NHS

Liberating the NHS:

Legislative framework and next steps

DH Department of Health

Liberating the NHS: Legislative framework and next steps

Presented to Parliament
by the Secretary of State for Health
by Command of Her Majesty

December 2010

Cm 7993 £35.50

Any enquiries regarding this publication should be sent to us at Customer Service Centre, Department of Health, Richmond House, 79 Whitehall, London SW1A 2NS

This publication is also available on http://www.official-documents.gov.uk

ISBN: 9780101799324

Printed in the UK by The Stationery Office Limited
on behalf of the Controller of Her Majesty's Stationery Office

ID 2406272 12/10

Printed on paper containing 75% recycled fibre content minimum.

Foreword

In July, we set out our ambitious plans for the NHS in the White Paper, *Equity and excellence: Liberating the NHS*. These plans had a simple aim: to deliver health outcomes for patients which are among the best in the world, harnessing the knowledge, innovation and creativity of patients, communities and frontline staff in order to do so.

The NHS is a great national institution. The principles it was founded on are as important now as they were when it was founded: of healthcare free at the point of use, funded from general taxation, and available to all based on need and not ability to pay.

It is our privilege to be custodians of these principles, and nothing we do will ever undermine them. That is why the Government has delivered on the Coalition commitment to increase health spending: the health budget will grow by 10 per cent in cash terms over the Spending Review period.

But these resources need to be used to support change. Put simply, for all the efforts and endeavours of frontline staff, outcomes for patients still lag behind the best healthcare systems internationally. In addition, productivity in the NHS has declined in the recent years. Through the coming years, every part of the NHS needs to make every penny count for patients.

That is why our White Paper set out plans for an NHS which:

- puts patients and local communities at the heart of decisions made in the NHS, expressed through the simple mantra, ‘no decision about me, without me’;

- focuses relentlessly on outcomes for patients, rather than on measurement of narrow processes, in order to deliver more effective and efficient care;

- enjoys greater local democratic legitimacy, with a new role for local government in joining up health, social care and public health services, and a lead role for councils in health improvement; and

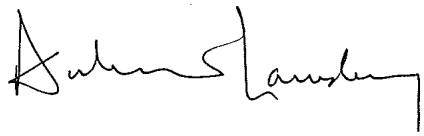
- liberates professionals at every level to take decisions in the best interests of patients – whether the GP, the community nurse, or the hospital manager – through GP commissioning, a radical extension of social enterprises, and the further extension of NHS foundation trust freedoms.

The energy and enthusiasm on the frontline to make these reforms happen demonstrate that we were right to embark on this journey. One-quarter of the country is already covered by ‘pathfinder’ GP consortia. By next year, we expect

25,000 staff – delivering some £900 million of NHS community services – to be doing so as members of social enterprises. The further development of NHS foundation trusts is proceeding at pace.

Much of this work has already been informed by the responses we received from you on how best we can implement our reforms. This document sets out how the Government will legislate for and implement our reforms, drawing on the insights and experience contributed by those who responded to the consultation. It sets out how the White Paper's reform programme will be taken forward to completion, and how the vision it contains will be made into a reality.

It sets out how we will deliver our ambition for an NHS which is once again the envy of the world.



Secretary of State for Health

Minister of State for Care Services

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1. INTRODUCTION

Equity and excellence: Liberating the NHS

1.1 On 12 July 2010, the Government published the White Paper *Equity and excellence: Liberating the NHS*, setting out our long-term vision for the NHS.[i] It is founded on our enduring commitment to the values and principles of the NHS as a comprehensive service, available to all, free at the point of use and based on clinical need, not the ability to pay. The White Paper describes a coherent framework of reforms, designed to help deliver our objective of a health service that achieves outcomes amongst the best in the world.

1.2 The reforms consist of three mutually-reinforcing parts:

- First, putting patients at the heart of the NHS: transforming the relationship between citizen and service through the principle of *no decision about me without me*;
- Second, focusing on improving outcomes: orientating the NHS towards focusing on what matters most to patients – high quality care, not narrow processes;
- Third, empowering local organisations and professionals, with a principle of assumed liberty rather than earned autonomy, and making NHS services more directly accountable to patients and communities.

1.3 The Government consulted from July until October on how best to implement the White Paper. We also consulted on further details of the proposals set out in four consultation documents: *Transparency in outcomes – a framework for the NHS*; *Commissioning for patients*; *Local democratic legitimacy in health*; and *Regulating healthcare providers*.[ii]

1.4 This paper is the Government's response to those consultations, with the exception of *Transparency in outcomes*, to which we will respond in full shortly. It reaffirms the Government's commitment to the White Paper reforms, and shows how we have developed them in the light of consultation[iii]. The insights and suggestions we heard in consultation have helped us strengthen our proposals in several areas, including rectifying certain aspects where we realised our original thinking was flawed. Equally important, they have also helped us refine our approach to implementation, in order to create flexibility, empower local leadership

and support the significant cultural change and staff engagement that respondents highlighted would be needed to make our reforms a success.

1.5 This document describes in more detail how we will put the reforms into practice, starting with the forthcoming introduction of the Health and Social Care Bill in Parliament. The document forms part of a series of publications developing further details on the Government's agenda. In September, the Government published *Achieving equity and excellence for children*, outlining how our reforms could improve services for children and young people.[iv] We launched further consultations in October, *An Information Revolution* and *Greater choice and control*, with a closing date for responses of 14 January 2011.[v] We are about to issue consultation proposals for reforming the education and training of the workforce. And we will shortly publish the first NHS Outcomes Framework alongside the detailed response to the consultation on *Transparency in outcomes.*

1.6 Meanwhile, these NHS reforms fit within a wider strategy for the health and care system; which, in turn, is a core part of the Coalition Government's approach to reforming public services, as demonstrated on education, policing, local government and elsewhere. In November 2010 we announced the Government's vision for social care reform, *A Vision for Adult Social Care: Capable Communities and Active Citizens*,[vi] setting out ambitions for greater independence and choice for users of social care. Then on 30 November we published a White Paper on public health, *Healthy Lives, Healthy People*[vii] describing our proposals for a new approach to: protect the population from serious health threats; help people live longer, healthier and more fulfilling lives; and improve the health of the poorest, fastest. A new streamlined public health service, Public Health England, will be created, alongside new freedoms and funding for local government.

1.7 This chapter provides more detail on:

A. The consultation process

B. How the Government has modified its original proposals

C. Key themes raised in consultation

D. The Health and Social Care Bill

E. The Government's reforms to public health

A. Consultation process

1.8 The Government has undertaken an extensive process of consultation and engagement around the White Paper proposals. To ensure that as wide an audience as possible was involved, summaries of the White Paper and related consultation documents were made available in various accessible formats, including easy-read, alternative language, large print, and braille. A presentation summarising the proposals and the consultation questions, and a guide to running a consultation event, were also produced for larger organisations to use when engaging with their members.

1.9 Strategic health authorities (SHAs) held a number of engagement events across the country targeted at regional NHS and local authority staff. The Department of Health also organised nationwide consultation events in collaboration with Regional Voices (a strategic partner of the Department which coordinates nine regional networks of voluntary and community sector bodies). These events were targeted at patient representative groups, the voluntary sector and community organisations.

1.10 A variety of other discussion and engagement events were held, with groups including the Department's Social Partnership Forum, the National Stakeholder Forum, the Third Sector and Social Enterprise Sounding Board, local authority chief executives and councillors, and strategic partners. A core principle of the White Paper is the need to eliminate discrimination and reduce inequalities in care; and the Department also held discussions about equality and diversity with members of the NHS Equality and Diversity Council and other key partners.

1.11 More than 6,000 responses were received on the White Paper and the related consultations. The number of respondents was less, as some people submitted separate contributions to the different consultations, while others sent a single consolidated response. A full list of organisations that responded is available on the Department of Health's website.

1.12 Responses were received from a very wide spectrum of individuals and organisations, including: patients and members of the public, clinicians, voluntary organisations, patient representative groups, local authorities, local involvement networks (LINks), NHS organisations and staff, independent providers, pharmacists, academics, professional bodies and Royal Colleges, think tanks and trade unions.

B. How the Government has modified its original proposals

1.13 The Government is very grateful to everyone who contributed to the consultations. The richness and diversity of consultation responses have provided valuable perspective on how the White Paper was received locally, highlighting the areas where there was most enthusiasm as well as the issues that raised greatest concern. Responses contained a broad mix of support, suggestions for improvement, and critical challenge; which we have drawn on to help develop our proposals and translate them into legislative provisions in the Bill. This document describes in detail how the consultation responses have influenced our thinking, and the key areas where we have modified our approach as a result. In particular, the Government has decided to:

- allow a longer and more phased transition period for completing our reforms to providers: for example, retaining some of Monitor's current controls over some foundation trusts while the new system of economic regulation is introduced;
- significantly strengthen the role of health and wellbeing boards in local authorities, and enhance joint working arrangements through a new responsibility to develop a "joint health and wellbeing strategy" spanning the NHS, social care, public health and potentially other local services. Local authority and NHS commissioners will be required to have regard to this;
- create a clearer, more phased approach to the introduction of GP commissioning, by setting up a programme of GP consortia pathfinders. This will allow those groups of GP practices that are ready, to start exploring the issues and will enable learning to be spread more rapidly;
- accelerate the introduction of health and wellbeing boards through a new programme of early implementers;
- create a more distinct identity for HealthWatch England, led by a statutory committee within the Care Quality Commission (CQC);
- increase transparency in commissioning by requiring all GP consortia to have a published constitution;
- change our proposal that maternity services should be commissioned by the NHS Commissioning Board. This reflects the weight of consultation responses arguing that, in order to focus on

local needs, maternity services should be the responsibility of GP consortia, backed by national support to secure improvements in quality and choice;

- recognise that our original proposal to merge local authorities' scrutiny functions into the health and wellbeing board was flawed. Instead we will extend councils' formal scrutiny powers to cover all NHS-funded services, and will give local authorities greater freedom in how these are exercised;

- phase the timetable for giving local authorities responsibility for commissioning NHS complaints advocacy services, and allow flexibility to commission from other organisations as well as from local HealthWatch;

- give GP consortia a stronger role in supporting the NHS Commissioning Board to drive up quality in primary care;

- create an explicit duty, for the first time, for all arm's-length bodies to co-operate in carrying out their functions, backed by a new mechanism for resolving disputes without the Secretary of State having to act as arbiter. In particular, Monitor and the NHS Commissioning Board will have to work jointly in setting prices, rather than have Monitor decide and the Board able to appeal.

C. Themes raised in consultation

The White Paper vision

1.14 There was widespread enthusiasm for the vision and principles of *Liberating the NHS*. The Health Foundation said it "*welcomes the Government's focus on putting the patient at the centre of health services and its commitment to empowering professionals and providers. It is right to recognise improving quality and outcomes as the primary purpose of healthcare.*" The Royal College of Surgeons commented: "*We commend the approach to put patients at the heart of the NHS along with a focus on clinical outcomes and leadership and a move away from targets that have no clinical relevance.*" Age UK commented that: "*These reforms represent a real opportunity to tackle some of the long term problems that have beset the system, it should not be wasted.*" The Foundation Trust Network said "*The FTN considers that the vision for the NHS articulated in the White Paper is the right one – putting patients and*

carers at the centre and giving providers and their clinicians the freedom to innovate and deliver on improved outcomes." An individual healthcare scientist wrote: "*I was delighted in the general tone of this landmark document, in particular the emphasis on freeing staff from excessive bureaucracy and top-down control, giving front-line staff more control, putting ownership and decision-making in the hands of professionals and patients and trusting professionals to drive up standards and deliver better value for money*".

1.15 The consultation responses raised many specific suggestions, comments, criticisms and concerns, across the entire spectrum of the White Paper; these are discussed more fully in later chapters. A considerable number of respondents opposed the Government's reforms altogether. GMB was "*strongly opposed*" and argued that the White Paper showed that the Coalition Government was "*determined to dismantle the NHS*". The Leeds Teaching Hospital Trust Branch of UNISON thought the reforms would have a "*seriously detrimental impact upon the services, values and founding principles*" of the NHS. However, there was support for the Government's reforms across the spectrum of the White Paper from a range of respondents. For example:

- On putting patients and the public first, YoungMinds said: "*We believe that the NHS White Paper, with its emphasis on the vital importance of patient involvement and outcomes presents an ideal opportunity for true patient involvement in services.*" Marie Curie Cancer Care commented: "*We support entirely the clear commitment, under the heading of informed choice, that patients have the right to make choices about their NHS care. Similarly, we support the existing right of patients to be given information about proposed treatment in advance and to choose their provider*."

- On focusing on outcomes, Sheffield Children's NHS Foundation Trust said: "*We strongly support and welcome the emphasis placed by the White Paper on improving the quality of care and clinical outcomes for patients*", while the North of England Cancer Network commented: "*As a network we welcome the renewed focus on quality and outcomes*".

- On commissioning, the Royal College of Paediatrics and Child Health said "*We welcome the increased focus on clinician-led commissioning, recognising the flaws with current commissioning models. Furthermore the emphasis on shared decision making across health professions is positive*". A Rotherham GP said: "*… I am optimistic about the headline 'liberating'. I firmly believe (and can*

evidence it) that giving clinicians management and budgetary control improves care and reduces cost".

- On local democratic legitimacy, Birmingham City Council said: "*We are resolutely committed to providing the local political and professional leadership envisaged by the white paper and to engaging with the clinically led NHS*".

- On regulating healthcare providers, Nuffield Health said: "*We strongly support the approach to economic regulation. A statutory, independent economic regulator is key to ensure that a provider market develops to the benefit of the health consumer and ensure the confidence of providers to make long term commitments and investment*", while the East of England SHA "*welcomes and embraces this vision*".

- On the broader reforms to public health, the Cambridgeshire Together partnership "*note and support the commitment to the Public Health agenda and the role that Local Government will play with a renewed focus on public health and prevention*".

Safeguarding the principles of the NHS

1.16 Some respondents, particularly many of the unions, were concerned that the White Paper reforms might weaken the core principles of the NHS or undermine its future. As discussed in Chapter 6, there were strong feelings about allowing competition from "any willing provider": although some were highly enthusiastic about the opportunities this could bring to create more responsive services for patients, others feared it might lead to privatisation and a two-tier service. For example, the National Federation of Occupational Pensioners said that "*increased commercialisation and active promotion of a market approach for NHS Services*" would "*destroy the ethos of the NHS as a public service working for the benefit of patients*", while Medact thought "*the proposed fundamental changes to the way the NHS is organised would break it up and result in creeping privatisation*".

1.17 The Government believes that these concerns are wholly unfounded; we are unshakeably committed to the values and principles of the NHS, both in the reforms themselves and in our approach to implementation. By promoting shared decision-making between patients and professionals, backed by clinically-led commissioning and greater freedoms for providers to innovate and respond, our reforms will strengthen the NHS as a universal, tax-funded service: using public resources more

effectively to secure higher quality, better integrated care in a way that supports patients' needs and choices. As many respondents recognised and welcomed, the Government will uphold and reinforce the NHS Constitution, which all providers and commissioners will be obliged to have regard to in carrying out their functions.

1.18 The White Paper also made clear that, in our drive to secure excellence in NHS services, we will not compromise the need to maintain and improve equity. There will be explicit duties to promote equality and tackle inequalities in the outcomes of healthcare service, and this received very positive support. For example, "*In particular, we welcome the commitment to eliminating discrimination and reducing inequalities in care*" (Royal College of Midwives), while the independent members of the Equality and Diversity Council welcomed "*the overall equality emphasis in the suite of White Paper documents*".

Scale of change

1.19 Many respondents supported parts of the White Paper, but argued that major structural reforms were unnecessary or disruptive. The King's Fund "*supports the government's aims but questions whether fundamental reforms are needed at this time*". The Royal College of Nursing wondered if this was "*Too much, too soon, and too little evidence?*", and many others argued that the reforms were untested – "*a leap in the dark*", as Arthritis Care described. A common assertion in many responses was that the Government's reforms were the most radical changes to the health service for decades, or even since the founding of the NHS.

1.20 The Government disagrees. Our proposals build on an extensive evidence base from the reforms of the previous administration and NHS reforms in the 1990s. GP-led commissioning is a development of the principles established over 20 years through GP fundholding and practice-based commissioning. We are strengthening and seeing through to fruition the previous government's ambitions for patient choice and for freeing NHS providers through the introduction of foundation trusts. Professor Julian Le Grand of the London School of Economics, a former adviser to the last government, made this point in writing about the Government's proposals, arguing that they were "*evolutionary, not revolutionary: a logical extension [of previous reforms]… they are one of the final building blocks in a structure with solid foundations, and a great future*"[viii].

1.21 What is new is this Government's determination to introduce a coherent institutional framework, underpinned in legislation. The NHS has suffered from change that was introduced piecemeal over many years, with ever more complexity layered on by successive reforms that were not fully followed through. This has produced a system that, despite many pockets of excellence, is hampered by excessive administration costs, duplication and blurred responsibilities. The Coalition Government is determined to learn from the experience of previous administrations, by consolidating and extending those reforms that have shown promise in the past. Instead of further incremental change, we will create a stable and sustainable framework that puts the NHS on the best possible footing to cope with the twin challenges of tighter funding and making services more responsive to patients.

Timetable and transition

1.22 The Government recognises that many respondents saw the timetable as challenging, and suggested greater use of piloting. Equally, enthusiasts have urged the Government to act more quickly. Bearing in mind these views, rather than wait for the Bill to come into force, we have decided to press ahead immediately with pathfinders of emerging GP consortia, encouraging them to test the different elements involved in GP-led commissioning and enable emerging consortia to get more rapidly involved in current commissioning decisions. The pathfinders will operate under existing legislation, without the full new statutory powers that Parliament will consider, but they will provide valuable early learning and momentum. We are encouraging local authorities to take a similar approach in developing health and wellbeing boards, through the new programme of early implementers. Similarly, on the provider side, we are re-energising the drive to get NHS trusts in a position to apply successfully for foundation trust status.

1.23 Rapid progress on reform is essential, not just to create a sustainable system for the long-term, but because this is the only credible way for the NHS to deliver the productivity improvements that are needed in the short term. Some respondents saw the reforms as a distraction from the task of making efficiency savings under the Quality, Innovation, Productivity and Prevention (QIPP) initiative; on the contrary, we believe they are essential to enable QIPP savings. There is no way to make a step change in the quality of commissioning without better engaging the GPs who already make the decisions that commit most NHS resources – as our reforms will do. Meanwhile, driving efficiency in provision depends on having the right incentives, which our reforms to pricing and regulation

will create, coupled with a relentless focus on the most financially challenged organisations – which we are determined to provide.

1.24 At the same time, we acknowledge that aspects of the framework may take longer to put in place than we had initially proposed. So, without compromising on our ultimate objectives, we have refined the timetable for introducing economic regulation, to draw on lessons from other regulated sectors. These reforms will be staged more gradually, with the final pieces put in place in 2014.

1.25 As explained in Chapter 7, the Department has put in place a single, integrated programme for the whole of the transition across the health and care system. This will help sustain performance under the existing regime at the same time as building the leadership to implement the changes. It means that the staffing implications of organisational changes can be considered in an integrated way, helping ensure that individuals are treated fairly. Overall, transition will occur through a carefully designed and managed process, phased over the next four years, to allow for rapid adoption, system-wide learning, and effective risk management. It will be aided by the creation of a number of specific time-limited transitional vehicles, with a focus on sustaining capability and capacity.

D. The Health and Social Care Bill

1.26 The new Bill[ix] proposes the legislative changes to underpin the White Paper's reforms and create a clear and stable legal regime. Under current health legislation, some individual bodies, such as the independent regulators and foundation trusts, have been given defined statutory responsibilities. Yet most of the way the NHS is run rests on the Secretary of State's general powers of delegation and direction. This has led to widespread political interference – or the perception or threat of interference – in the day-to-day operation of the health service.

1.27 The new Bill will give the NHS greater freedoms, improve transparency and help prevent political micro-management. The NHS Commissioning Board and GP consortia will have their functions conferred directly upon them; and the powers of the Secretary of State will be constrained and made more transparent, while retaining overall political accountability to Parliament. Inevitably, providing such a degree of clarity means that the Bill is considerably larger than previous legislation in this area. The Government will introduce the Bill in Parliament in January 2011.

1.28 All of the legislative measures outlined in this document are subject to Parliamentary approval.

E. The Government's reforms to public health

1.29 The Bill also establishes the basic legal architecture of a new public health service – Public Health England – which combines and builds on the work done now by a number of different agencies. *Liberating the NHS* and the report of the arm's-length bodies review[x] set out proposals to integrate and streamline existing health improvement and protection bodies. The Bill will go into more detail about the respective roles of the Secretary of State, the NHS Commissioning Board and local authorities. It will also provide arrangements for the functions of the Health Protection Agency and the National Treatment Agency for Substance Misuse to be transferred to the Secretary of State as part of Public Health England within the Department of Health.

1.30 We received a number of responses to the White Paper consultations about the Government's proposal for creating a public health service. The Public Health Commissioning Network said that it was an "*excellent opportunity to ensure vital knowledge and population health intelligence is shared between public health professionals in different localities, increasing productivity and reducing unnecessary duplication of work.*" Samaritans said that the new role of local authorities in public health "*opens up the opportunity to deliver services aimed at improving public mental health and well being, designed specifically around the needs of the local community*" and provides an "*opportunity to link public health with community development and address health inequalities*"; while North East Derbyshire District Council commented that giving local authorities responsibility for health improvement "*will help to provide more integrated health improvement and preventive services*".

1.31 More information about the Government's programme for public health, including the creation of Public Health England, was set out in the public health White Paper, *Healthy Lives, Healthy People*, which was published on 30 November 2010. A consultation on the regulation of public health professionals is already under way, and we intend to consult further on the public health outcomes framework and public health funding shortly.

Conclusion

1.32 The consultation process has strengthened both the Government's belief that these reforms are necessary and our resolve to follow them through. The following chapters, which are based on the structure of the White Paper, set out the next level of detail on how we have decided to put our proposals into practice.

1.33 This document focuses mostly on commissioning, local democratic legitimacy and regulating providers, because these are the main areas where this document is responding to consultation. There will be separate responses to the consultations on the NHS Outcomes Framework, the information revolution and extending patient choice. The new structures, roles and responsibilities that will be created by the Bill are also described.

1.34 However, is important to emphasise that the legislation is only the starting point. Implementing and embedding reform requires effective local leadership, a focus on our common NHS values and core purpose, and the creation of stronger partnerships with other organisations such as local councils.

2. PUTTING PATIENTS AND THE PUBLIC FIRST

Introduction

2.1 *Liberating the NHS* articulates a profound ambition to transform the culture of care. The Government proposes a shift in power that puts patients and their carers in charge of making decisions about their health and wellbeing, gives them more information, choice and control over how their care is delivered, and strengthens the voice of the public through HealthWatch, a new consumer champion. As Optua, a user-led disability organisation, told us in its response to the White Paper, putting patients and the public first is "*life-changing and long overdue*".

2.2 Patient-centred care is at the heart of our plans for the NHS. It underlies each of the following chapters, which consider in more detail the structural changes needed to improve outcomes and give professionals and providers more freedom to respond to their patients.

2.3 The Government has given careful consideration to what people have said in response to the White Paper consultation and during engagement events over the summer. Responses have shaped and, in some cases, changed how we will move forward, and responses to ongoing consultations on choice and information will continue to do so. For example, in view of some of the concerns expressed, the Government has decided to: provide additional funding to local authorities for local HealthWatch; change our approach to how NHS complaints advocacy will be provided; and take steps to give HealthWatch England a distinctive identity and role within CQC.

2.4 The Health and Social Care Bill will help to bring about the Government's vision. It contains provisions about the NHS Commissioning Board and GP consortia's duties in relation to patient engagement and choice, the creation of HealthWatch, and changes to support the Parliamentary and Health Service Ombudsman's work.

2.5 This chapter considers in turn:

A. Shared decision-making: no decision about me without me

B. Greater choice and control

C. An information revolution

D. Advice and support for shared decision-making and choice

E. HealthWatch

F. NHS complaints

A. Shared decision-making: no decision about me without me

2.6 The White Paper explained that patients should expect there to be 'no decision about me without me'. Only by putting people at the heart of their care and involving patients and their carers as much as they want to be in every decision about their care will the best outcomes be achieved. As Sir Derek Wanless recognised in 2002 as part of his long-term vision for health, increased participation of patients in decisions about their own health and care is key to securing the health system of the future.

2.7 Many respondents welcomed a move to shared decision-making. The Royal College of General Practitioners "*would always argue that health outcomes are maximised by consultation and cooperation between patients and their doctors*", whilst many charities and user-led organisations showed strong support. Stonewall, for example, believe it could be "*a key driver for the health service to tackle discrimination*", while a patient "*Very much welcome[d] the recognition of the value of shared decision making*".

2.8 We also received many helpful suggestions about the issues to be addressed and changes that are needed in order to make shared decision-making a reality.

A cultural change

2.9 Respondents such as Arthritis Care felt there needs to be a "*cultural shift*" towards shared decision-making - a change from both patients and clinicians. The Neurological Alliance said that "*for shared decision making to work there needs to be significant workforce development, including a culture shift in professional attitudes*", whilst a GP commented that patients will not necessarily wish to share decisions unless they can see the advantages of doing so. The Local Government Group argued from the experience of social care that "*the personalisation agenda… has resulted in a complete change in the relationship between professionals and service users so that the service users are informed, supported and empowered by professionals to become their own commissioners, making decisions about the services that best meet their needs. This requires a major culture change, a redefinition of the*

'doctor/patient' relationship… it will succeed or fail in the quality of face-to-face relationships between health practitioners and patients."

2.10 There is already a strong basis for shared decision-making in clinical practice, with training emphasising the importance of the consultation as a real conversation between practitioner and patient. Organisations including the British Medical Association (BMA), General Medical Council and the Royal Colleges of GPs, Nursing and Midwives said that shared decision-making is in line with their core professional values and guidance, and is actively being practised by many clinicians. But the Government also heard that it is not the norm for many patients. The National Family Carer Network, for example, was "*glad that sharing decision making is to become the norm. We still hear from families that they are not listened to, that their knowledge and expertise is ignored…* '*Nothing about us without us', which comes from Valuing People, needs to be taken seriously*".

2.11 The Government agrees that a cultural change is needed, which should be brought about through leadership and action across the health community. As National Voices said, "*progress requires… effective leadership, practical support and patient and public pressure*". We ask for views about how to bring about the cultural change in the consultation entitled *Greater choice and control*, which is open until 14 January 2011.[xi]

2.12 The direction of the cultural change needs to be guided by a clear and shared vision of the patient–clinician relationship. As the Patients Association said, patients have "*different requirements and definitions as to what it means to be involved in decisions regarding their healthcare*". The Children's Commissioner and the Black Health Agency also emphasised the need for opportunities and support for shared decision-making to be available to all, including those who need different levels of support and/or different communication techniques, such as children, young people, adults with a learning disability, and other vulnerable or marginalised communities. The Government agrees that there needs to be more systematic and sophisticated approaches to profiling and understanding people's needs and preferences, which will support all sections of the community to have a greater say in their health and care. We will work with clinical and patient leaders to help them develop an understanding of how a new type of patient–clinician relationship can work in practice, including respective responsibilities and entitlements, and how clinician and patient education can help.

Building shared decision-making into commissioning

2.13 Shared decision-making is not only relevant to patients and clinicians. As Leicester City PCT says, "*Patient choice should be top of the agenda when purchasing services*". Commissioners will need to make pathways flexible enough to allow patients the scope to make decisions about their care, using decision aids where appropriate, and to promote self-care.

2.14 The Government agrees with South East Coast SHA that measures to promote choice within commissioning should not be over-prescriptive or "*stifle innovation*". The Bill will place the NHS Commissioning Board under a duty, in exercising its functions, to have regard to the need to promote the involvement of patients and their carers in decisions about the provision of health services to them. The NHS Commissioning Board will also be under a duty to issue guidance on commissioning to GP consortia, which could include guidance about how to fulfil their duties in relation to public and patient involvement.

B. Greater choice and control

2.15 The White Paper proposed giving people more choice over their health and care services. Many people value choice and would like more opportunities to make choices about their health and care services. Choice should also create a more responsive NHS, as providers are encouraged to tailor their services to what people want, improve the quality and efficiency of their services, and ultimately improve outcomes.

2.16 Many responses to the White Paper consultation supported our vision of greater choice and control for patients and carers. The National Clinical Homecare Association "*really welcomes the commitment to greater patient choice and, in particular, the emphasis on allowing 'any willing provider' to step forward. This is very much the essence of clinical homecare and what our members stand for*", while Leicestershire County Council "*is committed to extending choice to people which it sees as the way forward in offering care and support that is tailored to individual needs*".

2.17 There was also support for the extension of choice for users of particular health services. Rare Disease UK welcomed in particular the White Paper commitments to extend choice for people who need diagnostic testing, care for long-term conditions or end of life care, and to provide more information about research studies. A member of the public felt that choice for mental health service users "*is a great empowerment tool*"

which will "*aid and increase many service users' recovery experience*". And the Royal College of Surgeons of England, Faculty of Dental Surgery said that "*In particular for hospital based medical, surgical and dental services the Faculty strongly supports the introduction of the patient… having the choice of a consultant led team who will provide elective care*".

2.18 Respondents such as the Health Foundation called for strong leadership and a consistent vision in order to achieve greater patient involvement and choice. The Bill will therefore place duties on the NHS Commissioning Board and GP consortia to, in the exercise of their respective functions, have regard to the need to enable patients to make choices with respect to aspects of health services provided to them.

2.19 The Government has also noted that a number of people and organisations have concerns about patient choice. Some respondents suggested that choice is not right for the NHS, with one GP saying that "*'Choice' is a luxury people should expect to pay for.*" Respondents, including the Royal College of Nursing, were uncertain about how choice would work in practice, asked for more detail about the proposals, and highlighted some of the issues that will need to be addressed before greater choice and control is a reality for all.

2.20 We have launched a consultation, *Greater choice and control*, which is open until 14 January 2011. It gives more information about the Government's proposals and how we believe choice will benefit people and the NHS. It also addresses some of the key concerns we have seen raised. Responses to *Greater choice and control* and the White Paper consultation will inform more detailed proposals on choice to be set out in early 2011.

Supporting choice through personal health budgets

2.21 The Government is pressing ahead with the personal health budgets pilot programme as a high priority. Many respondents welcomed this enthusiastically, with CLIC Sargent "*particularly*" supporting it and Rethink commenting, "*we would also like to see personal health budgets implemented more widely. This would provide an even greater level of choice, with patients acting as their own commissioners in choosing the services most suitable to them*". Others highlighted the need for careful management: the Staff Side of Nottinghamshire County PCT said "*We are pleased the government recognises the complexity of personal health budgets and welcome that more work will be done in this area. Use of personal health budgets for continuing care could work very well*

providing there are safeguards in place to protect the vulnerable and ensure that budgets were spent appropriately and compassionately".

2.22 The Bill will retain current legal provisions for piloting direct payments in healthcare as one of the ways to offer a personal budget. This includes the power to extend direct payments nationally (with the approval of both Houses of Parliament) following the pilot evaluation, which is due to report in October 2012.

C. An information revolution

2.23 An information revolution will be vital to put patients in the driving seat of their health and care. The White Paper stressed how information can drive better and safer care, improve outcomes, support people to be more involved in decisions about their treatment and care, and, through extending opportunities for people to provide feedback on their service experience, improve service design and quality. It proposed that patients should be able to control their own health records and share their records with third parties of their choosing.

2.24 Respondents showed strong support for the Government's vision of an information revolution. Bexley, Bromley and Greenwich Local Pharmaceutical Committee's view was that the "*'NHS information revolution' in which patients have ownership of their records is very positive; they should be able to share their records with all health professionals, so that decisions about their care are transparent*". Which? said that information is key to empowering patients to take control of their care, and a survey by the Patients Association showed that 79% of people surveyed agree.

2.25 Respondents particularly emphasised the important link between information and the improvement of services. National Voices agrees that there should be "*maximum transparency about performance, in particular to drive improvements in professional behaviour through benchmarking and peer to peer challenge*", while Breast Cancer Campaign noted that "*Without appropriate data collection and a baseline of how different services are performing now, we cannot expect to improve outcomes and be able to identify particular areas in need of attention*".

2.26 Respondents such as English Community Care Association, Choices Advocacy and BRAME highlighted some important issues to address in order to make the information revolution truly transformative; for example

how to use information and technology in a cost-effective way, safeguard confidentiality and ensure that information is accessible to all. The King's Fund also recognised the challenge of communicating effectively, noting that recent research suggests that "*many people find it difficult to understand and interpret data about the quality of providers*". A recent report published by Martha Lane Fox, the UK digital champion, also called for the Government to take advantage of digital technologies to deliver services, particularly to disadvantaged users.

2.27 The Government agrees that these are important issues. We have launched a consultation, *An Information Revolution*, which is open until 14 January 2011. It gives more information about our proposals and asks questions, the responses to which will help us to shape plans to help make the information revolution a reality.

Health and Social Care Information Centre

2.28 Respondents recognised the important role of the Health and Social Care Information Centre. Bury Council, for example, "*recognise[s] the need for effective information and data sharing, subject to the appropriate protocols for the safeguarding and sharing [of] data*" and "*broadly support[s] the role of the Health and Social Care Information Centre*". Likewise, the Local Public Data Panel said that there may be "*a useful role for the Information Centre in collating and analysing data over a longer time period, and in publishing raw data*".

2.29 Given its importance, the Bill will establish the Health and Social Care Information Centre on a firmer statutory footing as a non-departmental public body. It will collect data that needs to be collected centrally to support the central bodies in discharging their statutory functions. It will have powers to require data to be provided to it when it is working on behalf of the Secretary of State or the NHS Commissioning Board. It will be able to consider additional requests from other arm's-length bodies, and carry out those data collections if specific criteria are met. It will also have a duty to seek to reduce the administrative burden of data collections on the NHS, with powers to support this.

2.30 As the authoritative source of centrally collected data, the Information Centre will unlock the potential for making better use of information and become the focal point for national data collections for health and social care. It will generally publish the data that it has collected in a standard, aggregated format.

2.31 We intend to separate the collection and presentation of data. While the Information Centre has a vital role in the efficient collection of national data sets, we expect other third party organisations to use this data in many different ways – presenting the information in formats that best fit the needs of specific groups. There are many examples where government data has been used in innovative ways by third parties to improve services offered to citizens. The consultation, *An Information Revolution*, considers these issues in more detail and seeks views on how these 'intermediaries' can be as effective as possible.

D. Advice and support for shared decision-making and choice

2.32 Many respondents said that, in addition to the right information, the right tools need to be in place to help people to be involved in decisions and make choices about their health and care. Citizens Advice said that "*Whilst online information may be suitable for many individuals, more vulnerable people may need additional support to understand and implement the choices they are able to make*", while the Sefton Recovery Group Network said that "*the public need to be equipped with the tools and skills to self manage their lives*". Respondents also stressed the need for the level and type of advice and support provided to be tailored to the needs of individual patients and their carers and family, and that the vulnerable and those in need of specific support, such as children, should be empowered to be as involved as they can and want to be. The Children's Society, for example, felt strongly that "*Until there are mechanisms in place to ensure that every child can have a say about care they receive and that they are supported to do so if needed the 'no decision about me without me' agenda will not become real for many children, particularly for the most vulnerable groups*".

2.33 Whilst we are still consulting on how to best bring about shared decision-making and greater choice, the White Paper responses suggest that the Government should build on tools for support and advice that are already working well, including personalised care planning, self-care, and patient education programmes. In particular, respondents said that we should broaden the use of patient decision aids, which can be useful for some types of decision. FPA, for example, "*welcome[s] the Government's recognition that some people will require decision aids and support to be able to make their own choices, for example support for people with disabilities so that they can access information.*" As part of the Quality, Innovation, Productivity and Prevention programme, East of England SHA is already developing and piloting patient decision aids with a view to embedding them in practice. Use of decision aids could also be

incorporated in commissioning guidelines and quality standards developed by the National Institute for Health and Clinical Excellence (NICE).

2.34 Respondents also said how important the support patients receive from their clinicians will be. The King's Fund said that, although decision aids can help, "*in many cases patients will also benefit from a discussion to enable them to make sense of information. It will be important to ensure that ... clinicians have the skills needed to involve patients effectively in shared decision-making.*" Clinicians will continue to be a key source of advice and support for their patients, but some respondents, for example the BMA, were concerned that involving patients more fully in decisions could take extra time. The Government does not believe that this will necessarily be the case: evidence shows that encouraging patients to ask questions does not appear to have a significant effect on the length of consultations. Moreover, involving a person in decisions about their care, as the BMA also pointed out, should create longer-term gains such as "*improved patient satisfaction, possibly fewer follow-up appointments and possibly improved health outcomes*".

