By: Tristan Godfrey, Research Officer to the Health Overview and Scrutiny Committee

To: Health Overview and Scrutiny Committee, 22 July 2011

Subject: NHS Transition: Update.

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1. Equity and Excellence: Liberating the NHS

(a) The current proposals for reforming the health sector were originally set out in the NHS White Paper, *Equity and Excellence: Liberating the NHS*[1], and a suite of associated documents.

(b) Following a consultation process, the Health and Social Care Bill[2] began its process through Parliament to give effect to the proposals.

(c) On April 6th the Government announced a 'pause' in the legislative process, to accommodate a two-month listening exercise. A group of patient representatives, doctors and nurses and other health professionals were brought together to conduct the listening exercise and report back to Government. The Forum reported back to the Government on 13 June 2011[3] and a Command Paper containing the Government's response was published on 20 June 2011[4].

(d) The Health and Social Care Bill has subsequently recommenced its passage through Parliament. As before, the detail of a number of the Government proposals will follow Royal Assent in the form of guidance and secondary legislation. The power to bring in some of the other changes already exists.

(e) The following summary is intended to provide an overview of the proposals as they currently stand taking into account the NHS White Paper documents and the results of the listening exercise. They are therefore subject to Parliamentary approval. The main elements of the proposals are set out in the follow sections.

2 Department of Health

(a) The Secretary of State for Health will maintain responsibility for promoting a comprehensive health service. This will be exercised in

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[1] The range of NHS White Paper document can be accessed here: http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/index.htm

[2] Health and Social Care Bill proceedings and documents can be accessed here: http://services.parliament.uk/bills/2010-11/healthandsocialcare.html

[3] Department of Health, *NHS Future Forum Recommendations to Government*, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127443

[4] Department of Health, *Government Response to the NHS Future Forum Report*, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127444

large part through a mandate to the NHS Commissioning Board. This is likely to be a three-year document with yearly updates.

(b) The Secretary of State will have a range of intervention powers in the event of significant failure.

3. NHS Commissioning Board (The NHSCB)

(a) This will be a non-departmental public body accountable to the Secretary of State with an overarching duty to promote a comprehensive health service and promote the NHS Constitution. It is likely to be structured around the five domains of the NHS Outcomes Framework. These are:

1. Preventing people from dying prematurely;
2. Enhancing the quality of life for people with long-term conditions;
3. Helping people to recover from episodes of ill health or following injury;
4. Ensuring people have a positive experience of care; and
5. Treating and caring for people in a safe environment and protecting them from avoidable harm.

(b) Two distinct types of group will be established, hosted by the NHSCB;

1. Clinical Networks – These already exist in some areas such as cancer and bring together clinical experts, patient representatives, carers and so on. These will be strengthened and expanded to cover more areas to support the NHSCB and Clinical Commissioning Groups (CCGs).
2. Clinical Senates – These will bring together locally a range of experts, include doctors, nurses, allied health professionals, social care and public health professionals. They will provide pathway advice for commissioners and Health and Wellbeing Boards (HWBs).

(c) Both the above groups will also support the NHSCB regarding CCG authorisation as well as feeding back the views of CCGs on what is required in terms of service specification, tariffs and other areas falling within the NHSCB remit.

(d) The NHSCB will be responsible for authorising Clinical Commissioning Groups. Those that are ready will be authorised before the previous date of April 2013 and others will be authorised as soon as they are ready, which may be after April 2013. There will also be the possibility of partial, or limited, authorisation. The advice of the local Health and Wellbeing Board and clinicians will be sought prior to authorisation.

(e) The NHSCB will take on the responsibility for allocating resources to CCGs. It will have a legal duty to produce, with Monitor, standardised pricing currencies for the national tariff. As part of its role in promoting integrated care, tariffs for integrated pathways are possible. It will also develop model and standard contractual terms for providers.

(f) It will publish commissioning guidance and model care pathways. These will be based on Quality Standards produced by NICE, which will keep the acronym but be renamed the National Institute for Health and Care Excellence to incorporate a social care remit. Both the NHSCB and Department of Health will be forbidden from interfering with NICE Quality Standards.

(g) The NHSCB will be responsible for the financial performance of consortia and hold them to account for the quality outcomes they achieve. It will also have some specific powers in connection to consortia – ensuring there is comprehensive coverage of England by consortia; ensuring all GP practices are part of a consortium; overseeing a failure regime for consortia.

