



House of Lords Briefing: Health & Social Care Bill, Report Stage, Feb 2012

UNISON is the major union in the health service and social care sector, representing more than 450,000 healthcare staff and 300,000 social care staff employed in the NHS and local government, and by private contractors, the voluntary sector and GPs. UNISON members are nurses, student nurses, midwives, health visitors, healthcare assistants, paramedics, ambulance staff, occupational therapists, operating department practitioners, cleaners, porters, catering staff, admin staff, medical secretaries and primary care staff.

INTRODUCTION

This briefing outlines UNISON's concerns that the Health and Social Care Bill continues to represent a major threat to our National Health Service. Despite changes following the listening exercise and the proposed government amendments at Report Stage, the fundamental dangers of fragmentation, instability and inequity remain. Greater clinical involvement and greater patient voice can both be achieved without the upheaval necessitated by the Bill. UNISON therefore continues to believe that the Bill should be withdrawn.

Momentum against the Bill has been building. The House of Commons Health Committee found that the reorganisation brought about by the Bill "more often creates disruption and distraction that hinders the ability of organisations to consider truly effective ways of reforming service delivery and releasing savings"¹. Prof Kieran Walshe has suggested that £1bn could be saved in 2013 if the Bill was stopped now.² Many organisations have joined UNISON in calling for the Bill to be dropped: the Royal College of Nursing, the Royal College of Midwives and the BMA have all moved to outright opposition; very significantly, the Royal Colleges of GPs, whose members will be at the forefront of reform, called for the Bill to be scrapped on 3 February. The risks associated with the Bill have come more starkly into light, particularly with the lack of accountability of private firms involved in the PIP breast implant scandal. The risks to children and child health have been highlighted by the NHS Confederation and Royal College of Paediatrics & Child Health³. The Faculty of Public Health emphasised the harm that could be done in terms of dealing with public health emergencies and health inequalities⁴. The government continues to resist cross-party calls to publish its "risk register", but local risk assessments show the potential the Bill has to damage patient care⁵. A joint editorial in the *British Medical Journal*, *Health Service Journal* and *Nursing Times* stated that the upheaval has "destabilised and damaged one of this country's greatest achievements: a system that embodies social justice and has delivered widespread patient satisfaction, public support, and value for money".⁶

RECOMMENDATIONS

At Report Stage UNISON recommends that the following headline amendments are made to the Bill:

- **The private patient income cap should be reinstated** to ensure NHS patients are not pushed to the back of the queue for treatment. Any variation over existing levels of private patient income should be restricted to a far smaller amount than the 49% implied by government amendments in Committee.
- **The system of wholesale competition based on economic regulation should be resisted**, ideally by removing Part 3 of the Bill. The role and powers of Monitor should be restricted and EU competition law should not be the driving force in the NHS.
- **The wording of the 2006 NHS Act should be retained in relation to the Secretary of State** remaining legally and politically responsible for the NHS. This would remove any ambiguity about the accountability of government and Parliament. Government amendments still do not go far enough.

This briefing contains more information on the above and other recommendations for amending the Bill.

1. PRIVATE PATIENT INCOME CAP

Clause 164 of the Bill abolishes the existing system for restricting the amount of private patient income that foundation trusts can earn. There is currently a cap set at the percentage of income that each hospital made from private patients when foundation trusts were established in 2003. More recently the cap was set at 1.5% for mental health foundation trusts. The purpose of the cap is to stop foundation trusts from prioritising those who can afford private care over NHS patients in the pursuit of extra income.

The much publicised government amendments to Clause 163 at Committee Stage have brought in a new restriction that means a foundation trust's NHS income must always be greater than that it receives "from any other purposes". So in future a hospital could earn as much as 49% of its income from the treatment of private patients who pay for their care.

Based on the most recent figures from the regulator Monitor, only seven foundation trusts have a cap of more than 5%;⁷ the vast majority earn less than 2%, with many earning nothing at all. So increasing the amount they can make to 49% will have the same effect as removing the cap completely: some NHS patients will find they are pushed to the back of lengthening treatment queues by those that can afford to pay. NHS patients could also find that urgent surgery is cancelled if private patients expect to spend longer in NHS intensive care units than is clinically necessary.