E. HealthWatch

2.35 The White Paper proposed to evolve Local Involvement Networks (LINks) into local HealthWatch, supported and led by HealthWatch England as an independent consumer champion within the Care Quality Commission (CQC). Local HealthWatch will ensure that the views of patients, carers and the public are represented to commissioners and provide local intelligence for HealthWatch England. It will work alongside the role of public members and governors of foundation trusts in influencing providers. Local authorities will be able to commission HealthWatch to provide advocacy, advice and information to support people if they have a complaint and to help people make choices about services.

2.36 The Government has seen strong support for a stronger patient, carer and public voice. The Foundation Trust Network said that this is "*vital to ensure the system is in balance*" and the Academy of Medical Royal Colleges' Patient Lay Group believes mechanisms to enable a strong patient, carer and public voice that can "*speak freely, be listened to carefully, and have their views acted on*" are "*crucial*". The Association of Directors of Adult Social Services said that HealthWatch "*is completely in line with the intention to ensure that patients and users have choice,*

control and involvement in the commissioning of health and social care services".

Functions of local HealthWatch

2.37 Respondents highlighted the excellent work of many LINks and, like the British Heart Foundation, called for local HealthWatch to build on this. The Government recognises that many LINks organisations around the country are effectively supporting patients and helping to shape and hold to account health and social care services. But we also know that some patient needs - such as support to make choices - are not necessarily being met. We agree with the individual respondent who told us that a wider role for HealthWatch "*would be excellent and much needed*". The Bill will therefore give HealthWatch additional functions on top of LINks' current role.

2.38 There was broad support for local HealthWatch to continue to have a role in service design and delivery, to make sure that, through a "*robust local involvement in commissioning… local people's views influence the evaluation, design and development of services*" (in Picker Institute Europe's words). Respondents stressed that HealthWatch should ensure that the views of people of all ages and communities are heard. The Joint Forum emphasised that, in particular, "*the most socially marginalised and vulnerable must have their needs represented at commissioning level*". The Bill will therefore provide for local HealthWatch to continue LINks' role in promoting and supporting public involvement in the commissioning, provision and scrutiny of local care services.

2.39 When scrutinising local care services, HealthWatch could decide to take into account patients' views, including whether they feel their rights have been met under the NHS Constitution. Although one respondent told us that this would be "*difficult in practice*" and some LINks organisations commented that HealthWatch staff would need additional training, others felt that HealthWatch would benefit from using the NHS Constitution. As Stockport LINk said, a "*deeper understanding of the constitution will aid HealthWatch and its membership to hold commissioners and providers to account. Using the NHS Constitution as a way to hold providers and commissioners to account is one way which the HealthWatch can carry out its functions but not the only way*".

2.40 Many respondents agreed with the proposal that local HealthWatch would also support patients to make choices. Existing LINks organisations, such as Isles of Scilly LINk, would "*welcome a broader role in providing information and supporting individuals in making*

choices", with appropriate training and support to do this effectively, whilst Partnerships in Care hope that HealthWatch will "*ensure that patient choice in all sectors of health transcends dogma and becomes a driver for quality of service and agreed outcomes*". The Bill will therefore provide for local authorities to commission HealthWatch to provide advice and information to enable people to make choices about health and social care. This could include helping people to access and understand information about provider performance and safety, and the NHS Constitution.

2.41 Respondents such as Plymouth LINk particularly supported proposals for local HealthWatch to be able to escalate concerns about the quality of health and care services to CQC, which (as the regulator) hears concerns of individuals and organisations and makes decisions about which to investigate. The Bill will therefore give local HealthWatch the power to make recommendations to the HealthWatch England committee of CQC for CQC to carry out investigations into health and care services.

2.42 But there was clear unease about proposals for local authorities to commission local HealthWatch to provide advocacy services for NHS complainants. The Parliamentary and Health Service Ombudsman was concerned about "*a potential conflict of interest in the role of local HealthWatch as advocate for an individual complainant - and the part envisaged for HealthWatch in the local commissioning decision-making process*". Support Empower Advocate Promote, which provides advocacy services, also noted that advocacy is "*a skilled professional function that requires in-depth training and robust quality, risk, people and service management tools and techniques*", which could therefore require significant time and resources.

2.43 After careful consideration, the Government finds these responses persuasive. With local HealthWatch's recognisable public profile, we believe that it should have a role in the NHS complaints advocacy process, but this does not need to be by providing the service through its own staff. We will therefore provide flexibility concerning whom local authorities will commission NHS complaints advocacy services from – this could be either local HealthWatch, or other organisations with HealthWatch signposting these services to people.

2.44 Respondents such as the Centre for Public Scrutiny were concerned that the name 'HealthWatch' does not properly reflect its social care role. We were also told of existing organisations that use the name 'Health Watch'. Whilst the Government understands these concerns, we believe that service users do not tend to draw strict lines between health and social care. Through proper engagement with local communities and

services, the HealthWatch brand should become well known and be associated with both health and social care.

Resources for local HealthWatch

2.45 Respondents who supported HealthWatch's new functions were uncertain whether these could be provided with LINks' resources. The National Pharmacy Association echoed many when it said if HealthWatch has "*adequate support, resource and understanding of the full range of providers available to patients, then we believe that they will be able to deliver a valuable service*". The Association of Directors of Adult Social Services added that HealthWatch "*will need sufficient resources and an appropriately qualified workforce to deliver its key roles*", while the Local Government Group similarly questioned "*whether an organisation comprising mainly volunteers will have the capacity, resources and expertises to provide reliable consumer advice.*"

2.46 Funding for LINks will therefore continue through the transition into local HealthWatch, and will be enhanced to reflect HealthWatch's responsibilities. Local authorities will have funding for HealthWatch built into their existing allocations, including additional funding for NHS complaints advocacy and providing advice and information for people making choices. We anticipate that HealthWatch will have available funding of £53.9 million for 2012/13 plus £3.2 million for start-up costs. In 2013/14, when local authorities take on responsibility for commissioning NHS complaints advocacy, the combined funding available for local HealthWatch and NHS complaints advocacy services will rise to £66.1m. We also agree with the individual respondent, who said that local HealthWatch "s*hould be able to employ their own staff according to their perceived requirements*", and the Bill will provide for this.

2.47 Many LINks organisations called for local HealthWatch funding to be ring-fenced within local authorities' budgets. However, the Government believes that it is important that local authorities can manage local priorities; moreover, as local HealthWatch is a representative on local authority health and wellbeing boards, it is important that local HealthWatch should remain within local authority funding mechanisms.

A new role for local authorities

2.48 The Bill will set up local HealthWatch organisations and will place local authorities under a duty to make sure that it arranges with them to deliver the above functions. Local authorities currently commission a broad range of support services for local people, and we know from the

consultation responses that many do so very effectively through a range of models. For example, some local authorities contract with well established and influential organisations to provide effective LINks services. As one member of the public said, "*LINks are already demonstrating that they can make a difference*". But the Government has also heard that, in CQC's words, "*some LINks are not as effective as others*". UNISON highlights that some have found it difficult to provide support for users of social care services, while the Royal College of Surgeons England commented that patient involvement "*has often been fragmented with [the] influence of Local Involvement Networks (LINks) being limited*". As Leeds City Council said, this could mean that "*in many areas we will be building on shallow foundations, depending upon the legacy of the LINk and other local arrangements*".

2.49 Respondents such as the National Autistic Society commented on the importance of consistency in how local HealthWatch operates, whilst recognising that the priorities of each local HealthWatch may vary. Some, in Kent County Council's words, argued for local authorities to "*have the freedom to commission what is best for the population they serve*". The Government agrees that there needs to be a clear and consistent vision for local HealthWatch, which HealthWatch England will provide. The Bill will also provide for regulations to be made setting out what local HealthWatch membership should look like. But we also agree that local authorities are best placed to manage local priorities, and the Bill therefore will not prescribe exactly how each local HealthWatch should provide people with advice and information.

2.50 Some respondents were concerned that local HealthWatch would not be a fully independent voice when commissioned by local authorities. The NHS Confederation reflected the views of many when it said that there are "*inherent conflicts of interest*" between local HealthWatch being funded by the local authority and scrutinising local authorities' commissioning decisions.

2.51 The Government believes that if local HealthWatch are to play a full part in their local communities, it would not be appropriate for them to be funded nationally. We have also seen excellent examples of the relationship between LINks and local authorities working well in a collaborative yet challenging way. HealthWatch England will support local HealthWatch to continue to do this. For example, HealthWatch England will agree standards against which local HealthWatch organisations and local authorities could benchmark performance and spread good practice.

2.52 The Government will set out proposals for governance and stakeholder engagement at the time of the publication of the Bill. An early priority will be to set out how relationships and accountabilities will work, especially the relationship between local authorities, local HealthWatch and HealthWatch England.

2.53 Responsibility for commissioning independent mental health advocacy under the Mental Health Act will also move from PCTs to local authorities, together with the role of the supervisory body in respect of hospitals under the Mental Capacity Act deprivation of liberty safeguards. However, owing to its highly specialised nature, mental health advocacy will not be a part of the NHS complaints advocacy services that local authorities will be able to commission from HealthWatch.

HealthWatch England

2.54 From the consultation responses, the Government is clear that HealthWatch England will address a real need. It will provide guidance and leadership to support local HealthWatch to maintain a collaborative and challenging relationship with local authorities, meet Age UK's call for "*better consistency across the country*", and enable best practice to be shared. Hammersmith & Fulham LINk agreed that CQC should "*work in partnership with HealthWatch to ensure that the experience and knowledge about poorly performing services are brought to account*". HealthWatch England, supported by intelligence from local HealthWatch, will be able to escalate concerns about the quality of health and care services to CQC.

2.55 Respondents suggested a number of alternative functions for HealthWatch England, including acting as an arbiter in local disputes (from the British Association for Counselling and Psychotherapy and others) and holding employment contracts on behalf of local HealthWatch (from Rutland LINk and others). The Government has given these suggestions careful consideration, but has decided not to include them in arrangements for HealthWatch England's remit. HealthWatch England is intended to provide direction, leadership and support for local HealthWatch, but this is not a substitute for good local practice and decision-making.

2.56 There were mixed views on proposals that HealthWatch England should be a part of CQC. Some, in the Newcastle LINk host's words, "*would support a strong and equitable relationship between the two*", whereas others would prefer HealthWatch England to be an independent national body. The National Association of LINks Members, while fully supporting

the HealthWatch model, "*fundamentally disagree with the dependent relationship that HealthWatch is intended to have on the CQC and local authorities*".

2.57 The Government believes in the importance of a stronger voice for patients – and that this needs to be backed by a powerful and effective structure. Working in partnership with CQC with the ability to escalate local concerns, HealthWatch England should have real influence, adding a vital dimension to CQC's work on improving services and reflecting the importance we place on the high quality regulation that CQC provides. As NICE said, "*The connection between local HealthWatch and HealthWatch England, based in the Care Quality Commission, should greatly increase the likelihood that public and patient concerns about the quality and safety of local NHS services will be heard and acted upon*". In the words of a member of the public, it would give HealthWatch "*substantially more weight*".

2.58 As a committee of CQC, HealthWatch England will be able to take advantage of its infrastructure and expertise – for example, for data analysis and informatics – supporting HealthWatch England to provide a truly professional and efficient service. Black Country Housing, the host organisation for Sandwell and Walsall LINks, said that locating HealthWatch England within CQC was therefore "*highly appropriate and desirable*" to ensure the smooth transition of information from CQC to HealthWatch.

2.59 We intended to assure HealthWatch's independence by establishing it within CQC, which is wholly independent from the Government. But, recognising the concerns raised, HealthWatch England will also have a distinctive identity and role within CQC to support its independence. We agree with Southampton City Council and Southampton PCT that there should be "*clear separation from the more general areas that are the responsibility of the CQC*". The Bill will therefore establish a HealthWatch Committee within CQC. We intend that the Committee will be represented on CQC's board by its chair, who will be appointed by the Secretary of State for Health. The HealthWatch England Committee will carry out the work of CQC related to HealthWatch England and have powers to provide advice to the NHS Commissioning Board, Secretary of State for Health, CQC and Monitor.

2.60 The White Paper proposed that HealthWatch England would provide advice to the Information Centre on the information which would be of most use to patients to facilitate their choices about their care. However, in view of the NHS Commissioning Board's role in relation to public and patient involvement and choice (discussed in more detail above), we

believe it would simplify matters if HealthWatch England provided their advice directly to the Board in respect of health services and to the Secretary of State in respect of social care services.

2.61 The Government has noted the comments of respondents, including East Riding of Yorkshire LINk, that the Committee and governance of HealthWatch England need to be built up from the grass-roots and include good representation from local HealthWatch and other voluntary and user-led organisations. It will need the right mix of skills to ensure it is effective, particularly in supporting local HealthWatch. The Government is committed to working openly in considering how this can best be achieved. The Bill will include a power for the Government to set out in regulations how the HealthWatch Committee should be appointed.

Transition

2.62 The next 15 months will be critical for the successful transition of LINks into local HealthWatch. As Sheffield LINk noted, this is the time to explore the outstanding "*questions to be asked about the practicalities of expanding the role of LINks as local HealthWatch*" including "*governance, independence and accountability, relationships with other significant players, the transitional arrangements, the ability to speak authoritatively on behalf of patients and service users and… the national and local framework for delivery.*"

2.63 In early 2011, the consultations on choice and information will close, and the responses will be instrumental in shaping further detail about how HealthWatch will carry out its functions.

2.64 From 2011, the Government will be working with local authorities as they prepare for their new role in commissioning support for choice and complaints advocacy for patients. The Department of Health will publish a transition plan early in 2011, which will provide for LINks to continue to influence local services while local HealthWatch prepares to start exercising functions.

2.65 From April 2012, local authorities will fund local HealthWatch to deliver most of their new functions. In view of comments such as those of the College of Occupational Therapists, stressing that the transition of advocacy service commissioning must not detract from the delivery of advocacy services, we have decided that responsibility for commissioning NHS complaints advocacy will transfer to local authorities in April 2013. This phased introduction will give local authorities the opportunity to focus on putting in place robust and effective

arrangements for the new local HealthWatch roles. It will better ensure that the quality of NHS complaints advocacy services continues throughout the transition to local authority commissioning.

2.66 There were many calls from respondents – in particular existing LINks such as Wakefield LINk – for HealthWatch to be tested during the transition period. The Government will invite local authorities to develop pathfinder organisations to help with preparations for local HealthWatch. Pathfinders will be able to explore more fully a number of issues that the consultation has raised and look at how these can best be resolved to make sure that HealthWatch gives patients and the public the strong voice that the consultation responses called for.

2.67 For example, pathfinders will be able to test which models most effectively deliver locally commissioned services to support patient choice and complaints advocacy. They can highlight any potential conflicts that arise between HealthWatch's different roles and test ways of addressing these. Pathfinders for HealthWatch will also be able to test different structures for governance and accountability of local HealthWatch, including the role of hosts. It has been widely acknowledged, for example by Leicestershire LINk Board, that, as LINks hosts, voluntary sector organisations provide vital support and their role too will need to be addressed.

2.68 Pathfinders will also be able to explore how different patient engagement organisations can work in a complementary way, responding to consultation respondents who said that current structures for providing public and patient engagement and involvement can appear complex and overlapping. A retired clinician, for example, commented that there are "*parallel and overlapping groups often with overlapping representation and unclear boundaries tackling similar problems with some level of public funding.*" Pathfinders can explore how to make this less complicated, making sure that seldom-heard communities feel able to get their views heard and acted on.

2.69 Many GP practices engage with their patients through Patient Participation Groups (PPGs), while trusts' Patient Advice and Liaison Services (PALS) help people who have questions or experience problems when using NHS services. Foundation trusts also have links to their patients and the public through their members and governors. Respondents stressed the importance of relationships between HealthWatch and existing organisations: the National Association for Patient Participation said that it is "*vital to build long lasting and open relationships based on respect and openness*". Pathfinders will be able to identify how best to work together with these organisations, any overlaps

in the provision of information by these bodies, and how best to address these.

2.70 It will also be important for GP consortia pathfinders to develop their understanding of local communities by working closely with groups that represent and involve local patients – for example, current LINks organisations and HealthWatch pathfinders – as they consider how best to ensure patients and the public are involved and engaged in commissioning.

F. NHS complaints

2.71 In the light of events at Mid-Staffordshire and elsewhere, it is crucial that people know how to make complaints about health services, and that information about the complaints raised is used to improve services. In response to the White Paper, one individual said that "*Complaints, investigations, actions and feedback are essential to the operation of a safe service*" while another commented, "*complaining should be made much easier and every complaint looked at on its merits*".

2.72 In the first instance, a complaint about NHS services should be made either to the organisation where the problem or incident occurred, or to the body responsible for commissioning those services. Where a complainant is not satisfied with the outcome at local level, he or she can ask the Parliamentary and Health Service Ombudsman to investigate the case. The Ombudsman carries out independent investigations about unfair, improper, or poor service by the NHS in England. The Ombudsman's office works to put things right where it can, and shares lessons to improve services.

2.73 The Ombudsman wants to ensure her work leads to improvements in the quality of NHS services. To this end, in December 2009, she consulted on sharing and publishing information on complaints. The Ombudsman is subject to some significant legislative constraints in relation to sharing and publishing information about the complaints she receives. The Government agrees that it is important for complaints information to be shared more widely than the current legislation allows to help drive improvements in healthcare and, where appropriate, to be used by regulators to trigger further investigations and inform risk management meetings between relevant bodies. We will therefore use the Bill to change the Ombudsman's legislation to strengthen the arrangements for her to share more widely with the NHS and others investigation reports and the statement of reasons in those cases where she decides not to

investigate a complaint. However, whilst allowing for the sharing of complaints information as widely as is appropriate, it remains important to have regard to protecting the privacy of the Ombudsman's casework.

3. IMPROVING HEALTHCARE OUTCOMES

Introduction

3.1 *Liberating the NHS* set out a vision of an NHS that achieves amongst the best outcomes of any health service in the world. To achieve this, it outlined two major shifts:

- a move away from centrally-driven process targets which get in the way of patient care; and
- a relentless focus on outcomes and the quality standards that deliver them.

3.2 The main objective of the Government's plans for reform across health and social care is to enable services to deliver those improved outcomes. The cornerstone will be a framework of accountability that focuses squarely on how well services are improving outcomes for people.

3.3 This chapter gives a brief overview of the themes raised on the subject of outcomes during the consultation and responds to some of the issues raised. A full response to the consultation will be published alongside the NHS Outcomes Framework itself later this month. The chapter considers in turn:

A. Creating a balanced and comprehensive framework

B. Integrating outcomes across health, public health and social care

C. An NHS Outcomes Framework

D. Developing quality standards

E. Incentives for quality improvement

F. A new duty of quality improvement

G. Research

A. Creating a balanced and comprehensive framework

3.4 Responses to the consultation showed significant support for a focus on outcomes from both clinical and non-clinical groups. There was also broad support for the principles behind the framework and for the five

proposed outcome goals or domains. Some respondents applauded the ambition behind the approach. For example, University College London Partners commented: "*We think the [Department of Health's] overall approach is highly innovative – we do not know of a sizable health system internationally with such a comprehensive framework for outcomes. In particular, we like the sharp focus on outcomes…; the view that the outcomes framework is not primarily for performance management, but rather to drive continuous improvement; and the ambition to drive outcomes into every area of care.*"

3.5 There was a feeling that holding the NHS to account for a balanced and comprehensive set of outcomes could result in genuine improvements in standards of care. At the same time, some respondents pointed to a risk of unintended consequences if the outcomes presented in the framework were seen by the NHS as priorities that it should pursue at the expense of other areas. The King's Fund, for example, felt "*the inclusion of a large number of highly specific indicators could distort priorities, create perverse incentives and constrain local determination of need*". The Academy of Medical Royal Colleges thought avoiding this would require "*a cultural and psychological change beyond a simple statement of intent*".

3.6 There was a prevailing consensus for a move away from centrally-dictated process targets. While there was a degree of concern that a focus on outcomes rather than processes would reduce the pressure to maintain performance in certain areas, such as waiting times, a large number of respondents felt that healthcare professionals need to be freed to focus on what they do best: providing care to patients. The response from members of staff from Westminster PCT summed up the responses from many others when they said: "*This is a very positive move for patients, to focus on the clinical outcomes [rather] than the processes.*"

3.7 The Government is the first to recognise that having the right processes and structures in place is vital to the provision of high quality care. We agree with the NHS Confederation that "*it is important to be clear that process measures are not being abandoned*". But they do not need to be micro-managed by central government, nor to be treated as an end in themselves, rather than the means of meeting the objectives, i.e. the right results for patients. Instead of setting targets from the centre, our aim will be to ensure that, wherever possible, the NHS as a whole uses the measures that clinicians themselves use as a basis for improving their services: measures that are clinically credible and evidence-based.

B. Integrating outcomes across health, public health and social care

3.8 A further common theme was the need for integration across health, social care and public health, and for clarity as to how the sectors would be accountable for working together.

3.9 Some respondents felt that the outcomes frameworks for the NHS, public health and social care should themselves be integrated, while others saw the value in distinct expressions of accountability. For example, the NHS Confederation said: "*We believe the Government should develop overlapping outcomes frameworks for health, public health and social care… to ensure that… professionals from different sectors are working together to achieve shared outcomes*", while Dr Foster focused on the importance of "*clarity about who is accountable for delivery of these outcomes and… mechanisms that enable them to co-ordinate care*".

3.10 Proper integration across the NHS, public health and social care is critical and the consultation, *Transparency in outcomes – a framework for the NHS*, asked for views on how we can ensure that this takes place.

3.11 Respondents to the consultation felt that this could be achieved in a variety of ways, with the most common suggestions being to:

- develop outcomes across the whole pathway of care;
- ensure that health and care professionals and the public are engaged in developing the frameworks;
- have joint or overlapping indicators in different frameworks where necessary; and
- free up structures and architecture to support joint working.

3.12 The Government is clear that professionals and the public should be involved in every stage of developing the outcomes frameworks. We are also acutely conscious of the need to balance the dual imperatives of clear and unambiguous accountability, and properly joined-up services. The Government will therefore publish three separate frameworks for the NHS, public health and social care which are designed to incentivise collaboration and, in some cases, hold organisations to account for providing integrated services.

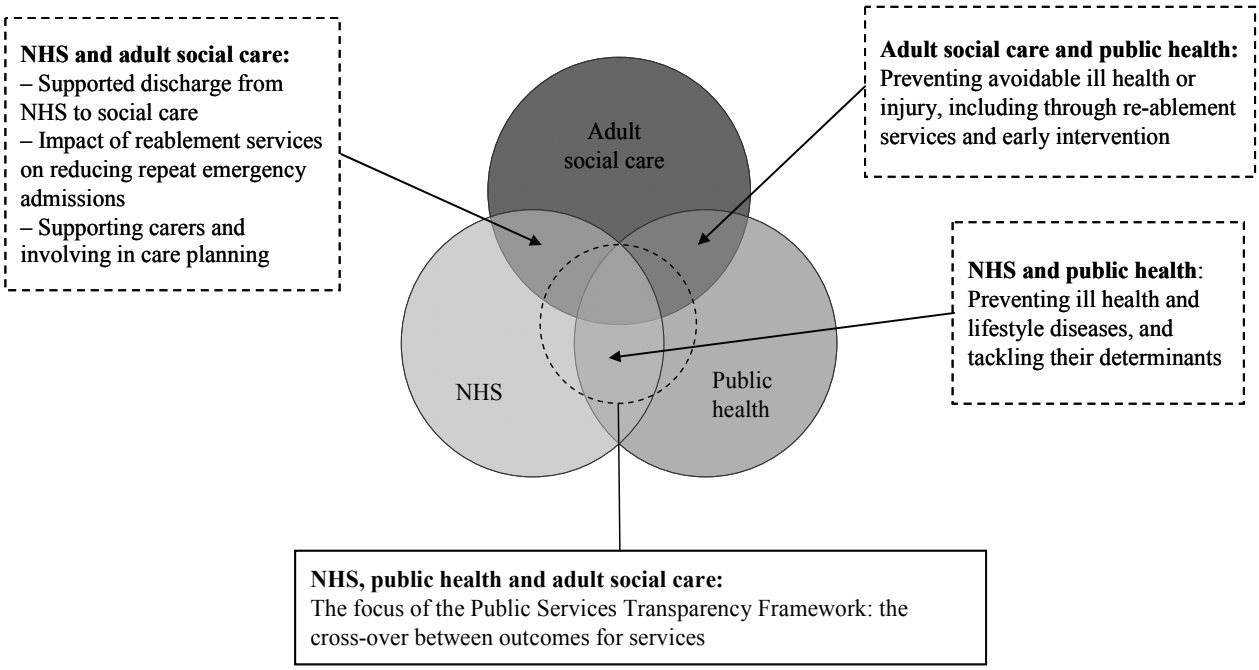
3.13 This recognises that the NHS, social care and public health sectors deliver services through unique delivery systems, each with their own

structures and governance, and provides for robust accountability mechanisms, which hold organisations to account for the things they are responsible for delivering.

3.14 For the NHS, the NHS Commissioning Board will be held to account through the NHS Outcomes Framework. An outcomes framework for social care, published for consultation in November 2010, will allow local areas to hold their councils to account for adult social care. In public health, the Public Health Outcomes Framework, which we will publish shortly for consultation, will allow the public to hold their councils and the Secretary of State to account for progress.

3.15 Although the three separate frameworks will be distinct, they are part of a single integrated vision for better health and care outcomes – as Figure 1 illustrates and as explained in the Department of Health's Public Sector Transparency Framework, published in November 2010.

Figure 1



3.16 Where the successful delivery of outcomes depends on services being integrated or joined up, the Government agrees with the King's Fund that "*the framework needs to measure integrated care*". In designing the three accountability mechanisms, we have been careful to select indicators that incentivise joint working. For example:

- Responsibility for preventing people dying prematurely spans public health and NHS fields of influence. Public Health England will be

responsible for stopping people becoming ill in the first place. Once people become ill, it is the role of the NHS to prevent them from dying where the condition is amenable to healthcare. Therefore, we intend to include an outcome on reducing preventable mortality in the Public Health Outcomes Framework, and one on reducing mortality that is amenable to healthcare in the NHS Outcomes Framework.

- Similarly, ensuring that individuals recover from serious conditions requiring rehabilitation and care involves contributions from both NHS and adult social care services. The NHS is responsible for treating the individual as effectively as possible and discharging them appropriately into social care services. Adult social care services are responsible for taking over care responsibilities for the individual once they are discharged. We therefore propose including an indicator around effective recovery in both the NHS and social care outcomes frameworks so that the two sectors are held jointly accountable for effective discharge and recovery.

3.17 The Government also recognises that accountability mechanisms, such as outcomes frameworks, can only do so much to foster integration. It will be the day-to-day behaviours at every level of the system which determine how successfully services collaborate with each other and whether this leads to improved outcomes.

3.18 The new role for local authorities outlined in Chapter 5 will help to ensure that the right behaviours are being adopted at a local level, as they promote joined-up working and look across outcomes in health and social care.

C. An NHS Outcomes Framework

3.19 The Government sees the first NHS Outcomes Framework as the first step in a cultural shift throughout the NHS away from performance management against targets and towards a whole-system focus on delivering better outcomes for people.

3.20 Many people asked for more clarity on how the NHS Outcomes Framework would work in practice. The response to the consultation, *Transparency in outcomes – a framework for the NHS*, will set out the detail. In summary, the framework will set out the outcomes for which the NHS Commissioning Board is accountable to the Secretary of State.

3.21 The first NHS Outcomes Framework will look to reflect overall the treatment activity for which the NHS is responsible, and so will be

structured around the five domains as proposed in the consultation document:

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

3.22 There will be a total of around 50 indicators under these domains. These indicators will track the progress of the NHS as a whole, in improving outcomes for people using its services.

3.23 The Government has drawn heavily on the responses to the consultation in analysing which indicators are most suitable for measuring outcomes under each domain, whilst appreciating the potential risks and unintended consequences of each. The full response to the outcomes consultation will cover in more detail the comments raised on each domain and on the suggested indicators.

3.24 The NHS Commissioning Board will negotiate levels of ambition for each outcome indicator once it is up and running in shadow form in 2011, agreeing these with the Secretary of State in time for the NHS Outcomes Framework to be used to hold the Board to account from 1 April 2012.

3.25 Measuring outcomes is not an exact science, and the NHS is relatively inexperienced at measuring progress from this perspective. Therefore, the NHS Outcomes Framework will be refined on an annual basis to make sure that the outcomes that matter most to patients are included in the framework and that the indicators being used best capture those outcomes.

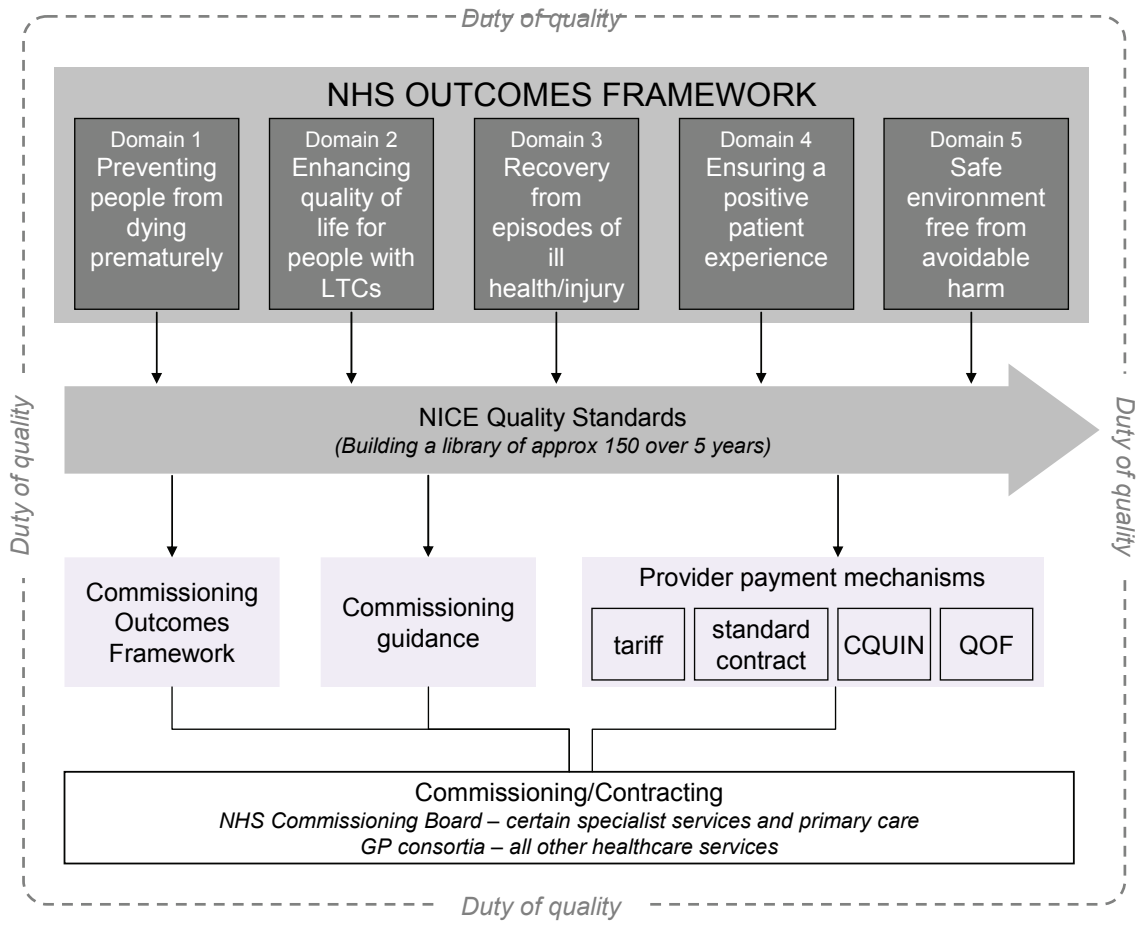
A more effective system of quality improvement

3.26 The NHS Outcomes Framework is by no means the only lever for quality improvement in the new system. Robust regulation, strong commissioning and clarity of roles across the system will provide the right environment for continuous quality improvement. The strengthened

inspection role of CQC and its system of registration will ensure that minimum standards are met.

3.27 Furthermore, all levers and incentives will be aligned to support the delivery of the outcomes goals set out in the framework. Figure 2 illustrates how the system for delivering improved outcomes will operate, and how the levers and incentives will be aligned.

Figure 2



D. Developing quality standards

3.28 NICE quality standards will improve the NHS's ability to identify and standardise best practice; and there was much support for them from the consultation. Commissioned by the NHS Commissioning Board, they will have a central place in the system for improving outcomes. They will act as the bridge between the outcomes the NHS is looking to deliver, and the processes and structures necessary to do so.

3.29 They set out a definition of high quality care for a particular pathway or cross-cutting area of care, based on accredited evidence and developed with clinicians and experts on the topic. They will be used by the NHS Commissioning Board to design the other levers and incentives for improving outcomes in the system.

3.30 From 2012, and subject to legislation, NICE quality standards will be developed for social care – something that was welcomed by respondents such as Dorset County Council and the Children's Heart Federation. This will mean that pathways spanning both health and social care will be covered by quality standards.

Commissioning Outcomes Framework

3.31 While the NHS Outcomes Framework will set out national outcome goals, it will be for the NHS Commissioning Board to determine how best to deliver improvements and to translate the national outcomes into outcomes and indicators that are meaningful at a local level in the Commissioning Outcomes Framework.

3.32 As described in more detail in Chapter 4, the Commissioning Outcomes Framework will be used by the NHS Commissioning Board to hold GP consortia to account for their contribution to improving outcomes and to support ongoing improvements in the quality of commissioning. Failure to achieve the minimum level of performance for a significant portion of the Framework (or key aspects of it) could trigger an intervention by the Board. The measures available to the Board range from directing a consortium to fulfil its functions in a different way to, in extreme cases, dissolving the consortium.

3.33 The Commissioning Outcomes Framework will be developed by the NHS Commissioning Board, with support from NICE. It will have a strong focus on patient reported outcome measures (PROMs) and patient experience, as well as progress in reducing inequalities.

Commissioning guidance

3.34 Drawing on NICE quality standards, the NHS Commissioning Board will develop high-level commissioning guidance for GP consortia. This will contain evidence and good practice on pathways, standards, outcome measures, currencies and contracting to help consortia commission the best outcomes for the patients they serve. Under the provisions in the Health and Social Care Bill, GP consortia will be required to have regard to the commissioning guidance.

3.35 Some respondents to the consultation were concerned that the reforms to the NHS could result in an increased 'postcode lottery'. Commissioning guidance will help to secure the right balance between services which are locally responsive to patients and services which are based on common, nationally produced guidance and evidence.

Putting NICE on a firmer statutory footing

3.36 As announced in *Liberating the NHS*, the Bill will establish NICE on a firmer statutory footing, clarify its role and functions, secure its independence, and extend its remit to social care. In future, NICE will be a non-departmental public body. Its primary purpose and function will be to provide advice to both the NHS Commissioning Board and the Secretary of State to enable them to discharge their respective quality improvement functions effectively. Both the Department of Health and the Board will be able to direct NICE to provide advice and guidelines. For example, the Board could ask NICE to develop quality standards on a particular area, then to disseminate commissioning guidance to GP consortia.

E. Incentives for quality improvement

3.37 The way that NHS services are paid for should support quality and efficiency. As Chapter 6 explains, from 2013/14, price-setting will be the joint responsibility of the NHS Commissioning Board and Monitor; the Board will be primarily responsible for designing the pricing structure, while Monitor will have primary responsibility for setting price levels. In the meantime, the Department of Health will start to design and implement a structure for payment to be linked to performance that is more comprehensive, transparent and sustainable.

3.38 The Department of Health has been working to refine the tariff for 2011/2012. Its priorities are to incentivise quality and better patient outcomes, to embed efficiency within the tariff – for example, through greater use of best practice tariffs – and to enable the tariff to support integrated commissioning of patient care more effectively. It will prepare for further expansion of the tariff in future years by introducing national currencies for adult and neonatal critical care, ambulance services, and cystic fibrosis (using a pathway year of care approach which could be extended in future to other long-term conditions), and it will introduce a mandatory currency for mental health care services. Respondents such as the Association of UK University Hospitals and Central London

Healthcare CIC welcomed the direction of travel and the move towards "*more sophisticated payment mechanisms*". The Department of Health will issue the tariff for 2011/12 in draft form, with a view to publishing the final tariff package in early 2011.

3.39 In addition to having primary responsibility for tariff structure, the NHS Commissioning Board will have the following payment incentives at its disposal:

- the *Quality and Outcomes Framework*: developed by the Board and NICE, this will be used to pay GPs as providers; and
- schemes under the *Commissioning for Quality and Innovation (CQUIN) payment framework*: to be developed by both the NHS Commissioning Board and GP consortia with providers, CQUIN is an important tool for commissioners to reward excellence and continuous improvement, and was widely welcomed by respondents, including for example Bliss, Barnsley PCT and Leeds Partnerships NHS FT.

F. A new duty of quality improvement

3.40 Under the Bill, the Secretary of State, the NHS Commissioning Board and GP consortia will be required to act with a view to securing continuous quality improvement in services provided by the NHS.

