sup>54</sup> Or latest statistics found.

<sup>55</sup> Department of Health, [Independent Sector Treatment Centres](#), February 2006

<sup>56</sup> Laing and Buisson, Press Release: [Self-pay Private Healthcare Falls as Economic Slowdown Bites but NHS Spending Support Growth for Private Hospitals](#), 29 October 2008

<sup>57</sup> Laing and Buisson, Press Release: [Self-pay Private Healthcare Falls as Economic Slowdown Bites but NHS Spending Support Growth for Private Hospitals](#), 29 October 2008

<sup>58</sup> Laing and Buisson, Press Release: [Laing's Healthcare Market Review](#), 27 January 2012

<sup>60</sup> <http://www.laingbuisson.co.uk/MediaCentre/PressReleases/LaingsReviewPressRelease201112.aspx>

			<p>patients;</p> <p>2. Offer patients a choice of where they are treated;</p> <p>3. Stimulate innovation in the provision of healthcare.</p>	2007 <sup>59</sup>	costs to cancelling contracts <sup>61</sup> and to closing ISTCs <sup>62</sup>
Secondary care (e.g. hip operations)	Independent Sector Extended Choice Network or Free Choice Network (IS ECN/FCN).	Patient choice includes IS	To provide choice to patients	£83m from Apr 07 to Dec 08 <sup>63</sup>	£356m in 2011-12 <sup>64</sup>
Specialist services (e.g. cancer care at the end of life)	For example, Marie Curie	Local NHS can commission services	To provide specialist services	Unknown	Unknown

<sup>59</sup> Laing and Buisson, Press Release: [Self-pay Private Healthcare Falls as Economic Slowdown Bites but NHS Spending Support Growth for Private Hospitals](#), 29 October 2008

<sup>61</sup> <http://www.thebureauinvestigates.com/2011/05/25/get-the-data-60m-spent-on-cancelled-healthcare-contracts/>

<sup>62</sup> <http://www.thebureauinvestigates.com/2011/05/25/get-the-data-bungled-contracts-force-nhs-to-pay-out-186m/>

<sup>63</sup> [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_098744.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098744.pdf)

<sup>64</sup> <http://www.laingbuisson.co.uk/MediaCentre/PressReleases/LaingsReviewPressRelease201112.aspx>



Primary care	Commuter Walk in Centres	DH central procurement	To offer convenient access	7 WiCs £ unknown	Approximately 92 centres <sup>65</sup> but reports of closures <sup>66</sup>  £ unknown
Primary care	Polyclinics/Equitable Access to Primary Medical Care programme	DH central procurement	To provide 'one stop shops' delivering a range of services	£40m in 2007 <sup>67</sup>	£250m pledged in 2010 <sup>68</sup>
Community services	Under Any Qualified Provider e.g. audiology	Local commissioning from central list of potential services	To expand choice	NA	Unknown
Diagnostics	MRI	DH central procurement	To provide MRI capacity	80,000 scans over five years <sup>69</sup>	£41m in 2011-12 <sup>70</sup>
Cross border health	NHS patients can	Driven by patients who may pursue care outside		Unknown	

<sup>65</sup> NHS Choices, [Walk in Centres](#)

<sup>66</sup> BBC News, [Are Walk In Centres on the Way Out?](#) 28 June 2012 <http://www.bbc.co.uk/news/uk-politics-18503034>

<sup>67</sup> Laing and Buisson, Press Release: [Self-pay Private Healthcare Falls as Economic Slowdown Bites but NHS Spending Support Growth for Private Hospitals](#), 29 October 2008

<sup>68</sup> Department of Health, [Equitable Access to Primary Care Services \(EAPMC\): Procurement at PCTs](#)

<sup>69</sup> Hansard, [21 Apr 2004 : Column 555W—continued](#)

<sup>70</sup> Laing and Buisson, Press Release: [Laing's Healthcare Market Review](#), 27 January 2012

care	have care provided by providers outside the UK	the UK under EU rules or Commissioners who may commission care where there is limited capacity in the UK (however this scheme closed in 2005) <sup>71</sup>		
Social care/domiciliary care	Care homes, day care centres, etc	Local authority and NHS and self pay/top up for care	£19bn 2008-9 by LA <sup>72</sup>  £2.15bn from users themselves in 2007-8 <sup>73</sup>	
PFI (Private Finance Initiative)	Private consortia, usually involving large construction firms, are contracted to design, build, and	Public Private Partnership – local NHS with IS	Improve the secondary care estate	£12bn <sup>75</sup>  £1.2bn in 2010-11 <sup>76</sup>  £1.76bn in 2012-13 <sup>77</sup>

