Health Committee
House of Commons London SW1A 0AA
Tel: 020 7219 6182 Fax 020 7219 5171 Email: healthcom@parliament.uk
Website: www.parliament.uk/healthcom Twitter: @CommonsHealth

From Dr Sarah Wollaston MP, Chair

Simon Stevens
Chief Executive
NHS England

31 August 2017

Dear Simon,

I write further to correspondence I have received regarding the provision and maintenance of wheelchairs in the South West of England. For your information I have enclosed the original correspondence which has been forwarded with the permission of its sender. I am writing to you in my capacity as Chair of the Health Committee not to investigate the circumstances of this specific case, but rather to highlight my concern regarding the wider structural issues it raises.

As you will see from the correspondence, a patient with athetoid cerebral palsy paralysed in all four limbs wrote to me highlighting problems he had experienced in the servicing and replacement of his prescribed wheelchair. The patient in question appears to have been seriously failed by the private provider to whom the CCG contracted the wheelchair service. In this case the patient resolved the problem by registering with a GP in a neighbouring CCG which had a different wheelchair service that was able to make available the care and equipment required. It goes without saying that being forced to register with a new GP practice in order to access vital equipment was entirely unsatisfactory for a patient whose care had been based around a long-standing relationship with his GP.

I am concerned that this case illustrates the inability of CCGs to effectively manage provider contracts and hold providers to account for failings in services provided to patients. In the case noted above the CCG was aware of the problems facing the patient but was unable to provide an assurance that the service provider would be able to fulfil their contractual obligations and meet the prescribed needs of the patient. I would be grateful, therefore, if you could advise me of the powers CCGs have, and should be using, to ensure that private contractors do not avoid being held to account for actions which directly affect patient care. In addition, does NHS England either in its local teams or at national level enjoy any powers that would allow it to scrutinise the performance of an individual independent service provider to ensure that it is meeting its contractual responsibilities? Moreover, what steps does NHS England expect CCGs to take to ensure
that private providers engage in patient complaints about their services and that
information about complaints is factored into any evaluation of provider performance
and future procurement?

My central concern is that contracted services can seemingly fail to meet the basic clinical
requirements without being held to account or compelled to acknowledge and remedy
their failings. This risks undermining the effective commissioning of services and could,
ultimately, compromise patient care and safety.

Yours sincerely,

Dr Sarah Wollaston MP
Chair of the Committee

Cc Sir Desmond Swayne MP
Sir David Behan CBE
Chief Executive, Care Quality Commission

31 August 2017

Dear Sir David,

I write further to correspondence I have received regarding the provision and maintenance of wheelchairs in the South West of England. For your information I have enclosed the original correspondence which has been forwarded with the permission of its sender. I am writing to you in my capacity as Chair of the Health Committee not to investigate the circumstances of this specific case, but rather to highlight my concern regarding the wider structural issues it raises.

As you will see from the correspondence, a patient with athetoid cerebral palsy paralysed in all four limbs wrote to me highlighting problems he had experienced in the servicing and replacement of his prescribed wheelchair. The patient in question appears to have been seriously failed by the private provider to whom the CCG contracted the wheelchair service. In this case the patient resolved the problem by registering with a GP in a neighbouring CCG which had a different wheelchair service that was able to make available the care and equipment required. It goes without saying that being forced to register with a new GP practice in order to access vital equipment was entirely unsatisfactory for a patient whose care had been based around a long-standing relationship with his GP.

I am concerned that this case illustrates the inability of CCGs to effectively manage provider contracts and hold providers to account for failings in services provided to patients. In the case noted above the CCG was aware of the problems facing the patient but was unable to provide an assurance that the service provider would be able to fulfil their contractual obligations and meet the prescribed needs of the patient. I am aware that the management and oversight of CCGs rests with NHS England but I would be grateful if you could address a number of matters that relate to the responsibilities of the CQC.
In system reviews of the overall quality of care within a single locality will the CQC be able to focus its attention on commissioning process and how they affect patients? In particular, will the CQC examine how independent providers are held to account by commissioners for the quality of service provision and the extent to which they are open and honest regarding their failings? Furthermore, in combination with the CQC’s core powers to register and inspect services could you clarify the circumstances in which the CQC could take regulatory action to address concerns regarding both quality of service and accountability to commissioners?