3.41 The new duty will embed the three dimensions of quality across all parts of the NHS:

- the effectiveness of the treatment and care provided to patients;
- the safety of the treatment and care provided to patients; and
- the broader experience patients have of the treatment and care they receive.

3.42 The Government's decision to build on the work of Lord Darzi was welcomed by respondents including UNICEF and Nottinghamshire Community Health, which was "*particularly heartened to see the continued use of the Darzi definition of quality*".

3.43 These levers and incentives combined are designed to promote a mature dialogue between commissioners and providers about how best to

deliver high quality care, improve health outcomes, and improve value for money.

Minimising the risk of failure in the new system

No healthcare system in the world can ever be 100% safe and not all serious failures in quality can be predicted. However, it is critical that organisations individually and collectively are able to detect the signs of failure at an early stage and take swift remedial action. Key parts of the new system for preventing and addressing failure will be:

A powerful voice for patients – A strong national and local presence for HealthWatch will mean that intelligence from patients' real experiences is shared with providers, commissioners and, critically, CQC. The Bill will include a power for HealthWatch England to recommend that CQC carries out an investigation, and a duty for CQC to have regard to HealthWatch's recommendations.

Strengthened governance of foundation trusts – The primary responsibility for quality lies with providers. The proposed new duties on foundation trusts outlined in Chapter 6 will ensure that governors are given a strong and meaningful role and will place genuine responsibility for performance on the organisations themselves rather than over-reliance on the regulator.

Strong regulation – The CQC will regulate providers on safety and quality, with wide-ranging enforcement powers to protect patients.

Better partnership working between regulators – As outlined in Chapter 6, the more clearly defined roles of CQC and Monitor will help to improve joint working, and the two regulators will be under a duty of co-operation. CQC will be the quality regulator, and Monitor the economic regulator.

G. Research

3.44 Many respondents to the consultation welcomed the Government's commitment to the promotion and conduct of research as a core NHS role and recognition of the importance of a thriving life sciences industry.

3.45 The Juvenile Diabetes Research Foundation echoed the view of others when it said it "*welcomes the Coalition Government's NHS White Paper and its commitment, in line with the NHS Constitution, to 'innovation and*

to the promotion and conduct of research to improve the current and future health and care of the population"".

3.46 Supporting and promoting research and development will be a core function of the future Department of Health, and the Government remains committed to providing the right environment for innovation to flourish. The increased funding for health research announced in the recent Spending Review gives us a strong platform to fulfil this ambition.

3.47 Currently a number of different arm's-length bodies have responsibility for different aspects of research regulation, including giving permissions. There is a strong argument for rationalising this and creating greater strategic coherence around research by placing responsibility for these different aspects of medical research regulation within one arm's-length body that would perform a stand-alone technical function as a research regulator. We have asked the Academy of Medical Sciences to conduct an independent review of the regulation and governance of medical research. In the light of this review, we will consider the legislation affecting medical research, and the bureaucracy that flows from it, and bring forward plans for radical simplification. There was support from respondents such as the five Academic Health Science Centres, who agreed that "*Changes to the regulatory environment are required to incentivise companies to conduct clinical trials in the UK, rather than elsewhere*", and said "*we applaud the Government's commitment to research within the NHS*".

4. COMMISSIONING FOR PATIENTS

"The freedom to make it work"

4.1 At the heart of *Liberating the NHS* is the Government's ambition for an NHS that puts patients first and continually improves the quality and outcomes of care for everyone. Underpinning these goals is an integrated set of structural reforms, designed to increase the autonomy and accountability of commissioners and providers.

4.2 The Government is replacing the current system of top-down control. Instead of hierarchical management by the Department of Health and strategic health authorities (SHAs), improvement will come from devolving power to professionals, patients and carers. The key elements are clinically-led commissioning, with providers freed up to innovate and be rewarded on the basis of best practice and patient choices, overseen by robust quality and economic regulation and an NHS Commissioning Board that is free from Whitehall micro-management. This chapter sets out plans to strengthen NHS commissioning and Chapter 5 presents complementary plans to enhance joint working with local authorities. Chapter 6 fleshes out our plans for provider reform before Chapter 7 describes transition in the round.

4.3 *Liberating the NHS* described plans to establish a comprehensive system of GP consortia to commission most NHS services, supported by and accountable to a new independent NHS Commissioning Board. These arrangements radically simplify current NHS structures, allowing the abolition of SHAs and PCTs and contributing to a one-third reduction in overall administration costs. They are about devolution of power and responsibility, within a clearer but less domineering national framework. As one Hampshire GP observed, "*Overall I welcome this and I think GPs will do their best to make it work. But involving us in this way will only work if we are given the freedom to make it work. If the new central commissioning body is too prescriptive or bureaucratic we will be back where we started, with a PCT/SHA holding back progress due to excessive caution or excessive interference*".

4.4 We received over 1,200 specific responses to the consultation document *Commissioning for patients,* and GP commissioning was one of the main issues raised in responses to the White Paper. Responses came from members of the public, GPs and practice staff, other health professionals, hospital trusts and other NHS organisations, as well as

local authorities, voluntary organisations, professional organisations, trades unions, commercial organisations and think tanks.

4.5 Taken together, the responses have illuminated a number of important issues and provided a rich array of perspectives. For example, some respondents asked what the plans mean in terms of the relationships between consortia and member practices, other professionals, the NHS Commissioning Board, local authorities and the public. Some questioned whether the Government had got it right on commissioning for maternity services and primary medical care. A constant theme was the need for effective leadership. There were divergent views on the pace of change, with some enthusiasts urging the Government to go faster, and other voices arguing that the transition should extend beyond 2013. The responses have warranted careful consideration by the Department, and they have helped shape our proposals for primary legislation – which will define the specific powers and duties of the consortia, those of the NHS Commissioning Board, and those of the Secretary of State. The consultation has also informed plans for implementation and managing the transition, including the pathfinder programme.

4.6 This chapter considers in turn:

A. The principle of GP commissioning

B. Granting GP consortia statutory powers and duties

C. Composition of GP consortia

D. Robust governance arrangements

E. Partnership working

F. A new relationship with the NHS Commissioning Board

G. Clear accountability

H. Commissioning primary care services

I. Commissioning specialist and complex services

J. Commissioning maternity services

K. Other statutory responsibilities

L. Freedom from political micro-management

M. Effective national stewardship of the NHS

N. GP consortia pathfinders and managing the transition

A. The principle of GP commissioning

4.7 The consultation, *Commissioning for patients*, asked questions specifically about the implementation of its proposals for GP commissioning. However, we also observed considerable support throughout the consultation and engagement period for the principle that key decisions affecting patient care should be made by healthcare professionals in partnership with patients and the wider public, rather than by managerial organisations. Overall we have heard much support for the objectives behind GP commissioning, with concerns focusing for the most part on getting the key design principles right, on whether GPs have the right skills to commission well, and above all, on managing the transition.

4.8 Some respondents opposed the policy of GP commissioning. A number interpreted the Government's plans for GP consortia as part of a hidden plan to privatise the NHS; conversely we have also heard that the plans are tantamount to the nationalisation of GPs. The Government's proposals would do neither. Some have argued against the policy of GP consortia on the basis that GP fund-holding or practice-based commissioning (PBC) did not work, and said that managers rather than GPs should remain responsible for commissioning decisions. Some respondents said that PBC in their area was working well and that it was unnecessary to make further changes; others that, even where PBC is working well, more autonomous and accountable consortia would work better.

4.9 Others expressed support for the proposed enhanced role of local government in health and wellbeing, and for GP consortia to have greater responsibility, whilst at the same time arguing that the Government should keep PCTs. The Coalition Government does not believe that such an approach is coherent, workable or affordable. The transfer of power and responsibility to consortia and local government means that it is no longer necessary to keep the structure of existing PCTs. The previous government attempted to revitalise practice-based commissioning with limited success, given the confusion and overlap in roles between PCTs and PBC groups. Furthermore, the need to increase productivity and reduce administration costs calls for a significant simplification of administrative structures.

4.10 Several Nottingham-based pharmacists argued that the "*proposal to set up GP consortia with real budgets and significant commissioning responsibilities has not been tried or tested*", and that "*there is no evidence*" to support the policy. Others observed that the Government's plans build on nearly 20 years of experience and research on the commissioner/provider split in England as well as international experience. The Nuffield Trust stated that "*research evidence points to the significant potential of GP commissioning consortia holding real as opposed to indicative, capitated budgets for the purchasing of local health services, and for these groups to be held to account for health outcomes, patient experience of services, and financial performance*".

4.11 GP commissioning builds on the key role that GP practices already play in coordinating patient care and acting as advocates for patients. Mill Stream Surgery, Benson, described how "*GPs are uniquely placed to see shortcomings in existing services and to be involved in the design of new services and patient pathways, given the involvement that they have with patients throughout their patient journey*". This proximity to patients makes it a natural extension for GP practices to play the lead role in deciding what wider healthcare services to commission on their patients' behalf. As the Royal College of General Practitioners (RCGP) set out, "*the College is confident that GPs, already having the greatest knowledge and understanding of the healthcare needs of their patients, are supremely well placed to shape the future development of NHS services*". A GP from Northampton commented: "*I fully believe that the proposals outlined in the White Paper are the right way forward for the NHS with clinicians employing managers rather than the other way round*".

4.12 We heard support from professionals other than GPs. For example, a consultant physician in Suffolk said: "*Giving GPs the responsibility to commission non primary care services is an excellent way of getting patients closer to the commissioning process. Whilst GPs will need technical help …, it is right to give ultimate clinical and financial … responsibility to GP clinicians*". The Royal College of Speech and Language Therapists welcomed "*the move to push decision-making closer to patients and local communities and ensure that commissioners are accountable to them. … We hope that the extension of commissioning will empower GPs to develop more flexible and responsive services to meet patients' needs*".

4.13 GPs also play a critical role in influencing NHS expenditure, both through referral and prescribing decisions and (less directly) through the quality and accessibility of the services they provide for patients and the impact

these have on emergency and urgent care provided elsewhere in the system. GP commissioning in this sense gives groups of GP practices financial accountability for the consequences of their decisions. Many respondents strongly supported this view, including the King's Fund who said that "*allocating commissioning budgets to GP consortia could improve the use of clinical expertise in the planning and purchasing of health care and impose a much needed financial discipline on the way providers deliver care by making them responsible for the wider cost implications of their clinical actions*".

B. Granting GP consortia statutory powers and duties

4.14 As the NHS Alliance stated, "*general practice commissioning consortia are to be constituted as statutory bodies, or at least on a statutory basis, with the ability to hold budgets and enter into contracts. The NHS Alliance believes that is appropriate and necessary*". In general the approach for consortia to be statutory bodies was widely supported. Some respondents expressed concern that a statutory model would risk overburdening consortia with bureaucracy. Others, for example the Healthcare Financial Management Association, argued that consortia should be subject to "*rigorous and detailed*" governance obligations.

4.15 The purpose of consortia being statutory bodies is to ensure that they have an identity that is separate from that of their member practices, with clarity between the commissioning responsibilities of the consortium as a whole and the specific responsibilities of individual practices. Being a statutory body means that consortia can have clear powers and duties. Compared to current practice-based commissioning, statutory arrangements will afford a more transparent framework for how consortia operate, including what happens when a consortium is unable to fulfil its functions. The Department can confirm that consortia being statutory bodies will not affect the status of GPs and GP practices as providers of primary care.

C. Composition of GP consortia

Ensuring sufficient geographical focus

4.16 We proposed that consortia should have "sufficient geographical focus" to commission locality-based services (such as urgent care) and meet certain other duties, but asked how far consortia should have flexibility to

include GP practices from different areas. This question attracted a very broad spectrum of views, ranging from a few calls for complete flexibility to the opposite view that all consortia without exception should be configured in line with local authority boundaries. Most respondents favoured an element of co-terminosity; in particular, local government responses tended to focus on the need for effective joint working arrangements, with an emphasis on the benefits of co-terminosity. Our plans in Chapter 5 for health and wellbeing boards set out a package of proposals designed to improve significantly joint working compared to current arrangements, whilst also enabling NHS commissioners to be more dynamic and flexible.

4.17 A former chair of the GP Committee at the Royal College of Physicians commented that "*consortia boundaries have to work for patients and in geographical terms these could be aligned around hospital natural catchment areas*". Berkshire West PCT reflected the views of many when it said that "*if it makes sense for patients for consortia to cross geographical areas this should be permitted*". Lancashire and Cumbria Consortium of Local Medical Committees suggested that GP practices that are currently "*artificially aligned with others within a PCT may wish to look to a different GP consortium that more ably reflects patient flows and natural communities. There are many such examples on the boundaries of likely consortia and this needs to be accommodated*".

4.18 The Government agrees: our intention is not to recreate PCTs or PCT boundaries. Cumbria County Council and Cumbria PCT argued for "*local autonomy to decide structures and arrangements which make sense for local communities, residents and systems, particularly to enable continued co-terminosity and co-ordination and avoid fragmentation. We would suggest that, as a very large and rural county with a significant diversity of need, local determination is very important*".

4.19 The vice-chair of a practice-based commissioning cluster argued that "*high flying consortia may attract new members who are impressed by their performance. This way the successful carry on growing and the unsuccessful will fail as the good practices move to good consortia*". Central London Healthcare CIC likewise said that "*Not being rigid about geographical boundaries allows like-minded practices to come together, sharing knowledge and good practice from their localities. This also allows competition between consortia and practices to choose the consortium with whom they are most compatible*". These points are well made, and the Health and Social Care Bill will therefore provide for membership of consortia to flex rather than be fixed forever, with consortia able to expand, contract, dissolve or merge. This is a very

different approach from the traditional model of NHS authorities having boundaries that are rigid over time, and it means that it is less important for the Government to take a view about initial configuration.

4.20 The variety of views on this issue is almost certainly evidence in itself that there is no single right solution. We therefore intend to give GP practices flexibility within the legislative structure to decide how they come together to form consortia and how these consortia evolve over time, subject to being able to demonstrate to the NHS Commissioning Board, when applying to be established, that they have workable arrangements to enable them to carry out their statutory duties.

4.21 This would also mean that, although consortia will need to serve a defined geographic area for the purpose of discharging certain of their responsibilities (for example, ensuring access to accident and emergency services in that area and commissioning care for people living in that area who are not registered with a GP practice), it would not automatically follow that every one of the practices in a consortium has to be physically located in that area, nor that all practices in a consortium have to be adjacent to each other. For example, it is possible that two towns could be covered by one consortium, but for the rural area in between to form part of a wider rural consortium. However, we do not consider it viable for a consortium to be made up of practices drawn from a multiplicity of disparate places as this would make it impossible for a consortium to deliver its responsibilities.

Varying and viable size

4.22 The question of size attracted similarly diverse views. Some responses called for a minimum population size, ranging from 100,000 to 500,000. Arguments for setting a minimum size were advanced by North Tees and Hartlepool NHS Foundation Trust, which said that this would ensure that consortia "*can afford the critical mass of management and administrative support to enable them to fulfil their functions*". Manchester Local Medical Committee reflected the views of a number of respondents when it said that consortia "*must be sufficiently large to provide financial viability and negotiating strength with providers*". Experience, particularly from the US, also suggests that smaller clinical groups are less able to manage risks related to natural fluctuations in local health needs. However, as others observed, this does not necessarily mean having one large consortium for every large hospital provider; consortia can group together for some purposes. For example, they can have lead commissioner arrangements for contract management, just as PCTs currently do, in order to increase coordination and minimise transaction costs.

4.23 Many respondents argued for flexibility. For example, a GP involved in commissioning urged the Government to "*try to protect smaller clusters*", which are "*much more innovative and inclusive of local GPs compared with other consortia in the area. In most areas we are the closest to breaking even. There needs to be a mechanism to protect small consortia who wish to stay small*". A respondent from a rural area pointed out that some districts have populations that are smaller than 100,000 and was concerned that a minimum size would force consortia to cover very divergent areas with widely differing health needs. We acknowledge the force of these arguments. As one GP put it, "*no maximum or minimum size [should be] prescribed as that would be against the spirit of flexibility that is such a strength of 'Liberating the NHS'*". Another individual respondent argued: "*I do not see a need to force a minimum size, but economics will effectively determine a minimum size*".

4.24 One of the key themes emerging from early discussions about potential consortia is that the precise size of a consortium is less important than the ability to scale up or scale down depending on the nature of the activity being undertaken. The history of NHS commissioning over the past ten years can be viewed as an elusive search for a right commissioning size, with GP fund-holding and primary care groups viewed as lacking the scale needed for some services but health authorities and PCTs seen as too remote from patients and clinicians. The Government's view is that, at some stage, most consortia will feel both too big and too small. A number of the proposed consortia which are emerging, are planning to overcome these problems either by forming at a relatively small scale and then collaborating with other consortia where larger scale matters, or by forming a large consortium but breaking down into smaller localities where this makes more sense. The Government has no view as to which is better. The Bill will therefore provide for boundaries to flex rather than be fixed: allowing members to leave and join another consortium, and letting consortia merge or dissolve. In relation to size, the only criteria will be whether the Board is satisfied that prospective consortia have made appropriate arrangements to ensure that they can discharge their functions and that they have an appropriate area (for example, for the purposes of their duties in relation to accident and emergency services).

Membership of GP consortia

4.25 All holders of primary medical contracts will have a duty to be a member of a consortium in respect of each contract they hold (i.e. each GP practice). The consultation responses reflected some concerns that GP-led commissioning could divert GPs from the day-to-day job of providing

family health services for patients, or that GPs will lack the specialist knowledge to commission certain healthcare services. Examples were given; for example, the National Autistic Society said that "*unless GPs are given the necessary support, they may struggle to commission the right services for people with autism*". A GP from the West Midlands wrote: "*When do I have the time to do this? I have had no training. Who sees my patients whilst I'm commissioning?*" It is important in this context to emphasise that the Government is not proposing to require individual GPs or individual GP practices to take commissioning and financial decisions on their own.

4.26 It will be for the consortium to decide within the legislative framework how it carries out its functions. It may be that only a minority of clinicians play a hands-on, executive role within the consortium. Consortia will be able to secure support for discharging their responsibilities from a range of sources, whether this is by employing staff (including the many excellent staff currently working in PCTs), buying in support from external organisations, or collaborating with local authorities. As an Essex GP stated, "*consortia will be able to make quite sophisticated decisions about who they choose to support them*". They will also need to draw in expert advice from a range of health and care professionals and systematically involve patients and local communities in their work.

4.27 Some GPs will want to play a leading role in running consortia. Other GPs may wish to focus on how to improve a particular aspect of services. As the RCGP stated, "*many of our members, particularly those fresh from training or in the first few years of practice, are keen to participate in the commissioning of services. They see inefficiencies that currently exist and already have ideas about how to address them. Others, already working exceptionally hard for their patients, are less keen to engage in commissioning*". The great majority of GPs will continue focusing on providing primary care.

D. Robust governance arrangements

4.28 A key issue raised during the consultation period concerned the nature and the quality of governance arrangements for consortia: what it means for the consortia to be made up of member practices and how good governance can be secured in the public interest. Governance arrangements need to establish clear and effective bonds across member practices as well as ensure that bodies responsible for large amounts of public money are fit for purpose.

4.29 The Appointments Commission wrote in its response to the consultation that "*GP consortia will need to demonstrate to their GP members, patients and the tax-paying public that they are discharging [their] functions responsibly and in the best interests of patients and the public*". We fully agree with these principles. Our objective is to ensure that there are clear and transparent arrangements for governance, whilst at the same time recognising that different styles of governance will suit different organisations.

4.30 Each contract-holder will nominate a clinician to represent it on the consortium. This nominated clinician will play the key role in helping to ensure that commissioning decisions reflect the healthcare needs of the practice's registered patients. In doing this, they will work with GPs or other partners, salaried GPs, practice nurses, practice managers and other practice staff, reflecting the importance many respondents placed on the involvement of other staff.

4.31 There was widespread support for the proposal that all consortia should have an Accountable Officer, who will play a key leadership role. Our legislative proposals will give the Accountable Officer specific responsibilities for ensuring that a consortium complies with its financial duties, promotes continuous improvements in the quality of the services it commissions and provides good value for money. The Bill will allow the Accountable Officer to be either a member or employee of the consortium, or a member or employee of one of its GP practices, whose appointment has been approved by the NHS Commissioning Board. We do not propose to stipulate that the Accountable Officer must be a GP or clinician, though we would anticipate that most consortia will wish to have a clinician in this role. Strong clinical leadership is a critical component of successful commissioning, and clinical experience will be essential in understanding how best to improve quality and outcomes.

4.32 Where the Accountable Officer is not a clinician, we envisage that consortia would introduce other professional leadership roles, including responsibility for sustaining relationships between clinical colleagues both within the consortium and across local networks of care. As a GP practice in Cleveland stated, "*GP consortia can be effective by having trust and ownership of shared goals and standards, sharing good practice and understanding differences in clinical practice. An effective relationship can be achieved by a combination of working together and developing trust and a collaborative approach*". Whether or not the Accountable Officer is a GP or other clinician, consortia might also choose to have an executive post (such as a chief operating officer) with specific duties for ensuring effective management systems.

4.33 The consultation sought views on any other core features of governance that should be required of consortia. A number of respondents supported the proposal for a flexible approach so that consortia can decide for themselves what structures and processes best enable them to deliver high-quality outcomes, manage resources effectively and ensure appropriate public and professional involvement. As the Nuffield Trust observed, "*research evidence on primary care led commissioning points to the importance of such groups not being seen as 'other' or as belonging to the state, but as being clearly owned and run by GPs (Smith and Walshe, 2004; Locock et al, 2004; Smith and Mays, 2007; Nuffield Trust and NHS Alliance, 2009; Casalino, 2010)*".

4.34 Some respondents referred to the importance of clinical governance. An allied health professional, for example, noted that clinical governance is key to bringing about "*necessary changes to improve access, quality and efficiency*", whilst the British Geriatric Society said that "*Commissioning for sustainable high quality services has direct implications for … clinical governance. Commissioning for sustainability must therefore include [this]*". We agree that the principles of clinical governance (in other words the structures, processes and culture needed to ensure that healthcare organisations and the individuals within them can ensure quality of care and are continuously seeking to improve it) apply equally well to commissioners as to healthcare providers. Whilst we do not want to prescribe a specific model of clinical governance, consortia will need to be able to demonstrate how they will fulfil their duty to secure continuous improvements in quality of services.

4.35 Other comments included the need to ensure clear systems for assuring quality of general practice and avoiding conflicts of interest. As the Royal College of Paediatrics and Child Health wrote, "*there may be conflicts of interest as consortia consider the quality of their constituent practices – clear and focused governance arrangements will be required to ensure that there is a consistent and systematic review of quality and that appropriate actions take place should quality of services be inadequate*".

4.36 Several respondents felt that governance arrangements should be highly prescriptive and based on the model for PCTs, with a requirement to have a formal board structure, specified non-executive directors and an independent chair. A number of responses called for more specific governance requirements in relation to patient and public involvement. National Voices described it as "*vital that there is equal lay participation in the governance of the consortia, and that their meetings are held in public*". There was also concern that more formal approaches may give disproportionate voice to those with the most time or inclination to get

involved. A London GP wrote: "*Patient Groups select a particular vocal segment of the population which does naturally favour particular sections of society. GPs can give a balancing view with the help of the local authority to represent the other sections of society not represented by the patient groups*".

4.37 The Coalition Government has considered very carefully the issue of lay and patient representation within consortia. We are clear that requiring there to be a statutory management board for each consortium would be over-prescriptive; and that placing legislative requirements for there to be lay or patient participation in the governance of consortia is unlikely to work. At its heart a GP consortium is about a nexus of professional inter-relationships, the exercise of peer influence, and professionals taking on direct responsibility and public accountability for the decisions they collectively make. The Government does not see how this can be mediated through imposing upon consortia a small number of lay or patient appointees. The Government certainly does not wish to discourage consortia from developing arrangements for lay or patient involvement, which can often work well, but it must be for consortia to make their own decisions on this.

4.38 In this debate, it is important to note that the arrangements set out in the remainder of this chapter – and critically, those described in Chapter 5 – will increase local democratic legitimacy, public involvement and accountability, and scrutiny of NHS commissioning decisions. Local government will have a clear ability to scrutinise GP consortia, as well as stronger powers to scrutinise any NHS-funded services, including providers of primary care. To support public accountability, consortia will also be required to make public their remuneration arrangements, to hold an annual general meeting that is open to anyone, make their commissioning plans available to the public, and publish an annual report which includes consideration of how well they have discharged their new joint arrangements with local authorities. The annual report will also be the place where GP consortia reflect the patient and public consultations that have taken place.

4.39 The debate has also revealed potential confusion between a lack of prescription over governance requirements and a lack of governance altogether. There were, for instance, concerns that consortia might end up without policies or processes to prevent or address conflicts of interest, or without transparent arrangements for reaching collective decisions. This is not the Government's intention. As part of their application to the NHS Commissioning Board for establishment,

consortia will have to submit a proposed constitution, and this will be publicly available.

4.40 The Bill will provide that each consortium's constitution must include, as a minimum: the name and members of the proposed consortium; the geographic area for which the consortium will be responsible (for the purposes of certain prescribed responsibilities such as securing emergency care); arrangements for discharging their statutory functions (which will include public and patient engagement, and multi-disciplinary working); procedures for decision-making and managing conflicts of interest; and arrangements for securing the effective participation of the consortium's members. The Bill will provide for the NHS Commissioning Board to issue guidance to consortia on the form and content of their proposed constitution. To reinforce the requirement that governance arrangements must be robust, the Board will also have the power to issue guidance to consortia on the form and content of their proposed constitution, drawing for example on the principles of good governance in public life.

E. Partnership working

Multi-disciplinary working

4.41 Throughout the consultation and engagement period, we have been encouraged by the increasing focus given to the partnerships that will be needed under the White Paper proposals. Whilst the Bill will introduce a number of duties of partnership, the strength of the new arrangements will draw primarily upon the leadership and behaviours demonstrated by leaders of GP consortia working together with patient groups, local authorities and other health and care professionals.

4.42 Consultation responses underlined the importance of multi-professional involvement in commissioning. The BMA described how "*consortia will be looking to involve clinicians from provider units in commissioning decisions, to utilise their expertise and create integrated pathways*". A Hampshire GP wrote that "*We need to work with colleagues in secondary care in a partnership of professionals to sort out the best pathways for patients. This will result in significant savings, as professionals work well together in the best interests of patients*", and the Royal College of Physicians agreed that "*Commissioning should always be clinically led and based on more effective dialogue and partnership between GPs and hospital specialists*". The Royal College of Nursing wrote that nurses

"*have an invaluable insight into the practical issues of service delivery, including advice on value for money, efficiency, and effective and quality care provision. Nurses have a pivotal role in being able to stand back and view the whole care pathway, take a holistic perspective to look above the day to day clinical issues and effectively support commissioners in the decision making process*". There was also strong support for GP consortia to involve other primary care professionals such as allied health professionals, community pharmacists and practice nurses in commissioning.

4.43 The consultation sought views on how in practical terms consortia could most effectively develop these professional partnerships. A number of respondents referred to examples of existing partnership work, for instance in relation to community paediatrics, health visiting and children's social services, that consortia could draw on. Several responses highlighted a role for clinical networks to advise on pathway design, and suggested that providers should release specialists who could contribute.

4.44 Some responses suggested establishing a multi-disciplinary committee to provide advice to each consortium, similar to PCT professional executive committees. However, other respondents expressed concerns about how to ensure impartial advice if a committee member was employed by a provider organisation. The forthcoming Bill will provide for consortia to make arrangements to ensure that they have appropriate advice from professionals with expertise in health. We propose, however, that consortia should have the freedom and flexibility to decide how best they exercise this duty, rather than rely on rigid prescribed structures

Patient and public involvement

4.45 Our proposals in Chapter 2 will strengthen patient choice, and GP consortia and the NHS Commissioning Board will be under statutory obligations to promote patient choice. Local HealthWatch will strengthen patient voice, and the enhanced role of local authorities, as described in Chapter 5, will increase democratic legitimacy of NHS commissioning decisions.

4.46 The White Paper proposed that, whilst the NHS Commissioning Board should hold consortia to account for financial performance and outcomes, there should be a stronger role for local authorities in helping to shape commissioning priorities and in promoting a joint approach to improving the health and wellbeing of local communities. Chapter 5 sets out how, in response to consultation, we are strengthening arrangements

for health and wellbeing boards. Consortia will have a duty, before the start of each year, to prepare commissioning plans, including proposals for how they intend to use their commissioning budget and how they intend to improve outcomes for patients. Consortia will need to discuss these proposals with local health and wellbeing boards (which must include a local HealthWatch member) to ensure that they reflect joint strategic assessments of need and joint health and wellbeing commissioning strategies.

4.47 Devolving power and responsibility to local GPs will also help to make commissioning more patient-centred. A Rotherham GP wrote in response to the consultation that "*Not only should GPs… be shaping the commissioning, but patients. We need their voice and narrative. I'm willing to bet there is not a day when all of us are [not] touched by the triumphs or failures of healthcare (I include our own families & friends). Up to now the commissioning process remains so remote from this as to be almost irrelevant to my working life*". As Partnerships in Care wrote, "*Liberating the NHS White Paper presents opportunities for patient engagement that are new and exciting*". The National Association of Primary Care (NAPC) said that delivering "*an NHS that is truly person-centred will more likely occur if primary care is the place where patients' views have a real influence on the care they choose and the services available to them. Primary care has a genuine understanding of patients' needs, coupled with an intuitive sense of the rightness of patient-centredness as a means of engaging them in their own healthcare, including preventative health choices.*"

4.48 We asked how GP consortia and the NHS Commissioning Board could best involve patients and community partners in making commissioning decisions. Our meetings with GP leaders suggest that there is a commitment to patient and public involvement within emerging GP consortia and a desire to keep existing structures that have worked well, as well as forge stronger links with local HealthWatch – a point emphasised by Picker Institute Europe. The Department has begun work with a number of emerging GP consortia who wish to develop their approaches to engagement and harness the benefits of public voice in their commissioning. This work will link into the broader GP consortia pathfinders programme. We are working alongside the BMA, RCGP, NAPC, NHS Alliance, Family Doctor Association and patient representative organisations to promote the benefits of good engagement and to capture and share learning with the wider GP commissioning community. We will also promote close working between emerging GP consortia and PCTs to help ensure that, during the transitional period, consortia are able to draw on the expertise and

experience of PCT staff and the repository of information about public views held at PCT or borough level.

4.49 A number of respondents emphasised the importance of ensuring that GP consortia not only listen to patients and handle their complaints, but also respond to people's views and feedback and that they seek out the views of those who may not be using current services. Turning Point called for "*a duty to be placed on GP consortia to engage with communities to ensure they know, and more importantly know how to meet, the needs of people not only accessing their services currently but those in the wider community they will be responsible for*". Advocacy Partners Speaking Up described how "*independent advocacy can be involved too at earlier stages of the commissioning process, reducing the causes of complaints, fostering a culture of public participation and patient voice, service innovation and collaborative working*". The Bill will therefore place a duty on GP consortia and the NHS Commissioning Board to ensure that people who may receive a service are involved in its planning and development, and to promote and extend public and patient involvement and choice.

F. A new relationship with the NHS Commissioning Board

4.50 *Commissioning for patients* sought views on how to develop the most effective relationship between the NHS Commissioning Board and commissioning consortia. A considerable number of respondents emphasised the need to avoid the Board's role turning into one of direct performance management. As one respondent wrote: "*Care will be needed to prevent top down directives smothering local initiative and determination. Primary Care Trusts have been smothered by national directives and my concern is that the same will happen with consortia*". A Derby GP also expressed similar concerns: "*Don't let too much top-down monitoring tie our hands behind our back*".

4.51 The Government supports this view. The headquarters of the NHS will be in the consulting room, not the NHS Commissioning Board. Innovation will come primarily from the leadership of liberated local commissioners and providers, supported by the NHS Commissioning Board, not the other way round. The Board will need to construct a very different relationship with GP consortia to that which currently exists between the Department and SHAs, and SHAs and PCTs. It will be less of a hierarchical performance manager than a quasi-regulator of commissioners, operating on the basis of clear and transparent rules, within well-defined statutory powers. In line with this vision, the Bill will

not grant the NHS Commissioning Board a general power of direction which implies general control. Nor will it be able, as SHAs are, to use hierarchical power as a way of resolving disputes between commissioners and providers. Instead, the Government is exploring how it can enshrine the principle of the autonomy of individual commissioners and providers as a duty both for the Secretary of State and for the NHS Commissioning Board.

4.52 The NHS Commissioning Board will hold consortia to account for the quality outcomes they achieve and for financial performance, but it will only have the power to intervene where there is evidence that consortia are failing or are likely to fail to fulfil their functions. We have taken particular note of the comments of many respondents, for example the Nuffield Trust, that there needs to be a clear statutory failure regime for commissioners. This is a lacuna in the current legislation in relation to PCTs, which our forthcoming Bill will address by granting the Board a clear and stepped series of powers to tackle consortium failure and the risk of failure.

4.53 The NHS Commissioning Board will have a number of further specific powers in relation to consortia. It will establish consortia if satisfied that certain legislative requirements have been met, including, for example, that the consortium will be able to discharge its statutory functions. The Board will also have to ensure that the areas for which consortia are established cover the whole of England. In order to discharge this duty to ensure a comprehensive system of consortia across England, the Board will have the power, if necessary, to assign GP practices to consortia. It will allocate commissioning budgets to consortia and it will have powers to enter into financial risk-pooling arrangements with consortia on the commissioning side.

4.54 The NHS Commissioning Board will have a vital role in providing national leadership for driving up the quality of care, including safety, effectiveness and patients' experience, promoting patient and public involvement, and the promotion of innovation and integration across the NHS, by supporting consortia in a number of ways:

- publishing commissioning guidance and model care pathways, based on the evidence-based quality standards that it has asked NICE to develop;

- developing model contracts and standard contractual terms for providers;

- designing the Commissioning Outcomes Framework and the new quality premium;

- designing the structure of price-setting, including best practice-tariffs and the CQUIN framework;

- helping ensure that consortia have access to high-quality information; and

- providing a forum for consortia to share knowledge, and support collaboration.

4.55 The NHS Commissioning Board will also work with NICE to ensure that GP consortia have access to the most up-to-date expert advice on the clinical and cost-effectiveness of different interventions, including medicines. Our plans for value-based pricing, which will be set out shortly in a consultation paper, are designed to ensure that the price of a medicine is based on an assessment of its value. Currently pharmaceutical companies are free to set whatever price they choose within the constraints of the Pharmaceutical Price Regulation Scheme. Value-based pricing will be introduced from 2014. It will be a national system benefiting all clinicians and all consortia by giving them greater confidence that medicines are cost-effective as well as clinically effective. It will be designed to help ensure that patients can access the most clinically appropriate treatments. Like PCTs now, GP consortia will be expected to fund services and interventions that are clinically- and cost-effective.

4.56 Some respondents also recommended that the Board should seek feedback on commissioning from local authority health and wellbeing boards and share this with consortia. We agree that this could form a useful part of the annual assessment that the Board will need to make of how effectively consortia are improving outcomes and meeting their statutory duties. The Bill will also include a duty for the Board to promote collaboration between GP consortia and local authorities, to reinforce the importance of health and wellbeing boards.

4.57 One of the key questions raised by respondents was how a single national organisation would manage effective relationships with a number of GP consortia. Responses suggested that the NHS Commissioning Board would need to have some of its staff located away from its headquarters, including possibly being co-located with consortia themselves, to allow for a closer two-way relationship with consortia. Suggestions also included ensuring that each consortium had a named single point of contact within the Board. We do not propose here to pre-

empt the decisions that the Board itself will need to make on how it designs the most effective and cost-efficient operating models, but we will ensure that the shadow Board is able to draw on these suggestions during 2011/12 as it prepares to take on its full responsibilities from April 2012. It will be for the Board to determine the optimal configuration of its sub-structures, with the freedom to adapt these over time.

4.58 Another key theme was the importance of demonstrating that the NHS Commissioning Board is responsive to the needs of consortia and ensuring that it holds the confidence of healthcare professionals. It will need to be able to demonstrate good clinical evidence in support of its decisions, maintain effective relationships with the Royal Colleges and other professional bodies, and have strong internal professional leadership. The Bill will put duties on the Board to obtain professional advice in the exercise of its functions (which it could discharge, for example, through employing or otherwise securing the services of national clinical experts) and to promote involvement in research and the use of research evidence.

4.59 We intend that the NHS Commissioning Board will publish a business plan setting out how it intends to achieve its statutory duties and the objectives or requirements that have been set for it by the Secretary of State. The business plan will cover a three year period and will be updated annually. The Board will also publish an annual report setting out progress against the proposals it made in its business plan for that year, its statutory duties and the published objectives and requirements set for it by the Secretary of State.

