

## **GOVERNMENT CHANGES IN RESPONSE TO THE NHS FUTURE FORUM**

The following list summarises the key changes that we intend to make, largely structured around the four workstream themes considered by the NHS Future Forum. Some, but not all, of these changes require amendments to the Health and Social Care Bill.

### **Overall NHS accountability**

#### NHS Constitution

- We will take further steps to embed the NHS Constitution, and the principles and values it contains, in the way the NHS works. The NHS Commissioning Board and commissioning consortia will be required to take active steps to promote the Constitution. The Board, Monitor and the Care Quality Commission will say in their annual reports how they have met their existing duty to have regard to the Constitution.
- We will uphold all of the patient rights in the NHS Constitution. Where necessary we will adapt the way these rights are given legal force, to ensure they have the same legal force under the new legislation. This includes the right to drugs and treatments recommended by NICE, which we will retain after the introduction of value-based pricing for new drugs from January 2014.
- We will make clearer that NHS care must be free at the point of use and that charges for patient services could only be introduced by legislation; and we commit not to introduce any new charges during this Parliament.

#### The role of the Secretary of State

- The policy is that the Secretary of State will be responsible – as now – for promoting a comprehensive health service. The wording of section 1(1) of the 2006 NHS Act will remain unchanged in legislation, as it has since the founding NHS Act of 1946. This will be underpinned by the new duties that the Bill already places on the Secretary of State, around promoting quality improvement and reducing inequalities.

- We will also make clear that the Secretary of State will also retain ultimate accountability for securing the provision of services, though rather than securing services directly, the Secretary of State will be exercising his duty in future through his relationship with the NHS bodies to be established through the Bill, e.g. the NHS Commissioning Board by way of the “mandate”.
- We will make clear that Ministers are responsible, not for direct operational management, but for overseeing and holding to account the national bodies – in particular, the NHS Commissioning Board and the regulators – backed by extensive powers of intervention in the event of significant failure. The Bill will give Secretary of State explicit powers to report on the performance of all of the national NHS bodies, as part of the Department of Health’s annual report on the health service.

### **Clinical commissioning**

#### Clinical commissioning groups

- Commissioning consortia will continue to be groups of GP practices, but we will make a number of changes to provide greater assurance that commissioning will involve patients, carers and the public and a wide range of doctors, nurses and other health and care professionals. To reflect this stronger emphasis on wider professional involvement in commissioning decisions, we intend to use the term “clinical commissioning group” to describe these local NHS organisations.
- Clinical commissioning groups will have a duty to promote integrated health and social care around the needs of users. We accept the recommendation of the Future Forum that their boundaries should not normally cross those of local authorities, with any departure needing to be clearly justified.
- Clinical commissioning groups seeking establishment on the basis of boundaries that would cross local authority boundaries, will be expected to demonstrate to the NHS Commissioning Board a clear rationale in terms of benefit to patients – for example, to reflect local patient flows, or to enable groups to take on practices where, overall, this would secure a better

service for patients – and provide a clear account of how they would expect better integration between health and social care services to be achieved. The NHS Commissioning Board will need to agree proposed boundaries as part of the establishment process. Before establishing any clinical commissioning group, the Board will be required to seek the views of emerging Health and Wellbeing Boards. HWBs may choose to object. The Board will always have to satisfy itself that any such objections have been taken properly into account.

- Clinical commissioning groups will be expected to have a name that uses the NHS brand and has a clear link to their locality. We will make it explicit in the Bill that commissioning groups must commission all urgent and emergency care within their boundaries, and are also responsible for any unregistered patients who live in their area. In other words, they will be responsible for their whole population not just their registered patients.
- Clinical commissioning groups will have flexibility to work in partnership when commissioning services, for example with other groups, local authorities and the NHS Commissioning Board. But as public bodies, they will be unable to delegate their statutory responsibility for commissioning decisions to private companies or contractors.
- We will [soon] publish further details on the processes for authorising and assessing clinical commissioning groups and on the accountabilities and relationships between the NHS Commissioning Board, commissioning groups and Health and Wellbeing Boards.

### Governance and accountability for commissioning groups

- Every commissioning group will have a governing body with decision-making powers, to ensure that decisions about patient services and use of taxpayers' money are made in an open, transparent and accountable way. There must be at least two lay members, one with a lead role in championing patient and public involvement, the other with a lead role in overseeing key elements of governance such as audit, remuneration and managing conflicts of interest. One of the lay members will

undertake either the role of Deputy Chair or Chair of the governing body. If Deputy Chair, the lay member would take the Chair's role for discussions and decisions involving a conflict of interest for the Chair.