The nature of the case outlined above illustrates the damaging effects on patient care that can occur when a provider operates without accountability or effective scrutiny. I would welcome your thoughts on how the system can be further developed to ensure that commissioners have the wherewithal to hold private providers to account when they fail to provide safe and effective care.

Yours sincerely,

[Signature]

Dr Sarah Wollaston MP
Chair of the Committee

Cc Sir Desmond Swayne MP
Dear Dr Wollaston,

Re: [Redacted] – CCG contracts.

Thank you for your letter of 31 August enclosing correspondence from [Redacted] who raises a number of concerns about his experience of a local CCG contract for wheelchair services.

CCGs commission healthcare services from providers (whether NHS, private sector or charitable organisations) under the NHS Standard Contract, published by NHS England and mandated for use by CCGs.

Ensuring that patients have access to a range of high-quality services is the core function of NHS commissioning. The Contract supports this by giving a robust framework through which a commissioner can set clear standards for a provider and hold it to account for the quality of care it (and any sub-contractor) delivers. Please see the attached briefing note which summarises the key elements of the Contract dealing with quality. It is essential that commissioners use the tools within the Contract to set high standards for providers and to monitor service quality continually, alongside expenditure and activity levels, and that they maintain a constant and close dialogue with providers about any issues relating to service quality.

You asked whether NHS England, either in its local teams or at national level, enjoys any powers that would allow it to scrutinise the performance of an individual independent service provider to ensure that it is meeting its contractual responsibilities. This depends on whether the provider is providing services to NHS England or to a CCG. If it is providing services to NHS England then NHS England will hold the contract with the provider and will be able to use the full range of contractual processes to ensure that the provider meets its obligations. In respect of services commissioned by a CCG from a private provider, NHS England does not have any direct formal role, as it is not a party to the relevant contract. Other national bodies such as NHS Improvement and the Care Quality Commission will, however, have a role in licensing such providers and inspecting the quality of their services.

Everyone who provides an NHS service in England must have their own complaints procedure. A complaint can be made to the NHS service provider directly or to the commissioner of the services.

Yours sincerely,

Simon Stevens
CEO, NHS England

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Briefing note: NHS Standard Contract – quality

NHS England publishes Contract Technical Guidance which, at section 39, summarises the key elements of the Contract relating to quality of care as follows (note that ‘SC’ refers to the Service Conditions of the Contract and ‘GC’ to the General Conditions):

- The Contract requires providers to run services in line with recognised good clinical or healthcare practice, and providers must comply with national standards on quality of care – the NHS Constitution, for instance, and the Fundamental Standards of Care regulations (SC1).

- The Contract sets clear requirements in respect of clinical staffing levels (GC5). Providers must continually evaluate individual services by monitoring actual numbers and skill mix of clinical staff on duty against planned numbers and skill mix, on a shift-by-shift basis; they must carry out and publish detailed reviews of staffing levels, and their impact on quality of care, at least every six months.

- The Contract requires providers to adhere to national guidance on specific service areas, such as hospital food standards (SC19), infection control (SC21), safeguarding (SC32), the care of dying people (SC34) and the duty of candour (SC35).

- The Contract sets specific national quality standards which the provider must achieve (Schedules 4A and 4B), with scope for additional local quality requirements (Schedule 4C).

- In addition to these nationally-mandated requirements, commissioners can describe detailed service requirements – whether in terms of outcomes, quality measures or inputs and processes – through locally-designed service specifications (Schedule 2A).

- The Contract requires the provider to put in place policies and procedures which will support high-quality care. Among these are the provisions on clinical audit (GC15 and SC26), consent (SC9), patient, carer and staff involvement and surveys (SC10, SC12), complaints (SC16) and incidents and Never Events (SC33).

- The Contract requires the provider to demonstrate that it is continually reviewing and evaluating the services it provides, taking into account patient feedback, complaints and surveys, Patient Safety Incidents and Never Events, learning lessons and implementing improvements (SC3).