G. Clear accountability

Accountability for quality and outcomes

4.60 A central feature of our vision for GP consortia is to ensure that in future, NHS commissioners have a stronger focus on improving the quality and outcomes of care for patients. This focus on better care is for all patients: both the NHS Commissioning Board and GP consortia will be under a statutory obligation to reduce inequalities in healthcare provision. The new duty of quality is a key element in supporting quality improvement, and underpins the new NHS Outcomes Framework, as described in Chapter 3. The NHS Commissioning Board will draw on the national outcome goals in the Outcomes Framework to develop a new Commissioning Outcomes Framework, to help hold consortia to account

for effective commissioning and to promote improvements in quality. The proposal to develop a Commissioning Outcomes Framework attracted widespread and strong support. For example, Genetic Alliance UK believes that it is "*an opportunity to create, for the first time, robust outcome measures capable of truly capturing the patient experience*".

4.61 We received a range of suggestions on the possible features of the Commissioning Outcomes Framework, including: "*Quality improvement, Cost effectiveness, Delivery of outcomes, Evidence based care*" (Directors of Nursing, West Midlands region). There was a particular focus on patient experience, patient-reported outcomes and quality of life measures, with the Cambridgeshire County Council Adults Wellbeing and Health Scrutiny Committee proposing that outcome measures "*should be able to capture people's real experience at the crucial points in their lives*". Respondents also referred to the importance of assessing quality of care for hard-to-reach and disadvantaged groups, including being "*more effectively aligned with mental health priorities*" (Lundbeck) and focusing on the specific needs of looked after children (raised by several respondents, including the National Children's Bureau) and people with multiple problems, such as substance misuse. Some respondents suggested the framework should include key public health indicators to reinforce the need for close joint working between consortia and local authorities on health improvement.

4.62 Respondents highlighted possible tensions between a nationally defined framework and the need to pursue outcomes based on the joint strategic needs assessment (JSNA). Kent County Council wrote that the "*The key emphasis must be on flexibility, relevance and outcomes for patients so that the indicators can be evolved on a 'fit for purpose' basis. Key to this is that each outcome framework reflects what is important to people in the area, i.e. localised outcome frameworks*". This points to the need for further work, which we intend to pursue with the help of consortia pathfinders and local authorities, to ensure that the Commissioning Outcomes Framework supports the process of identifying local priorities and to allow other local priorities identified through the JSNA to feed into the developing Outcomes Framework. We also heard concerns that too strong a focus on outcomes might lead to a disproportionate focus on outcomes that are "recovery-centred" and detract from assessing quality of life for people with long-term conditions. Parkinson's UK called for outcome indicators "*to be about the quality of life, maintaining dignity and independence*". We agree that it is essential to capture these aspects of commissioning.

4.63 It will be for the shadow NHS Commissioning Board to take forward work on developing the Commissioning Outcomes Framework during 2011/12, with the support of NICE. To help maintain momentum, the Department will publish a discussion document early in 2011, seeking more detailed views on possible features of the framework, and we will ask NICE to engage with professional and patient groups on proposals for the design and testing of specific outcome indicators.

Financial accountability

4.64 GP consortia will be under a clear duty to ensure that their expenditure does not exceed the commissioning budgets allotted to them. Respondents agreed with the need for a clear line of financial accountability from consortia to the NHS Commissioning Board and in turn to the Secretary of State. As Accounting Officer, the NHS Commissioning Board's Chief Executive will be accountable to the Department of Health for the overall commissioning revenue limit. The NHS Commissioning Board in turn will hold the individual Accountable Officers of each consortium responsible for their share of the total funding allocation, and this will include the duty to achieve financial balance. The NHS Commissioning Board will be responsible for preparing a consolidated annual account in respect of all consortia, which will form a key element in the Department's overall resource account.

4.65 We intend that the Department of Health will specify to the NHS Commissioning Board the precise form and content of the accounting information it requires, and that the Board will, in turn, give directions to consortia on the form and content of the accounting information it requires from them and the timetable to which that information must be provided. This will ensure consistency in accounting arrangements and requirements as they flow between the Department, the Board and individual consortia.

4.66 The consultation proposed that the NHS Commissioning Board should play a leading role in supporting effective management of financial risk and sought views on the principles that should underpin the relationship between consortia and the Board in this respect. Responses indicated broad support for the principles in the consultation document and reinforced the need for support for consortia in this area. The RCGP commented that consortia "*will need considerable education resources, as financial risk management at the scale of consortia is beyond the current skills set of most GPs. Beyond this, the NHS Commissioning Board should be prepared to step in quickly with support if it looks like a*

consortium may be failing financially, and there should be transparent processes for these situations so that any risk to continuity of care is avoided".

4.67 A number of responses specifically supported the case for some form of risk pooling between consortia, and risk-sharing between consortia and providers. Respondents welcomed a supporting role for the NHS Commissioning Board, including potentially some form of weighted 'insurance' premium to ensure appropriate incentives for good financial management. Under the provisions in the forthcoming Bill, the NHS Commissioning Board will have the powers to establish and maintain a risk pool with consortia in this way, to issue guidance to consortia on financial risk management and to intervene where there is a significant risk of financial failure. The Board may establish a contingency fund to make payments to consortia where they are necessary for the Board or consortia to discharge commissioning functions. The Board will also have the power to adjust consortia allocations in future years to reflect previous overspends or underspends, potentially similar to the way that PCT allocations currently operate, so that there are further incentives for good financial management. It will operate a clear and rules-based system.

4.68 A key theme in consultation responses was the need to ensure a fair approach to handling current deficits and surpluses. A number of respondents expressed concerns about "*potential overspends inherited by GP led commissioners from PCT organisations*" (a Staffordshire GP), as the effect on "*a fledgling GP commissioning consortium*" could be to "*severely hamper its development*" (a GP from Hounslow). On the other hand, the Government recognises concerns that guaranteeing that consortia would start from a completely clean sheet would mean taking surpluses away from local health economies where GPs have been instrumental in generating those surpluses and would reduce incentives for emerging consortia to support PCTs in tackling existing deficits and in driving forward the QIPP agenda in 2011/12 and 2012/13.

4.69 The Department is working with SHAs to address circumstances where PCTs have debts (whether they are related to actual deficits or to money owed under local brokerage arrangements), with the expectation that any debt will be fully resolved by the end of 2012/13. This issue will be covered in further detail in the NHS Operating Framework 2011/12. A number of respondents also raised questions about residual contractual liabilities associated with the current PCT commissioning arrangements. PCTs will be expected to involve emerging GP consortia in any decisions

that result in liabilities (in respect of healthcare-related contracts) extending beyond the PCT's operational life.

The right incentives for quality and financial performance

4.70 The consultation document proposed that consortia should receive a 'quality premium' based on the outcomes achieved for patients, together with the consortium's financial performance. The consultation sought views on the proposal that consortia should have discretion to disburse this quality premium amongst GP practices, so that a proportion of the total NHS income that a GP practice receives would depend upon the performance of their consortium.

4.71 Some observed that outcome measures, particularly those that need to be assessed on a long-term basis to be meaningful, would not lend themselves to financial incentives of this kind, and that some process measures might also be desirable. A number of respondents felt that too extensive a focus on prescribed metrics could be counter-productive, and in the words of one respondent, "*stifle innovation*". Taking account of these comments, we propose that the Commissioning Outcomes Framework should cover a range of outcomes, including – for instance – some outcomes that may be more relevant for some communities than others (for example, for conditions more prevalent amongst minority ethnic groups), and that only a sub-set of these indicators should be used to inform the proposed quality premium for GP consortia.

4.72 The BMA expressed the view that a quality premium would cause "*damage to the doctor/patient relationship, fundamentally destroying the GPs' prime role as advocate for the individual patient and their professional duty to have the care of the patient as their prime concern*". The RCGP were also concerned by the doctor-patient relationship being put under strain "*if GPs are perceived to be prescribing or referring with a view to their practice income*".

4.73 Equally, a number of respondents including GPs, practice-based commissioners and PCTs recognised that there will always be a cash limit in a tax-funded health system like the NHS, that - rather than having managerial organisations decide how best to spend local resources - it would be better for these decisions and trade-offs to be made by local clinicians, and that there should be clear incentives for optimising the use of those cash-limited resources. A common theme from the consultation is that it is essential that consortia have sufficient clout with their member practices to discharge their responsibilities, and that this means the premium must be sufficiently large to act as an incentive for driving better

results. Lincolnshire PCT wrote, "*If GP consortia are to be empowered to improve the quality of primary care then they need to be furnished with compelling information, frequently updated and benchmarked on the performance of primary care in relation to access, patient experience and management of resources. Allied to this, consortia must be given good levers to exert pressure for change. Peer pressure and public information needs to be accompanied by a ladder of reward and penalty for consortia to use to incentivise quality improvement*".

4.74 These views indicate the need for care in designing the proposed quality premium – that is, deciding which indicators are used to reward consortia for outcomes and deciding how the combination of outcome measures and financial performance should be used to determine payment. They also indicate that care is needed in deciding how the quality premium should be funded, and in getting the proportion of total GP practice income right: sufficient to influence behaviour, but not so large that it creates distortions. The forthcoming Bill will introduce the basic powers necessary to allow a quality premium, but we will discuss further with stakeholders including the BMA and the wider profession, on how to ensure that these arrangements create the right incentives for collaborative work between practices to improve quality and outcomes and enable GPs to make the right clinical judgements for individual patients.

Accountability for fairness in investment decisions

4.75 Respondents supported the proposal that there should be systems in place to ensure fairness and transparency of decision-making, particularly in relation to any decisions to commission services from GP practices. There were, however, different views as to how these safeguards should operate with suggestions including the publication "*of annual report and audits*" (a member of staff from South Gloucestershire), or having an "*Independent representative on commissioning decisions over a certain threshold*" (a specialist registrar in Public Health from Birmingham). In general, there was support for the principle that the hallmark of these arrangements should be transparency of decision-making, with a number of respondents suggesting "O*pen-book accounting regarding investment in services*" (an individual at North East Essex PCT) for any arrangements that involve commissioning from GP practices.

4.76 The views raised during the consultation and engagement period have reinforced our view that it would be counter-productive to have a system that relies on consortia having to obtain prior approval for commissioning

decisions of the sort that bedevilled the previous administration's approach to practice-based commissioning. Our proposed approach is based instead on:

- ensuring clear statutory duties on commissioners in relation to procurement and in relation to avoiding anti-competitive behaviours (as set out in Chapter 6);

- developing a clear set of underpinning rules and guidance to apply to consortia, so that they have the necessary support to make decisions that are fair and transparent and avoid any perceived conflicts of interest;

- a requirement that each consortium's constitution sets out arrangements for decision-making and for managing any potential conflicts of interest; and

- proceeding on the basis of 'assumed responsibility' rather than 'earned autonomy', so that consortia are free, within the legislative framework, to make the decisions that they judge are right for patients and value for money, but with a clear duty on the NHS Commissioning Board or, if necessary, the economic regulator to intervene if there are concerns that a consortium has not met its duties in relation to fairness and choice or has engaged in anti-competitive behaviour.

4.77 The consultation also proposed that, wherever possible, consortia should commission services on an 'any willing provider' basis. In other words, the consortium should specify the services and quality standards required and any provider that meets these standards should then be able to provide the service at the specified price. This enables patients to choose (usually at the point of referral) from whom they want to receive a service, and it enables a wide range of providers (including, where appropriate, GP practices) to offer to provide the services without the need for long procurement processes. 'Any willing provider' arrangements will be constructed in such a way that GP consortia have the freedom to promote adoption of best practice, use contractual levers to manage within their expenditure limits, and develop integrated care pathways, for example using capitated payments.

4.78 The BMA's response referred to the General Medical Council's published guidance on probity in situations where clinicians have a financial or commercial interest in commissioning decisions. It suggested establishing a split between parts of the commissioning process to help ensure a fair process, with GPs involved in the design of the care

pathway, but any procurement of services handled by internal managers or external support. We would not want to prescribe the exact approach that consortia should take in managing conflicts of interest, but we will look to Monitor and the shadow NHS Commissioning Board to draw on these and other suggestions in drawing up proposed rules and guidance on how to ensure commissioning decisions are fair.

H. Commissioning primary care

4.79 The White Paper proposed that the NHS Commissioning Board should commission primary medical care services (i.e. the core services provided by GP practices) together with the other family health services (including pharmacy services, dental services and NHS sight tests), but that consortia should have a key role in helping improve quality of general practice services. This approach received general support. The Health and Ethics Law network at the University of Southampton shared the view of many respondents that this would be necessary "*in order to meet the concerns about conflicts of interests and GP practices commissioning from themselves*".

4.80 At the same time, a majority of respondents called for GP consortia to have a stronger and more prominent role in helping to drive quality improvement within general practice. The BMA wrote, "*Where improvement in the quality of primary medical services is sought it may be sensible for this to be done across a group of consortia with a lead consortium … although low level performance issues could be dealt with on a peer-to-peer level within individual consortia. Comparison and analysis of robust and trusted data in small peer groups has been known to be effective in altering behaviour. This has allowed practices to examine how they work and ensure they are reaching a common standard*". The Lancashire and Cumbria Consortium of Local Medical Committees described how "*clinicians are best placed to discuss clinical performance with their peers utilising comparative data and applying peer review and challenge*".

4.81 A number of respondents also described the intrinsic incentives that GP consortia will have to ensure that GP practices are providing high-quality services that improve population health and avoid unnecessary expenditure in secondary care – and the corresponding importance of ensuring that GP consortia are able to influence the clinical and practice behaviours of GPs. As the NHS Confederation put it, "*GP consortia need more influence on primary care*"*;* it felt that this was an unexploited opportunity in the White Paper. A Wirral GP expressed how he would "*be*

happy to be involved in guiding practices to commission more effectively and also to nurture improvements in performance".

4.82 Given these responses, the Department is persuaded of the case to strengthen its proposals for legislation in this area. We intend to introduce an explicit duty for all GP consortia to support the NHS Commissioning Board in continuously improving the quality of primary medical care services. This will not alter the NHS Commissioning Board's overarching responsibility for commissioning GP services and holding GP contracts. However, it will mean that consortia will play a systematic role in helping to monitor, benchmark and improve the quality of GP services, including through clinical governance and clinical audit. It will mean that consortia will have a core role in improving patient care across the system, including both the quality and accessibility of the care that GP practices themselves provide and the wider services that consortia commission on patients' behalf.

4.83 While most respondents supported a more prominent role for consortia in relation to primary care, it was generally felt that this should stop short of having to invoke disciplinary action against GPs or practices. Cornwall and Isles of Scilly PCT wrote that "*it is not appropriate for GP consortia to be carrying out performance management roles for the practices within the consortia*". We agree that the NHS Commissioning Board should retain the formal responsibility for ensuring that a practice is meeting its core contractual duties. It will also have responsibility for holding national lists of the GPs, dentists and other practitioners who are registered and fit to perform primary care services. It will be able to delegate some responsibilities for managing the GP performers list to GP consortia, where it makes sense to do so. The Care Quality Commission will be responsible for ensuring that GP practices (like any other providers of NHS services) are meeting necessary standards of safety and quality. As many respondents, including the NAPC, observed, consortia will, however, be well placed to spot potential issues of poor performance at an early stage, to identify the root causes of these problems, and to work with the NHS Commissioning Board, the Care Quality Commission and other agencies to support practices and practitioners in improving performance.

4.84 All this points to the need for a strong and mutually supportive relationship between the NHS Commissioning Board and consortia in relation to primary care. The NHS Alliance summed it up as follows: "*The relationship between [GP consortia] and primary care providers, particularly GP practices, is key to success. Yet the NHS Commissioning Board will formally hold the contracts of primary care providers. This is*

fraught with difficulty but can be managed if there is a clear scheme of delegation between the NHSCB and [GP consortia]. In short, the NHSCB should delegate the power to hold providers to account, but retain the responsibility for contractual performance. This in turn requires a model scheme of relationship (rules of engagement) that sets out the relationship between the NHSCB, [GP consortia] and primary care providers. [GP consortia] should be collectives in the true sense of the word, and not used as local enforcers. Their style should be supportive and developmental and yet they will need clear powers, sanctions and have clear responsibility. These are the key ingredients of the rules of engagement which should avoid confusion and duplication".

4.85 Turning to other primary care services, there was general support for the principle that the NHS Commissioning Board rather than GP consortia should commission pharmacy, dental and ophthalmic services. This included support from groups representing these professions and their patients: Avon Local Pharmaceutical Committee said that they "*welcome the proposal to transfer responsibility for the national community pharmacy contract to the NHS Commissioning Board*" and both Visionary and the UK Vision Strategy welcomed "*the decision to retain General Ophthalmic Services as a national service with the National Commissioning Board*". The Dental Schools Council saw opportunities opening up for "*co-ordinated and intelligent dental commissioning*". To enable flexibility, consortia will have the ability to commission further services from family health providers in addition to those commissioned by the NHS Commissioning Board. The Bill will enable consortia to be responsible for the costs associated with the prescriptions that are dispensed in the community by pharmacists and others.

4.86 Respondents raised a number of practical points about how the NHS Commissioning Board would develop the necessary degree of local knowledge and clinical expertise. For example, a Health and Social Care Forum operating in Sefton suggested that the NHS Commissioning Board needs to build relationships with partnerships and committees that operate at the local level and would need to collect information on services in each locality. We intend to work further with the relevant professions to develop these new arrangements. This will include a key role for health and wellbeing boards in assessing needs, including responsibility for pharmaceutical needs assessments, which are closely aligned with joint strategic needs assessments. It will also include an important role for local HealthWatch in helping patients make informed choices about the primary care services that they access.

I. Commissioning specialised and complex services

4.87 Responses to the consultation broadly showed support for the proposal that the NHS Commissioning Board should commission national and regional specialised services. For example, a member of staff from South Gloucestershire wrote: *'National or regional commissioning will be needed to ensure patient safety in… highly specialist services – … devolving too much down to local level could be a risk*". Responses highlighted the advantages for patients in maintaining the necessary focus of clinical expertise in these highly specialised areas and the benefit to GP consortia in reducing financial risks and avoiding duplication of effort.

4.88 Responses, for example from the UK Primary Immunodeficiency Network, also highlighted the importance of ensuring that national and regional specialised commissioning remains highly patient-focused. Respondents broadly supported the principle that specialised commissioning should draw on engagement with GP consortia, whilst highlighting a number of challenges involved in achieving this objective given the characteristics of the services involved (i.e. that they are rare, involve a complex pathway of care and a small number of providers). The NHS Alliance wrote that "*It is right that the commissioning of specialised services should be undertaken at a more centralised level than [GP consortia], but there will need to be a clear connection between [consortia] and those commissioning specialised services for local populations*". We fully agree.

4.89 There were a limited number of suggestions for specialised services currently commissioned on a regional basis (for example, certain elements of mental health services) that could potentially be commissioned by GP consortia. This underlines the need for regular review. One respondent wrote, "*Just as at present, services should be reviewed regularly to judge when they are no longer specialised and can be delivered in secondary care*". The Foundation Trust Network proposed that "*Criteria should be developed, on the basis of incidence of conditions or volume of procedures per population, which could be used to inform which services should be commissioned by the Commissioning Board or by a lead consortium across a given population*". The Department agrees with the suggestion of a criteria-based approach. This could potentially mean the NHS Commissioning Board taking on responsibility for further services that meet the criteria, or consortia becoming responsible for commissioning services that no longer met the criteria. We will consider the best way to keep the specialised services portfolio under regular review.

4.90 In line with this, the Bill will provide for a flexible approach. We intend that regulations, which can be amended over time, prescribe what services are commissioned by the NHS Commissioning Board; by default, all other services will be commissioned by GP consortia. In the consultation document we said that it would make sense for the NHS Commissioning Board to have responsibility for health services for those in prison or custody. We received no objections to this and will proceed on this basis[xii]. The NHS Commissioning Board will also be responsible for commissioning high security psychiatric services and we have agreed with the Ministry of Defence that the current PCT duties in relation to healthcare for the armed forces and their families will be transferred to the NHS Commissioning Board.

Commissioning other complex or low volume services

4.91 As mentioned above, a common theme emerging already from discussions about possible consortium arrangements was the likely need for consortia to operate at different levels. For instance, some GPs are planning to establish relatively small consortia, but then collaborate with other consortia and/or establish a lead consortium for low volume services or those that require a strong interface with local authorities. Others are planning to establish larger consortia, which might have local clusters that focus on more common pathways.

4.92 We expect that all consortia are likely to need to work collaboratively with each other on particular aspects of commissioning, reflecting in part specific areas of expertise of consortia members. The Royal College of Paediatrics and Child Health wrote that it would support "*the development of sub-national commissioning arrangements that enable either subgroups of the National Commissioning Board or clusters of GP consortia to collectively consider commissioning requirements*". The BMA commented: "*Unless a consortium was large enough to manage the risks of commissioning for low-volume services itself, we believe it would be most appropriate for consortia to join together in regional consortia federations with a single lead consortium. The lead consortium would commission low-volume services on behalf of the group, while the member consortia would share the risks associated with these services by joining together*".

4.93 The Bill will provide the necessary powers for consortia to collaborate in this way. It will also enable the NHS Commissioning Board to commission some services on behalf of consortia, where this is agreed by both parties, and for the NHS Commissioning Board and consortia to be able to enter into pooled budgetary arrangements. In this way

consortia will have flexibility to decide at what level to commission services that are outside the scope of national or regional specialised commissioning.

4.94 A number of comments reinforced the need to ensure, particularly in relation to more complex or specialist services, that consortia have support to help them understand the best care pathways and best clinical practice. This was, for instance, an issue raised in relation to many children's services, such as disabled children, and to mental health. MIND indicated that "*A recent survey by the mental health charity Rethink found that only 31 per cent of GPs surveyed felt equipped to commission mental health services. This compared to the three quarters of GPs who indicated that they were ready to take responsibility for services for physical illnesses such as diabetes and asthma*".

4.95 We will ensure that there is particular emphasis within the 'pathfinder' programme on testing ways of ensuring that consortia quickly develop knowledge and expertise in relation to these areas. This will include exploring joint commissioning with local authorities, for instance in relation to care and support for children (including looked after children and children living in families with multiple problems), people with long-term mental health conditions, and people with learning disabilities. As Sunderland City Council wrote, "*how GP Consortia will be supported in delivering their commissioning arrangements needs to be explored locally, as there are opportunities for the Council to provide the required support due to their history in successful commissioning linked to the people based service areas (Children and Adult Social Care)*".

4.96 We will also ensure that the NHS Commissioning Board has a particular focus on promoting quality improvement in relation to more complex or specialist services. Many respondents specifically requested that the NHS Commissioning Board have a role in quality assurance. The National Specialised Commissioning Group and NHS Specialised Services response stated that, when developing "*clinical criteria for specialised services*", the NHS Commissioning Board would need to ensure that there was "*a robust quality assurance process*". The Genetic Alliance UK wrote: "*In many cases, the arguments for commissioning a specialised service on a national level are irrefutable, and an enormous benefit in terms of quality of service and economies of scale*". This key role for the Board on quality improvement will build on the work of the National Quality Board and NICE in identifying the best care pathways.

J. Commissioning maternity services

4.97 The Government's proposal that the NHS Commissioning Board should commission maternity services generated much response and criticism. Some respondents welcomed the proposed role of the NHS Commissioning Board as a way of driving improvements in maternity services. Premature birth charity Bliss recommended "*that services, such as maternity, newborn and neonatal care… are commissioned in a coordinated manner under a single body, such as the NHS Commissioning Board*". The Royal College of Midwives wrote that it "*welcomes in principle the proposal that the NHS Commissioning Board will commission maternity services in future*" and Independent Midwives UK welcomed "*the White Paper's proposed plans for the Commissioning Board to commission maternity services*". The Royal College of Obstetricians and Gynaecologists wrote that it "*welcomes the initiative of national maternity commissioning and sees this as an exciting opportunity for development and genuine service change*".

4.98 However, the majority of those commenting on this proposal questioned the distinction between maternity and other services delivered on a large scale and mainly locally, and argued that the Government's proposals were flawed. For example, the NHS Confederation said that "*we can find no convincing reasons why maternity services have been excluded from the scope of GP commissioning*". North Lancashire PCT said "*separating these commissioning responsibilities from the consortia will create practical difficulties given the local nature of services*" and the Institute of Healthcare Management concurred. A GP from London wrote that "*the role of general practice in maternity and newborn care is absolutely crucial – the ability of general practice to influence reconfiguration of these services should be strengthened not weakened*".

4.99 These comments reinforce the need for close collaboration between the NHS Commissioning Board and consortia. Like many other NHS services, maternity services should reflect local needs and circumstances and be integrated with other local services, whilst also benefiting from national support to secure improvements in quality and choice. Taking account of all these views, the Department of Health is persuaded that maternity services need a different approach to reflect their special nature and circumstances. While responsibility for commissioning maternity services should sit with GP consortia, we will expect the Board to give particular focus to promoting quality improvement and extending choice for pregnant women. The Board will support consortia to work together collaboratively to commission services: consortia will be able to group together, or pool resources with

the Board, where this makes most sense. The Board will also directly commission specialist neonatal services. The Department considers that this approach is most likely to deliver improvement and a joined-up approach to local services for women and newborn babies.

K. Other statutory responsibilities of GP consortia

4.100 A common feature of discussions about GP commissioning during the engagement period was the request, particularly from GPs themselves, for greater clarity as to which specific PCT responsibilities will be passed to them, coupled with an anxiety that the 'core' role of improving quality could be diluted by having a plethora of other statutory duties placed upon them. The Bill will set out in full the proposed statutory duties for consortia. We will be publishing alongside the Bill a document setting out the main 'groups' of duties and powers that consortia will have and, for each of these groups, examples of the practical activities that consortia may wish to carry out (or have others such as local authorities carry out on their behalf) to fulfil these duties.

4.101 There are many responsibilities currently placed on PCTs which we do not propose to place upon consortia. Some PCT responsibilities will transfer to local authorities (particularly in relation to public health) or to the NHS Commissioning Board; some will be removed entirely; others will be subsumed within more general responsibilities or recast so that they better reflect the nature and functions of GP consortia. The legislative framework will be designed to enable consortia to focus on improving quality of care within the resources available to them, whilst maintaining sufficient safeguards to ensure accountability. It will also ensure that consortia are subject to a number of important duties that apply to a range of public bodies: for instance, both consortia and the NHS Commissioning Board will be subject to the duties in the Children Acts 1989 and 2004 to discharge their functions in ways that safeguard and promote the welfare of children, and to be a member of Local Safeguarding Children Boards.

L. Freedom from political micro-management

4.102 This chapter has set out the Government's plans for devolution of commissioning responsibility to GP consortia, supported and held to account by the NHS Commissioning Board. Both are part of a wider drive to establish more autonomous and transparent NHS institutions. As Kent

County Council argued, it "*is essential the future NHS architecture is built with confidence and clarity about the statutory arrangements for all its component parts*" – and this includes the powers and role of ministers and the Department of Health over the NHS, particularly through the NHS Commissioning Board. Although the Secretary of State will retain overall accountability for the NHS, the whole purpose of establishing the NHS Commissioning Board as an independent body is to free it from political micro-management. And most respondents, as South of Tyne Local Medical Committees said, "*fully support less political interference in the management of the NHS and welcome this change*" – for example, the Hospital Consultants and Specialists Association said that the Board will "*need to be truly independent and free from political interference to fulfil its purpose*". Bury Council commented that "*parameters setting out the level of acceptable intervention by the Secretary of State will be necessary*". Westmorland Primary Care Collaborative offered "*support [for] the creation of this Board, free from day-to-day political interference – but time will tell if freedom from interference really happens*".

4.103 Political interference arises from a combination of power and will. At present, the Secretary of State has very extensive powers over the NHS including powers of direction over SHAs and PCTs collectively and individually – about both what they do, and how they do it. This legislative structure has enabled a culture of centralised control, and the perception, threat and sometime reality of political interference in day-to-day operational decisions. The Government will therefore bring forward wholesale reform to the legal powers of the Secretary of State – setting for the first time in the history of the NHS clear constraints on the ability of the Department to intervene in the NHS.

4.104 Unlike SHAs and PCTs, the functions of the NHS Commissioning Board will be defined in primary legislation rather than being at the discretion of the Secretary of State through a process of legal delegation. Nor will the Secretary of State have a general power of direction over the NHS Commissioning Board. Instead, direction for the NHS will be restricted to a more formal and transparent once-a-year process, which will provide for greater stability and planning certainty. The Secretary of State will set a mandate for the NHS Commissioning Board, which will include the totality of the Government's requirements and expectations for the NHS over what is likely to be a three-year period, updated annually. For the first time the Secretary of State will be under specific duties to promote improvement in quality and outcomes, and reduce inequality in healthcare provision, and will set out objectives for the NHS Commissioning Board in these areas including specific levels of improvement. The mandate will also include financial allocations to the

NHS Commissioning Board. The Board will be under a duty to seek to achieve the objectives set for it in the mandate, and will have a duty to comply with any requirements imposed on it for that purpose.

4.105 The Bill will specify that the Secretary of State will only be able to alter the mandate in-year, or change the financial allocation to the Board, if he thinks that there are exceptional circumstances, which he must explain transparently by laying a report before Parliament, or if the Board agrees to the change. This means that, exceptional circumstances aside, ministers will be prevented in law from imposing new requirements on the NHS in-year. A new government following a general election would have the ability to change the mandate in-year and lay a report in Parliament setting out its reasons.

4.106 The Government has also made the important decision that each year the Secretary of State will be obliged to undertake a formal public consultation on the priorities contained within the mandate before issuing the final version. This constitutes a significant enhancement of public engagement in setting NHS priorities, compared with the current process for setting the NHS Operating Framework 2011/12.

4.107 Alongside the mandate, the Bill will provide for the Secretary of State to make “standing rules” through regulations, setting legal requirements for commissioners. These will, for example, provide the basis for the legal rights in the NHS Constitution that currently depend on directions to PCTs, and will also give power for ministers to ensure compliance with EU obligations. The Government’s intention is for the Bill to include a limited list of areas where standing rules can be made. Balancing the need for future flexibility with proper Parliamentary scrutiny, the Secretary of State would be able to make new standing rules in additional areas only through regulations made by the affirmative procedure, with the approval of both Houses of Parliament. Furthermore, the expectation is that the Secretary of State would make such changes to the standing rules only at the same time as the mandate is set; where that is not the case, the Secretary of State will be obliged to lay a report in Parliament explaining why. Such changes may well be proposed by the NHS Commissioning Board, and the Secretary of State will consult the Board on any changes.

4.108 The Bill will go further in removing the ability of the Secretary of State to intervene in relation to any individual commissioner. The Bill will make clear that any requirements or objectives set by the Secretary of State must apply generically. There will be no power to direct an individual commissioner – except in the sole instance of where the Secretary of State rules on an appeal by a local authority against a proposed change

to services subject to additional regulation, as described in Chapter 5, or to ensure compliance with EU requirements. Where there is failure of an individual consortium, this will be a matter for the Board; ministers will in turn hold the Board to account for how well it discharges its oversight functions.

4.109 In the event of emergencies, however, it is vital for the Government to be able to act decisively. As the head of emergency planning at Hampshire PCT wrote: "*Clear arrangements need to be in place with all parts of the health system having emergency planning responsibilities*". To address this, the Board will be under a duty to ensure NHS preparedness and resilience by assuring that clear arrangements are in place, services are co-ordinated and there are designated lead individuals. In the event of an emergency, the NHS Commissioning Board would also have responsibility for mobilising the NHS. A gap within the current framework is that, in relation to emergencies, the Secretary of State does not have powers over NHS foundation trusts. The Bill will remedy this omission, and strengthen current intervention powers so that the emergency power of direction applies over all commissioners and providers of NHS-funded care. This will form part of the stronger, more integrated system of health protection set out in the public health White Paper *Healthy Lives, Healthy People*.

4.110 Finally, the Bill will enshrine the principle of autonomy at the heart of the NHS. We intend that the Secretary of State, in carrying out any NHS-related function, must have regard to the principle of maximising the autonomy of individual commissioners and providers and minimising the obligations placed upon them, in a way that is consistent with the effective operation of a comprehensive health service. As described earlier, we are exploring how to enshrine this principle as a duty for the NHS Commissioning Board. These legislative changes to the powers of the Secretary of State are a critical part of the Government's vision to liberate the NHS and they will also serve to strengthen the NHS Constitution.

M. Effective national stewardship of the NHS

4.111 The Government agrees with the many respondents who welcomed the aim of setting limits on the role of the Secretary of State, but emphasised that there must be clear accountability: for example, the Kidney Alliance argued for "*appropriate delegation of powers but not abandonment of responsibility*". Derbyshire County Council called for "*clear and coherent*" lines of accountability, while the Spinal Injuries Association highlighted

the need for the public to have "*confidence in the accountability of Ministers to Parliament*".

4.112 The Secretary of State will remain responsible for the design of the system, the legislative framework and overall strategic coordination. This will include powers to appoint the chair and appoint or approve the appointments of non-executive board members in the Department's arm's-length bodies, and the ultimate power to remove non-executive board members if an organisation is in the extreme position of failing to perform its functions. In line with government policy on quango pay, the Bill will require that pay and terms and conditions of all national bodies must be agreed with the Government. Ministers will continue to account to Parliament through Parliamentary questions, debates and select committees. To improve transparency further, the Department of Health will also be subject to a new duty to report each year on the overall performance of the NHS and Public Health England.

4.113 In future, there will be no single national managerial headquarters of the NHS; different national organisations will have clearly defined and separate functions. Inevitably, as many respondents highlighted, tensions and disagreements will arise at times between organisations – just as they have in the past. The Government is acutely conscious that it has an important overall responsibility to act as steward of the NHS system and to ensure that the different national parts together operate effectively and provide an aligned and coherent context for local action. Equally, we have no intention for this stewardship role to creep into the territory of direct management, through becoming engaged in resolving disputes between national organisations.

4.114 At present there is no comprehensive duty on the Department's arm's-length bodies to co-operate with each other, nor any formal means to ensure that in practice they do. The Government has decided to rectify this omission. The Bill will provide for key non-departmental public bodies and special health authorities to be required to co-operate with each other in performing their functions.

4.115 If the Secretary of State believes that this duty of partnership is being breached, or at risk of being breached, he will have a new ability to write formally and publicly to the organisation in question. If the breach in the duty of partnership is significant, is sustained and is having a detrimental effect on the NHS, the Secretary of State will have a further ability to lay an order, subject to positive approval by both Houses of Parliament, specifying that, for up to a year, the organisation could take certain actions only with the approval of another specified body (other than the Secretary of State himself). In this way, the organisations in dispute

would be required to recognise their interdependence as part of a national system. As a matter of last resort, either party would be able to invoke independent arbitration under Arbitration Act arrangements. In this way, the organisations in question will be pressed to resolve their differences, without recourse to the Secretary of State and the Department stepping in and deciding in a top-down or hierarchical way the outcome of the dispute on their behalf.

4.116 The existence of this order-making power will help increase the independence of organisations from ministers. It would be used only rarely, in exceptional circumstances. It is also important to note that the powers and duties described in this section are about co-operative behaviours and they do not in any way undermine the independence of arm's-length bodies to make specific regulatory decisions. For example, the Secretary of State could not use the provisions to constrain Monitor from taking action against anti-competitive purchasing by the NHS Commissioning Board.

N. GP consortia pathfinders and managing the transition

4.117 Many commentators observed that the greatest challenge in *Liberating the NHS* lies less in the detailed future design and legislation, important though these are, than in getting the implementation and transitional arrangements right. For example, the NHS Confederation described it as "*the area of greatest risk*". The Department is in full agreement. One of the most critical areas to get right is the transition on the commissioning side, from the existing system of the Department of Health, SHAs and PCTs, to the new system of the NHS Commissioning Board and GP consortia. We similarly agree with the many respondents who said that the success of commissioning consortia will depend critically on leadership, behaviours and relationships – and on the work done during the transitional period to prepare consortia and the NHS Commissioning Board to take on their new roles.

4.118 Consultation responses emphasised the central importance of a sustained focus on improving quality and productivity over the transitional period. On the commissioner side, it is the Government's view that the QIPP agenda can only be secured fully through better engagement of GP practices in the commissioning process, given that primary care is responsible, directly and indirectly, for such a significant element of NHS expenditure. For this reason, the early development of consortia is essential to the delivery of productivity savings in 2011/12 and 2012/13 in advance of consortia formally taking on all their new responsibilities.

4.119 Pace of change is a key implementation question. As the NHS Alliance put it, "*Some will say that the transition is too fast, others that it is too slow. That is an oversimplification of the reality that in some parts of the country GP commissioning consortia will be ready to assume responsibility for commissioning now and in the very near future, and in others, will require more development support and time to be in that position. The NHS Alliance believes that there should be sufficient flexibility within the proposed timetable to accommodate both the fast movers and those who require a more considered timescale*". The King's Fund, who "*question whether root and branch changes ... are needed*", observed that "*if the proposals set out are to be pursued, there are strong arguments for moving quickly ... a good example is GP commissioning, where GPs and managers in some areas are ready to make a start as soon as possible. Supporting GPs and managers in these areas to be early adopters by using 2011/12 as a shadow year for introducing GP commissioning would send a clear signal that ministers recognise the complexity and ambition of their plans ... the purpose ... would be to inform national implementation by distilling lessons from the early adopters*".