(h) The NHSCB will also undertake some commissioning. It will commission primary care services (such as community pharmacy, ophthalmology and dental services along with primary medical services provided by GPs). It will also commission a number of specialised services currently commissioned regionally or nationally.

(i) The NHSCB will have shadow status by October 2011, become a statutory body by October 2012 and take on its full responsibilities by April 2013. PCT Clusters will move to becoming regional arms of the NHSCB.

4. Clinical Commissioning Groups (CCG, formerly GP Commissioning Consortia)

(a) The majority of health services will be commissioned by GPs and their practice teams through CCG. These will be statutory bodies and all holders of a primary medical services contract must belong to a CCG.

(b) CCGs will be responsible for commissioning health services for patients registered with constituent practices and unregistered patients within their boundaries, as well as arranging emergency and urgent care within their boundaries. Boundaries will not normally cross local authority (upper tier/unitary) boundaries.

(c) CCGs will be authorised by the NHS Commissioning Board under the principle of earned autonomy (see above). The official names of CCGs are likely to require the inclusion of ‘NHS’ and a reference to the locality it covers. All practices will either be part of a CCG or a shadow CCG by April 2013.

(d) They will be required to put robust governance arrangements in place and will have an Accountable Officer (not necessarily a clinician). They must have a decision making governing body, with at least two lay members (a patient representative and one on the governance and audit side). One of the lay members must be Chair or Vice-Chair. Meetings must be held in public, publish minutes and details of contracts.

(e) The boards of CCG must also contain a registered nurse and secondary care specialist (normally a hospital doctor). These must be from outside the area so as not to have a conflict of interest by representing actual or potential providers.

(f) CCGs will receive quality premiums to reward commissioners for improving health outcomes and reducing inequality in outcomes. Premiums will partly relate to a CCG's contribution to the outcomes set out in the Joint Health and Wellbeing Strategy.

(g) CCGs must involve patients and the public in commissioning plans and their annual plans.

5. Monitor

(a) Monitor currently regulates NHS Foundation Trusts but under the proposals would become the economic regulator for the health sector. The Bill allows for Monitor's role to be extended to regulating adult social care at a later date by Government.

(b) Questions had been raised around Monitor's duty to "promote competition." There will be a shift of emphasis so that competition is not viewed as an end in itself and move to a focus on preventing abuse and anti-competitive behaviour to ensure a "level playing field between providers." Competition between providers will be on quality, not price, and areas like pricing and eligibility criteria will be looked at to prevent "cherry-picking." There will also be a requirement on Monitor to support the delivery of integrated care where this would improve quality.

(c) The current rules around co-operation and competition will remain, and the Co-operation and Competition Panel will move into Monitor but retain a distinct identity.

(d) Monitor will maintain its oversight role of Foundation Trusts until 2016, or two years following an FT's authorisation.

(e) Monitor will have a function in licensing providers (along with the Care Quality Commission), a role in price-setting, and a role in supporting the continuity of vital services in the event of failure.

6. Foundation Trusts (FTs) and Other Providers

(a) There is an expectation that NHS Trusts will become Foundation Trusts (or part of an FT) by 1 April 2014 and NHS Trust legislation would be repealed (meaning non-FT NHS Trusts will not exist). However, the deadline has been removed to allow flexibility. The FT process will be overseen by Strategic Health Authorities until their abolition in April 2013 when a Trust Development Authority will continue this aspect of SHA work. The ten SHAs will cluster into a smaller number later this year.

(b) FTs will be required to hold board meetings in public. Separate accounts must be produced covering public and private activity.

(c) The areas covered by patient choice of Any Qualified Provider (AQP) will be gradually extended in the future, beginning in April 2012 and starting with selected community services. AQP will not apply to accident and emergency and critical care services and will be restricted to those services for which there is a national or local tariff. A fixed national or local tariff will be developed for any service covered by Any Qualified Provider

(d) There will be a robust provider failure regime.

(e) Any policy aimed at deliberately increasing or maintaining the market share of any sector (private, public or voluntary) will be forbidden. Choice and competition will need to add value.

(f) The scope for 'right to provide' (R2P) where staff are able to form mutuals or social enterprises and run services is to be increased.

(g) Personal health budgets will be extended and include integrated personal health and social care budgets.