- Finally, the Contract provides processes through which commissioners can intervene to ensure that high-quality care is delivered – by requiring regular submission of monitoring information (SC28), agreeing Service Development and Improvement Plans (SC20), offering incentive schemes to improve quality (SC37 and SC38), requiring Remedial Action Plans to address service deficiencies (GC9), applying financial sanctions for failure to achieve national standards (SC36), and ultimately by suspending services temporarily (GC16) or terminating them permanently (GC17).
Dr Sarah Wollaston MP  
Chair  
Health Committee  
House of Commons  
London  
SW1A 0AA

By email: healthcom@parliament.uk

27 September 2017

Dear Sarah,

Thank you for your letter of 31 August 2017 regarding the provision and maintenance of wheelchairs in the South West of England, and for bringing to my attention the case of [redacted].

Your letter detailed problems particularly with the management of servicing and replacements of prescribed wheelchairs, the poor management of contracts by the Clinical Commissioning Groups (CCGs) and the distress this causes patients that use these services.

As you say, the management and oversight of CCGs rests with NHS England, however, as part of the Local System Reviews (LSRs) the Care Quality Commission (CQC) will be reviewing aspects of health and social care commissioning in 20 areas, which will include CCGs.

Effective commissioning plays a central role in driving up quality and, as part of the LSRs, we will be identifying if there is a strategic approach to commissioning across the health and social care interface, informed by the identified needs of local people. As part of this we will be looking to see if commissioners include standards in their contracts to hold providers to account. We would expect these standards to cover good practice and be evidence based.

CQC are undertaking the LSR reviews under Section 48 powers. Section 48 powers can be used to enable CQC to carry out a special review or investigation outside of its usual regulatory remit. For more information, see Health and Social Care Act 2008>Reviews and Investigations>Section 48. For the LSRs this means that it gives us the powers to review the work of commissioners, but not to take regulatory action or provide ratings.
Under our regulatory remit we can hold providers to account if they provide a regulated service. However, a commercial wheelchair contractor would not come under our remit.

Please do not hesitate to contact me if you have any further queries.

Yours sincerely,

[Signature]

Sir David Behan CBE
Chief Executive

Sarah,
I am happy to discuss this with you and find it helpful.
The move you raise is a long standing one.

[Signature]
Dear Simon

Thank you for your letter of 20 September, in reply to mine of 31 August concerning CCG contracting.

I regret that your reply, while helpful, has not provided me with the reassurance I was hoping for regarding the maintenance of quality, and customer service, in contracted-out services.

You note that "it is essential that commissioners use the tools within the [NHS Standard Contract] to set high standards for providers and to monitor service quality continually [...] and that they maintain a constant and close dialogue with providers about any issues related to service quality." The experience which [redacted], who has clearly engaged closely with the relevant CCG, has related to me very strongly suggests that the CCG was not able to do so in his case.

You state in answer to my specific questions that NHS England does not have any formal role in respect of services commissioned from a private provider. Nevertheless, NHS England does have responsibilities relating to the oversight of the performance of the CCG. It also produces the NHS Standard Contract which CCGs are, as you point out, mandated to use when commissioning healthcare services, and which they should use to ensure that service quality is maintained. I would therefore expect NHS England to display a keen interest in ensuring that CCGs are using the tools in the Standard Contract appropriately.

In the light of [redacted] correspondence, I would be grateful if you would let me know:

- whether you are satisfied that the NHS Standard Contract provides adequate tools to hold a private (or any other) provider to account in the case of substandard service provision;
• what action NHS England takes when it is brought to your attention that a CCG is not using the tools in the Standard Contract to appropriate service provision by a contracted provider; and
• what action NHS England takes to ensure that information about service providers’ performance under existing contracts with CCGs is available to other CCGs when those providers bid for contracts to provide similar services elsewhere.

Following the response from Sir David Behan to my correspondence on the same matter (attached), I would also be grateful if you could tell me how NHS England is planning to use the results of the CQC’s Local System Reviews to ensure that any systemic problem with the use of the NHS Standard Contract by CCGs is identified and dealt with.

I should emphasise, as I did in my previous correspondence, that I am not seeking to investigate the circumstances of this particular case, but to ensure that the wider issues which it raises are appropriately addressed.

I am copying this correspondence to [redacted] and to his MP, Sir Desmond Swayne.

Yours sincerely,

Dr Sarah Wollaston MP
Chair of the Committee
Dear Dr Wollaston

Thank you very much for your letter of 2 November 2017 to Simon Stevens, You have raised a number of important issues and he has asked me to address them.

The robustness of the NHS Standard Contract

You ask whether the NHS Standard Contract provides adequate tools to hold a provider to account in the case of substandard service provision.