4.120 During the consultation process we were highly encouraged by the number of GPs and other primary care professionals who have come forward indicating that they are eager to take on a leadership responsibility for commissioning – and by the clear appetite to work in partnership with other health and care professionals, with local government, and with patients and the public. A Derby GP told us, "*I welcome your new White Paper with open arms as a way of, finally, making the NHS deliver what it is capable of. I intend to remain active locally to help the White Paper's programme take root in Derby and deliver for our patients*". The RCGP, whilst noting that additional training and education would be essential, felt that "*we are confident that GPs are able to perform the functions described in the White Paper*".

4.121 A number of consultation responses from clinical commissioning groups already operating around the country emphasised how they had already developed considerable capacity and skills to lead commissioning. For example, Cumbria County Council and Cumbria PCT described how they were "*ahead of the national curve on many of the changes outlined in the White Paper, with a jointly appointed Director of Public Health, devolution of commissioning decisions and budgets to 6 GP localities (coterminous with district council partners and local social services arrangements), a successful Health and Well Being Board and a strong tradition of collaboration across health and social care commissioning*". The Cambridgeshire Together partnership described how the approach and

principles of the White Paper had "*strong parallels with the development of [existing] GP 'clusters' … a 'bottom up' approach and the concept of 'localism'*".

4.122 In the light of what we heard, and to capitalise on the enthusiasm that already exists, the Department is establishing a rolling programme of GP consortia pathfinders. Pathfinders will not necessarily evolve into GP consortia, since GP practices will be able to adjust arrangements before applying to the NHS Commissioning Board for establishment. But they will test the different elements involved in GP-led commissioning and enable emerging consortia to get more rapidly involved in current commissioning decisions. The pathfinder programme will also, in the words of the NHS Alliance, allow for "*concerted work to create productive transitional plans between consortia and PCTs and for them to learn from the experiences and outcomes of others*" as a means of ensuring a smooth transition.

4.123 We are seeking to maximise and legitimise this enthusiasm and interest by establishing a rolling programme of pathfinders starting in December 2010 and working up to the period from April 2012 when consortia will start to be formally established. During this period, the programme of pathfinders will have a key role in helping to model the future, by making early progress themselves as well as by exploring some of the issues involved in ensuring effective implementation across the country.

4.124 The shadow NHS Commissioning Board will produce and publish an analysis of the findings of the pathfinder programme and set out the lessons learned that will be applied as consortia become formally established during 2012/13.

4.125 Pathfinders in the programme will be:

- testing out design concepts for GP commissioning and exploring how emerging consortia will best be able to undertake their future functions. This will include the pathfinders having a key role in identifying what commissioning support GP consortia may require in future and how best this should be secured, including any functions that may need to be undertaken at scale. The Department, SHAs and PCTs will work with pathfinders to this end. It is important to note that it is GP consortia that will have the power to decide what commissioning support they want, and from whom. Transitional support arrangements from PCT clusters need to be set up with that clearly in mind, with emerging consortia acting as customers;

- exploring how consortia can develop effective relationships with constituent GP practices and local government, patient groups and secondary care clinicians. For example, we will support the GP consortia pathfinders in working with the shadow NHS Commissioning Board to explore how best to shape the relationship between the NHS Commissioning Board, consortia and practices in relation to primary medical care;

- embedding and reinforcing the importance of engagement with patients and the public and local partnership working with local authorities;

- exploring how consortia can best commission services at different geographical levels, and commission some of the more specialised and complex local services such as mental health, maternity and children's services. This will include looking at issues relating to size, such as how smaller consortia can best collaborate or how larger consortia can break down into smaller localities, where this makes sense;

- demonstrating how clinical leadership of commissioning can improve care, reduce waste and deliver value, including through developing and continuing effective partnerships with specialists, secondary care clinicians and other primary care clinicians;

- exploring good practice in governance arrangements;

- designing their new organisational structures and exploring how best to secure the skills and expertise they need, including the human resources issues involved in the transition from PCTs (on which Chapter 7 provides further detail);

- taking on increasing delegated responsibilities from PCTs (whilst PCTs retain statutory responsibility) and playing a leading role in tackling the NHS quality and productivity challenge, including, for example, through input into NHS contract negotiations with local providers; and

- providing a platform to share learning across the GP community.

4.126 The Government's expectation is that any group of practices that wishes to become a pathfinder consortium will be able to do so, provided that they are able to demonstrate evidence of GP leadership and GP support and local authority engagement, and an ability to contribute to the delivery of the QIPP plans for their locality. All pathfinders will need to

take full account of current financial and operational plans. The first pathfinders were announced on 8 December 2010. The Department was delighted with the scale of interest shown, which substantially exceeded our expectations for this stage of the implementation process.

4.127 Submissions from GPs and professional organisations also reinforced the early need to promote leadership development and to help emerging consortia with organisational development. "*Significant improvements in health outcomes will follow clear and strong leadership by professional bodies, royal colleges and individual clinicians*" wrote the Health Foundation. The Department is therefore providing support for leadership development through the National Leadership Council, which is working with national primary care organisations to develop a competency set for consortium leaders. SHAs are working with PCTs and with local professional leaders to ensure that emerging consortia also have access to support for organisational development. The NHS Operating Framework 2011/12 will set out further details of the financial support and other types of support that PCTs will be expected to make available to support the development of emerging consortia.

4.128 A large number of consultation responses focused on the practical issues involved in managing the transition from the current PCT commissioning structures and doing this in a way that did not distract from the ongoing focus on improving quality and productivity. Our proposed approach to implementation is designed to allow these objectives to go hand in hand, recognising that increased clinical involvement in today's decision-making will not only improve quality and productivity but also help equip emerging consortia with the knowledge and skills that they will need when they take on full statutory responsibilities from 2013. The Government does not agree that the introduction of consortia will increase the level of risk involved in achieving the QIPP agenda; on the contrary, delay in securing GP involvement in QIPP is the greater risk.

4.129 We are proposing a carefully staged transition towards full implementation of the new commissioning arrangements. Our intended approach is that from December 2010 the first cohort of pathfinder consortia will begin to test the key elements of GP commissioning. From January 2011 and throughout 2011/12, a growing number of shadow consortia will become pathfinders and start to take on increasing responsibilities for commissioning, using powers and budgets delegated to them by PCTs within the current statutory framework and with PCTs increasingly putting staff at the disposal of consortia.

4.130 During the first transitional year of 2011/12, emerging consortia will have the opportunity to plan how they intend to carry out their future functions,

in particular by deciding what activities they will undertake for themselves by employing or engaging their own staff, what activities they will carry out on a collaborative basis (for example, through a lead consortium arrangement or through collaboration with local authorities), and what activities they wish to buy from external support organisations.

4.131 Building on the early findings of the pathfinders, during 2011/12 emerging consortia will work with PCTs to develop transition plans that include:

- identifying those posts within emerging consortia staffing structures that match existing posts within PCTs and therefore provide the basis for a transfer of staff from PCTs to consortia, with staff typically transferring from April 2012 onwards once consortia are statutorily established;

- identifying how they intend to fill other posts within their future staffing structures;

- enabling PCTs, SHAs and the shadow NHS Commissioning Board to identify the areas where there will be significant demand for external commissioning support, to encourage potential providers to develop support in these areas, and to consider how best to support consortia in accessing cost-efficient and effective support;

- agreeing a managed process for transferring any information and IT systems associated with these commissioning functions;

- identifying the individual contracts that will need to be transferred from PCTs to consortia;

- identifying partnership arrangements with local authorities, including pooled budget and lead commissioner agreements, that will transfer to consortia and working with local authorities to make future plans for these areas; and

- developing relationships with emerging health and wellbeing boards, with Local Involvement Networks (as they develop into local HealthWatch) and with other community partners and patient groups.

4.132 We want to strike a balance between retaining essential talents and capabilities of SHA and PCT staff and giving GP consortia the freedom to innovate and access the support they need through the transition to the new system. Whilst it will be for consortia to make these decisions, bearing in mind the associated costs, we anticipate that a number of PCT

staff across all grades will be essential in providing consortia with the skills and knowledge required to take on their new commissioning role.

4.133 The work in 2011/12 will provide the foundations for a final transitional year (2012/13) during which consortia are statutorily established and typically take on the leading responsibility for commissioning healthcare services, with PCTs (whilst still statutorily accountable) transferring responsibility to consortia for budgets and commissioning decisions. From April 2012, the NHS Commissioning Board will establish consortia, based on the applications prepared in the previous year, or – where there are reasons why a consortium cannot be established straight away – work with prospective consortia to help resolve these issues. Once established as statutory bodies in their own right, consortia will be able to take on staff from PCTs. In the autumn of 2012, consortia will receive notification of the budgets for which they will be statutorily accountable from April 2013 onwards. From April 2013 it is likely there will be a period of embedding and consolidating the new system with further adaptation as consortia learn from experience.

Investing in sustainable organisations

4.134 A large number of respondents argued that the consortia will require sufficient resources to spend on administration if they are able to perform their functions effectively. For example, the NHS Confederation said "*we are concerned that the White Paper makes the presumption that management is a cost rather than an investment*". The Government hears this concern; our view is that management is both an overhead on frontline services and a critical investment in ensuring that those services operate in an optimal manner, achieving better quality for patients and better value for the taxpayer. Under the previous government, administration costs increased dramatically and in a manner which was not justified. A number of respondents agreed that it is right that in future the Government sets clear administration cost controls on the NHS Commissioning Board and GP consortia. This will be essential in reducing the total cost of administration from £5.1 billion in 2010/11 to £3.7 billion by 2014/15.

4.135 The Bill will therefore provide for the Government to set a control total for administration spend for the NHS Commissioning Board, and a separate control figure for consortia based on pound per head of population. A number of respondents expressed confidence that consortia were likely to keep a good grip on administration costs. As a Wolverhampton GP put it, "*In general practice we run a tight ship as regards to management in*

our practices and understand to use this vital resource responsibly and effectively… We would aim to do the same in the consortium".

4.136 The Government also recognises that investment in commissioning is essential. The NHS Operating Framework provides further detail on this. The Department of Health will be exploring further with consortia what constitutes an optimal level of total running costs that meets the twin aims of securing sustainable organisations and maximising resources going to front line services.

4.137 We expect that many PCT staff will find roles within the new organisations, so some administration costs will be transferred around the system, including to GP consortia, the NHS Commissioning Board and local authorities. Chapter 7 explores this point further.

Establishment of consortia

4.138 As mentioned above and proposed in *Commissioning for patients,* the NHS Commissioning Board will have a duty to ensure that a comprehensive system of consortia in place from April 2013, with the power if necessary (in the final resort) to assign GP practices to a consortium. Linked to this, the Bill will place all providers of primary medical services under a new legal obligation to be a member practice of a consortium from April 2013. Potential consortia will have to pay regard to the need for every GP practice to become a member of a consortium and for consortia to have sufficient geographical focus to carry out their functions effectively.

4.139 The Board will have the responsibility for considering applications to be established as a consortium and for determining those applications – or in other words authorising the consortium. The process of authorisation will be an important element of ensuring that consortia are ready to take on their responsibilities. It is also a way of ensuring that commissioning is devolved: the Board will have an obligation to approve any applications that meet the required criteria.

4.140 Respondents raised a wide range of views on the factors that the Board should take into account before granting authorisation. We have considered these carefully. We propose that the core matters as to which the Board will need to satisfy itself before granting an application will be that the consortium has a satisfactory constitution, that it has an appropriate area (in relation to prescribed duties such as commissioning of accident and emergency services), that all members will be providers of primary medical services on date of establishment, and that it has

made appropriate arrangements to enable it to discharge its functions. This will mean that the Board is able to satisfy itself that the consortium has, for instance, made appropriate arrangements for managing financial resources, improving health outcomes, involving patients and professionals, and acting in partnership with local authorities.

4.141 The Bill will provide for consortia to be established from April 2012, prior to taking on full statutory responsibilities from April 2013. This allows at least 12 months for the shadow NHS Commissioning Board and PCTs to support consortia in preparing for authorisation. We intend that authorisation is seen as the culmination of this prior process of developmental support, with the Board having a duty to ensure by April 2013 that there is a comprehensive system of consortia across the country. The shadow NHS Commissioning Board, working with SHAs and PCTs, will ensure that consortia have the support to prepare for their statutory establishment from April 2012, enabling them to develop the necessary internal governance arrangements and to work systematically through the areas that they will need to cover in their application for establishment, with the aim of ensuring that the great majority of consortia are able to be established in April 2012 or shortly thereafter.

4.142 Some respondents raised concerns that a minority of consortia might not be ready to take on full statutory responsibilities by April 2013. Whilst a core role of the NHS Commissioning Board during 2011/12 (in shadow form) and 2012/13 will be to help consortia prepare to take on these responsibilities, we recognise that there may be a small minority of consortia for whom this is not possible. The Bill will enable the Board in these circumstances to establish the consortium but to specify conditions about how it discharges some of its functions, or (in what we consider would be rare circumstances) to arrange for the Board itself – or another consortium acting on behalf of the Board – to exercise certain functions for a limited period while the consortium develops the necessary capacity.

Establishing the NHS Commissioning Board

4.143 As set out in *Liberating the NHS*, the NHS Commissioning Board will be established in shadow form as a special health authority for the year 2011/12 prior to becoming a full non-departmental public body from April 2012. Its main office will be in Leeds, with a small London base and representation at sub-national level in a range of locations to be decided.

4.144 During the first half of 2011/12, the shadow NHS Commissioning Board will be focused on:

- identifying the full senior team;
- designing the structure and shape of the new organisation;
- designing transitional control arrangements for 2012/13;
- initial work on methods for performing its specific functions; and
- preparing a clear operational plan for executing the start-up arrangements in quarters 3 and 4.

4.145 Once the top team is fully in place by the end of September 2011, the second phase is about executing the start-up plan designed in the first phase, so that it is fit for purpose and ready to go live from 1 April 2012. It will focus on:

- appointing its staff;
- finalising its business plan for 2012/13 in the light of the Department of Health mandate;
- working with PCT clusters and emerging consortia, to maintain capability for transitional control in 2012/13, and to support the 2012/13 contractual process;
- developing new financial arrangements, including allocations to consortia, and financial risk management arrangements;
- supporting consortia and helping them prepare for authorisation, so that there is a comprehensive system, covering all practices, ready for April 2012;
- developing the Commissioning Outcomes Framework;
- making progress on tariff design and setting, working closely with Monitor; and
- establishing new commissioning relationships with GP practices, community pharmacists, dentists, prison healthcare services, and specialised services.

4.146 The Department is working with the independent Advisory Committee on Resource Allocation (ACRA), academics and relevant stakeholders to develop an appropriate methodology and formula for resource allocation at the practice level which will form the building block for consortia allocations. This will be used in shadow form in 2012/13 and for substantive allocations from 2013/14.

Conclusion

4.147 Our proposals for GP commissioning and the NHS Commissioning Board are intended to transform the quality of care and health outcomes for patients. They will devolve day-to-day decision-making as close as possible to individual patients, so that those decisions can be more sensitive and responsive to their needs and wishes. At the same time, they will ensure that these decisions take place within a clear framework established and developed by the NHS Commissioning Board to promote quality, choice, patient and public involvement, and effective stewardship of public resources.

4.148 The proposed legislative framework and the practical programme for testing and developing the new commissioning arrangements build on the thousands of responses received to the consultation. For example, we will be ensuring a clear transition path up to April 2013 including the rolling programme of pathfinders; we are strengthening the duties of consortia in relation to promoting quality improvement in general practice and multi-disciplinary working; and we have revised our proposals on maternity services. Our plans are intended to unlock the benefits of the growing number of examples of GP-led commissioning already developing around the country, all focused on achieving a step-change in the quality of patient care, delivering better value for the taxpayer and improving the health of local communities.

5. LOCAL DEMOCRATIC LEGITIMACY

Mutually respecting partners

5.1 The previous chapter set out the Government's plans for a comprehensive system of GP consortia, supported by the NHS Commissioning Board. These new arrangements are essential for better NHS commissioning, but taken alone they are insufficient because the successful pursuit of better health and wellbeing will only come from increased co-operation between the NHS and local authorities. As the NHS Alliance put it in their response, there is a need for "*close working between local government and GP commissioning consortia as mutually respecting partners*". We agree with those who said that what is most important is the quality of local leadership and relationships, and we see the Government facilitating this through structural and legislative reform.

5.2 *Local democratic legitimacy in health*, a joint Department of Health and Department for Communities and Local Government consultation, aimed to enhance the role of local authorities in health services. In the light of consultation responses, the Government has decided to expand, strengthen and adapt significantly its proposals for legislation in this area. We are introducing enhanced obligations in relation to joint assessment of need and development of strategy, and revised proposals on scrutiny. This chapter also sets out the principles and framework for initial implementation.

5.3 Together, the two White Papers *Liberating the NHS* and *Healthy Lives, Healthy People*, provide local authorities with an enhanced health role. Local authority commissioning of local HealthWatch arrangements becomes more important with the increase in functions beyond those performed by LINks. Local authorities will take on the major responsibility of improving the health and life-chances of the local populations they serve. This new opportunity has been widely and warmly welcomed; for example, Winchester City Council was "*delighted*". These functions will be conferred on local authorities as a whole, rather than being functions of the health and wellbeing board.

5.4 This chapter considers in turn:

A. Statutory health and wellbeing boards

B. Flexible geographical scope

C. Core membership

D. Enhanced joint strategic needs assessment (JSNA)

E. The new joint health and wellbeing strategy (JHWS)

F. Increased joint commissioning and pooled budgets

G. Health and wellbeing boards as an open-ended vehicle

H. Referral and enhanced scrutiny

I. Implementation framework

A. Statutory health and wellbeing boards

5.5 *Local democratic legitimacy in health* set out proposals for local authorities to lead on improving the strategic coordination of commissioning across NHS, social care, and related children's and public health services. We suggested they might do this through the creation of new health and wellbeing boards, which would also increase the local democratic legitimacy of NHS commissioning decisions. Health and wellbeing boards will bring together the key NHS, public health and social care leaders in each local authority area to work in partnership.

5.6 We sought views as to whether local authorities should be obliged to discharge this new strategic coordination function through a prescribed form called the health and wellbeing board, or whether they could make alternative arrangements. Respondents across health, local government and voluntary sector organisations were near unanimous in preferring the specification of health and wellbeing boards, and for "*these to be a statutory requirement for all upper tier local authorities*" (the Local Government Group). Birmingham City Council felt that statutory specification was "*essential*" and "*would reassure the public and patients that the proposals have longevity*", Oxford City Council felt it would "*strengthen the respective roles and responsibilities of current partners*", and Leeds City Council suggested that it would provide an opportunity to build "*local leadership for the health improvement and preventative agenda*". Rethink suggested that a statutory basis "*would make health and wellbeing boards more easily understandable and therefore transparent and accessible for patients and the public.*" The Health and Social Care Bill will, therefore, require the establishment of a health and wellbeing board in every upper tier local authority.

B. Flexible geographical scope

5.7 The Bill will provide flexibility for health and wellbeing boards both between and within local authority areas. Respondents felt that the determining principle should be "*whatever makes sense locally*". We agree. A number of respondents, for example Greater Manchester, sought the ability for a number of local authorities to establish a single board covering their combined areas, should each authority wish to do so, in order to build on pre-existing patterns of collaboration.

5.8 Our consultation document was silent about district councils. The District Councils Network picked up on this: "*We consider that the district councils' role in improving public health, tackling health inequalities and supporting community infrastructure and enabling individuals and communities to access health care, has not been given sufficient prominence and look forward to working with the Department of Health in developing proposals and ideas*". Many local government and NHS responses, for example from Derbyshire, Lancashire, and Hampshire, echoed this point. As Stevenage Borough Council put it: "*A delicate balancing act which allows for the district level voice to be heard at the county level is required. A board with representatives from the districts would lead to unwieldy meetings, but local knowledge is invaluable*". East of England SHA added that "*health and wellbeing boards will need to reflect District and Borough council agendas and local population needs and this may be a challenge in a very large two tier authority*". The Patients Association also highlighted that "*the role of District Councils in terms of health and social care must not be overlooked in favour of the role of the County Councils - particularly in the more rural communities*." The Bill will allow for health and well being boards to include representatives from lower tier authorities.

5.9 Health and wellbeing boards will enable new fluidity and dynamism amongst NHS commissioning arrangements by providing a vehicle for NHS and local authority commissioners to come together on a geographical basis. As the previous chapter set out, some GP consortia boundaries may be coterminous with local authority areas, but others will not. A significant number of respondents raised concerns that this may mean future partnership arrangements are less effective than those that currently exist. However, boards will exist to support future arrangements, and the Government considers that consortia will be most effective if they are not forced to conform with and stick to a prescriptive geographical model. Instead, the intention is to permit communities of GPs to form organisations that best work locally, and for those

organisations to adapt and flex over time – spreading, merging, shrinking, dissolving – according to success and failure.

5.10 This intended flexibility in relation to consortia is one of the reasons why the Government places such importance on the existence of health and wellbeing boards. Taken together, policies on GP commissioning and health and wellbeing boards will increase the dynamism of NHS commissioning and at the same time strengthen joint working between the NHS and local government.

C. Core membership

5.11 Alongside the existing duty to co-operate between NHS bodies and local authorities, we will – in line with the consultation responses – place a duty on relevant GP consortia to participate in the work of the board by requiring them to be members. For example, many NHS respondents have suggested that membership would "*enable consortia to contribute to effective joint action*" (Newcastle upon Tyne Hospitals NHS Foundation Trust), and local authorities and voluntary sector organisations, such as the MS Society, have added that they "*believe it is necessary for GP consortia to be obligated to sit on health and wellbeing boards if there is to be a meaningful attempt to imbed integration between health and social services in all local areas*". To reduce the burden of every consortium in a local authority area being required to send a representative, the Bill will allow for "lead consortium" arrangements, with one consortium delegating representation on the board to another, where this has the explicit agreement of the health and wellbeing board.

5.12 The work of the health and wellbeing boards will also cover some areas which fall under the NHS Commissioning Board's responsibilities, such as specialist commissioning. Some, for example the Association of North East Councils, raised doubts as to whether the NHS Commissioning Board could establish a credible standing local presence. Rather than place a significant burden on the NHS Commissioning Board by requiring it to participate in the same manner as consortia, the health and wellbeing board will be able to require its attendance only where appropriate, for example in relation to local commissioning responsibilities.

5.13 Consultation revealed broad support for the membership arrangements proposed. Given one of the main purposes of the health and wellbeing board is to increase democratic legitimacy in health, the Bill prescribes

that there must be a minimum of at least one local elected representative. 2020Health supported the proposal to "*give a stronger role for elected council members who know their wards and the broader picture of needs*". The Bill provides that the other core members of the health and wellbeing board will be GP consortia, the director of adult social services, the director of children's services, the director of public health, and local HealthWatch.

5.14 Beyond this core, we will leave it to the local authority to decide who to invite and it will have flexibility to include other members. There will be flexibility for the local authority to delegate functions to the health and wellbeing board where it feels appropriate. Manchester City Council and Manchester Adults Health and Well Being Partnership Board welcomed "*local freedom to determine the most appropriate membership reflecting the national statutory framework*". Similarly, Norfolk County Council supported this approach "*which sees only a limited number of partners subject to a 'duty to cooperate' leaving top-tier authorities with the freedom and flexibility to decide any wider representation, and to decide any local arrangements*". To engage effectively with local people and neighbourhoods, boards may also choose to invite participation from local representatives of the voluntary sector and other relevant public service officials. They will also want to ensure input from professionals and community organisations that can advise on and give voice to the needs of vulnerable and less-heard groups. Boards may also want to invite providers into discussions, taking care to adhere to the principles of treating all providers, existing or prospective, on a level playing field.

5.15 As a result of their statutory footing and core membership, health and wellbeing boards will provide a key forum for public accountability of NHS, public health, social care for adults and children and other commissioned services that the health and wellbeing board agrees are directly related to health and wellbeing. Like all committees of local authorities, meetings will generally be in public. They will ensure local democratic input to the commissioning of these services, alongside patient engagement through local HealthWatch.

D. Enhanced joint strategic needs assessment (JSNA)

5.16 The core purpose of the new health and wellbeing boards is to join-up commissioning across the NHS, social care, public health and other services that the board agrees are directly related to health and wellbeing, in order to secure better health and wellbeing outcomes for

their whole population, better quality of care for all their patients and care users, and better value for the taxpayer.

5.17 At the heart of this role is the development of the joint strategic needs assessment (JSNA). This provides an objective analysis of local current and future needs for adults and children, assembling a wide range of quantitative and qualitative data, including user views. The production of the joint strategic needs assessment is a statutory duty for primary care trusts and local authorities. In future the joint strategic needs assessment will be undertaken by local authorities and GP consortia through health and wellbeing boards; in line with what South Gloucestershire Council wanted to see, there will be "*a clear set of expectations on partners in discharging their duty to participate*". To complement the responsibility for undertaking JSNAs and in line with the suggestion from Bolton Local Pharmaceutical Committee, we will also transfer responsibility for the pharmaceutical needs assessment to local authorities, to be discharged through health and wellbeing boards, so that local needs can be considered in the round.

5.18 We consider joint endeavour to be an important principle. Bassetlaw Local Strategic Partnership stressed that "*all relevant parties must have an opportunity to feed into the JSNA preparation*" and Southend Borough Council added that the JSNA "*will help to ensure that members of the board are fully aware of the services that will need to be commissioned*". For this reason, the Bill does not place the function of producing the JSNA directly on the health and wellbeing board, which is part of the local authority, leaving NHS commissioners cast merely in a supporting role. Instead, local authorities and GP consortia will each have an equal and explicit obligation to prepare the JSNA, and to do so through the health and wellbeing board.

5.19 In the reformed system, the process and product of the joint strategic needs assessment takes on much greater importance. The health and wellbeing board will have a role in helping meet the need - expressed by the NHS Confederation and others - for GP consortia to have "*access to public health expertise so that they can take a population health viewpoint, in particular access to epidemiological advice and insight into parts of the population that are either unregistered or invisible to general practice*", through for example the Director of Public Health being a member of the board. As Southampton City Council has suggested, the focus on the JSNA will help "*ensure that GP consortia take commissioning decisions based on the overall needs of the population in future rather than the needs of their current set of patients*".

5.20 The Government fully agrees with the view of the Association of Directors of Adult Social Services that "*all commissioning should be driven by the JSNA or shared assessments across local authority boundaries, whether these are GP commissioning, council commissioning or joint commissioning*". Many respondents, for example the Association of Directors of Public Health, Nottingham City Council, Oldham PCT, and Peterborough City Council, felt that the value of the JSNA could be enhanced by clearer expectations about its use within commissioning plans. The point is well made. At present JSNA obligations extend only to its production, not its application. To remedy this lacuna, the Government is therefore introducing in the Bill a new legal obligation on NHS and local authority commissioners to have regard to the JSNA in exercising their relevant commissioning functions.

E. The new joint health and wellbeing strategy (JHWS)

5.21 The joint strategic needs assessment will be the primary process for identifying needs and building a robust evidence base on which to base local commissioning plans. But our aspirations for health and wellbeing boards range some distance beyond mere analysis of common problems. We intend for them to become deep and productive partnerships that develop solutions to commissioning challenges, rather than just commentating. Collaboration must be the norm. We want elected representatives along with other key local stakeholders to be engaged in early conversations about how local services can best meet requirements rather than reacting as commentators and critics to proposals emanating from the NHS. This vision was supported by a number of local authorities and NHS organisations, such as Bedfordshire PCT, who "*support the creation of health and wellbeing boards with clear and sufficient legal powers to provide local leadership and a strategic framework for coordination of health improvement and addressing health inequalities in local areas, based on local health needs identified by the JSNA*". North East Derbyshire District Council added that "*Local authorities should have statutory powers to lay out an overall strategy for health, health services, quality of health services, health improvement and well-being within which health improvement and health service commissioners will be expected to work*".

5.22 In line with this ambition, and building on the enhanced JSNA, the Government is taking the important additional step of specifying that all health and wellbeing boards should have to develop a high-level "joint health and wellbeing strategy" (JHWS) that spans the NHS, social care and public health, and could potentially consider wider health

determinants such as housing, or education. Like the JSNA, we would encourage organisations to develop a JHWS that provides a concise summary of how they will address the health and wellbeing needs of a community and help reduce inequalities in health – rather than a large, technical document. This will help address what Eaglescliffe Medical Practice termed the "*artificial boundaries between Health and Social Care*". Health and wellbeing boards will have the freedom to decide how best to develop these on the basis of minimal bureaucracy and maximum value-added. As South Birmingham Community Trust put it, "*best practice guidance is always helpful in avoiding reinventing the wheel and wasting resources; however this needs to be balanced by avoiding a detailed prescription of tasks that would work against local flexibility for local circumstances*". The Bill will place GP consortia and local authorities under a new statutory duty to develop these health and wellbeing strategies together, in exactly the same way as they will the JSNA, through the health and wellbeing board. There will be no statutory guidance on the nature of these strategies, nor will the health and wellbeing board be required to submit them to the Department, the NHS Commissioning Board or any other central organisation, but they will be made public. To ensure that national and local strategies remain consistent, the health and wellbeing board will have a duty to have regard to the NHS Commissioning Board mandate in preparing the JHWS.

5.23 The strategy should provide the overarching framework within which commissioning plans for the NHS, social care, public health and other services which the health and wellbeing board agrees are relevant, are developed. Knowsley Health and Wellbeing (a joint partnership between Knowsley NHS PCT and Knowsley Council) suggested that: "*The health and wellbeing board should be empowered to use all of the flexibilities at its discretion but be required to plan to integrate local health and social care services using integrated commissioning with explicit council and consortium commitment being expected.*"

5.24 A comprehensive suite of duties and powers in the Bill will put beyond doubt the expectation of "*explicit council and consortium commitment*" to the JHWS:

- just as GP consortia and local authorities will be required to have regard to the joint strategic needs assessment, they will also be under a new statutory duty to have regard to the JHWS;
- health and wellbeing boards will be able to consider whether the commissioning arrangements for social care, public health and the

NHS, developed by the local authority and GP consortia respectively, are in line with the JHWS;

- the health and wellbeing board will be able to write formally to the NHS Commissioning Board and the GP consortia if, in its opinion, the local NHS commissioning plans have not had adequate regard to the JHWS. Equally, it will be able to write to the local authority leadership if the same is true of public health or social care commissioning plans; and
- when GP consortia send their commissioning plans to the NHS Commissioning Board, they will be under an obligation to state whether the health and wellbeing board agrees that their plans have held due regard to the JHWS and send a copy of their plans to the health and wellbeing board at the same time.

5.25 A number of respondents wanted the Government to go further and grant the health and wellbeing boards formal decision-making rights over GP consortia in relation to their commissioning plans. For example, the Local Government Group suggested that "*health and wellbeing boards should have the authority to sign off GP commissioning plans*". The Coalition Government has considered this suggestion carefully and rejects it for a number of important reasons.

5.26 At the heart of the Government's plans for GP consortia, the principle of autonomy lies alongside that of accountability. In their joint response, which echoes responses from the voluntary sector and local authorities, Calderdale Council and PCT, observed "*that for the reforms to work, it is vital that the NHS Commissioning Board feels and behaves different from the current arrangements between [the Department of Health] and local health systems, which is heavily top down in management style*". As a member of the public asked in response to the consultation, "*will the influence of political allegiances in local government be allowed to override public health knowledge and expertise when planning local services*". In line with this, the NHS Commissioning Board will not have the authority to agree and sign off GP consortia commissioning plans; the planning information that consortia submit to the NHS Commissioning Board will focus on financial forecasting, to enable effective pooling of risk. Consortia will be accountable to the NHS Commissioning Board, and in turn, the Secretary of State for Health and Parliament; but this accountability will be for the results they achieve – improving outcomes and living within their cash-limit.

5.27 Hertfordshire County Council, echoing the views of a range of NHS and local authority organisations, stressed the importance of "*complete clarity as to the respective roles and authority of the [health and wellbeing]*

board and GP commissioning consortia". Sutton and Merton PCT reflected the views of many respondents when seeking clarity on what "*health and wellbeing boards are accountable for and how that accountability sits with clinical commissioning consortia's accountability to the NHS Commissioning Board*". Formal approval rights for health and wellbeing boards would put them in a more powerful position than the NHS Commissioning Board, to whom the consortia are primarily accountable, in line with the Government's plans for the NHS to remain a national service, funded out of national taxation and accountable to Parliament. Formal approval rights for health and wellbeing boards over consortia could unbalance the sense of mutuality; to paraphrase a number of GP respondents, it would not feel much like liberation if the removal of one perceived master (the PCT) is only to substitute another (the local authority). The health and wellbeing board will not be a commissioning body. The commissioning authorities will be the local GP consortia and the local authority. The Government is also clear that it cannot grant authority without responsibility: it would contravene the principles of financial accountability to give local authorities the ability to make NHS commissioning decisions that could commit additional expenditure from GP consortia, without local authorities having to take responsibility for that expenditure.

F. Increased joint commissioning and pooled budgets

5.28 In addition to assessing needs and developing an overarching commissioning strategy, health and wellbeing boards will also be able to make use of the existing flexibilities between the NHS and local authorities, both formally established under the NHS Act, and more informally through teams working together locally. These flexibilities, and the ability to invest differently at the interfaces of the NHS, public health, social care and children's services, will be increasingly important in meeting the challenge of delivering the best possible outcomes for communities and sub-groups of the population within a more constrained financial environment. Swindon PCT felt that "*integration, supported by pooled budgets, provides excellence in services through effective commissioning*". Health and wellbeing boards will be able to look at totality of resources in their local area for health and wellbeing. Within their health and wellbeing strategies they will be able to consider how prioritising health improvement and prevention, the management of long-term conditions, and provision of rehabilitation, recovery and re-ablement services can best deliver reductions in demand for health services, as well as the wider benefits to health and wellbeing. As Places for People

argued, echoed by the Proprietary Association of Great Britain, "*by coordinating investment into an area, waste and duplication would be eliminated and concentrations of deprivation can be tackled in a more effective way. We feel that such a framework would be an important way to encourage joint working and achieve better health outcomes at a local level*".

5.29 Some consultation respondents voiced concern that existing pooled budget arrangements, for example in mental health, child health and wellbeing and learning disability services, could inadvertently fall as a result of the abolition of PCTs in April 2013, and the need for GP consortia to be proactive in establishing new arrangements in time. For example, Westminster City Council said that "*[we] do not wish to see the strengths in our local joint commissioning arrangements lost in the transfer to GP commissioning; rather as a Council we would like to capitalise on the opportunity to further enhance joint working between health and social care and create seamless services for patients / clients. The health and wellbeing board provides a forum in which to join up our thinking across health and social care and drive efficiency savings through more effective commissioning*". In many cases, we would expect GP consortia to continue with agreements that have historically been working well. The position of all existing pooled budgets will be an important part of local transition planning. As a backstop, the Bill will also make provision for any existing arrangements that have not been addressed as part of the transition, to continue, prior to GP consortia and local authorities entering into new arrangements.

5.30 To find ways to promote joint working, we also asked what currently gets in the way of joint working. Some respondents cite conflicting performance frameworks and NHS organisations having had to look up to Whitehall rather than out to local partners and service users. Other issues include accounting and audit arrangements and these require further exploration; the Government will actively seek to remove needless barriers wherever possible.

5.31 Some respondents, for example Camden Council, wanted the Government to "*require local authorities and health commissioners to pool resources*". Although we do not think this is practicable, we understand the sentiment. As Solihull Care Trust suggested, "*local authorities will struggle to co-ordinate commissioning without a commitment from partners to joint/pooled budgets*". However, we agree with Suffolk and Great Yarmouth LPC when they say that "*integrated working depends on the quality of local working relationships and although the Department can outline areas where integrated working is*

required this should not be too restrictive to prevent local innovation to occur". This is backed up by the Lesbian and Gay Foundation's suggestion that "*lead commissioning and other flexibilities should be explicitly promoted and supported by the Department for the delivery of high quality community based specialist services*". Staff at Norfolk PCT echoed the views of many NHS respondents when they welcomed "*the opportunity to increase dialogue between services and join services together for the good of patients*". The Bill will therefore place a duty on GP consortia and local authorities, through the health and wellbeing board, in drawing up the joint strategy, to consider how to make best use of the flexibilities they have at their disposal, such as pooled budgets. To reinforce this duty, the Department has also decided that the NHS Commissioning Board should be placed under a duty to promote the use of flexibilities by consortia. These duties do not require flexibilities to be used, but they signal the importance of maximising the use of the tools available.