<sup>71</sup> <http://www.dh.gov.uk/en/Healthcare/Entitlementsandcharges/OverseastreatmentguidanceforNHS/index.htm>

<sup>72</sup> <http://www.communities.gov.uk/documents/statistics/doc/1299474.doc>

<sup>73</sup> [www.kingsfund.org.uk/document.rm?id=8243](http://www.kingsfund.org.uk/document.rm?id=8243)

<sup>75</sup> <http://lookafterournhs.org.uk/wp-content/uploads/private-finance-initiative-no-links-01066.pdf>

<sup>76</sup> Harker, R NHS Funding and Expenditure, 3 April 2012, House of Commons Library

<sup>77</sup> <http://www.guardian.co.uk/news/datablog/2012/jul/05/pfi-contracts-list>

	in some cases manage new projects. Contracts typically last for 30 years, during which time the building is leased by a public authority <sup>74</sup>				
LIFT (Local Improvement Finance Trust)	NHS LIFT is a vehicle for improving and developing frontline primary and community care facilities. It is allowing PCTs to invest in new premises in new locations <sup>78</sup>	Public Private Partnership – local NHS with IS	Improve the primary care estate	£1,500m over LIFT programme <sup>79</sup>	£1,500m over LIFT programme <sup>80</sup>
FESC (Framework for procuring External	Consultancies	PCTs can use companies included on	To provide support	£15m to 16	Unknown

<sup>74</sup> [http://www.dh.gov.uk/en/Procurementandproposals/Publicprivatepartnership/Privatefinanceinitiative/DH\\_677](http://www.dh.gov.uk/en/Procurementandproposals/Publicprivatepartnership/Privatefinanceinitiative/DH_677)

<sup>78</sup> <http://www.dh.gov.uk/en/Procurementandproposals/Publicprivatepartnership/NHSLIFT/index.htm>

<sup>79</sup> DH Press Release, 13 March 2009, Express LIFT framework partners announced

<sup>80</sup> DH Press Release, 13 March 2009, Express LIFT framework partners announced

Support for Commissioners)		the FESC to support them in their commissioning functions	for commissioning	July 2009 <sup>81</sup>	
Commercial Resource Framework	Consultancies	DH and NHS can use companies to provide commercial support	Framework provides the Department and NHS organisations with easy access to a list of pre-qualified suppliers for non-permanent workers with commercial skills	Unknown (open from 1 June 2009)	Unknown (open from 1 June 2009)
Other	Consultancies	Commissioners can use other companies to support them in their commissioning functions	To provide support for commissioning	£350m in 2007-8 <sup>82</sup> (which is likely to include expenditure on FESC)	Unknown

<sup>81</sup> Response to PQ by Norman Lamb, 16 July 2009

<sup>82</sup> RCN News [NHS Spending on Management Consultants is Shocking](#), 10 May 2009

In addition the DH and other central agencies (for example, NICE, CQC, Monitor) will themselves make use of the IS to inform their own work. In 2007-8 the DH spent £132 million on management consultants.<sup>83</sup> In 2010-11 the DH and other central agencies spent £197 million on management consultants.<sup>84</sup> However, a further £274 million is estimated to have been spent by NHS Trusts.<sup>85</sup>

The Nuffield Trust suggests that by 2011-12 the NHS spent £8.7 billion. This compares to £5.6 billion (in 2011-12 prices) in 2006-7.<sup>86</sup> Within this, the biggest spend is on community health services (£2.37 billion), followed by general and acute (£1.8 billion).

It is important to place the scale of expenditure in context; the total expenditure on the NHS is £105 billion for 2011-12.<sup>87</sup>

## Tell us what you think

This briefing is intended as background on the IS in England and the Policy and International Department would like to receive comments/feedback from as many members as possible on this important issue - [policycontacts@rcn.org.uk](mailto:policycontacts@rcn.org.uk)

## Further Reading

RCN, [Section 75 Regulations](#)

RCN, Policy Briefing 01/2010 [The Independent Sector in Health and Social Care in England](#), 2010

RCN, Policy Briefing 07/2010 [Competition in the NHS in England](#), 2010

Nuffield Trust, [Public Payment, Private Provision](#), May 2013

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<sup>83</sup> Response to PQ by Frank Dobson, 22 July 2009

<sup>84</sup> Bureau of Investigative Journalism, [DoH lack of transparency hides \\$470 m spent on management consultants](#), 23 December 2011

<sup>85</sup> Bureau of Investigative Journalism, [DoH lack of transparency hides \\$470 m spent on management consultants](#), 23 December 2011

<sup>86</sup> Nuffield Trust, [Public Payment, Private Provision](#), May 2013

<sup>87</sup> Harker, R NHS Funding and Expenditure, 3 April 2012, House of Commons Library