As set out in the briefing note attached to Simon’s letter of 20 September, the Contract provides reasonable safeguards for Commissioners to manage provider performance. We provide support to commissioners to use the tools within the contract through a variety of methods including: the Contract Support helpline; a regular programme of training for commissioners; and by consulting regularly and widely on the Contract, to seek feedback and views on how it can be strengthened.

Further support is given by Commissioning Support Units, which offer both procurement and contract management expertise to the CCG sector, to help them to use the tools in practice. It is reasonable to assume, given the relatively high volume of contractual arrangements across all NHS organisations, that the tools in the contract might not be used in line with best practice on every occasion. However, overall the Contract provides commissioners with a set of processes and levers for managing quality of care.

NHS England intervention

You ask what action NHS England takes when it is brought to our attention that a CCG is not using the tools in the Standard Contract to ensure appropriate service provision by a contracted provider.

Arrangements are in place to ensure that regulators and local commissioners co-ordinate their actions through their involvement in local and regional Quality Surveillance Groups (QSGs). QSGs bring together representatives of all the

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relevant organisations to review, on a regular basis, any concerns relating to service quality within their particular patch. Their remit includes private providers. Local QSGs (of which there are 25 across the country) involve senior staff from NHS England, NHS Improvement, the CQC, Public Health England, Health Education England, as well as representatives from CCGs, local authorities and local Healthwatch.

QSGs are not a substitute for prompt, effective action by individual organisations, nor are they our vehicle for performance management of CCGs. They enable all of the different organisations involved to share their local intelligence about providers and systems, to identify any areas of concern and to ensure that coordinated and effective action is taken in response. Where a material concern is identified by a QSG about the quality of care at a particular provider, it may be agreed that the next step will be for the commissioner(s) to take specific contractual action in respect of the provider – or a range of other actions in respect of the provider or wider system. Through this approach, we believe that QSGs can play an important role in ensuring that commissioners make effective use of contractual levers, but do so in a way that joins up with the approach being taken by local regulators. The QSG system of regional and national escalation enables intelligence about a provider to be shared, if appropriate, with other CCGs.

The arrangements described here are summarised in the National Quality Board publication *Shared commitment to quality*, and more detail can be found in separate guidance documents on the operation of QSGs and Risk Summits. All of these are available via [https://www.england.nhs.uk/ourwork/part-relnqb/](https://www.england.nhs.uk/ourwork/part-relnqb/).

**Ensuring that information about providers’ performance is readily available**

The Care Quality Commission (CQC) publishes regular reports on individual providers and our expectation is that relevant CQC reports on provider performance will routinely form one important aspect of every CCG’s process for evaluating tenders. In addition, we publish information on comparative provider performance through *MyNHS*, a web tool that allows anyone to compare the performance of services over a range of measures at local and national levels (available at [https://www.nhs.uk/service-search/Performance/Search](https://www.nhs.uk/service-search/Performance/Search)).

Current legislation does not place a requirement on CCGs to publish detailed information about the ongoing performance of each individual provider with which they hold a contract. Each CCG typically holds a large number of separate contracts with different providers. These will be with NHS Trusts and Foundation Trusts, covering a wide range of different services, and with a wide range of (mostly smaller) non-NHS providers (including private hospitals, charities and social enterprises and care homes). This will also include contracts for ‘enhanced services’ with general practices, pharmacies and optometrists. To mandate detailed public reporting on all aspects of all of these contracts would create a significant administrative burden for CCGs and, to a significant extent, duplicate the role of the CQC as the national body with responsibility for reviewing the quality and safety of each provider’s services.

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CQC Local System Reviews

Finally, you are keen to understand how NHS England is planning to use the results of the CQC's Local System Reviews to inform use of the NHS Standard Contract by CCGs.

We would expect that the report of any Local System Review would be discussed at the local QSG and that the CCGs concerned would wish to consider any recommendations made by the CQC in relation to their approach to contractual issues. In practice, judging by the findings of the Reviews published so far, they may not comment in detail on CCGs' use of the specific levers within the NHS Standard Contract. More generally, once all 20 Local System Reviews have been completed, the CQC will publish a national report of key findings and recommendations, and we will review that report when available.

Yours sincerely,

[Signature]

Professor Stephen Powis
National Medical Director
NHS England

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