7. Health and Wellbeing Boards (HWBs)

(a) Upper tier authorities will be required to set up a HWB, which will be a statutory committee. The membership will consist, at a minimum, of one elected representative, the director of adult social services, director of children's services, director of public health and representative from the local HealthWatch, and one representative from each relevant CCG (unless the HWB agrees to a single representative of more than one CCG). There will also be involvement from the NHS Commissioning Board. As it will be an executive arm of the local authority, the authority can insist on a majority of the membership being elected councillors.

(b) Local authorities and CCGs will have a responsibility to produce a Joint Strategic Needs Assessment (JSNA) and will develop them through the HWB. They must also develop a joint health and well-being strategy (JHWBS) which will set out how the needs identified in the JSNA will be

met. The HWB will be required to involve the public in the production of the JSNA and JHWBS beyond the participation of the HealthWatch representative.

(c) Other powers and responsibilities, except that of scrutiny, can be conferred on the HWB. It will have a strong role in promoting joint commissioning and integrating service provision. It can also be the vehicle for commissioning certain services. Members of the HWB will be subject to local authority overview and scrutiny.

(d) The CCG will involve the HWB as they develop their commissioning plans and there is an expectation that they will be in line with the JHWBS. The HWB will not have a veto on the plans but can refer them back to the CCG or up to the NHSCB. The CCG will have to amend the plans or explain why the particular decision was made.

(e) The HWB will also have a role in authorising CCG as well as in their ongoing assessment.

8. Scrutiny

(a) From April 2013, the functions of the current Health Overview and Scrutiny Committee will be conferred on the local authority directly. The exercise of this function could be through a specific health scrutiny committee or through a different arrangement (with the exception that it cannot be exercised by the HWB).

(b) The powers of health scrutiny will expand to include any NHS funded provider and any NHS commissioner. The ability to challenge substantial service change will remain, though it is possible that the decision to refer will require a vote of the full Council. As is the case currently, the details around health scrutiny will be contained in official guidance and Statutory Instruments. There is likely to be consultation specifically on health scrutiny regulations at a later date.

(c) The Operating Framework for 2011/12[5] states that the four tests for service reconfiguration set out in May 2010 stand. These are likely to continue in the future. These are:

- support from GP commissioners;
- strengthened public and patient engagement;
- clarity on the clinical evidence base; and
- consistency with current and prospective patient choice.

(d) The duty of PCTs to consult overview and scrutiny committees on substantial service change is to remain during the transition.

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[5] Department of Health, *The Operating Framework for the NHS in England 2011/12,* p.33, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122738

9. HealthWatch

(a) HealthWatch England (HWE) will be established as a subcommittee of the Care Quality Commission. The CQC must respond to advice from HWE and the Secretary of State must consult with it on his or her mandate to the NHSCB. The HWE will also provide support to local Healthwatch.

(b) Local Involvement Networks (LINks) will transform into local HealthWatch. They will be commissioned and funded by upper tier local authorities and be based in local authority areas. The functions of promoting and supporting public involvement in the commissioning and provision of local health services will continue. The local authority will be able to commission HealthWatch to provide advice and information to people about health and social care.

(c) Local HealthWatch are explicitly required to ensure the membership represents different users, including carers.

(d) Commissioners and providers are to have due regard to findings from local HealthWatch.

(e) Where there are local disputes involving local HealthWatch, the emphasis will be on local resolution with the Health and Wellbeing Board likely to be the forum in which this is pursued, rather than invoking HWE as arbitrator.

(f) HWE will be established as soon as possible and local HealthWatch from October 2012. Local authorities and local HealthWatch will take on formal responsibility for commissioning complaints advocacy from April 2013.

10. Public Health

(a) A separate Public Health White Paper, *Healthy Lives, Healthy People*, was published by the Department of Health on 30 November 2010[6]. Separate papers on the commissioning and funding of public health and public health outcomes have also been published.

(b) A new service, Public Health England (PHE), will be set up as an executive agency of the Department of Health. This will involve the transfer of functions and powers from the Health Protection Agency and National Treatment Agency for Substance Misuse.