G. Health and wellbeing boards as an open-ended vehicle

5.32 Beyond core functions, and core membership requirements, local authorities will have the freedom to delegate additional functions to the health and wellbeing boards in whatever way they think appropriate. For example, local authorities may well wish to use health and wellbeing boards to consider wider health determinants such as housing and leisure, or co-ordinating commissioning of children's services. It will be entirely up to them. As some respondents, such as the Pennine Acute NHS Hospitals Trust have suggested, the health and wellbeing board "*should be the vehicle and focal point through which joint working could happen*" and "*the encouragement of joint commissioning extending beyond the current service areas could enhance service integration*". Health and wellbeing boards could become a vehicle for driving wider place-based initiatives, such as the community budget areas announced in the recent Spending Review, focussed on helping turn around the lives of families with multiple problems, improving outcomes and reducing costs to welfare and public services by enabling a more flexible and integrated approach to delivering the help these families need. As the chief executive of Manchester PCT said, "*the [health and wellbeing] board can provide strategic direction for integrated commissioning, place based budgets and even a productivity or pooled fund*."

5.33 GP consortia will inherit a number of the existing statutory functions of primary care trusts. Where they feel it may improve commissioning, they will have the freedom to enter into voluntary arrangements with a local

authority to perform any of these functions on its behalf. For example, statutory arrangements for the provision of wheelchairs for adults and children, or participation in a range of other partnership arrangements, may be undertaken via the local authority who may choose to delegate this to the health and wellbeing board. Consortia may well look to the local authority as a core source of local advice, support and strategic leadership. Some consortia may also wish to secure commissioning support from local authorities, given local authority expertise in commissioning and contracting.

H. Referral and enhanced scrutiny

Keeping scrutiny separate

5.34 We proposed that the functions exercised by the health overview and scrutiny committee (OSC) would be subsumed within the health and wellbeing board. Respondents were of one voice in saying that the Department had got this wrong. For example:

"*we believe the proposals to replace health scrutiny represent a misunderstanding of the nature and scope of health scrutiny practice*" (The Centre for Public Scrutiny);

"*as currently constituted, the plans represent a major downgrading of the councillor role in scrutinising local decisions ... health and wellbeing boards represent a confusion of commissioning and scrutiny responsibilities*" (UNISON);

"*it is not appropriate for Health and Well-being Boards to have both the executive and scrutiny functions as they cannot effectively scrutinise their own decisions*" (County Councils Network).

5.35 The Department hears these arguments and is persuaded that its original proposal was flawed. The Bill will not therefore confer the health scrutiny function on health and wellbeing boards.

5.36 We have also heard in the consultation responses – and wish to acknowledge in this command paper – that there are many examples of very effective health OSCs, undertaking excellent work. It is not the Department's intention to downgrade the role of councillors in scrutinising local decisions. Scrutiny has a crucial role to play in providing transparency and "*amplifying the voices and concerns of the public*" (Centre for Public Scrutiny).

5.37 Wider government policy for local government, announced in the Coalition Agreement and the Department for Communities and Local Government Structural Reform Plan, is to give local authorities greater freedom to discharge its functions in different ways – for example, through the general power of competence for local councils. This should include scrutiny functions, and a number of respondents, for example, the Association of Directors of Adult Social Services, said that "*there needs to be local determination and flexibility to decide the best possible arrangements for scrutiny functions*". Cambridgeshire County Council supported this approach, "w*e consider that the scrutiny role, and its relevant statutory powers, including the power of referral, should be independent of the health and wellbeing board, and remain the responsibility of the local authority, who, with partner organisations, can build on their experience to develop scrutiny arrangements that are appropriate to local circumstances*". We therefore propose to give local authorities a new freedom and flexibility to discharge their health scrutiny powers in the way they deem to be most suitable – whether through continuing to have a specific health OSC, or through a suitable alternative arrangement. To enable this flexibility, the Bill will confer the health overview and scrutiny functions directly on the local authority itself.

5.38 If we had moved ahead with our original proposals for health and wellbeing boards to have scrutiny functions, local HealthWatch organisations would have had a direct role in relation to scrutiny. Given the changes we propose to make to the delivery of scrutiny functions, we would ask that local authorities consider how local HealthWatch organisations relate to the delivery of their scrutiny functions. We will ensure that the HealthWatch pathfinders, referred to in Chapter 2, work with local authority early implementers to explore how this might work in practice.

Service reconfiguration and referral

5.39 Liberating the NHS outlined the Government's intention to free providers of healthcare services so that they can focus on improving outcomes, be more responsive to patients, and innovate. Chapter 6 provides the details. In future, there will be a clearer distinction between: those services which are designated as subject to additional licence conditions and which Monitor will ensure continue to be provided, even if the provider fails; and those services where providers have greater freedom to adapt in line with changing demands, for example through patient choice, without recourse to formal public consultation. The Foundation

Trust Network in particular has been clear about the critical importance of providers being granted the freedom to become more agile.

5.40 The distinction between services that are designated for additional regulation and those that are not will apply to all provision of NHS-funded services, whether they are currently provided by NHS bodies, private providers or those in the voluntary sector. As Chapter 6 explains, the Bill will require consultation on the guidance that Monitor produces for designating services for additional regulation, and full local consultation by NHS commissioners as to which services they propose to designate – including consultation with the local authority.

5.41 In addition to being consulted on the designation of what services are subject to additional regulation, the local authority will be able to refer decisions about significant changes to any designated services to the Secretary of State. In this way we will retain the "right to refer", the importance of which was emphasised by a number of NHS, local government and third sector organisations. In the words of Norfolk Community Health and Care, there should be a "*principle of referring to the NHS Commissioning Board and then, by exception, to the Secretary of State for Health*". The Department agrees.

5.42 There was support for the idea that, as Telford and Wrekin Council argued, "*proposals that are referred nationally should be on an exceptional basis and resolution of disputes should be addressed locally where possible*", with commissioners and local authorities working to discuss proposals and reach consensus from an early stage. University Hospitals Bristol NHS Foundation Trust suggested that there should be "*clear thresholds that must be met before a referral is accepted that specifies what should have been undertaken locally first and by whom, what level of evidence is required to support a referral and specify the level of consensus that must surround any referral*".

5.43 To ensure that the health scrutiny model is consistent with other forms of scrutiny in local authorities, and as democratic as possible, we propose that any decision to refer a substantial service change proposal should be triggered by a meeting of the full council. This is in line with the views expressed by the Association of Directors of Adult Social Services and many councils that "*flexibility*" and "*local determination*" are crucial, combined with a recognition that the strengthened role of local authorities in relation to health should be reflected in a new approach to scrutiny and referral.

5.44 The exception to this will be if a number of councils choose to establish a joint scrutiny arrangement, in which case the joint OSC will hold the

referral power. To support joint working and to provide the clarity and consistency asked for by many respondents such as Somerset PCT, Ealing NHS Trust, Liverpool and Lewisham PCTs, we propose that when local authorities establish joint OSCs, they do so on the basis that at an early stage they agree for the decisions of the joint OSCs to be binding on all contributing councils. The Department is also considering revisions to the regulations governing referrals, so when deciding to make a referral, local authorities are obliged to publish a timescale for the decision-making process and take account of a wider range of considerations including the duties on NHS commissioners to improve the safety, effectiveness and patient experience of services, and the need for services to be financially sustainable. We will consult on these proposed changes to the scrutiny regulations.

5.45 In future, the local authority's right of referral described in paragraph 5.41 will apply in relation to any type of provider of NHS-funded services, whatever their governance arrangements and ownership structure. Given the importance the Government places on local authority referral, the Bill will include a regulation making power that can enable the Secretary of State to direct NHS commissioners (either directly in the case of the NHS Commissioning Board, directly or via the NHS Commissioning Board in the case of GP consortia) to stop reconfigurations of those services subject to additional regulation, when they are referred to him. This is one of the few occasions, other than in an emergency, or possibly in complying with EU law, when we envisage the Secretary of State will have any ability to interfere with an individual commissioner or provider. In making decisions, the Secretary of State will, as now, be guided by the Independent Reconfiguration Panel, and additionally be required to take account of the safety, effectiveness and patient experience of services and the need for services to be financially sustainable.

Enhanced power of scrutiny

5.46 Our strong desire to increase local democratic legitimacy and scrutiny, and to create a level playing field, has led the Government to decide to take the important step of significantly extending the powers relating to the scrutiny function of local authorities. At present, health is unique amongst all local authority scrutiny arrangements in having powers for the local authority to require autonomous providers to attend scrutiny meetings. This power currently extends to NHS trusts, foundation trusts and primary care trusts.

5.47 The Centre for Public Scrutiny suggested that the scrutiny powers should be strengthened so that "*any provider of health and social care paid for*

by public funds should be under an obligation to be transparent, inclusive and accountable for how they plan and deliver services." The Bill will enable the Government to extend the powers of local authorities to enable effective scrutiny of any provider of any NHS-funded service, including, for example, primary medical dental or pharmacy services and independent sector treatment centres, as well as any NHS commissioner. The powers will also include scrutiny of local public health services. They will include the ability to require any NHS-funded providers or commissioners to attend scrutiny meetings, or to provide information. In this way local democratic scrutiny will be increased very substantially. The proposed powers for the local authority to scrutinise matters relating to GP consortia's commissioning functions is a very important way of ensuring local public accountability.

5.48 Our intention in developing this revised set of provisions has been to design an integrated and balanced package of measures which seeks to:

- distinguish more clearly between local authority executive and scrutiny functions and does not therefore place scrutiny functions within the health and wellbeing board;
- achieve consistency with the principles of provider autonomy and economic regulation and ensure local democratic input about what services are subject to additional regulation;
- maintain referral rights for local authorities, extended to any provider, in relation to services subject to additional regulation;
- uniquely amongst the Secretary of State's newly limited NHS functions, provide in relation to local authority referrals an ability to direct a specific NHS commissioner;
- extend the principles and powers relating to scrutiny to any provider of any NHS-funded service;
- provide for clear local scrutiny of GP consortia commissioning plans.

I. Implementation framework

5.49 This chapter has set out the legislative framework for partnership between NHS and local authorities and how the Department has strengthened and revised its proposals following consultation responses. The Government fully recognises that legislating for change including through new structures is not at all the same as making change happen;

it is a necessary step, but insufficient. Liberating the NHS and improving the health and wellbeing of the nation is about wholesale long-term cultural change, effecting significant shifts in power and responsibility from the centre to localities, and above all, about local leadership and the forging of new and stronger relationships. Successful culture change will be essential in order to make the new arrangements work.

5.50 Subject to Parliamentary approval, the health and wellbeing board will become a statutory committee of the local authority at the same time that GP consortia take on responsibility for the NHS budget. Although boards will only formally assume their powers and duties in April 2013, they will come into existence in advance of this date. Many areas are already well advanced in their approach to integrated working, and are thinking about and beginning to model how these future arrangements might work. It is important that the system learns from these areas.

5.51 For those areas where there is further to go, early progress in strengthening partnership arrangements is needed to deliver on the short-term partnership agenda. Leaders in local authorities, emerging GP consortia (or where they do not yet exist, relevant local clinicians who are likely to be part of GP commissioning arrangements) and primary care trusts should start considering and establishing the right local arrangements, including the following:

- they should ensure joint arrangements are in place for local areas to agree priority areas for investment of £1 billion of NHS funding made available in the Spending Review to support social care, by March 2011;

- we are asking all primary care trusts to ensure that their QIPP and reform plans are developed through collaboration with local government partners. It will be increasingly important throughout 2011/12 that local joint mechanisms have their QIPP and reform plan fully embedded in their discussions;

- to consider options for the transfer of existing pooled budgets and joint commissioning arrangements to GP consortia and the NHS Commissioning Board;

- GP consortia pathfinders will need to work with councils from the outset on setting up health and wellbeing boards;

- to work through arrangements for the transfer of public health functions in line with *Healthy Lives, Healthy People.*

5.52 A number of respondents argued that the creation of health and wellbeing boards would impose additional bureaucratic burdens. The Government does not accept this argument. The statutory framework for health and wellbeing boards will provide a more robust basis and stronger incentives for integrated working and local democratic engagement that should already be taking place.

5.53 In being members of health and wellbeing boards, NHS and local authority commissioners will not be burdened by additional bureaucracy, but will mainly be discharging duties that naturally fall to them – to assess needs, develop strategies and work across boundaries to solve common problems. Many councils and NHS organisations consider this to be a key part of their functions and it is already happening: for example in Sheffield, the health and wellbeing partnership is chaired jointly by the council chief executive and the PCT chief executive; in Cambridgeshire the JSNA has been used to prioritise action across health, social care and district councils; and Hammersmith and Fulham have close strategic integrated working between the council and PCT.

5.54 We expect that a clear forum for partnership will improve the efficiency of the process of managing the interface between the NHS and local government. For these reasons, the Government does not anticipate any additional cost burden falling on local authorities as a result of the establishment of health and wellbeing boards. We do not anticipate any staff being transferred from bodies in the current system (PCTs, SHAs etc) to administer the health and wellbeing board. For example, currently the JSNA falls to the directors of public health, directors of adult social services and directors of children's services to carry out, as set out in the JSNA guidance.

5.55 We agree with Stockport Metropolitan Borough Council and Stockport PCT, who noted in their joint response that "*the creation of Shadow Health and Wellbeing Boards, or similar arrangements, in advance of the legislation would enable the relationship between GPs and local authorities to develop in a relatively 'safe' way ... successful partnerships are not born overnight; and relationships are best developed before the responsibility of collaborative decision-making becomes necessary.*" We will therefore be encouraging early implementers to operate during the remainder of 2010/11 and during 2011/12.

5.56 The Department will shortly write to local authorities inviting interest in becoming an early implementer and to clarify the key transition milestones as they impact upon local government. Early implementers in 2010/11 will take the form of non-statutory partnership arrangements. Our intention in inviting interest will be to recognise local energy and

enthusiasm wherever it exists. Subject to the scale of interest, the Department will then work with the early implementers to establish a shared development agenda and explore key issues, such as:

- strengthening arrangements for JSNAs and how the new joint health and wellbeing strategies might work;
- improving efficiency across the NHS and local authority boundary;
- identifying and addressing cultural and practical barriers to developing strong relationships;
- sharing experiences about what membership arrangements work best in different parts of the country;
- tackling barriers to pooled budgets and joint commissioning;
- exploring opportunities for local authorities and health and wellbeing boards to provide practical support for GP consortia;
- joint working across children's services;
- clarifying how health and wellbeing boards should work with the Local Safeguarding Children Boards in order to ensure the effectiveness of local arrangements to safeguard and promote the welfare of children;
- exploring opportunities for using health and wellbeing boards to support wider place- based arrangements and initiatives for example in relation to families;
- finding ways of sharing best practice in emerging health and wellbeing boards with other systems; and
- providing input into future Department of Health regulations and guidance.

5.57 The outputs of this work – the first phase – will be shared with other councils and GP consortia as a way of sharing learning and making sure that early best practice is embedded. As London Councils put it, "*Local authorities already have a wealth of experience in promoting health and wellbeing, including conducting JSNAs. Where local authorities would welcome additional support, organisations such as London Councils and Local Government Improvement and Development are best placed to offer this, working alongside officers and members.*"

5.58 The second phase of implementation is the establishment across the country of a comprehensive system of ‘shadow’ health and wellbeing boards, in every upper-tier authority, from April 2012. During the year 2012/13, the health and wellbeing boards will be a partnership without statutory powers and duties; but all boards will need to start preparations to perform all the functions envisaged by the Bill. In particular, the boards will need to make preparations to carry out JSNAs, develop JHWSs and link these to emerging commissioning plans, in advance of GP consortia and local authorities getting their real NHS commissioning and public health allocations from April 2013.

5.59 The final phase of implementation is from April 2013, when the statutory powers and duties in relation to boards will take full effect, and the new arrangements start to become more embedded across the country. The Department also intends that the enhanced scrutiny powers for local authorities will come into force from April 2013.

5.60 Health and wellbeing boards will form alongside the changing landscape of NHS commissioning and local HealthWatch. This timing will means there will be excellent opportunities to forge new relationships. Equally, early implementers will need to be mindful that the local picture will evolve, as well as being actors in that evolution; in some cases, the shape of GP consortia will not be clear until April 2012. There is little point in a local authority making rapid progress on a health and wellbeing board if that progress does not achieve effective engagement with local GP partners. Making the new arrangements work against this shifting context will depend on leadership and collaborative behaviours, and on the NHS and local government committing to investing the time and effort that will be needed to share existing knowledge and move forward in partnership. The early implementers will help provide a strong basis for learning and improvement. It will be important that all the key partners work locally at the same pace, learning and building together as mutually respecting partners.

6. REGULATING HEALTHCARE PROVIDERS

Introduction

6.1 To achieve the Government's goal of an NHS which achieves results that are amongst the best in the world, we need providers of treatment and care who are free to innovate and drive sustainable improvements in quality and efficiency. Patients should be able to expect to receive high quality healthcare from the best providers available, in an NHS where high performance and standards are rewarded, and poor quality or failing services are not tolerated.

6.2 That is why the *Liberating the NHS* and the consultation document, *Regulating healthcare providers*, set out plans to give more autonomy to NHS providers and put in place effective quality and economic regulation, so that patients know services are safe and the taxpayer gets value for money. We received over 200 specific responses to *Regulating healthcare providers* from a wide range of respondents, as well as a large number of related comments within responses on the White Paper itself.

6.3 This chapter gives a brief overview of the key consultation themes, then describes in more detail how the Government has decided to implement the reforms in light of the views raised. It covers:

A. Overarching themes from consultation

B. Freeing NHS providers

C. Transition for freeing NHS providers

D. A new framework of regulation

E. Monitor's roles and duties

F. How economic regulation will work: licensing

G. How economic regulation will work: promoting competition

H. How economic regulation will work: price setting and regulation

I. How economic regulation will work: supporting service continuity

J. Education and training

K. Pay and pensions

A. Overarching themes from consultation

6.4 Overall, competition and provider freedoms were the issues that most divided respondents. Some – particularly trade unions and some existing NHS organisations and professionals – objected on principle to the idea of a more competitive environment for providers. For example, the BMA "*supports an NHS that cares for patients through cooperation, not competition, and is opposed to any new opportunities for the private and independent sectors to deliver healthcare*", while Unite said that creating a regulator to promote competition illustrated that the Government proposed "*the total destruction of the collective provision of a public good – universal, public healthcare, free for all before and after treatment*".

6.5 However, others agreed with the Government about the potential benefits of competition, and emphasised the importance of designing regulation well: "*There is now good evidence that an appropriately incentivised and well regulated system of competition in healthcare can be a powerful force for enhancing efficiency, improving health outcomes and, indeed, saving lives. There is also evidence that an inappropriately incentivised and poorly regulated system can do the reverse… It is of the utmost importance to get the detailed regulation right so that competition drives health outcomes in the right direction*" (Professor Bruce Lyons of the ESRC Centre for Competition Policy at the University of East Anglia). The Nuffield Trust argued that "*market-based incentives in the NHS have the potential to deliver the goals of improved efficiency and quality*". They supported the Government's proposal to turn Monitor into an economic regulator, while recognising that the new system would take time to develop and would require a range of policies such as greater patient choice and national tariff prices to be developed in tandem.

6.6 There was some opposition to the idea of allowing "any willing provider" to offer NHS services. For example, a GP feared that "*increasing amounts of public money will become private sector profit under the 'any willing provider' rules – I think that if all else is equal commissioners should favour an NHS provider*". Yet many who commented specifically on this supported the principle of fairness between providers: "*A level playing field needs to be in place. The previous government policy of favouring NHS institutions for contracts should be revisited*" (an NHS professional).

6.7 Social enterprise, voluntary and independent sector providers were particularly supportive of removing barriers enabling them to enter new markets. Circle, a clinician-led independent provider, said that the White Paper's proposals "*when fully implemented, will increase value by improving quality (patient experience and clinical outcomes) as well as reducing the unit cost of the delivery of care*". The charity, Turning Point, said "*We particularly support the principles of any willing provider and advocate strongly for the role of social enterprises and civil society organisations in not only supporting statutory organisations but in directly providing alternative solutions*".

6.8 Many of the issues raised about economic regulation were practical: independent providers commented that achieving a genuine level playing field would require concerted action to avoid unfair tendering and to take account of policies that might implicitly favour NHS organisations, such as access to public sector pensions. Similarly, some smaller voluntary organisations were concerned about being squeezed out of the market and the potential bureaucratic burden of regulation. Several responses made helpful suggestions about clarifying relationships between Monitor and the NHS Commissioning Board and the Care Quality Commission. And several respondents discussed the scope and limits of competition, endorsing the Government's view that there are many NHS services, such as accident and emergency services, where an "any willing provider" approach would not be suitable. For example, a response from the five Academic Health Science Centres argued that a sophisticated approach to competition policy "*which recognises the very different competitive markets for different kinds of healthcare*" would be needed in order to promote more integrated care for the benefit of patients.

6.9 As with competition, the Government's proposals to level the playing field for existing NHS providers polarised opinion, especially the idea of removing the cap on private patient income for foundation trusts (FTs). Critics saw FT freedoms as a potential "*dismantling of the NHS*" (individual GP) or a step towards privatisation, which could potentially act as an incentive for FTs to undertake more non-NHS activity at the expense of NHS provision. Other respondents were cautiously positive: supporting the removal of the private income cap or the statutory FT borrowing code, but proposing alternative safeguards to guarantee that NHS patients would not be disadvantaged.

6.10 However, there was enthusiasm from many respondents, especially from some existing FTs. Papworth Hospitals NHS FT said it "*supports the proposals outlined in the [White Paper], including the proposals to…increase freedoms of Foundation Trusts and make them more*

accountable for the results they achieve". Other FTs argued that increasing their freedoms would create "*a more even handed approach to competition*" (The Christie NHS FT) and would "*enable us to innovate and improve services*" (South Essex Partnership University NHS FT). Meanwhile ACEVO (Association of Chief Executives of Voluntary Organisations) saw the opportunity for "*a more responsive, flexible, efficient set of providers, having genuinely to compete with other organisations in the market and also better able to build partnerships with other providers (including third sector organisations)*".

6.11 The other cross-cutting theme that arose was implementation. Many respondents who welcomed the Government's reforms still emphasised the degree of practical challenge in supporting all trusts to FT status and in introducing economic regulation effectively; evidence from other sectors is that economic regulation can take many years to embed fully. University College Hospitals London NHS FT highlighted the pressures on providers to "*respond to the extremely challenging financial environment and to manage the implementation of the proposed changes while continuing to maintain high quality care*". In that context, others thought it would be highly ambitious to switch over immediately from the existing FT regime to a system of licensing with more freedoms for individual providers.

6.12 The Government has listened and accepts that reform of the provider side of the NHS is likely to take time and needs careful staging. Therefore we have revised some of our proposals to allow for a longer and more phased transition period: for example, certain of Monitor's current controls will be retained over some FTs while the new system is introduced, but only temporarily and with a clearly defined end point. There will be robust statutory requirements for Monitor to manage any conflicts between its residual FT-specific role and its new functions as economic regulator. Equally, the Government will ensure rapid progress is made on the NHS trust pipeline to foundation trust status and in opening up choice and competition, for example in community services. Meanwhile, as outlined in Chapter 4, the NHS Commissioning Board and GP consortia will have appropriate tools to manage demand. The key structural reforms needed to increase providers' autonomy will be embedded before the end of this Parliament.

B. Freeing NHS providers

6.13 *Regulating healthcare providers* outlined the Government's intention to liberate NHS providers so they can be free to focus on improving

outcomes, be more responsive to patients, and innovate. In future, where controls are needed on providers, these will largely take effect through regulatory licensing and clinically-led commissioning rather than central or regional management. We will support all NHS trusts to become FTs, based on the ethos of social enterprise: working towards our objective of creating the largest and most vibrant social enterprise sector in the world. The logic of this is that FTs will rely less on external oversight from Monitor, in its current role as regulator of foundation trusts, and more on their own internal governance. So the Government consulted on a series of reforms to reduce the legislative constraints that FTs face, in line with their original conception, and to make them more directly accountable for the results they achieve. As we made clear in the July 2010 White Paper, FTs will not be privatised.

Strengthening governance

6.14 There was widespread support for retaining the strengths of the current FT governance model. Although some respondents, particularly FTs themselves, liked the idea of enabling further local freedoms, most responses emphasised the benefits of the existing model and identified risks in allowing greater flexibility. For example, Chesterfield Royal Hospital NHS FT said "*The existing governance model has served and continues to serve foundation trusts well… It is important to retain the existing complementary but significantly different roles of councils of governors and boards of directors. Governors have a crucial role as the public facing and publicly accountable element of the governance structure*".

6.15 The Government wants to build on the success of FT governance. The FT sector now has more than 1.7 million members, responsible for electing several thousand governors to foundation trusts. Strong, transparent and accountable governance arrangements are vital to the safe and effective operation of an FT (as the failings at Mid Staffordshire demonstrated), and many respondents emphasised this. The Institute of Healthcare Management thought FT governance should be "*made more robust, given the potential greater freedoms*". The Foundation Trust Network argued that the aspiration should be for governors to "*act in the interests of future generations as the local proxy for the public's interest in [FTs' assets and services] as tax payers and citizens*", and therefore it was right to "*strengthen the ability of the governors as a whole to hold the board to account*". East of England SHA thought "*it would be helpful to increase the accountability of an organisation to its governors, for example by allowing them to call a special general meeting, ensuring they are invited to an annual general meeting which receives a report on*

executive pay and requiring a special general meeting to approve any significant transactions". Taking account of responses, the Government has decided to make a number of changes to clarify responsibilities and make the directors and governors of an FT more directly accountable for their decisions and for the performance of the trust. The Health and Social Care Bill will:

- make explicit the duty of governors to hold the board of directors to account, through the chair and non-executive directors (whom they have power to appoint and remove);
- give governors power to require some or all of the trust's directors to attend a meeting. For transparency, the FT's annual report would have to list any occasions when this power was used;
- extend to FT directors the duties imposed on directors under company law, such as the requirement to promote the success of the organisation;
- require FTs to hold an annual general meeting for its membership, at which members would be able to discuss the trust's annual report and accounts. We envisage requiring FTs to report on directors' pay and the expenses of directors and governors and the work of their remuneration committees.

6.16 Although these are relatively small legislative changes, they reflect a significant cultural shift: placing genuine responsibility on FTs themselves rather than on Monitor as FT regulator. The Government agreed with respondents, such as Salford PCT, who emphasised that boards of governors will need additional support to "*develop their skills and understanding. This would also empower governors to hold the organisation to account*". We recognise the significance of this issue and will clarify that FTs are responsible for supporting governors to fulfil their roles. We will also discuss with the Foundation Trust Governors' Association, the Foundation Trust Network and Monitor what action needs to be taken to develop the capability of FT governors.

6.17 *Regulating healthcare providers* discussed the prospect of enabling FTs to have employee-only memberships. Not many respondents commented on this proposal but, with some exceptions, those that did were generally not supportive. The CQC said that staff-only models without patient and public involvement could be at odds with public accountability and should be avoided, while the BMA thought they would do nothing to improve patient care. The Government has considered these concerns and concluded that staff-only membership would not be compatible with the foundation trust model.

6.18 However, we remain convinced that employees should be given new opportunities to provide innovative services, and an alternative way to achieve this is for staff to set up their own independent organisations to run services. Staff providing community health services in PCTs already have the "right to request" to set up an employee-led social enterprise; the Government is exploring a similar "right to provide" for staff working in NHS trusts, and will actively encourage FTs to consider similar requests from their staff.

Foundation trusts' freedom to amend their constitutions

6.19 Many respondents agreed that foundation trusts should be able to change their constitution without the consent of Monitor, with particularly strong support from some FTs and other NHS organisations. As Norfolk PCT commented, "*this would speed up the process and mirror the arrangement that private companies have with Companies House*". Others, such as the RCN, were supportive, on condition that FTs would still be required to comply with a "core" constitution as set out in the NHS Act 2006. The Government agrees. The Bill will remove the need for Monitor's consent, but retain the essential elements governing the requirements for a constitution.

6.20 If an FT's constitution were to change, some felt that changes should be subject to external scrutiny. The Specialist Orthopaedic Alliance said that FTs should be obliged to consult with their members about changes to their constitution. The Government is fully committed to the public playing a full and active part in the provision of healthcare services. The public membership of an FT reflects the views of the community, and public members elect the majority of an FT's board of governors. The Bill will strengthen the power of the governors by requiring their agreement to any changes to an FT's constitution. As an additional safeguard, the FT's members could overturn any constitutional change concerning the governors' own role within the organisation, if a significant majority of the members voting at an annual meeting opposed it. FTs will be under a new statutory obligation to inform the regulator about amendments to their constitution, but it will be the responsibility of trusts rather than Monitor to assure themselves that changes are compatible with legislation.

6.21 The Government believes that these arrangements strike the right balance between allowing flexibility for organisations to adapt and retaining appropriate safeguards. However, in case the details need to be refined in the light of experience, the Bill will give power to use regulations to amend the precise voting mechanisms and the amount of

support required from members, governors and directors for making changes relating to the constitution and governance of an FT. Any regulations would need the positive approval of both Houses of Parliament.

Freedom to make organisational changes

6.22 The Government is pressing ahead with the proposal to give foundation trusts the flexibility to merge, acquire another FT or NHS trust, or de-merge without the approval of Monitor, to allow them to respond quickly to the needs and choices of patients. Many responses supported this: for example, staff at Cambridge University Hospitals NHS FT commented: "*At the moment, FTs wishing to merge must be dissolved and re-formed with new boards and appointments. Not only is this a disincentive to organisational change but it creates unstable leadership when a firm hand is most needed. This needs to change*". However, given the potential impacts on patients, commissioners and staff, a significant number of respondents wanted some oversight. The Bill will therefore require an FT's governors to agree any merger, acquisition, separation, or any other change that the FT's constitution defines as "significant". Like any other provider, FTs will be subject to merger controls to protect competition. Also like other providers, they could face restrictions from their lenders, or from Monitor in relation to any services that are "designated" as needing additional regulation.

Taxpayer investment in foundation trusts

6.23 The Government currently holds an investment stake of £24 billion in foundation trusts and NHS trusts, in the form of public dividend capital and loans; *Regulating healthcare providers* asked how this investment should be overseen in future, and whether there should be a role for regulation. Respondents commented that it was important to protect the interests of taxpayers, though there were various views about who should have primary responsibility for overseeing the investment stake. South East Coast SHA thought "*there is a need to avoid the risk of the economic regulator being subject to accusations of bias from non-FTs. As a result, it would not be appropriate for Monitor to continue to perform this role*". The Allied Health Professions Federation said that "*there could be a conflict of interest if Monitor were to take on this role [of overseeing taxpayer investment in FTs]. Therefore it should be vested with the Department of Health*". That view was also shared by the National Pharmacy Association and the Optical Confederation.

6.24 The Government has decided to introduce clearer mechanisms to safeguard the taxpayer interest in FTs without artificially constraining their operational freedom. In future, the management of the Department of Health's investment stake in FTs will be undertaken through an operationally independent banking function. This will align the risk to the investment with the management of that risk, and ensure that investment management and lending decisions are made in line with commercial principles and informed by specialist knowledge and expertise.

6.25 In future, the new banking function will also be responsible for managing new public lending to FTs – a role that the Department has managed in the past through its existing FT Financing Facility and finance directorate. To ensure that this is managed transparently and without restricting FTs' operations, the Bill will:

- repeal the Secretary of State's power to give grants or subsidies to FTs; in future, only repayable loans made on commercial principles will be permitted. Under government finance rules, loans can only be given when due diligence demonstrates affordability, so in future the Department will not have powers to lend to FTs in special administration; and
- require the Department to consult on and publish the principles by which loans will be made; and make clear that the Department will only make loans where there is a reasonable expectation that loans will be repaid in line with the terms of the loan. Conditions on new or existing debt could include rules to constrain borrowing beyond levels that would present an unacceptable risk to repayment.

6.26 These provisions should address the concerns from respondents such as Monitor and Sheffield Teaching Hospitals NHS FT that giving any role to the Department could lead to government trying to exert control over FTs. The Bill is not about increasing the Department's control over foundation trust finances; on the contrary, it will circumscribe the powers that the Department already has and ensure that these are exercised in a more transparent way, on a more commercial basis.

6.27 The Bill will also make a related financial change on the provision of information by FTs. As public sector organisations, FTs' spending already has to be managed within the Department's budget for the NHS. For effective financial planning, the Department needs regular information about FTs' forecast spending. Currently Monitor collects this from FTs as a by-product of its other functions, and shares it with the Department on a voluntary basis. In future, since Monitor will not be gathering routine information from FTs in the same way, the Bill will

provide power for the Department to collect it directly. This will correct a flaw in the current legislation, and ensure the Department can secure the financial information necessary for managing within its expenditure limits, and other information required to discharge its duties to report on public bodies.

6.28 Due to changes in government accounting rules, the Secretary of State will need accounting information from FTs to consolidate into the Department's accounts and to discharge his responsibilities to Parliament and HM Treasury in reporting and managing resources against financial and other controls. At present, the Secretary of State does not have the powers necessary to discharge this obligation. The Bill will remedy this situation; in future, the Secretary of State will have power to define accounting and reporting requirements for FTs.

Freedom from statutory borrowing controls

6.29 Responses were mixed on the Government's proposal to abolish the current statutory borrowing limits for foundation trusts. Many respondents believed that FTs should not be allowed to borrow in an uncontrolled or unsustainable way, and some believed that the statutory controls should remain in place to manage the risk. On the other hand, others such as Cornwall Partnership NHS FT, Guy's and St Thomas' NHS FT, Clatterbridge Centre of Oncology NHS FT, and Sandwell PCT's Health and Wellbeing Board firmly supported the removal of statutory limits, seeing borrowing as primarily a question for the FT's own governance.

6.30 The Government has decided that it is right to abolish statutory limits, and the Bill will remove the current borrowing regime. As a matter of principle, statutory controls that apply only to one sector of providers run counter to our objective of a fair playing field. In practice, FTs have not borrowed irresponsibly, even during a period of high growth in funding. Existing lenders (in particular the Department's banking function) will have an interest in new borrowing being sustainable, and we believe that the new system of economic regulation – with stronger incentives and a credible risk of failure – will promote financial discipline and prudent borrowing.

Freedom to earn private income

6.31 The proposal to remove the cap on the income FTs can earn from private patients provoked strong views. Some respondents, in particular trade unions, saw this as fundamentally unfair, with UNISON arguing that FTs would "*treat fee-paying patients first… potentially pushing those that*

cannot afford private healthcare further back in the queue", and the Royal College of Midwives was concerned that it could "*accelerate the development of a two-tier service*".

6.32 On the other hand, others argued that the cap was a needless constraint on FTs, and one that does not apply to NHS trusts. They felt it was important for FTs not to be at a disadvantage relative to other providers and therefore the Government's proposal was consistent with the policy to move towards a fair playing field for all providers, increase patient choice and allow NHS providers to earn additional income to support their public duties to NHS patients. For example, the Royal College of Psychiatrists argued that mental health FTs need flexibility to provide social care and other health-related services, and that "*capping [private] income…limits the scope for [Mental Health] FTs to be innovative, entrepreneurial, and address breadth and quality of care in partnerships with others*". Further responses mentioned that removing the cap would enable internationally respected providers to export health care activities, and argued that it would support not obstruct the principal purpose of FTs, which is to provide goods and services for the health service.

6.33 A few respondents, particularly private hospital providers, supported the fair playing field but were concerned that FTs' private patient services should not be unfairly cross-subsidised by their NHS-funded services. Equally, many responses suggested extra restrictions on the use of private income, such as "*explicit guidance for FTs to reinvest their private patient income in improving NHS services – and this would need to be demonstrable and monitored*" (UNISON).

6.34 The Government has decided to use the Bill to remove the cap, which is both arbitrary and unfair in its effects: giving extensive freedoms to some trusts and imposing tight constraints on others, based solely on the historical accident of how much private patient income they earned in 2002/03. Although we recognise the concerns, we are not persuaded that there is a case for additional restrictions in the Bill. Like other organisations based on the principles of social enterprise, FTs have to reinvest their surpluses rather than distributing them externally. Furthermore, their social ethos and values already act as a powerful protection for NHS services. A risk is that any new legal restriction, however well intentioned, would be cumbersome to administer and enforce, and could, like the current cap, have perverse consequences. What is more, the Government believes that FTs are motivated by their desire to serve NHS patients, not maximise private income for its own sake. As Stockport NHS FT said, "*the current system operates as a bar to FTs pursuing innovative arrangements with the private sector which*

have the potential to benefit the NHS both directly, through enhancing the services that may be provided to NHS patients, and indirectly, through enabling surpluses to be generated which can recycled".

6.35 However, the Government accepts the arguments for requiring FTs to produce separate accounts for their NHS and private services to improve public scrutiny, and the powers in the Bill to set the form of FT accounts will enable this. This will be an additional protection to help ensure that NHS resources are not diverted for the benefit of private patients and that competition is fair.

C. Transition for freeing NHS providers

The FT pipeline

6.36 Many, though not all, consultation responses endorsed the Government's ambition for all NHS trusts to become, or be part of, an FT within three years; existing FTs in particular welcomed the objective while urging against any lowering of the threshold for those applying for foundation status. The Foundation Trust Network said: "*Our members consider that the challenges of transition to [an all-FT provider sector] will be considerable, but the principles are sound and achievable provided that there is system clarity and adherence to rules.*" Others were sceptical about whether the timetable would be observed, noting that similar deadlines had been set and missed before in the past.