The government has added in a requirement for foundation trust annual reports to include information about the impact of income generated from private patients, but there is nothing on local governance arrangements that could require, for example, that any variation in existing levels of private patient income was firstly approved by foundation trust members or governors, or by the local HealthWatch or Health and Wellbeing Board.

In the new ultra-competitive system, hospitals may feel compelled to prioritise patients that bring in extra income over NHS patients, particularly as they will be under a huge amount of extra pressure to increase their income from whatever source possible as they struggle to make savings as part of the £20bn so-called "Nicholson challenge".

The Bill's impact assessment acknowledges that there is "a risk that private patients may be prioritised above NHS patients resulting in a growth in waiting lists and waiting times for NHS patients".⁸ The NHS founding principle that access should be based on need not ability to pay is under threat.

Reassurances about the need for foundation trusts to reinvest their private patient income in NHS services have so far been completely inadequate. There is no existing evidence that foundation trusts currently use their private patient income to improve services for patients, so it is fanciful to suggest that they will do so in future. There is, however, evidence that a number of trusts, such as the Royal Marsden, Moorfields Eye Hospital, Papworth Hospital and the Christie foundation trust are preparing to substantially increase their private patient work.⁹

The author of the listening exercise report, Prof Steve Field, said that the abolition of the cap was an area that "we didn't put as much in our report as perhaps we could have done." He summarised the "gut feeling" from the listening exercise as "the private cap should stay because people felt that would provide the protection".¹⁰

- *UNISON supports amendments to Clauses 163 and 164 to reinstate the private patient income cap and to ensure that any variations within the current system are severely restricted.*

2. COMPETITION, FAILURE AND THE PRIVATE SECTOR

Almost a third of the Bill's clauses are devoted to setting up the full-blooded market system of Part 3. Contrary to the recommendations of the government's "listening exercise", Monitor will still become an economic regulator. It will retain its powers to enforce competition law in the way that regulators do in the privatised utilities and railways – completely inappropriate for the NHS. Instead of "promoting competition", Monitor will "prevent anti-competitive behaviour" – which is likely to mean the same thing in practice.

Despite the latest government amendments, changes to ensure services are "provided in an integrated way" continue to lack any definition or enforcement powers, in stark contrast to a whole Chapter (clauses 70-81) devoted to the role of the Competition Commission and the Office of Fair Trading in enforcing competition. The Bill's balance between free market thinking and a more collaborative ethos therefore remains extremely lop-sided – a point emphasised by the recent YouGov poll of NHS staff that found only 8% confident that the Bill had the right balance between competition and integration.¹¹

Despite government claims that its plans will not change anything in relation to EU competition law, health minister Simon Burns has himself stated that "as NHS providers develop and begin to compete actively with other NHS providers and private and voluntary providers, UK and EU competition laws will increasingly become applicable".¹² This raises the prospect of an increasingly litigious culture surrounding the health service, as healthcare companies look to enforce competition law through the courts, costing the NHS valuable time and money. Those representing the private sector have already stated that they are prepared to use the courts to achieve market entry.¹³

Concerns remain about the excessively complex and bureaucratic proposals for dealing with provider failure, despite the move away from a commercial insolvency regime. The government should still be able to bring a failing foundation trust back fully under state control; NHS chief executive David Nicholson has himself stated that the option "to renationalise a foundation trust should be part of the armoury of any government... I believe that from time to time it may be necessary for the state to take the direct management of an organisation".¹⁴

The prospect has been raised by Monitor of outsourcing the financial regulation of providers to credit rating agencies such as Standard and Poor's, Moody's and Fitch¹⁵, which has alarming echoes of US financial oversight in the run-up to the sub-prime mortgage crisis that caused the worldwide financial crash in 2008. This is the clearest example yet of government plans sending the NHS into a market free-for-all.

Monitor will also be handed an inappropriate control of price setting in the NHS, rather than this power remaining directly with the government. Analysis of recent experience in the energy and rail markets suggests that "when the government gives up such powers regulators are susceptible to producer capture leading to increasing complexity, less transparency and a lack of accountability".¹⁶ In addition, the latest government amendments to clauses 118-126, appear designed to give a greater say to healthcare companies in Monitor's consultation on the national tariff: consultees will now include all "relevant providers" rather than just those incumbents that are already "licence holders".