(c) Local health improvement functions will transfer to local government, along with ring-fenced funding. Local Government will be accountable

[6] The Public Health White Paper and related documents can be accessed at the Department of Health website, http://www.dh.gov.uk/en/Publichealth/Healthyliveshealthypeople/index.htm

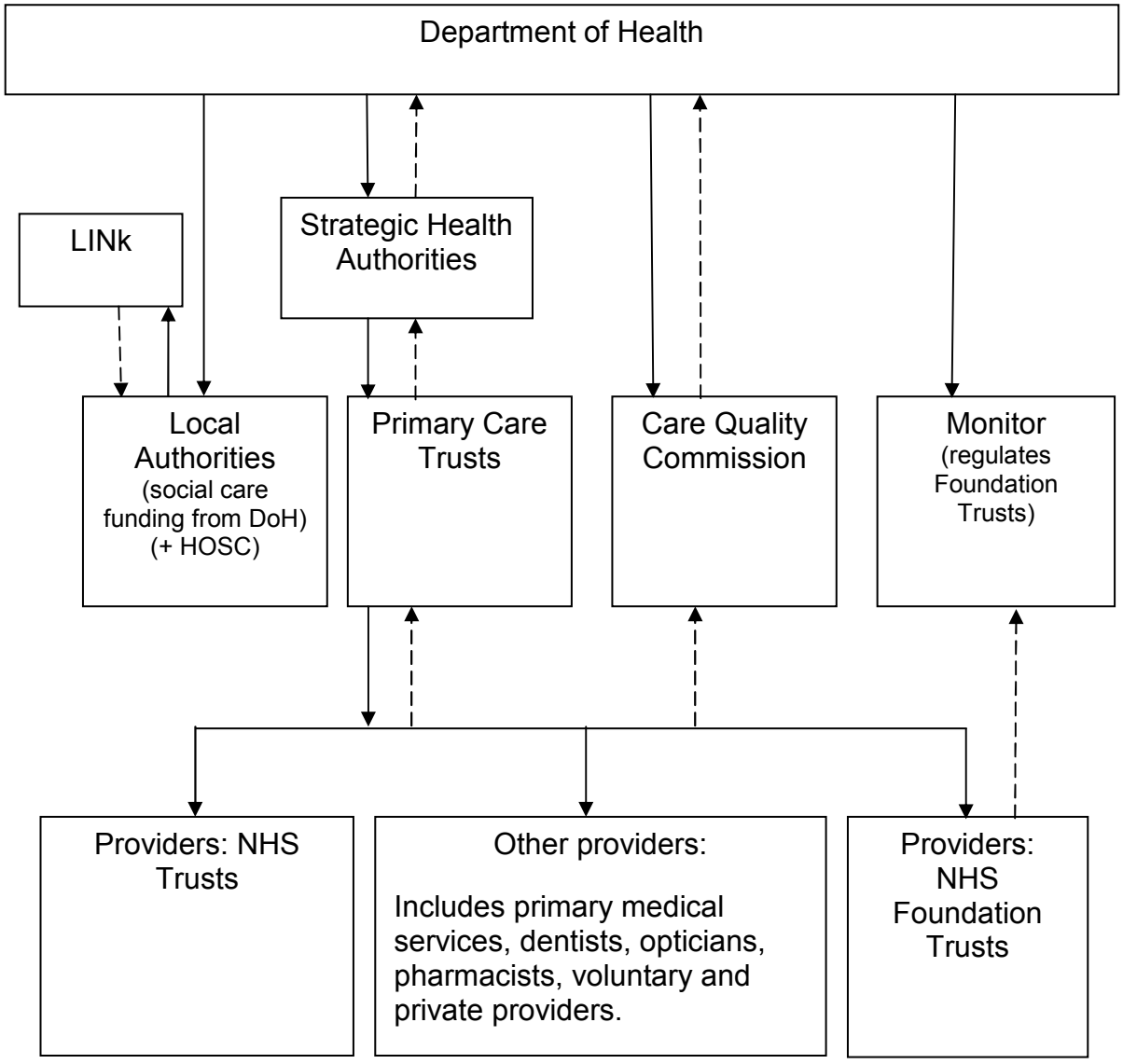
to PHE for spending the grant. It will be separate from the current funding of local authority functions with public health implications, such as leisure).

(d) There will be a health premium linked to progress made against a proposed public health outcomes framework.