- We do not intend to prescribe in detail the wider professional membership of the governing body, but it will have to include at least one registered nurse and one doctor who is a secondary care specialist. They must have no conflict of interest in relation to the clinical commissioning group's responsibilities, e.g. must not be employed by a local provider.
- To enhance transparency and accountability, governing bodies will be required to meet in public and publish their minutes, and clinical commissioning groups will have to publish details of contracts with health service providers.
- The authorisation process for clinical commissioning groups will ensure that they have robust governance requirements consistent with Nolan principles and are accountable and transparent. This will not be a one-off test: the NHS Commissioning Board will hold commissioning groups to account for this on an ongoing basis.
- We will revise the provisions in the Bill on the quality premium, and we understand the concerns raised. We will make clear that its purpose is to reward clinical commissioning groups that commission effectively and so improve the quality of patient care and the outcomes this leads to, including reducing inequalities in health outcomes. There will, however, be circumstances where it would clearly not be appropriate to award a premium, for instance if a commissioning group has achieved high-quality outcomes by spending more than the money allotted to it and thereby compromising the resources available to other parts of the country. We recognise, however, that great care will be needed to design rules on when a quality payment can be reduced or withheld to reflect factors such as these. We will therefore ensure that any such rules are subject to regulations that have to be approved by Parliament. We will also change the Bill so that regulations can be used to make

provisions for how commissioning groups can use any quality payment awarded to them.

### Timetable for establishing the new commissioning system

- Primary Care Trusts will cease to exist in April 2013. However, clinical commissioning groups will not be authorised to take on any part of the commissioning budget in their local area until they are ready and willing to do so.
- By April 2013, GP practices will be members of either an authorised clinical commissioning group, or a 'shadow' commissioning group, i.e. one that is legally established but operating only in shadow form, with the NHS Commissioning Board commissioning on its behalf. This is required so that there is clarity about how different clinical commissioning groups cover the whole country without gaps. It will always be clear to patients and the public which GP practices are members of which local group. No individual GP will need to get involved in the work of a commissioning group if they don't want to.
- Clinical commissioning groups that are ready and willing by April 2013 could be authorised to take on full budgetary responsibility. Some will only be authorised in part. Others will only be established in shadow form. This will be determined through a robust process of authorisation, run by the NHS Commissioning Board, with input from emerging Health and Wellbeing Boards and local clinicians.
- Where a clinical commissioning group is not able to take on some or all aspects of commissioning, the local arms of the NHS Commissioning Board will commission on its behalf, and in this role will be subject to the same duties of transparency and engagement. All groups will have the right to take on full responsibility, once they have demonstrated they are ready. The NHS Commissioning Board will work with the GP practices and other stakeholders in these areas to develop fully operational commissioning groups and hand over commissioning responsibility to them as they become ready, so that we move, over time, to avoid a two-tier system of commissioning in the NHS.

- The primary care trust “cluster” arrangements will be reflected in the local arrangements of the NHS Commissioning Board. Those local arrangements will be established before PCTs are abolished.
- The NHS Commissioning Board will be established by October 2012 to start to authorise clinical commissioning groups, but will only take on its full responsibilities from April 2013. The ten Strategic Health Authorities will remain in place as statutory bodies until April 2013, but we will form them into a smaller number of clusters later this year for management purposes, as we have done with PCTs.
- Good management is essential in improving the quality of front-line services and ensuring that money is well spent. We will take steps to boost the quality of management and leadership: for example, by retaining the best talent from PCTs and SHAs in the new system, and through a commitment to the ongoing training and development of managers.

### Wider clinical involvement and advice

- We will retain and strengthen the clinical networks of experts, including patient and carer representatives, that exist in areas like cancer care, so that they cover many more areas of specialist care. We will give networks a stronger role in commissioning, in support of the NHS Commissioning Board and local clinical commissioning groups.
- We will enable doctors, nurses and other professionals to come together in “clinical senates” to give expert advice, which we expect clinical commissioning groups to follow, on how to make patient care fit together seamlessly in each area of the country. To support the better integration of services, they should include public health specialists and adult and child social care experts. Clinical senates will have a formal role in the authorisation of clinical commissioning groups. In addition they will have a key role in advising the NHS Commissioning Board on whether commissioning plans are clinically robust and on major service changes.

- Both clinical networks and clinical senates will be hosted by the NHS Commissioning Board; they will not be organisations or new forms of bureaucracy.
- The NHS Commissioning Board will establish close links with the Royal Colleges and other professional bodies so that partnership working across a wide range of experts is firmly entrenched at a national level. It will have a medical director and a chief nursing officer on its board.
- We will strengthen the existing duties on the NHS Commissioning Board and clinical commissioning groups to secure professional advice and ensure this advice is from a full range of health professionals where relevant. For example, commissioners will need to work with public health experts and in line with public health guidance. We will also place Monitor under a new duty to obtain appropriate clinical advice.