As Monitor chair and chief executive David Bennett has himself recently suggested, much potential remains for conflicts of interest at the regulator: "Unless Monitor can clearly demonstrate it has acted properly, allegations and challenges around improper conduct owing to undue influence being exercised by one regulatory function or the other are likely to be numerous".¹⁷ One way of beginning to address these problems would be to formally separate Monitor's regulation of foundation trusts from any other responsibilities in the Bill, or better still to defer any change in Monitor's role until it has completed the task of authorising foundation trusts – currently set for 2016.

As a direct result of these measures within the Bill, and accompanying reforms such as Any Qualified Provider, a much greater role for the private sector will be created within the NHS, both as providers and

commissioners of care. And contrary to the government's claim to have blocked any deliberate policies to change the mix of private and public sector delivery of services, the Annex to the latest NHS Operating Framework states that choice will be performance assessed in part based on "trend in value/volume of patients being treated at non-NHS hospitals" – implying that assessment will increasingly be based on how well commissioners are able to outsource services from the NHS.¹⁸

The uncertainty and anxiety experienced by thousands of vulnerable people and their families following the collapse of care home operator Southern Cross demonstrated the dangers of essential services being transferred away from the public sector and with insufficient safeguards. Alarming parallels with the NHS are now being drawn by the likes of the *Telegraph* which revealed that "vulture funds" have descended on the debts of the UK's largest private hospital provider, General Healthcare Group, which is backed by private equity firm Apax.¹⁹

Similarly, the recent PIP breast implant scandal provides a worrying glimpse into a future where less accountable private providers are permitted a greater share of healthcare delivery: the health secretary was reduced to calling impotently from the sidelines for private cosmetic clinics to produce the same information as the NHS on the procedures they carried out. In the words of the editor of the *Lancet*, "this is the future for the NHS. A system of healthcare that cannot be held accountable by the government; one that has no obligation to collect or supply accurate information about what it is doing; one that is more concerned with cost than it is with quality".²⁰

The government response to the Future Forum report said that Clinical Commissioning Groups (CCGs) will be held responsible for their decisions, but "this does not in any way preclude NHS commissioners from using external agencies to provide commissioning support".²¹ This was borne out by recent Department of Health guidance that suggested a role for the private sector in virtually every part of the commissioning process.²² Many CCGs will simply hand over the bulk of their commissioning to unaccountable companies such as KPMG and United Healthcare, who are already working with a number of emerging CCGs.

UNISON recommends the removal of Part 3 from the Bill entirely and supports amendments to:

- *remove Monitor's role as economic regulator for the health system;*
- *defer any change in Monitor's role until it has completed the task of authorising foundation trusts;*
- *reduce the role of competition legislation in the NHS;*
- *return price setting to the government;*
- *retain powers to de-authorise foundation trusts.*

3. THE SECRETARY OF STATE'S RESPONSIBILITY FOR THE NHS

The government is now effectively onto its third version of Clause 1 of the Bill. Having heeded the latest criticisms of the House of Lords Constitution Committee, the amendments accepted by the government would mean that the latest wording is preferable to the previous versions, in that the Secretary of State now "retains ministerial responsibility to Parliament for the provision of the health service in England".

However, this is not the same as a strict legal duty on the Secretary of State himself to provide (or secure the provision of) services. To avoid any remaining ambiguity it would be stronger to use the wording of the 2006 NHS Act, in which the Secretary of State must "provide or secure the provision of services according to this Act" (rather than the wording that remains in Clause 1 in which the Secretary of State must "exercise the functions conferred by this Act so as to secure that services are provided in accordance with this Act"). The government has still not made a convincing case for moving away from the 2006 wording.

The government's amendments to Clauses 4 and 22 mean that the new autonomy duties added by the Bill become secondary to the Secretary of State's duty to promote the comprehensive health service. The

assumption remains, however, that autonomy is in itself a desirable outcome and the Secretary of State must consider avoiding imposing anything that could be considered an unnecessary central burden on providers and commissioners.

Moreover, the main thrust of Clause 12 of the Bill remains unamended: the 2006 Act is changed so that it is CCGs not the Secretary of State that must arrange for the provision of health services. This means that CCGs will determine what actually constitutes the health service, potentially opening the door to some commissioners charging “top-up” payments for certain services they deem as being outside their definition of health services. The latest government amendment to ensure CCGs “act consistently with” the Secretary of State’s duty to promote a comprehensive service is not as strong as a direct duty of comprehensiveness on CCGs themselves.