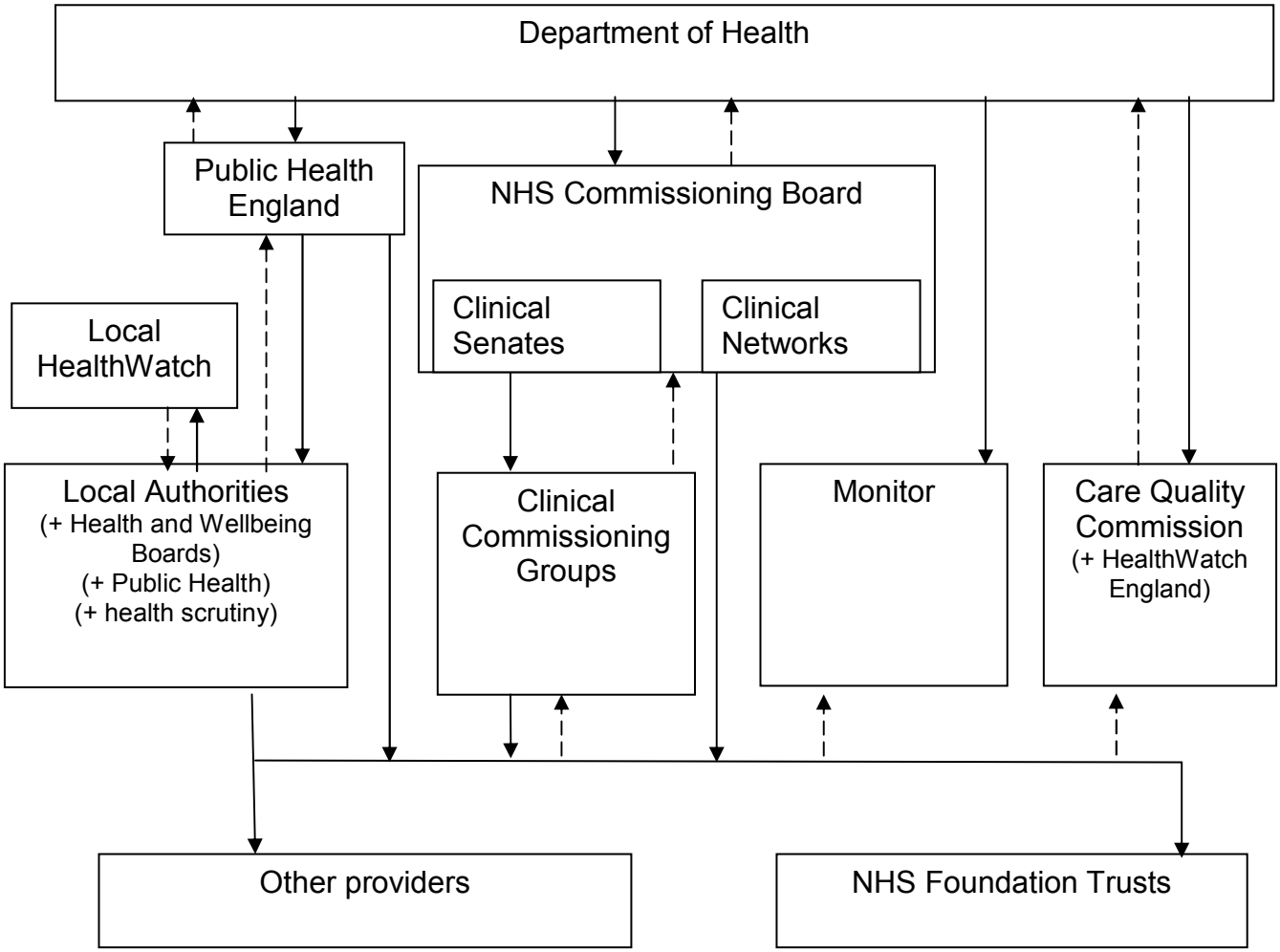
(e) Directors of Public Health will be employed by local government and jointly appointed by the local authority and Public Health England. The DPH will play a leading role in the development of the JSNA and JHWBS through the HWB. One other key role will be to produce an authoritative independent annual report on the health of their local population.

11. Current and Proposed Structure of the NHS

- **Chart 1: Current Structure of the NHS**



➢ **Chart 2: Proposed Future Structure of the NHS[7]**



(a) Key to charts[8]:

⇢ Accountability → Funding

[7] Chart incorporates changes following the recent listening exercise and should be seen as indicative only.

[8] Both charts adapted from: House of Commons Library, Research Paper 11/11, *Health and Social Care Bill*, p.7, http://www.parliament.uk/briefingpapers/commons/lib/research/rp2011/RP11-011.pdf