### Research

- We will create a new duty for the Secretary of State to promote research.
- We will create a new duty for clinical commissioning groups to promote research and innovation and the use of research evidence, in line with the current duty on the NHS Commissioning Board.
- We will ensure that a culture of research and innovation is embedded in the arrangements for both the Board and Public Health England.
- We will also make sure that clinical commissioning groups and the NHS Commissioning Board ensure that treatment costs for patients who are taking part in research funded by Government and Research Charity partner organisations are funded through normal arrangements for commissioning patient care, as set out in existing guidance.

## **Public accountability and patient involvement**

### Health and Wellbeing Boards and local authorities

- We will give Health and Wellbeing Boards a new duty to involve users and the public.
- The Bill will make clear that HWBs should be involved throughout the process as clinical commissioning groups develop their commissioning plans, and there will be a stronger expectation, set out in statutory guidance, for the plans to be in line with the health and wellbeing strategy. Though they will not have a veto, HWBs will have a clear right to refer plans back to the group or to the NHS Commissioning Board for further consideration.
- HWBs will have a stronger role in promoting joint commissioning and integrated provision between health, public health and social care.
- They will be given a formal role in authorising clinical commissioning groups and the NHS Commissioning Board will have to take HWBs' views into account in their annual assessment of commissioning groups.
- Health and Wellbeing Boards discharge executive functions of local authorities, and should operate as equivalent executive bodies do in local government. It will be for local authorities to determine the precise number of elected members on a Health and Wellbeing Board, and they will be free to insist upon having a majority of elected councillors.
- HWBs will be subject to oversight and scrutiny by the existing statutory structures for the overview and scrutiny of local authority executive functions. The existing statutory powers of local authority overview and scrutiny functions will continue to apply. In line with the principles of the Localism Bill, local authorities will have greater discretion over how to exercise these powers.
- Local authorities will still be able to challenge any proposals for the substantial reconfiguration of services, and we will retain the Government's four tests for assessing service reconfigurations.

### HealthWatch

- There will be a new requirement for the Care Quality Commission to respond to advice from its HealthWatch England subcommittee. The Secretary of State will be required to consult HealthWatch England on the mandate to the NHS Commissioning Board.
- We will add an explicit requirement that local HealthWatch membership is representative of different users, including carers.

### Patient and public involvement

- Monitor will have a new duty to carry out appropriate public and patient involvement in the exercise of its functions.
- We will further clarify the duties on the NHS Commissioning Board and clinical commissioning groups to involve patients, carers and the public in commissioning decisions and will require commissioning groups to consult on their annual commissioning plans to ensure proper opportunities for public input. They will have to involve the public on any changes that affect patient services, not just those with a “significant” impact.
- We will amend commissioners’ duties to involve patients and carers in their own care to better reflect the principle of “no decision about me without me”.

### Protecting confidentiality

- We have heard concerns that the powers in the Bill for the Information Centre in relation to personal information are too broad. We will consider further how to amend the Bill to protect patient confidentiality in a way that supports our plans to drive quality improvement through greater access to information; and to promote high quality research.

### Respecting the autonomy of front-line organisations

- We will amend the Bill to set a clear expectation that the Secretary of State’s mandate to the NHS Commissioning Board is a multi-year document, to avoid the impression that a new mandate would be set every year.

### Independent public health advice

- Public Health England will be established as an executive agency of the Department of Health, subject to completing the normal government approval processes for establishing new bodies. This will ensure that expert and scientific advice is independent, while at the same time integrating policy and action to allow a more joined-up approach to health protection and emergency planning. We will make further announcements in the government response to the Public Health White Paper.

### **Choice and competition**

#### Patient choice

- We will amend the Bill to strengthen and emphasise commissioners' duty to promote choice, in line with the right in the NHS Constitution for patients to make choices about their NHS care and to receive information to support those choices. As recommended by the Future Forum, the Secretary of State's mandate to the NHS Commissioning Board will set clear expectations about offering patients choice: a "choice mandate".
- Subject to evidence from the current pilots, the mandate to the Board will also make it a priority to extend personal health budgets, including integrated budgets across health and social care.
- As recommended by the Future Forum's report, HealthWatch England will have the power to establish a citizens' panel, or equivalent arrangement, to look at how choice and competition are working, and inform HealthWatch's annual report to Parliament.
- We will maintain our commitment to extending patients' choice of "Any Qualified Provider", but we will do this in a much more phased way, and will delay starting until April 2012. Choice of Any Qualified Provider will be limited to services covered by national or local tariff pricing, to ensure competition is based on quality. We will focus on the services where patients say they want more choice, for example starting with selected community services, rather than seeking blanket coverage. There will be

some services, such as A&E and critical care, where Any Qualified Provider will never be practicable or in patients' interests.