Although the amendments are improvements, the Bill continues to put the provision of health services increasingly at arm’s length from the Secretary of State and from Parliament. It opens the way for the comprehensive nature of NHS services to be eroded as CCGs could look to shed expensive or unprofitable services. It increases the likelihood of a postcode lottery of provision, with different CCGs providing different services.

- *UNISON supports amendments to return to the wording of the 2006 Act in terms of the powers and duties of the Secretary of State, and to make any autonomy of providers and CCGs clearly subordinate to this.*
- *Anything in the Bill that weakens the overall position of the NHS as a national, universal and comprehensive service should be removed.*

4. PROBITY, TRANSPARENCY, DEMOCRACY AND INVOLVEMENT

The government’s attempt to improve the openness and transparency of CCGs is too weak, including a get-out clause for those that want to avoid meeting in public: the wording of Schedule 2 says “except where the consortium considers that it would not be in the public interest to permit members of the public to attend a meeting or part of a meeting”. There is a similar problem with attempts to open the meetings of boards of directors of foundation trusts to the public: Clause 151 allows foundation trusts to exclude members of the public from a meeting “for special reasons” with no explanation about what these “special reasons” are, leaving this clause open to abuse.

The latest government amendments are designed to ensure clearer arrangements for managing conflicts of interest at CCGs, but there is no mention of a comprehensive register of interests to ensure that those involved with a group who are also shareholders in other companies can be held to account. Both the General Medical Council and the Royal College of GPs have previously expressed anxiety about the conflicts of interest that GPs will face when their new roles as budget-holders and rationers of care are added to their professional duty to treat individual patients.²³ A major concern remains therefore that the Bill will undermine the trust that the public have in their GPs, because there will be a fear – whether justified or not – that a financial imperative lies behind the treatment decisions they make.

The Campaign for Freedom of Information has expressed concerns that government plans will “significantly curtail” FOI, because independent providers working on NHS contracts will not be covered by the Freedom of Information Act directly (although they would be required to assist a commissioner’s response to an FOI request).²⁴ At the very least, the government should ensure a minimum level of governance with CCGs and foundation trusts subject to the Public Bodies (Admission to Meetings) Act 1960, which gives access to the public and press and which currently extends to PCTs and SHAs. This is certainly the opinion of lawyers on how the Bill could be improved.²⁵ All meetings should be public and all papers published, with properly appointed non-executive directors making up the majority of CCG boards.

The latest government amendments have attempted to strengthen the new system's ability to engage with individual patients. But as far as the wider public are concerned, Clause 25 (new section 14Z) of the Bill undermines their right to be fully consulted – calling merely for the public to be “involved”. In terms of health scrutiny, the Bill leaves both local and national HealthWatch too lacking in power to protect patient interests adequately. In line with calls from those currently involved in Local Involvement Networks (LINKs), to ensure its independence HealthWatch England should not be a part of the Care Quality Commission.²⁶ (The latest government amendments – to ensure the majority of HealthWatch England members are not from the CQC – do not go far enough.) There is also a need for greater democracy: both HealthWatch England and local HealthWatch should draw their membership from elections rather than appointments. And the prospect of councils being obliged to put out to commercial tender the work of HealthWatch is particularly worrying. Any amendments to this effect should be resisted as this would embroil the existing LINKs in excessive bureaucracy and undermine any evolution from the current system.²⁷

Concerns also persist with the new Health and Wellbeing Boards, established by Clause 193. As currently worded, the Boards need only consist of “at least one” councillor rather than a majority of democratically elected members. The make-up of the Boards includes a role for directors of children's services but not for representatives from education, which is an oversight given the idea of the Board is to join up services across areas; UNISON backs the demands of the National Children's Bureau for the Boards to have a stronger role in integrating health, social care and health-related services for children and young people.²⁸ The Boards also lack the input of trade union representatives, which would be a way of ensuring that the staff voice is heard.