6.37 The Government agrees that this is a considerable challenge. At present there are 120 organisations, or 48% of NHS statutory providers, that have yet to become FTs. Respondents emphasised the need to deal with underlying structural issues in some of these remaining NHS trusts, especially "*the 20 to 30 trusts that are likely to find it extremely difficult if not impossible in the short/medium term to satisfy Monitor's current foundation trust requirements*" (The King's Fund). We recognise that a minority of trusts – the analysis suggests around 20 – face very significant challenges and will not be able to achieve FT status in their current organisational form. This may be because they have services that are not currently clinically sustainable; or because of financial problems, for example as a result of Private Finance Initiative (PFI) and legacy debts, or falling levels of acute sector income. We are therefore taking a stronger, more testing and more transparent approach to managing the pipeline.

6.38 The Government has already taken steps to separate and consolidate the provider development function within SHAs, which will have a critical role from now until April 2012 in driving progress on the trust pipeline. In September 2010, the Department wrote to all NHS trusts that had not yet applied for FT status to set clear expectations and ask them to consider accelerating their plans. The SHAs then reported in November detailing their views on the readiness of each trust and the underlying issues that needed to be resolved.

6.39 As outlined in the NHS Operating Framework 2011/12, a work programme for the pipeline is currently being designed, based around the issues identified, and this will be published in early 2011. It will map out the planned trajectory of work required to meet the 2014 deadline, in terms of the number of FTs authorised over the period, and the specific actions that will be taken to achieve this. It will also describe a menu of options for providing local or national intervention and support. To address the scale of the challenge within the timetable, these will include: turnaround teams to support efficiency programmes, regional facilitation of health economy reconfigurations, more robust performance management on key indicators, and mentoring support to build board capability and capacity; as well as options such as mergers, acquisitions or franchising of a trust's management. Trusts will be classified according to their prospects and the issues they face; the plan will focus on the most challenged trusts early on, to mitigate the risk that the most difficult cases will be left to the end. As CIPFA (Chartered Institute of Public Finance and Accountancy) pointed out, "*those providers not presently en route to Foundation Trust status will require significantly increased support to obtain that status, or plans will need to be developed for them to become part of an existing Foundation Trust. As some of the issues involved will inevitably be less tractable than those faced previously in the Foundation Trust preparation process, contingency plans are likely to be required*".

6.40 The need for central support for the pipeline will continue until the end of 2013/14. Rather than maintain the 10 SHAs for this period or transfer staff into the central Department, the Government has decided to establish a transitional Provider Development Authority to provide dedicated expertise. This will be a special health authority that will report directly to the Department rather than having its own non-executives. *Liberating the NHS* originally said that Monitor should take responsibility for overseeing any remaining NHS trusts from April 2013. However, we accept the arguments that these trusts are likely to need specialist turnaround support, and that providing this could be a distraction from Monitor's focus on introducing economic regulation. The Provider

Development Authority will therefore continue in its role until 31 March 2014, when it will be wound up.

6.41 The final date for applications to be a stand-alone FT will be 31 March 2013. In the event that a few NHS trusts and SHAs fail to agree and deliver on credible plans, and where the NHS trust is unsustainable, the Secretary of State may apply the trust administration regime introduced by the Health Act 2009.

6.42 To make the timetable credible and demonstrate the Government's commitment, the Bill will remove the power to deauthorise a failing FT and return it to NHS trust status. We are also taking the unusual step of specifying directly on the face of the Bill a date (2014) when the NHS trust legislation will be repealed. It would only be possible to extend this date through a positive vote in both Houses of Parliament. For this reason, remaining an NHS trust beyond 2014 will not exist as an option (except on a purely transitional basis for a trust under a franchised contract – for example, Hinchingbrooke). The Government can also confirm that NHS trusts applying for FT status during this transition will be assessed against Monitor's standards with no easing of requirements; this is why our robust strategy for the pipeline is essential.

6.43 From April 2012 authorisation will be a one-off test for new applicants, with FT terms of authorisation becoming obsolete as the new licensing regime begins. In addition, the Bill will remove the legal powers that theoretically allow organisations other than NHS trusts to become an FT. These have never been used, and we are not aware that there has been any interest from other bodies in seeking to apply for foundation status.

Transitional intervention powers

6.44 Monitor currently has intervention powers to remove the directors and governors of an FT and direct an FT to do or not do specific things in the event of a significant failure at a trust. In the future, in its fundamentally different role as an economic regulator, Monitor will need to treat all providers of NHS services equally, rather than have special powers over FTs. Where possible, the existing controls will be removed in April 2012, when Monitor takes on its new functions.

6.45 However, some responses highlighted the risks of abolishing all of the current controls immediately, especially since further new FTs will continue to be authorised after that date and it may take some time for governors to consistently use their new powers to hold an FT's directors to account effectively. As Harrogate and District NHS FT commented, "*It*

is also important to protect the FT brand as one of excellence within the NHS and Monitor's oversight provides this consistency." The Government was persuaded by Monitor's suggestion that "*it would be helpful to establish transitional arrangements in the form of residual, time-limited 'safety net' powers for the regulator, that stay in place until each foundation trust has had time for their governance arrangements to mature to an appropriate degree*".

6.46 Therefore, the Bill will allow Monitor to retain intervention powers temporarily for new FTs authorised after April 2012 and for a defined subset of existing FTs (Monitor will determine appropriate criteria for identifying which established FTs should be covered). For these trusts only, Monitor will still have the power to intervene to direct trust boards or remove board members if there are instances of FTs struggling to cope with their new freedoms. Because terms of authorisation will end in 2012, the transitional arrangements will be linked to new licensing conditions; Monitor will be able to work out how to achieve this based on a principle of minimum bureaucracy. The transitional arrangements will be time-limited, and will end no later than March 2014 or two years after the individual FT's authorisation date, whichever is later. Again, this end date could be extended but only through further Parliamentary approval in both Houses.

6.47 It makes sense for Monitor to remain responsible for these transitional arrangements, building on its existing expertise. However, the Government recognises the concern highlighted by respondents such as Bupa, Mind and University Hospitals Coventry & Warwickshire NHS Trust, that Monitor will face potential conflicts of interest if it retains any functions specific to FTs. Therefore, the Bill will place a duty on Monitor to manage conflicts between its functions – for example, by setting up a ring-fenced committee to manage its FT functions separately. This is in line with best practice in other regulators.

6.48 The focus of the future system is about regulating services for patients and allowing providers to be innovative and respond to patient needs. Many organisations will use their new freedoms and take this opportunity to thrive, despite the tough financial times ahead. It is possible that some organisations will not manage to do this. Taxpayers' funding needs to be used to pay for the services that patients need, not to prop up failing organisations that make ineffective use of the resources they receive. The transitional arrangements will ensure that there is no unnecessary failure: if there are simple steps that can be taken to make an organisation succeed, Monitor will retain a role during the transition to ensure that these steps are taken.

Monitor's role as FT registrar

6.49 Once its transitional intervention powers have ceased, Monitor's only remaining function that relates purely to foundation trusts will be that of registrar. This will primarily be an administrative task, to maintain an up-to-date list of FTs. In line with the Government's principle of freeing NHS providers, Monitor will have no powers to scrutinise or intervene in an FT's internal governance. The registrar function will be managed separately to avoid any conflicts of interest.

6.50 Some respondents asked what would happen if an FT's governors had concerns that the organisation was not complying with its own constitution or the underlying legislation. The Government does not believe that Monitor should have powers to intervene; however, we accept that some kind of external source of advice for governors would be valuable. Therefore the Bill will provide powers for Monitor to host an independent panel to consider complaints of this kind from governors. The panel's decisions will be published; and although they will not be binding, they will be an authoritative source of advice, which will reinforce our reforms to strengthen the role of governors. Ultimately, though, the responsibility for ensuring that their governance systems are fit for purpose will lie with foundation trusts themselves.

D. A new framework of regulation

6.51 The Government believes that, for providers to be able to exercise their freedoms to improve services, the environment they operate within must be fair, stable and transparent. Therefore, the White Paper announced our proposals for liberating providers from hierarchical management and creating a consistent framework of regulation across all types of provider. Monitor would become an economic regulator, while CQC would be strengthened as an effective quality inspectorate.

Strengthening the Care Quality Commission

6.52 The Government's aim, which received much support from respondents such as the Nursing and Midwifery Council, is to strengthen CQC in its role of registering providers against essential levels of safety and quality. All providers who are currently required to be registered by CQC will continue to need to be registered; and registration will be extended to primary care providers during 2011 and 2012.

6.53 The regime will be risk-based and proportionate; CQC will make judgements about providers based on information that it receives from a range of sources, including patient feedback and complaints, staff experience, and information from HealthWatch England and local HealthWatch, councils' health and wellbeing boards and OSCs, GP consortia, Monitor and the NHS Commissioning Board. CQC will continue to have wide-ranging enforcement powers, including the ability to issue statutory warnings, set extra registration conditions and impose fines. In the cases where patients and service users are at greatest risk, CQC can suspend or remove registration – in effect closing down the service or the provider.

6.54 To reinforce this core task of protecting safety and quality, the Bill will remove CQC's responsibility for assessing NHS commissioners (in future, this will be the responsibility of the NHS Commissioning Board) and for carrying out periodic reviews of NHS providers. The rationale for this is not in any way to reduce the scrutiny of NHS services. On the contrary, the Government's plans for an information revolution and for clinically-led, outcome-based commissioning will transform the amount and quality of available information, and make providers more directly accountable for the results they achieve. We will make CQC more effective as a quality inspectorate by enabling it to focus its resources on its core role of regulating providers.

Introducing economic regulation

6.55 As explained in *Regulating healthcare providers*, Monitor will become an economic regulator, with three core functions: promoting competition; setting or regulating prices; and supporting the continuity of services. As a mechanism to support these functions, Monitor will have the power to license providers of NHS-funded care.

6.56 The Government believes that economic regulation has the potential to protect the interests of patients and taxpayers by promoting efficiency, transparency and fairness in the way that resources are used. A robust regulatory regime will end unfair subsidies, create certainty over prices and offer incentives for the best providers to thrive, while safeguarding essential services. In addition, economic regulation is fundamental to our vision of putting patients first, by enabling innovative and flexible healthcare providers, which respond to the needs and choice of patients and commissioners.

6.57 Extensive experience of economic regulation from other sectors has demonstrated the benefits that it can bring in driving efficiency and

protecting the public interest; and has proved the advantages of having an expert and independent regulator. We have drawn on lessons from the utilities, rail and telecoms, and we have borrowed provisions where applicable. However, as respondents such as East Kent Hospitals University NHS FT pointed out, the NHS is exceptional or unique in many respects, including: the diversity and complexity of its services; the multiple market imperfections in healthcare, only some of which can be ameliorated; the level of public and political interest; and the fact that NHS funding comes from the taxpayer and is cash-limited. The Government recognises that the NHS is different to other sectors, which is why we have tailored our proposals to the particular circumstances of the health service rather than trying to import a regime wholesale.

6.58 The Government also understands that, as Cheshire East Council pointed out, "*fundamental structural reforms such as these need time, support and resource before they are fully established*" and will require a significant culture change. There are nonetheless clear benefits in implementing clear strategies and organisational developments with pace. We will not repeat the mistakes of previous reforms, where elements of the regulatory system were changed in isolation; *Liberating the NHS* sets a coherent vision for all parts of the system. Therefore the Government is creating the new framework for economic regulation now, and will progressively bring it into force during this Parliament. But the full effects will only be seen in the next Parliament and beyond.

6.59 The next sections of this chapter give more details on Monitor's new role and functions.

E. Monitor's role and duties

6.60 The Bill will confirm the Government's proposals to keep Monitor's status as an independent non-departmental public body. The Bill will make clear that Monitor's overarching duty will be to protect the interests of patients (and other service users) in the provision of health and adult social care by promoting competition where appropriate and through regulation where necessary. In performing this duty, Monitor must promote economy, efficiency and effectiveness in the provision of services. As outlined in *Regulating healthcare providers*, the funding for Monitor would be agreed with HM Treasury.

6.61 To avoid ambiguity as to who is responsible for defining standards of access to care and securing services to meet patient/population need, Monitor will be required to take account of the need to support

commissioners in ensuring access to services to meet the needs of their patients and populations, where necessary, by maintaining continuity of supply. Monitor will also have explicit duties to have regard to the need to promote research and investment by providers, and to the need to secure continuous improvement in the quality of services.

6.62 As mentioned above, the Bill will place an overarching duty on Monitor to make effective arrangements to manage potential conflicts between its functions – particularly between economic regulation and its remaining role over FTs.

F. How economic regulation will work: licensing

6.63 The Government proposed that licensing should be the mechanism to give Monitor the ability to collect information to set prices, promote competition and to safeguard the continuity of services designated for additional regulation. Respondents broadly approved of the proposed scope and purpose of the economic regulator's licensing regime. There was general support for the proposal that the economic regulator's licensing regime should encompass all providers of NHS-funded services in England, whether foundation trusts or from the private or voluntary sector. Respondents also agreed with the idea of an exemption regime for providers that do not require regulation of prices, sector-specific competition powers and continuity of service provisions. Most respondents were clear that "*there should be no exceptions with regard to licensing and economic regulation*" (Avon and Wiltshire Mental Health Partnership NHS Trust) for large organisations, with a test for smaller providers of "*materiality - only providers of a certain size should need to be licensed*" to ensure the system is "*transparent and proportionate*" (East of England SHA).

6.64 The Bill will therefore confirm the Government's proposals, creating powers for a licensing system. The details of the exemption regime would be set out in secondary legislation.

6.65 Monitor will have a duty to consult when developing the first set of general licence conditions (those conditions that will apply to all licensed providers or all providers within a defined category). This will include a specific requirement to consult the Secretary of State, the NHS Commissioning Board, CQC and HealthWatch England.

Enforcement of Monitor's licensing regime

6.66 The Government proposed giving Monitor a range of enforcement levers, including the power to fine providers for failing to comply with licence conditions and possibly powers to suspend or revoke a licence for failing to comply with its conditions. These proposals were broadly supported in the consultation: for example, East of England SHA proposed that Monitor should be "*able to take enforcement action*" wherever necessary. The Bill will therefore provide enforcement powers for Monitor modelled on the powers available to other economic regulators and set out in the Regulatory Enforcement and Sanctions Act 2008. Specifically, if licence conditions are breached, Monitor will be able to order a provider to remedy the breach (or commit to do so) or issue fines of up to 10% of turnover.

Objections to licence modifications

6.67 *Regulating healthcare providers* proposed that groups of providers should have the right of appeal to the Competition Commission against modifications to general licence conditions, and individual providers should have the right of appeal against changes to their special licence conditions. Respondents such as Cornwall Partnership NHS FT strongly supported the principle that providers should be able to object to licence modifications – especially if the changes might affect a provider's ability to deliver patient care or significantly affect a provider's finances. We considered whether anyone other than providers should be able to object. This issue was raised by a number of respondents, including Central Lancashire Local Pharmaceutical Committee, which proposed that "*bodies that represent [groups] of providers should have the right to appeal*". Monitor also raised the question of consumer bodies being able to appeal licence modifications. However, drawing on best practice from other regulatory regimes, the Government has decided only to allow objections by providers themselves.

6.68 Under the Bill, therefore, if Monitor wishes to modify providers' licence conditions, it will need to consult with providers, who will have an opportunity to agree or object to the change. If the number of objections is above a threshold (to be defined in regulations, and weighted according to the market share of those complaining), Monitor would be required to respond to the objections or make a reference to the Competition Commission, which would have the power to make a binding decision.

Monitor's power to charge fees

6.69 The consultation responses broadly agreed with the Government's proposals for Monitor to levy fees on providers to cover the costs of licensing, so long as the fees were "*reasonable and proportionate*" (Liverpool Women's NHS FT, Stockport NHS FT). However, some valid concerns were raised, and in response we have amended our approach to make it clear that: (i) the licence fees gathered by Monitor will only be able to be used to support its licensing-related functions (for example, the issuing of licences, the assessment of providers and the undertaking of any related enforcement action); and (ii) Monitor will fund its other regulatory activities, particularly competition enquiries, by drawing grant-in-aid funding from an allocation agreed with the Treasury. The costs of Monitor's FT registrar activities would be recovered from those on the register.

6.70 We acknowledge the concerns raised in a minority of responses about the risk associated with any regulator funding its activities by levying providers, namely that the regulator will become beholden to or 'captured by' the interests that it is responsible for regulating. However, evidence from other sectors and from experience so far from CQC has demonstrated that this risk can be minimised if a regulator is appropriately constituted and is transparent about both its fee-raising regime and how it takes into account the views of providers.

Joint working with CQC

6.71 Additional questions were raised about how Monitor and CQC would work together to align their regimes. The Royal College of General Practitioners and the Standing Commission on Carers asked for greater clarity on the relationship between Monitor and CQC, and the NHS Confederation highlighted its support for a "*more collaborative approach*" between the organisations. Collaboration was seen as particularly important in the event of failure (see below on supporting service continuity). Respondents stated rightly that "*insolvency shouldn't be allowed to compromise patient care*" (Guy's and St Thomas' NHS FT) and that "*Monitor needs to continue to work closely with CQC to ensure services continue to meet essential standards of quality and safety*" (CQC).

6.72 We have studied precedents from other sectors where there are both quality and economic regulators to ensure that our proposals are consistent and watertight. It is vital that Monitor and CQC openly share information with each other about the providers that they oversee and

any regulatory actions being taken in relation to those providers, and that the regimes work together to support the continued access to safe healthcare services. To ensure this takes place, the Bill will explicitly require Monitor and CQC to co-operate in operating their regimes, over and beyond the new duty of partnership for non-departmental bodies and special health authorities outlined in Chapter 4.

6.73 In particular, the two regulators will be under a duty to work together to minimise bureaucracy and create a single integrated process of licensing and registration for providers. However, each will retain its statutory independence. Many respondents asked about the potential tensions between economic and quality regulation; the Government believes that keeping the functions separate rather than combining them in a single regulator will allow any tensions to be resolved transparently and objectively, avoiding internal conflicts of interest; and will ensure that essential safety standards are not sacrificed in the interests of economic viability. So, for example, CQC would be able to take enforcement action independently of Monitor, and vice versa.

Minimising regulatory burdens

6.74 Some respondents raised questions about the "*risk that this approach increases the regulatory burden for providers, in particular around information requirements*" (Birmingham and Solihull Mental Health FT). Minimising the burden of regulation is a fundamental objective for this Government. The Bill therefore requires Monitor to ensure that its regulatory activities are transparent, proportionate, consistent and targeted only at cases where action is needed. As described below, Monitor will also have a duty to carry out a regulatory impact assessment for any major new licence condition it introduces. This is consistent with best practice from other sectors, and there will be further engagement with external organisations during the development of the new licensing regime to ensure that this best practice is embedded into the new system.

G. How economic regulation will work: promoting competition

6.75 The White Paper explained that, in future, the first of Monitor's three core functions will be to promote competition. This is not, as some respondents alleged, because the Government sees competition from an ideological perspective as an end in itself. Rather, we see competition as

an important means for driving up the quality, responsiveness and efficiency of all health services.

6.76 The Government is committed to putting patients at the heart of NHS services. As described in Chapter 2, in future, patients will have more control over their care and, for most services, the ability to choose between any willing provider that meets NHS standards and prices. Money will follow the patient, and providers will have far greater freedoms to respond to patients' needs and preferences. This will enable the best providers to thrive and will put pressure on those providing poorer quality or unresponsive services. The Government will not force patients to use, or taxpayers to subsidise, poor quality or inefficient services.

6.77 As outlined at the start of this chapter, competition was a controversial topic in the consultation, and some respondents were opposed to it on principle. However, many responses supported our proposals to use patient choice and competition to drive improvements in standards of care. Most of these pointed out that it was essential to introduce competition in the right way in order to deliver the intended benefits. Some commented that the economic regulator needed appropriate powers to ensure that competition and patient choice operate effectively; for example, Monitor's consultation response noted the possible need for "*sector-specific competition provisions*". Others emphasised that different forms of choice and competition are appropriate in different circumstances. The Government agrees.

6.78 Under the Bill, Monitor will have a duty to promote competition where appropriate, including through its licensing regime and through enforcing competition law.

Tackling anti-competitive behaviour by providers

6.79 The Bill will give Monitor concurrent powers with the Office of Fair Trading to apply the Competition Act 1998 in health and adult social care services. This would allow Monitor to investigate practices by individual providers or groups of providers which might restrict competition, such as actions to exclude competitors or agreements to restrict patient choice. Given the complexity of applying competition law in the NHS (as respondents such as Maclay Murray & Spens LLP highlighted), the Government intends to bring Monitor's powers into force initially only for healthcare, then for adult social care at a later date; there was support for this phased approach from consultation responses.

6.80 We also proposed that Monitor should have the power to set licence conditions to protect competition. The majority of respondents supported this, though there was a range of views on when this power should be used. Some argued that Monitor should only be able to impose these conditions when it could demonstrate that particular individual providers had a position of dominance or market power: for example, "*to deal with barriers to entry such as estate monopoly or anti-competitive behaviour such as evidence of non-co-operation across patient pathways*" (Norfolk Community Health and Care). This would mirror arrangements in some other regulated industries. However, evidence from other sectors indicates that it can be very difficult to provide conclusive evidence that a provider has significant market power, and it would be particularly hard to do in healthcare where, unlike some other regulated industries, there are a very large number of providers and different services.

6.81 Others respondents thought Monitor should be able to set licence conditions to protect competition where there was evidence that choice and competition were not yet functioning effectively, recognising that this process would take time. Age UK said: "*Monitor is assigned limited responsibilities regarding opening up the social market to competition, however we believe that there is a clear need to go further. Monitor, working in collaboration with the NHS Commissioning Board and local consortia, needs to develop a robust market stimulation strategy with specific emphasis on encouraging new providers and provider innovation in less well served areas and reducing barriers to market entry.*"

6.82 Patient choice and competition in the NHS are still at a relatively early stage and, as some respondents commented, it is not possible to tell at this point exactly what types of licence conditions will be needed to protect choice and competition in future. Therefore, the Government has decided for the Bill that Monitor should have power to set licence conditions wherever it can demonstrate that there is a need for regulation to protect competition. Conditions might include provisions:

- preventing providers from discriminating between other providers when offering services to them;
- requiring providers to grant access to particular services or facilities to other providers on reasonable terms, where necessary to promote choice and competition;
- requiring providers to accept services which have been commissioned from other providers where this is clinically appropriate;

- prohibiting particular practices such as tying and bundling the sale of certain services in ways that prevent new firms entering the market; or
- to facilitate patient choice (for example, by requiring providers to make particular kinds of information available).

6.83 As a check on this power, Monitor will need to carry out impact assessments demonstrating the benefits of any major new licence conditions and explain why it could not address the problem by applying concurrent competition powers. Providers will have the right to object to proposed changes to their licences, as mentioned above. Monitor will also be under a duty to review the need for licensing regulation as patient choice develops.

6.84 Monitor's concurrent powers as a competition authority will include powers to apply for disqualification of directors for material breaches of competition law. This would be consistent with the concurrent powers of other sector-specific competition authorities such as Ofcom, Ofgem and Ofwat.

Tackling anti-competitive behaviour by commissioners

6.85 Like providers, commissioners can in some circumstances act in ways which undermine choice and competition, for example by failing to tender services where appropriate or discriminating against particular types of provider. *Regulating healthcare providers* proposed to legislate to set out the duties of the NHS Commissioning Board and commissioners to promote choice, to act transparently and non-discriminatorily in their commissioning activities, and to prohibit agreements or other actions by commissioners to restrict competition against patients' and taxpayers' interests. We also proposed that Monitor should have powers to investigate and remedy complaints regarding commissioners' conduct in this area.

6.86 A large majority of respondents agreed that there is a need for legislation to ensure that commissioners respect best procurement practice and to prevent anti-competitive conduct. Pharmacists and other providers of community-based services were particularly concerned that "*GP consortia may use their new powers to commission their own practices to deliver services*" (National Pharmacy Association), and argued that procurement conditions "*that would favour the GPs who are part of a commissioning consortium must be outlawed*" (Pharmaceutical Services Negotiating Committee). Some responses emphasised the need for commissioners to tender significant contracts transparently so that the

full range of providers could bid for them. Others were concerned that "*if the economic regulator tries to enforce tendering of services then this will become a high cost transactional approach*" (Birmingham and Solihull Mental Health FT), and argued for reasonable minimum thresholds to avoid costly procurement for smaller contracts.

6.87 In the light of consultation responses, the Government has decided to include a power in the Bill for the Secretary of State to issue regulations to govern commissioners' procurement activities and ensure they protect choice and competition. We will need to do further work, and consult in due course, regarding the precise contents of these regulations. However, they are likely to include requirements relating to:

- when to competitively tender services (there will be clear minimum thresholds);
- the governance of tendering processes;
- managing conflicts of interest;
- protecting competition and choice in the delivery of services.

6.88 Parties with a legitimate interest will have a right to complain to Monitor if they believe commissioners have breached the rules. If it finds a breach, Monitor will have powers to direct the commissioner, including requiring it to modify its procurement approach or re-tender a contract. Commissioners and providers will be able to seek judicial review if they are dissatisfied with Monitor's decision.

6.89 These proposed regulations should ensure that commissioners respect due process and best practice procurement. In addition, the Bill will ensure that NHS commissioners will be subject to comparable prohibitions of anti-competitive conduct as those for providers under national competition law. The legislation will help prevent commissioners from taking individual actions or reaching agreements which restrict competition against the public interest.

6.90 The rules governing procurement and competition will apply to the NHS Commissioning Board and GP consortia when commissioning NHS services. The Department and its delegated authorities should also have regard to the rules when commissioning public health services.

Regulation of mergers

6.91 In addition to ensuring good practice, it will be important to regulate mergers to protect patient choice in the new system. At present, the

Department's Co-operation and Competition Panel advises the Department and Monitor on whether to permit certain mergers between NHS trusts and FTs. However, the Office of Fair Trading (OFT) and the Competition Commission also investigate mergers between "enterprises" in healthcare where they qualify for assessment under the Enterprise Act 2002.

6.92 When the new system is fully established, the OFT and the Competition Commission will be the sole organisations with responsibility for investigating mergers in health and social care services. For the avoidance of doubt, the Bill will make clear that mergers between FTs should be subject to the OFT and the Competition Commission's merger controls from April 2012 onwards.

6.93 The Secretary of State would continue, as at present, to decide whether to permit NHS trusts to complete mergers until all remaining NHS trusts have become FTs. Where these mergers are not subject to the OFT and Competition Commission's merger controls, the Secretary of State will seek advice from Monitor on the impact of the merger on competition before reaching a final decision.

6.94 Under general merger controls, organisations are not obliged to pre-notify the OFT of mergers. They can choose either to pre-notify the OFT and wait for clearance or complete the merger without OFT approval, running the risk that the authorities subsequently investigate and require them to undo it. There is a risk that providers might fail to make the right judgements on whether to pre-notify the OFT of mergers. If they complete mergers which the authorities then undo, this could impose major costs.

6.95 To mitigate this risk, Monitor would be able to establish a licence condition requiring FTs to pre-notify the OFT of mergers which qualify for investigation under the Enterprise Act 2002 and wait for clearance before completing them. The purpose of the licence condition will be to facilitate the transition to OFT merger controls; and for that reason it will be limited to five years.

Ensuring a fair playing field

6.96 As mentioned at the start of the chapter, those who supported the aim of greater choice and competition were firmly in favour of a fair playing field, so that different types of provider can compete on their merits, and patients receive the best care from the best possible providers, regardless of who owns or runs them. Responses raised a wide range of

practical issues including: the advantage for public sector providers of having access to the NHS pension scheme; and differences in access to capital for public and private providers. Voluntary and community organisations were particularly aware of the barriers facing smaller providers, and that "*not all providers start from the same point*" (National LGB&T Partnership). Respondents made clear that it was important to address these practical issues effectively. For example, ACEVO, which was very enthusiastic about the opportunities that the White Paper brought for voluntary organisations to provide services "*which are often simultaneously high-quality and save the state significant sums of money*", emphasised that the design of "any willing provider" models "*Should not be too bureaucratic or complex, making market entry unnecessarily difficult*".

6.97 The Government remains committed to creating a fairer playing field between public, private and voluntary providers over time. Our proposals to ensure that commissioners respect procurement practice, and to prevent anti-competitive conduct will do much to ensure that providers can compete on their merits to deliver services. In the new system, Monitor will play an important role in developing a fair playing field, including considering the factors which may put particular providers at a disadvantage.

Market investigations and reviews

6.98 Like other sectoral regulators, Monitor will have the ability to carry out market studies and to refer markets for health or adult social care services to the Competition Commission for investigation if it suspects that features of the market restrict or distort competition. When it receives a reference, the Competition Commission must carry out an investigation and has powers to impose remedies to address adverse effects on competition.

6.99 Economic regulation will cause the market for NHS services to evolve and develop significantly. Following discussions with other regulators and the competition authorities, the Government believes that there would be great value in having a regular expert review of competition enforcement and regulatory activities. Therefore, the Bill will require the Competition Commission to carry out a review of the development of competition and regulation in public healthcare services every seven years, with the first review to be completed no later than 2019. We believe this is a reasonable interval, which reflects the likely time for significant changes to take place in the structure of provision or regulation.

6.100 The Competition Commission will be able to assess any aspects of the functioning and development of competition and regulation in the markets for public healthcare services. At the end of the review, it should publish a report to the Secretary of State, Monitor and the NHS Commissioning Board setting out its findings and making recommendations for the development of competition and regulation.

H. How economic regulation will work: price setting and regulation

6.101 The second of Monitor's three core functions proposed in *Liberating the NHS* was to regulate prices for NHS services. This draws on lessons from other sectors where price setting has been delegated to a regulator. Economic regulators develop technical expertise which can improve the accuracy of pricing; while their independence gives confidence for providers to enter the market and invest.

6.102 Many respondents supported a price setting role for Monitor. For example, the Terrence Higgins Trust wrote: "*We welcome the establishment of an economic regulator through Monitor, and especially the inclusion of a responsibility for setting tariffs and promoting competition. We are keen to see an acceleration of tariff development in those areas of the NHS where they currently don't exist.*" Others highlighted how the task of setting prices fairly and transparently is a vital component of enabling a fair playing field between providers: as Rowlands Pharmacy argued, "*The tariffs set must not disadvantage one provider compared to another and must allow fair and equitable competition*".

Ensuring the affordability of tariff prices

6.103 Unlike other regulated sectors, the funding for NHS services comes from a single cash-limited budget set by the Government, and therefore *Regulating healthcare providers* asked specifically about how Monitor should have regard to affordability constraints.

6.104 Although some argued that prices should be based solely on the efficient costs of provision, irrespective of the available budget, most respondents emphasised that affordability considerations "*must be an essential part of the price regulation regime*" (Medway NHS FT). While delivering financial balance will be the responsibility of commissioners, pricing will significantly affect their ability to achieve this. Most respondents' view

was that in setting prices, Monitor should have regard to the overall financial envelope within which the NHS must operate – and this is what the Government will set out in the Bill. In addition, we accept Monitor's own suggestion that "*the Secretary of State should issue guidance to the economic regulator, which is consistent with the arrangements in other sectors*".

6.105 Both on price-setting and more generally, there was recognition of the need for a close and constructive relationship between the NHS Commissioning Board and Monitor, and the need for appropriate checks and balances within the system to ensure that all parties' interests are reflected appropriately. Prices must balance quality, efficiency and affordability. The risk of delivering efficiency to the detriment of quality was highlighted – particularly for aspects of quality that are less easy to observe.

6.106 Having considered the concerns raised by some respondents, the Government has dropped the original proposal that the NHS Commissioning Board should be able to appeal certain pricing decisions by Monitor. In practice, it would be extremely hard to draw a definitive line between the Board's function of designing the tariff and Monitor's responsibility for price setting; while allowing appeals could undermine the incentives for collaborative working. We liked the proposal from South Gloucestershire PCT, who said "*There should be a statutory requirement to cooperate. Close working between the two bodies is essential*". The Bill will create a joint process for setting prices, with Monitor and the NHS Commissioning Board each having primary responsibility for specific aspects of the process, as well as the duty to reach agreement at key stages.

6.107 The NHS Commissioning Board will have primary responsibility for developing the pricing structure for NHS services. This will be done in consultation with interested parties and will ensure that the approach to pricing supports the policy direction set out in the White Paper. The Board will work closely with Monitor throughout, and have a duty to agree tariff structures and currencies with Monitor.

6.108 Meanwhile, Monitor will be primarily responsible for designing a pricing methodology, and for using this to set prices in line with the agreed pricing structure. It will have to agree the prices with the Board. In the event that the two organisations cannot agree, either one could invoke a dispute resolution procedure under the Arbitration Act.

6.109 It is vital that the views of GP commissioners and providers are taken into account, so there will be a duty for Monitor and the Commissioning

Board to consult on the pricing methodology at the same time as the prices are published. GP commissioners and providers will be able to object to it; and, as with objections to licence modifications, if the number of objections is above a threshold, Monitor will have to respond to the objections or make a reference to the Competition Commission. As the Audit Commission commented, "*the grounds for appeal should clearly be controlled to prevent excessive or mischievous appeals slowing up the tariff setting process*", so it will only be possible to object to the methodology rather than the final prices themselves.

Monitor's power to modify prices

6.110 *Regulating healthcare providers* proposed that Monitor should have power to modify tariffs to reflect local conditions in order to support the continuity of essential services: for instance, in a rural facility with a small, isolated population. Some responses envisaged that price regulation might be used more broadly to take account of "*material differences in cost structures*" between providers, for instance because of PFI debts (Sherwood Forest NHS FT). Other respondents were cautious. For example, East of England SHA's Competition Panel argued for "*some discipline to discourage the subsidy of inefficient providers of essential services in areas where there is little or no competition – for example by tendering such services in all cases and only proceeding to negotiated tariffs and special licences where tenders have failed.*" The Bill will confirm a power for Monitor to modify prices for services designated as subject to additional regulation. Monitor would have to balance this against its wider duties to promote competition and efficiency.

6.111 Any subsidies of this kind would need to be clearly justified and transparent, to avoid distorting competition, breaching state aid rules or placing unfair burdens on local commissioners. Nevertheless, commissioners would retain a degree of control and responsibility, since Monitor's power to modify local prices would be confined to services that the commissioners themselves had agreed to designate for additional regulation (see below on service continuity). In addition, where GP consortia are faced with unavoidable extra costs, the NHS Commissioning Board would be able to take such factors into account when constructing the formula for financial allocations.

I. How economic regulation will work: supporting service continuity

6.112 The third of Monitor's core functions will be to support the continuity of supply of essential local health services if a service provider becomes insolvent. Not all services or providers are equally successful. The Government will not force patients to use, nor taxpayers to subsidise, poor quality, inefficient services or providers. Whereas in the past the response to failure has usually been to prop up the provider as an institution, in future there will be a clear and transparent mechanism for managing provider failure, which protects services for patients but not ineffective management or poor quality care. This will allow commissioners to replace existing services with higher-quality or better value options smoothly and without risk of interruption in access to services for patients.

6.113 Almost without exception, respondents agreed that there was a need for regulation to help protect essential healthcare services, and that Monitor needed powers to enforce that regulation in support of commissioners. Central and Eastern Cheshire PCT thought that "*Monitor will need to be able to impose additional regulation on providers to continue the essential (but unpopular/costly/statutory) services*", while the Royal College of Physicians said that Monitor will need "*powers to impose additional regulation to help commissioners maintain access to essential public services*". There was also support from providers; though some, including Liverpool Women's NHS FT, City Hospitals Sunderland NHS FT and Leeds Teaching Hospitals NHS Trust, emphasised that additional regulation on providers would need to be applied fairly and only where necessary, and that any extra costs should be reimbursed through additional funding to avoid undermining the provider's viability.

6.114 The Government has therefore decided to develop a continuity of service regime based on the high-level principles laid out in *Regulating healthcare providers*, including giving Monitor similar powers to those found in other regulated sectors, to protect services designated for additional regulation. Some important points of detail were raised in consultation, and we have further developed our proposals in response.

Defining "designated services" for additional regulation

6.115 *Regulating healthcare providers* did not specify how the services designated for additional regulation are to be identified for each provider of services, and was silent on how the views of local patients, carers and the public would inform the decision. Many respondents asked for

greater clarity. For instance, the Expert Patient Programme CIC argued that a clear definition of essential services was vital, as otherwise "*any instance of inefficient performance by a provider…will require some level of intervention and discretionary funding*". The King's Fund commented that "*striking a balance between the freedom of providers to manage their business efficiently and the needs of patients and local populations is difficult. One option could be to define essential services in a more general way and from the perspective of local commissioners*".