- Following the Future Forum's recommendation, we will carry out further work on the feasibility of a citizens' 'Right to Challenge' poor quality services and lack of choice.

### Competition

- Monitor's core duty will be to protect and promote patients' interests.
- We will remove Monitor's powers to "promote" competition as if it were an end in itself. Monitor will be limited to tackling specific abuses and unjustifiable restrictions that demonstrably act against patients' interests, to ensure a level playing field between providers. Monitor will be required to support the delivery of integrated services for patients where this would improve quality of care for patients or improve efficiency.
- The NHS Commissioning Board, in consultation with Monitor, will set out guidance on how choice and competition should be applied to particular services, guided by the mandate set by Ministers. This includes guidance on how services should be bundled or integrated.
- We will narrow Monitor's powers over anti-competitive purchasing behaviour so that these are more proportionate and focus on preventing abuses rather than promoting competition.
- We will remove Monitor's powers to open up competition by requiring a provider to allow access to its facilities to another provider.
- We will maintain the existing competition rules for the NHS introduced by the last Government (the Principles and Rules for Co-operation and Competition), and give them a clearer statutory underpinning. The body that applies them, the Co-operation and Competition Panel will transfer to Monitor and retain its distinct identity.
- We will retain our proposals to give Monitor concurrent powers with the Office of Fair Trading, to ensure that competition rules

can be applied by a sector-specific regulator with expertise in healthcare. The Future Forum recommended that this was the best safeguard against competition being applied disproportionately. The Bill does not change EU competition law.

### Safeguards against privatisation

- Competition will be on the basis of quality not price. We will create additional safeguards against price competition and “cherry picking”.
- So that providers cannot “cherry pick” the profitable, “easy” cases, services will be covered by a system of prices that accurately reflect clinical complexity, except where this is not practical. Commissioners will be required to follow “best value” principles when tendering for non-tariff services, rather than simply choosing the lowest price.
- We will outlaw any policy to increase the market share of any particular sector of provider. This will prevent current or future Ministers, the NHS Commissioning Board or Monitor from having a deliberate policy of encouraging the growth of the private sector over existing state providers – or vice versa. What matters is the quality of care, not the ownership model.
- We will require foundation trusts to produce separate accounts for NHS and private-funded services.

### Integration of services

- In addition to revising Monitor’s core duty, we will create a new duty for clinical commissioning groups to promote integrated services for patients, both within the NHS and between health, social care and other local services; and we will strengthen the existing duty on the NHS Commissioning Board.
- The NHS Commissioning Board will promote innovative ways of demonstrating how care can be made more integrated for patients: for example, by developing tariffs for integrated pathways of care, and exploring opportunities to move towards single budgets for health and social care. We will work with

organisations such as the King's Fund and the Nuffield Trust to develop these ideas further.

### Providers

- We strongly expect that the majority of remaining NHS trusts will be authorised as foundation trusts by April 2014. It will not be an option to stay as an NHS trust, but there will no longer be a blanket deadline in the Bill for abolishing NHS trusts as legal entities. All NHS trusts will be required to become foundation trusts as soon as clinically feasible, with an agreed deadline for every trust. The stringent tests set by Monitor will remain and they will continue to obtain assurance from the Care Quality Commission as part of the authorisation process.
- To enable time for foundation trusts' governors to build capability in holding their boards to account, we will further extend, to 2016, the transitional period where Monitor retains specific oversight powers over foundation trusts.
- We will have an effective failure regime that ends the culture and practice of hidden bailouts and gets the right incentives into the NHS, whilst protecting essential services. But we have heard concerns about the practicality of our current proposals for an up-front system of designating services for additional regulation, and we will be amending the Bill accordingly.
- We will amend the Bill to require foundation trusts to hold their board meetings in public.
- We will introduce a "duty of candour": a new contractual requirement on providers to be open and transparent in admitting mistakes.

### **Education and training**

- We will ensure a safe and robust transition for the education and training system, and will set out further details in the autumn. During the transition, deaneries will continue to oversee the training of junior doctors and dentists, and we will give them a clear home within the NHS family.
- We have set out broad proposals for ensuring all providers contribute to the costs of education and training. However, it is

vital that any changes to the funding of education and training must be introduced in a careful, phased way that does not create instability. We will therefore take the time to develop our proposals, working with our health and care partners and through further consultation, and we will publish more detail this autumn.

- To reinforce its importance, we will introduce an explicit duty for the Secretary of State to maintain a system for professional education and training as part of the comprehensive health service.