- *UNISON supports amendments to ensure genuinely open meetings of CCGs and foundation trusts; to grant HealthWatch England independence from the CQC; and to give Health and Wellbeing Boards greater democratic legitimacy.*

5. STAFFING, EDUCATION AND REGULATION

The government itself anticipates nearly 13,000 redundancies as a result of its planned reorganisation. This represents a personal tragedy for those affected and also a colossal waste of talent and resources at a time the NHS can ill afford it; even with the revised figures, the government still predicts redundancy costs alone running to £810m²⁹, and reportedly £1m per month is being spent on agency staff to cover for the uncertainty caused by institutional overhaul.³⁰

The government has completely failed to acknowledge the need to retain national workforce structures for terms and conditions, pay and bargaining. The Bill would allow CCGs greater leeway to break away from the Agenda for Change pay system. Not only does this rob health staff of certainty about their pay and conditions, but the potential for local pay negotiations also creates a massive extra administrative burden for local negotiators, and undermining Agenda for Change may lead to an increase in equal pay litigation for the NHS, which the existing system was designed to avoid for all parties – indeed government defended the system rigorously in the recent Hartley case. Although there has been a belated recognition in the Bill of the importance of education and training for NHS staff, there needs to be an explicit reference to a multi-professional approach to preserve the importance of the team ethic that the NHS thrives on.

Healthcare assistants in UNISON have been arguing for regulation for some time, having identified a clear public protection risk. However, UNISON cannot support the amendment tabled by Baroness Emerton and Lord Patel (after Clause 207) that would hand responsibility for this to the Nursing and Midwifery Council (NMC). UNISON's surveys of healthcare assistants consistently point to the importance of designing a system which could cover more than one occupational group and have the capacity to cover both health and social care, recognising the contribution that all support workers play in delivering patient care irrespective of where it is delivered.³¹ For this reason, UNISON believes the Health Professions Council should be the body regulating healthcare assistants as it would allow a greater possibility for workers to

cross over between the NHS and social care – rather than the NMC, which is much more narrowly focused on nursing as a profession. In addition, the resignation of a number of senior nurses from the NMC has been followed by the announcement of a strategic review by the Council for Regulatory Excellence aimed at “strengthening the NMC’s leadership and governance”.³² Now is therefore not the time to place the extra responsibility for this crucial set of NHS workers within the remit of the NMC.

The plans to develop a code of conduct and minimum training standards for healthcare support workers and adult social care workers in England are a step in the right direction. However, given that these staff are mainly low paid women workers, the success of these plans will depend upon them being funded and sustained by employers. Coming up with the plans is stage one; delivering them in health and social care across both the public and private sectors will require statutory regulation. Without this the existing postcode lottery will simply be maintained. A code of conduct and competency standards are a platform from which statutory regulation can be introduced³³, but without it the fear is that this work becomes meaningless if the very organisations that need stronger regulation are able to ignore the plans.

The Bill heralds a significant change for social workers who are currently registered with the General Social Care Council (GSCC) but in future will have to register with the new Health & Care Professions Council. This means that the right of appeal will be to the High Court rather than the current Care Standards Tribunal. This is a detrimental change which is causing great disquiet among social workers because permissible grounds for appeal are much narrower and less responsive to the complexities of social work cases. Pursuing an appeal will become more expensive and risky. UNISON is very concerned that the new system will reduce access to justice as parties have to instruct barristers or solicitors with higher rights, and social workers pursuing appeals run the risk of having costs awarded against them. The current Care Standards Tribunal system has proved itself to be accessible, efficient and cost-effective in ensuring fair outcomes for social workers.

UNISON is therefore calling for the current appeal arrangements to be retained. Social workers are also concerned that the change means a more than doubling of the annual registration fee. UNISON is calling for subsidy of the fees, for them to be phased in, and for a pro-rata fee rate for part-time staff. The changes only apply to social workers in England registered or eligible to register with the GSCC. This is potentially very problematic as Scotland, Northern Ireland and Wales will continue to operate the old Codes of Practice and with the lower fee level. There are many questions about portability of registration when social workers move around the UK. UNISON wants to ensure that in addressing these, there are not unreasonable barriers to social workers’ mobility.

- *UNISON supports amendments to protect national pay, terms and conditions in the NHS; to ensure a multi-professional approach to education and training; and to retain the current appeal arrangements for social workers.*
- *UNISON calls upon peers to reject the amendment by Baroness Emerton and Lord Patel to insert a new clause (after Clause 207) for healthcare support workers to be registered by the Nursing and Midwifery Council.*

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