6.116 The Government agrees that there needs to be clarity. The Bill will establish an overarching principle that additional regulation will not apply unless commissioners can demonstrate that the loss of a particular service provided by an individual provider would result in material damage to patients due to an inability of the commissioner to secure a timely replacement service or to make timely appropriate alternative arrangements. In formulating this judgement, taking account of suggestions from respondents such as the Royal College of Surgeons, commissioners will be required to pay due regard to:

i. the health needs of current and future patients;

ii. whether the potential loss of a particular service would significantly increase inequalities in access to healthcare across the population as a whole; or for particular socio-economic groups;

iii. the requirement for commissioners to make the best use of limited NHS resources;

iv. the impact of their decisions on sustainability of all local healthcare services in the present and future considering the population's health needs; and

v. the duty of commissioners to secure improvements in quality of care for patients.

6.117 Local commissioners, providers and members of the public will be able to engage in discussions about local service delivery and take control of the decision about which services to designate for additional regulation. Monitor will offer guidance and support throughout this process, which would run broadly as follows:

- Monitor will issue, after engagement with stakeholders, guidance notes identifying key principles that can be used by local organisations when considering which services to designate as additionally regulated.

- Local commissioners will take the lead in examining levels of provision and the likelihood of competition in a local area, before provisionally identifying which services should be designated, using Monitor's guidance to inform their decision. Commissioners will need to take a unified approach in deciding whether or not a service is designated, and the NHS Commissioning Board will have a responsibility to ensure that there are local arrangements in place to achieve this. This might be either through a lead GP consortium arrangement or a joint committee of consortia.
- The commissioners will then engage with providers, other interested parties (such as local authorities through the health and wellbeing board) and the public.
- Providers will submit their list of designated services to Monitor, which will incorporate them into its licence for the provider. Those services will be designated for a regulatory period defined by Monitor. During that period the provider will not be able to reduce, significantly reconfigure or cease provision of those services without the prior approval of both commissioners and Monitor. This is in contrast to their services which have not been designated for additional regulation, which providers will be able to cease offering, subject only to any contractual limitations.
- As outlined in Chapter 5, local councils will have the power to require any provider of any NHS-funded services to account to a scrutiny session, enhancing the level of local democratic oversight. This is irrespective of whether they are or are not designated for additional regulation.

6.118 We expect that the guidance notes to be issued by Monitor will focus on the contribution of each provider to its local health economy and the possibilities for alternative supply, rather than the ownership status of the provider. Therefore any provider of NHS-funded care, whether public or independent sector, could provide designated services.

6.119 This approach is in line with the White Paper and the Government's commitment to localism and local democratic legitimacy. Decisions as to which services should be designated for additional regulation will not be taken centrally, but by local commissioners in co-operation with their providers, and after engagement with health and wellbeing boards, other local stakeholders and the public. This will deliver the "*vigorous public debate as to which services are to be considered truly essential*" that the RCGP's consultation response called for. It will align decision-making with financial responsibility: commissioners will face a financial consequence from designating services for additional regulation, for

example through a transparent unitary charge, to reflect the costs of guaranteeing service continuity. This will help ensure that additional regulation is used only where it is necessary. Meanwhile, the role of Monitor will be to provide a mechanism for monitoring and enforcing locally-made decisions.

6.120 The process of designating services should be complete in time for April 2013, when the new regime for provider failure is due to come into force.

Intervention in case of provider distress

6.121 Most respondents welcomed the Government's proposals to stimulate competition and end the culture of supporting failing organisations, while protecting designated healthcare services through the introduction of a special administration regime. However, a number of commentators noted that Monitor, in line with other regulators, should also have the power to intervene in providers of additionally regulated healthcare services to minimise the need for special administration. Leeds Teaching Hospitals NHS Trust said "*it is probably more appropriate to ensure that Monitor acts in such a way as to step in before the need for Special Administration becomes apparent*". EC Harris LLP said: "*We would suggest that given the complexity of delivery of healthcare services, while there should be a defined period whereby Monitor could trigger special administration to protect additionally regulated services before the start of insolvency processes, it is critical to ensure that an early warning system is in place to prevent this position occurring*". Many respondents welcomed the Government's proposals to place the primary responsibility for service continuity in the hands of commissioners, but noted that for them to undertake this duty, providers and Monitor would need to provide accurate and timely information to commissioners regarding the risk of local provider failure and exit.

6.122 The Government recognises that, while a clear and transparent provider failure and exit is a vital component of the competitive regime that is essential to improving the quality of healthcare services in England, failure should be seen as the last resort. In line with other regulated sectors, the Bill will give Monitor a broad set of legislative intervention powers to ensure the continuity of designated healthcare services. This includes powers in extreme circumstances to enable Monitor to direct an organisation to take specific actions in order to prevent failure.

Creating a special administration regime

6.123 There was support from many respondents for the Government's proposals, drawing on well-established special administration regimes in other sectors. For example, Monitor's consultation response "*welcomes the Government's proposals to…enable the health service to benefit from the dynamic effects of competition and exit, while ensuring continuity of provision for those services deemed to be essential or 'additionally regulated' through a special administration regime funded by a risk pool*".

6.124 Creating a special administration regime for designated services will also fill a gap in the current regime for foundation trusts. The original FT legislation gave powers to establish an insolvency regime, but they were never used because there was no provision for special administration. Belatedly the previous government introduced an "unsustainable provider regime" in the Health Act 2009, which was appropriate for NHS trusts but undermined the principles of FT autonomy. The Government will now remedy this, by both bringing FTs within the scope of ordinary corporate insolvency procedures, and creating an alternative special administration regime to ensure the continuity of designated services where a provider fails.

6.125 We recognise that designing the regime will be highly complex, especially given that the definition of designated services will be more complicated in health than in some sectors. Therefore, following precedents such as the Banking Act 2009, we intend to use secondary legislation to define the special administration and insolvency regimes. However, the Bill will set out the objective of special administration and the scope of the regulations to be made. It will also include clear principles that the special administration regime must follow: in particular, that the regime will be triggered by Monitor, not the Secretary of State. The regime will be run by a court-appointed administrator, with oversight from the economic regulator, without the ability for political interference.

6.126 Special administration regimes in other sectors do not include requirements for a special administrator's proposals to be subject to consultation. Recognising the level of public interest in NHS services, the Government intends to follow the precedent of the existing unsustainable provider regime by introducing an explicit requirement for public consultation if the special administrator's proposals would involve significant changes to the provision of designated services.

6.127 The Secretary of State will be under a legal obligation to make the regulations for special administration and insolvency, and to consult on them beforehand. The Government intends to introduce those regimes in

April 2013 if possible – or by April 2014 at the latest, recognising that it may take time to develop regulations and supporting rules on such a technical subject. As a result, there will be a transitional period from 2012 until 2013 (or the final date if later) when Monitor will exist as an economic regulator but the special administration regime will not yet be in force. During this period the current unsustainable provider regime will continue to apply. However, the Bill will modify it, to make Monitor rather than the Secretary of State responsible for triggering the regime in the case of foundation trusts, and to remove the possibility of de-authorising FTs.

Risk pooling

6.128 Overall, respondents to the consultation expressed support for the development of a funding facility to support continuity of services when providers are placed into special administration, stating that "*we agree that Monitor would be responsible for establishing funding arrangements*" (South Essex Partnership University NHS FT) and with CQC noting that "*funding continued provision of services needs to be done in a way that first and foremost ensures people continue to get safe care*" (CQC). A significant majority of respondents went a step further and supported the specific proposal for that funding formula to be in the form of a 'risk pool' with the power to collect levies and disburse money to special administrators. Responses stated that "*a provider-funded, risk-based contribution system would be appropriate as a funding mechanism and incentive for de-risking providers*" (Cornwall and Isles of Scilly PCT).

6.129 A few respondents suggested that there should not be a standing "pre-funded" risk pool but that providers should pay into the pool as and when they needed to fund a special administration in order to avoid "*tying money up and putting it beyond use for long periods of time*" (Foundation Trust Network). Others noted that pre-funding was the only way to ensure that resources would be available in an orderly fashion and that raising levies on providers at the point of failure of another provider could create perverse incentives.

6.130 Given the strong support from respondents, we have decided to include measures in the Bill to give Monitor broad powers to implement a risk pool to protect patients' interests by providing finance to support the continuity of designated services. In line with best practice seen in similar continuity of service schemes operated in other sectors, Monitor will have power to ensure that the providers who cause greatest risk bear a greater share of the costs.

6.131 Some respondents were concerned lest the risk pool could be used to subsidise under-performing providers. The Bill will therefore make clear that risk pool funding can only be accessed once a provider has entered special administration by Monitor, and management control has passed to the special administrator.

J. Education and training

6.132 There was a great deal of interest, particularly from professional bodies and workforce representatives, in the Government's proposals for a new approach to the education and training of staff. Respondents endorsed our aim of managing and introducing reforms carefully, with full consultation. For example, the Council of Deans of Health said "*The transition arrangements for any new system of education and training will be particularly important and need to be managed carefully, particular in regards to Strategic Health Authorities being abolished from 2012*"; while the General Medical Council was "*keen to continue to engage with the government to ensure that the new arrangements lead to improved standards*". The Government will shortly publish further proposals for consultation.

K. Pay and pensions

Pay

6.133 *Liberating the NHS* set out the short-term position – reflecting what was announced in the 2010 Budget – that pay will be frozen in 2011/12 and 2012/13 for those earning more than £21,000. The Government will ask the Pay Review Bodies to make recommendations on pay for those earning below this threshold, with a minimum increase of £250 for each year of the freeze. We also committed to work with NHS employers and trade unions to explore appropriate arrangements for setting pay in the longer term, in line with our overall aim that pay decisions should be led by healthcare employers rather than imposed by government.

6.134 Those who responded were generally opposed to a move away from nationally negotiated terms and conditions. The BMA commented that national conditions were essential "*to ensure an equitable spread of doctors across the UK…[and] to safeguard against poor working conditions*", while UNISON recommended "*that the Government commits to the national determination of pay and national collective bargaining for*

terms and conditions, leaving employers and trade unions nationally to agree what local flexibilities are appropriate". Concerns were raised that local pay bargaining would be inefficient and could create a two-tier workforce, bid up pay rates for scarce staff groups and reintroduce the risk of equal pay claims. Many responses saw the independent Pay Review Bodies as fair and highly valued; there was concern that their longer term role was unclear.

6.135 The Government is committed to preserve employers' ability to decide locally – in the spirit of determining what is best closest to the front line – whether to use national terms and conditions or to create local systems. Foundation trusts already have freedom to set pay and terms and conditions, and GP consortia will have too. It would be for individual employers to decide, with their employees, what are the best solutions. Therefore it would be out of step with the approach taken in the White Paper to prevent those employers who want to, from moving away from national systems. However, if they did, they would need to be very clear about introducing systems that do not expose themselves to equal pay challenges – by delivering a fair and objective pay system (as Agenda for Change has achieved nationally).

6.136 We do not intend to abandon the national pay frameworks, and so we will expect them to be maintained for those employers who want to continue to use them. But in future we envisage employers taking the lead in negotiating changes to those national frameworks. In the coming period we will discuss with the staff side and employers in the sector the appropriate approach to the national pay frameworks when the two-year pay freeze has ended.

Pensions

6.137 The White Paper made clear that our position on NHS pensions would be developed in the light of Lord Hutton's Independent Public Service Pensions Commission. Lord Hutton has produced an interim report indicating the likely options for changes to public sector pensions but also some shorter-term recommendations about current schemes. Following this, the Government announced in the Spending Review:

- a commitment to some form of defined benefit pension for public sector pensions (the nature and precise level of contributions await Lord Hutton's final recommendation);
- a public consultation on the discount rate to set pension contribution rates;

- implementation of progressive changes to the level of employee contributions, which will lead across the whole of the public sector to additional savings of £1.8 billion a year by 2014/15 – equivalent to three percentage points on average to be phased in from April 2012 (how this will fall proportionately between public sector schemes is for further discussion with the Treasury); and
- the launch of a pan-Governmental consultation on the Fair Deal policy (this has particular impact on the White Paper reforms, where transferability of staff is a key issue).

7. EFFECTIVE IMPLEMENTATION AND A MANAGED TRANSITION

Introduction

7.1 This document has described how the consultation responses have helped to inform the design of the structural reforms that require primary legislation. Previous chapters focused on the individual parts of the new system: HealthWatch and the Health and Social Care Information Centre (Chapter 2); NICE (Chapter 3); GP consortia, the NHS Commissioning Board and the Department of Health (Chapter 4); health and wellbeing boards and local government (Chapter 5); and providers, the Care Quality Commission and Monitor (Chapter 6). These chapters also described the implementation framework for each part; for example, the GP pathfinder programme, the programme of early implementer systems for health and wellbeing boards, and the transition for Monitor.

7.2 This chapter describes how these arrangements for implementation work together as part of a single overall strategy, rooted in our values and our knowledge of effective change management. The Department and the NHS leadership team will retain a clear and relentless focus on managing the business and challenges of today while we build the new system. Some have argued that the reforms involved in liberating the NHS constitute an unwise distraction from meeting the quality and productivity challenge facing the NHS. On the contrary, the reforms will support the delivery of NHS quality and productivity plans to deliver efficiency savings of up to £20 billion to reinvest in patient care over the Spending Review period, by creating new incentives for efficiency.

7.3 In future, arrangements for financial control and risk management will also be more robust and transparent, with enhanced control and focus in the short term. The new system will be more economical, with lower administration costs. Overall, transition will occur through a carefully designed and managed process, phased over four financial years, to allow for rapid adoption, system-wide learning, and effective risk-management. It will be aided by the creation of a number of specific time-limited transitional vehicles, with a focus on sustaining capability and capacity.

7.4 This chapter covers:

A. Shared values and the NHS Constitution

B. An integrated transition programme

C. Meeting the quality and productivity challenge

D. An increased focus on financial control

E. Cutting the cost of administration

F. A phased transition over four calendar years

A. Shared values and the NHS Constitution

7.5 *Liberating the NHS* is about putting patients first, improving outcomes, and devolving power and responsibility to local professionals and organisations. We agree with respondents who have said that realising this vision is about long-term transformational change. As the NHS Confederation observed, "*it is clear that the culture change being proposed is at least as important and, based on health reform elsewhere, will take many years to have an impact*".

7.6 We were heartened to see so many respondents emphasise the importance of the NHS Constitution providing for shared values across the new system's "*collective DNA*" (Wakefield Metropolitan District Council's Social Care and Health Overview and Scrutiny Committee), and we can confirm that the new organisations will have a duty to have regard to it. Beyond the obligations that fall on individual organisations, the Government also believes that an important national leadership role remains in raising consciousness of what the NHS Constitution means for patients and for staff. We intend to locate that leadership role within the NHS Commissioning Board and we intend that the Board should have an obligation to promote awareness of the NHS Constitution across all NHS-funded services.

7.7 The Department will ensure that the core purposes of the NHS remain embedded in legislation, while supplementing the original 1946 duty to promote a comprehensive health service that is free at the point of use. As Chapter 3 described, there will be a new duty of quality improvement, covering safety, effectiveness, and patient experience; and there will be an important new duty to reduce inequalities in healthcare provision. Our purpose in liberating the NHS is to achieve excellence and equity.

7.8 The principle of local freedom will also be reflected in law: there will be new duties on the Secretary of State and the NHS Commissioning Board to maximise the autonomy of individual commissioners and providers by

limiting their general powers of direction; an obligation on Monitor to regulate only where necessary; and the Health and Social Care Information Centre will be under an obligation to keep data burdens to the minimum that are necessary.

7.9 Overall, the changes in the NHS legislative framework will strengthen the NHS Constitution and lead to it being updated. The Department will therefore consult on changes to the NHS Constitution during 2011, prior to a revised version coming into being by April 2012. As a corollary of his responsibility for the legal architecture of the NHS and his role as overall steward, the Secretary of State will remain the guardian of the NHS Constitution and its Handbook. And in line with this, the Department will retain responsibility, across the NHS and where relevant the public health service, for the three-yearly statutory report on the effect of the NHS Constitution on patients and staff. However, the Department will ask the NHS Commissioning Board to play a key role in contributing to the analysis in relation to the NHS.

7.10 Organisations and structural reforms are important, but at their heart our plans for improving the NHS are all about people: giving all patients more clout in the system and increasing local voice; trusting professionals to do the right thing, and rewarding innovation, excellence and equity; and giving local leaders the responsibility that comes with increased authority. Our model of improvement is about trust and empowerment: a model of assumed liberty, not earned autonomy. The Government sees its role as creating an enabling framework to support and energise local change. And as the NHS Confederation put it: "*in general, we support the approach of confining policy to the specification of the broad frameworks and allowing local organisations to develop solutions that are appropriate to their own circumstances*".

7.11 We also agree with the many respondents (for example, the Leeds Teaching Hospitals NHS Trust and Norton Medical Centre Practice) who said that effective implementation will occur only through the development and continuation of strong mutually supportive relationships, and through effective leadership. This is primarily as much about behaviours and capability as it is about regulations and law, "*requiring a culture change where professional boundaries have to come down*" (North Lancashire PCT). That said, the legal framework can set expectations. For this reason, the forthcoming Health and Social Care Bill will not solely concern itself with the functions of individual organisations. In the light of consultation responses, the Department has also given careful thought to the way in which the construction of duties and powers can support common purpose and the relationships between

organisations. For example, we have developed a much more comprehensive approach in legislation to requiring partnership arrangements locally (for example, through health and wellbeing boards), and supporting these nationally (for example, through the new duties of co-operation between national organisations, and the ability of the Secretary of State to encourage co-operation, but without getting drawn into arbitrating in disputes).

7.12 As outlined in Chapter 1, some respondents argued that the Government's reforms will fragment the NHS. The reverse is true. As we devolve power, our plans reinforce the fact that the NHS is an integrated system. Its core purpose of focusing on outcomes will become clearer. We are promoting shared decision-making between patients and professionals. In future there will be far more effective arrangements than exist currently for ensuring joined-up working across the NHS, public health and social care. Commissioning will be clinically-led, with groups of GP practices working together far more effectively – and also in concert with other community-based professionals and clinicians in secondary care.

7.13 Freeing up commissioning and provision will not only increase innovation, choice and competition – it will also enable greater integration of services, for example around out-of-hospital care. In its response, the King's Fund argued that "*policy makers should heed the lessons from high-performing health care organisations around the world ... specifically, the evidence suggests the need to focus on ensuring that quality of care is the core strategy pursued, clinicians lead work on quality improvement, staff are provided with the skills required to improve quality, and incentives are aligned in support of these objectives. Actions also need to be aligned across organisations with the emphasis placed on whole system thinking and working, not just organisational performance and competition between fragmented providers of care*". The Government is in complete agreement.

7.14 But whilst the King's Fund proposes making more incremental adjustments to current structures, the Government's view is that such an approach will be wholly insufficient to achieve our shared goals of focusing on quality, empowering clinicians, developing on whole-system thinking across the NHS, public health and social care, and focusing on integration as well as increased competition. Unlike the previous administration, the Coalition Government's intention is to undertake structural reform rapidly, and once only, and show constancy of purpose in adhering to our plans. North East Lincolnshire Care Trust and North East Lincolnshire Council were among those advocating accelerated

change, describing the timetable for reforms as "*too slow*" and suggesting that we "*set up shadow consortia more quickly*". We will ensure that the new arrangements for the NHS Commissioning Board and GP consortia have greater inbuilt flexibility and adaptability than SHAs and PCTs, rendering further top-down reform unnecessary – the Board will have freedom to organise itself as it sees fit, and consortia will be able to expand, shrink, dissolve or merge. In this way, the structural change we are introducing now will provide a platform for greater long-term stability.

7.15 The new system will be underpinned by clear values and stronger relationships; in addition, the Department and the NHS leadership team is also seeking to ensure that the manner in which the transition is implemented is based on our shared values and effective co-operation, as set out in the NHS Constitution and reiterated in *Liberating the NHS.* These should remain our touchstone throughout the transition period.

B. An integrated transition programme

7.16 Taken together, the vision for social care, *Liberating the NHS*, and the public health White Paper form a comprehensive, clear and coherent programme for reform across health and care services that touches on every institution, including the Department itself and its existing arm's-length bodies. Unlike previous reforms, developed piecemeal over a number of years, the Department has moved with pace to provide a complete high-level picture of the new landscape, in order that the plans are properly aligned – and to reflect the fact that the NHS, public health and social care are part of an integrated and highly interdependent system.

7.17 Our approach to taking forward these plans in primary legislation is similarly comprehensive, dealing with institutional reform for the most part in one place. In addition to implementing the changes set out in *Liberating the NHS*, the Bill will also provide for implementing *Healthy Lives, Healthy People* and the role of Public Health England within the Department of Health, and the new role of local government in public health.

7.18 The Bill and related secondary legislation will also rationalise public bodies, including, among others, the abolition of the Appointments Commission and the Office of the Health Professions Adjudicator, the removal from the sector and the change in functions of the Council for Healthcare Regulatory Excellence, abolition following removal from the

sector of the Alcohol Education and Research Council and the transfer of functions and abolition of the National Information Governance Board, NHS Institute for Innovation and Improvement, the National Patient Safety Agency and the General Social Care Council. It will deal with changes to the functions of the Care Quality Commission, and the establishment in primary legislation of the two bodies being re-established, NICE and the Information Centre. The changes to the Human Fertilisation and Embryology Authority and the Human Tissue Authority including the proposed creation of a new research regulator will be dealt with elsewhere, through separate means.

7.19 As a number of respondents (for example, Bupa, North Lancashire PCT and the NHS Alliance) suggested, the Department is taking a fully integrated approach to managing the transition, through a single programme of work that spans across the NHS, local government, the Department and its arm's-length bodies. We are ensuring alignment of plans for 2011/12 for QIPP, for human resources, finance, estate and informatics; plans for early implementers; and work on future organisational design. Sir David Nicholson, the Chief Executive of the NHS, has written to the NHS about managing the transition; Sir Neil McKay will set out the next phase of the human resources strategy; the Department has published the NHS Operating Framework 2011/12; and David Behan, Director General for Social Care, will set out for local government plans for engagement and invite interest in becoming a health and wellbeing early implementer.

C. Meeting the quality and productivity challenge

7.20 The single greatest challenge that the NHS faces over the lifetime of this Parliament is to increase quality and productivity. This is a core role for all existing and future organisations.

7.21 Compared with other Departments, the Spending Review set out a generous settlement for healthcare: funding will increase by more than 10 per cent in cash terms over the Spending Review period. By historical standards, this level of growth represents an unprecedented financial challenge. The Spending Review reiterated the NHS's long-standing challenge to deliver up to £20 billion in efficiencies over the next four years, and many consultation respondents (for example, Bupa, African Health Policy Network, ACEVO, MS Society) commented on the need for efficiency savings to be made. For example, the Royal College of Speech and Language Therapists neatly explained the challenge we face in its response: "*In order to improve the quality of care at a time of*

increased social and healthcare need (due to a complex and ageing population), smarter commissioning and effective use of scare resources is a priority". The NHS is responding to this challenge through the QIPP work, by identifying new ways to increase productivity and efficiency while delivering better quality services to patients. Higher quality care is often cheaper – unsafe or ineffective care can cost money to put right, or require more care and treatment than is necessary; for example, a reduction in the incidence of grade 3 and 4 pressure ulcers will improve clinical safety and patient experience at the same time as reducing treatment costs.

7.22 Many respondents have argued that implementing structural reform is incompatible with achieving the immediate quality and productivity challenge. For example, the Chartered Society of Physiotherapy argued that the process of implementing the reforms might "*potentially undermin[e] the current efficiency drive*". It has also been said that the right time to embark on these reforms was five or so years ago, and that it is unwise to commence structural change now. The Government certainly agrees that it would have been preferable for the previous administration to have completed the design and implementation of the reforms started under Tony Blair, upon which *Liberating the NHS* clearly builds: the completion of the transition to foundation trusts, freeing up the provider side to allow greater innovation, introduction of patient choice of any willing provider, the extension of payment by results, the clearer separation of commissioning and provision, and devolving power to practice-based commissioners. As a number of people have observed, the Government's plans represent a logical extension of those reforms. If the previous administration had implemented in full its own original reform plans, the scale of change envisaged in *Liberating the NHS* would seem considerably less radical.

7.23 But whilst the financial context is unarguably more challenging than it was five years ago, the scale of the efficiency challenge is such that it can only be met by system-wide reform. Successful delivery of plans to improve quality and productivity is not something separate from making early progress with structural reform. Instead it is inextricably linked with implementing reform. Plans to manage QIPP, and plans to manage transition, are in practice one and the same thing. This is because the reforms comprise an extensive array of new mechanisms designed to improve quality and efficiency:

- giving patients more choice and control over their care improves quality and efficiency. Our plans for an information revolution will result in better informed patients who understand their condition and

know when to seek help. This will not only improve individual experience and outcomes, it will make better use of resources and reduce cost waste arising from poorly planned care and patient confusion;

- a comprehensive set of quality standards developed by NICE and supported by the NHS Commissioning Board will help spread adoption of the most effective care. It will improve safety and help reduce the costs of emergency readmissions and adverse incidents. Quality standards will be reflected in the new Commissioning Outcomes Framework, the GP Quality and Outcomes Framework, and the development of best practice tariffs and CQUIN;

- aligning the clinical and financial aspects of commissioning through GP consortia is a prerequisite for the QIPP agenda. It is GPs, not primary care trusts, whose actions incur the majority of NHS expenditure, whether directly through prescribing and referring, or indirectly through the access they offer for urgent care and how well they help prevent and manage long-term conditions. In these more challenging financial times, the only way that the NHS commissioning function can be confident of living within available resources and making optimal decisions about priorities is if it is owned and controlled by local practices working together. For this reason, the criteria for selection as a GP consortia pathfinder includes active engagement with the QIPP agenda;

- the new arrangements for GP consortia will also enable and incentivise successful commissioners to expand, and there will be a clear statutory failure regime. These are important advances on the current arrangements for PCTs;

- strengthening the local authority role as integrator of commissioning across the NHS, public health and social care is vital to delivering more integrated care, which is more efficient and offers a better user experience;

- giving providers freedom to innovate will drive major productivity and efficiency improvements – for example, in community services;

- the development of Monitor as economic regulator will strengthen the drive for provider efficiency through greater price transparency, increased competition, and a clear and independent provider failure regime; and

- driving and completing the foundation trust pipeline will ensure that all existing NHS trusts become clinically and financially sustainable, either as a stand-alone organisation, or as part of an existing FT or another organisational form. A forensic focus on the organisations that require the greatest development is an essential part of our plans to drive quality and productivity on the provider side.

7.24 The opportunity that the reforms offer for increasing quality and productivity calls for rapid progression during 2011/12, with planning for the new commissioning system and GP consortia arrangements, the new joint working arrangements with local government, and progression for NHS trusts towards NHS foundations trust status. Cheshire West and Chester Borough Council were among those advocating accelerated change, describing the timetable for reforms as "*too long*". The 2011/12 plans for reform will be integrated with plans for QIPP within a single framework. PCTs will remain statutorily accountable during 2011/12, and pathfinder consortia will need to work with PCTs on planning for and delivering financial and operational plans. QIPP support processes will be reshaped to support the new delivery system. The NHS Operating Framework 2011/12 will set out clear milestones for progressing reform against which SHAs and PCTs will be held to account.

7.25 The National Quality Board (NQB), which brings together all the key national bodies currently responsible for overseeing the NHS system, will provide further support throughout the transition period, advising on how to enhance resilience for quality and safety. Early in 2011, the NQB will report on any additional measures that should be taken to strengthen the system's ability to identify and respond to concerns about quality during the transition period, including on issues such as the effective transfer of knowledge and intelligence on quality between old and new organisations. Later in the year, they will produce a further report setting out advice on how to underpin the statutory roles and responsibilities of the new and existing bodies with practical mechanisms for ensuring collaboration in order to maximise the potential for delivering high quality services for patients at the same time as managing risks across and within provider organisations.

D. An increased focus on financial control

7.26 Besides promoting incentives for greater efficiency, the Government's reforms will help ensure affordability. Greater clarity of function, increased financial transparency, and failure regimes on both the commissioner and provider side will strengthen financial control. The

Department of Health will continue to be accountable to Parliament and HM Treasury for the overall health budget. Within that, the NHS Commissioning Board will be accountable for living within a total NHS expenditure limit, subject to clear financial rules. In turn, GP consortia will be accountable to the NHS Commissioning Board for managing public funds within their allocated budget and will be subject to transparent controls and incentives.

7.27 The Board will have powers and responsibility for designing systems to incentivise good financial management and manage financial risk. It will have the power to hold a central contingency from within its allocated budget. In order to help manage volatility, such as the fluctuation in demand for low-volume but high-cost treatments, GP consortia will also be able to collaborate and pool resources locally. Each consortium will be able to exert leverage (for example, the discretion to disburse any quality premium from the Board among its constituent practices as reward for good patient outcomes and financial performance, as set out in Chapter 4) over the commissioning behaviour of its constituent GP practices in order to encourage cost-effective use of resources.

7.28 On the provider side, the new system of economic regulation will promote financial discipline, efficiency, transparency and fairness in the way that resources are used. There will be a special administration regime overseen by Monitor, the operation of which will be completely independent of ministers, for protecting services subject to additional regulation. Monitor will have clear powers to create a provider risk pool, and as with the commissioning system, there will be powers to levy contributions according to risk. The provider risk pool administered by Monitor will only be used to fund services that have been placed in special administration, not as a source of subsidy to prop up unviable providers. In future, any price subsidies will have to be justified and transparent; and where commissioners wish for local services to be subject to additional regulatory control by Monitor, they will be subject to a higher maximum price.

7.29 The Department and HM Treasury are committed to continuing to work together in partnership to ensure that these arrangements for clearer and more effective risk pooling on both the commissioner side and the provider side are constructed in such a way as to recognise the volatility of risk across different years, and to maximise the proportion of resources that are allocated directly to frontline services.

7.30 During the transition, the Department will require SHAs and PCTs to have an increased focus on maintaining financial control. GP consortia will have their own budgets from 2013/14. They will not be responsible

for resolving PCT legacy debt that arose prior to 2011/12. PCTs and clusters must ensure that, through planning 2011/12 and 2012/13, all existing legacy issues are dealt with.

7.31 During the final year of transition (2012/13), the new PCT clustering arrangements, outlined later in the chapter, will be accountable to the NHS Commissioning Board for ensuring robust financial control, prior to the GP consortia arrangements across the country assuming statutory responsibility from 2013/14. Furthermore, to manage risk within the foundation trust sector, we are planning to retain, on a time-limited basis, compliance and intervention powers for Monitor in relation to a pre-identified cohort of organisations that are most at risk.

E. Cutting the cost of administration

7.32 In addition to driving efficiency and strengthening financial control, *Liberating the NHS* set out plans to reduce the costs of administration, through a combination of significant simplification of management layers, rationalising arm's-length bodies, and removing unnecessary functions. These steps are vital to ensure that front-line services and staff are afforded as much protection as possible, getting more, higher quality care from each pound spent in the NHS and spending that money on care, not on duplication or inefficiency. Equally, the Government has been clear that reductions in administration costs, whilst significant, only represent a minority of the total efficiencies needed, and that the major part will need to come from better ways of organising and managing care, to be delivered through our reforms and the quality and productivity agenda.

7.33 The majority of respondents, including, for example, the Academy of Medical Royal Colleges, and the Care Quality Commission, were strongly supportive of our moves to "*cut unnecessary bureaucracy and duplication*" (Cheshire West and Chester Borough Council). The Government agrees with the view of the Isle of Wight's LINk that management in the NHS "*has become too dense and top-down*". Since 2002/03, management costs in PCTs and SHAs have increased by over £1 billion. In *Liberating the NHS*, the Government committed to cutting NHS management costs, and unlike the previous administration, our plans comprise a strategic approach to realising savings that arise from a change in functions and structures – we are not embarking on a process of 'salami-slicing' everyone, with functions and structures untouched.

7.34 However, some of the existing organisations expressed doubt as to whether the reforms could really save money (for example, this was raised at the Yorkshire and the Humber SHA engagement event),, with speculation that "*creating a larger number of smaller commissioning organisations will create costs rather than save them*" (Wirral PCT). Some concerns were expressed about the likelihood of management cuts being realised, with speculation that consortia would "end *up as a reincarnation of the PCTs with the same staff*" (Sefton Local Pharmaceutical Committee). A number of respondents also expressed concern that the focus on cutting administration would undermine the effectiveness of GP consortia, and suggested that the Government had failed to appreciate the importance of good management.

7.35 The main way in which savings are being made is by simplification and removing of functions such as the performance management of process targets. By giving responsibility for commissioning to those who coordinate the majority of patient care, GP consortia, PCTs will cease to exist from 2013. The proposed changes mean that 151 PCTs will be reorganised into GP consortia, the number of these to be determined locally. The NHS Commissioning Board will become fully operational from April 2012, removing the need for SHAs. The new NHS Commissioning Board will combine functions of the Department and the 10 SHAs, and certain functions of PCTs, in a much more streamlined way. As a result of these changes, the Department will be able to invest substantially in management to support commissioning, both in the NHS Commissioning Board and for GP consortia. The Government recognises that investing in administration to support commissioning is a vital necessity, and not just an overhead on frontline services.

7.36 The report of the arm's-length bodies review set out how we intend to simplify the national landscape by reducing the number of arm's-length bodies from 18 to between 8 and 10 by 2013/14, removing duplication and better aligning the arm's-length bodies sector with the rest of the health and social care system. In future:

- functions will only be carried out at national level where it makes sense to do so;

- the number of arm's-length bodies will be kept to a necessary minimum and the scope of each arm's-length body will be clearly defined with clear accountability for those organisations remaining in the system;

- arm's-length bodies will be expected to collaborate and co-operate to avoid duplication of activities and minimise unnecessary burdens and costs to health and social care organisations;

- arm's-length bodies will have less freedom to determine how they spend their money on pay, expenses, travel, consultancy, communications and IT, and they will be expected to publish information and benchmarking data online; and

- where appropriate, arm's-length bodies will be expected to exploit commercial opportunities and maximise commercial discipline across the sector.

7.37 By 2013/14 the changes set out in the review will have been completed. They will not only result in a more streamlined sector but also generate savings in the region of £180 million by 2014/15, as a result of greater efficiencies across remaining organisations, sharing resources and services, effective estate management, and exploitation of commercial opportunities where appropriate. These savings will be used to support front-line NHS services.

7.38 In the Spending Review, the Government made clear that it will indeed be able to reduce administration costs across the health system by a third in real terms, saving around £1.9 billion annually by 2014/15. The baseline in the current financial year for the total administration budget has been set at £5.1 billion. By 2014/15, the administration budget for the whole system will fall to £3.7 billion.

7.39 The total running costs of the NHS commissioning system will be in the range of £2.3 billion to £2.7 billion a year from 2013/14. The NHS Operating Framework 2011/12 sets out expectations for the maximum potential costs of GP consortia. Administration expenditure on the core Department, public health service administration in Public Health England and local authorities, and other arm's-length bodies will be around £700-800 million.

7.40 An impact assessment of the structural changes will be published in January 2011 alongside the Bill. It is important to note that the significant redundancy costs would have been incurred anyway as a result of the previous government's plans to reduce NHS management costs by 30%. Some have argued that the cost of the changes will be very large, running at several billion pounds in total. It is expected that significant numbers of PCT staff will transfer to roles in the new organisations. Even if levels of redundancy are at the higher end of our expectations, the additional one-off costs will be rapidly exceeded by the cost-savings from

the reduction in NHS administration costs, which will be reduced by around £1.9 billion a year by 2014/15 (in nominal terms). This will mean that there are substantial net savings within the lifetime of this Parliament, and the changes will put the NHS in a far better position in the longer term.

F. A phased transition over four financial years

7.41 Perhaps the most significant theme arising from the consultation was the need for effective management of the transition during what will be a challenging financial environment. The Department specifically invited comments during the consultation period on how best to secure implementation as well as on the detailed design of the new arrangements. We have received a wealth of insights, opinions and practical suggestions and these have shaped the way in which we intend to proceed. For example, the NHS Confederation produced a plan for managing the transition which contained a number of helpful suggestions on which the Government has decided to act, and in response to the overwhelming number of GPs who wanted to press ahead with pathfinders, we have introduced the programme early.

7.42 The Government has carefully considered respondents' suggestions around pace when looking at next steps, and is therefore proposing a phased transition, allowing enthusiasts to proceed early, as well as giving them time to plan, test, and learn, under existing legal and accountability arrangements. Our approach to implementation is based on the core change principles of co-production, local professional leadership, subsidiarity (or doing the right things at the right level) and system alignment. At national level, we are establishing shadow arrangements for the NHS Commissioning Board and will be making early progress with Monitor on their preparations for becoming an economic regulator, as well as establishing a Provider Development Authority. This will provide overall governance, and performance manage and support non-FTs until they become FTs. The Provider Development Authority will cease to exist at the end of March 2014.

7.43 A key lesson from previous reforms in the NHS is the need to get the balance right between progress on the commissioning side and progress on the supply side. Many respondents (for example, Durham Dales Integrated Care Project, and the Greater Manchester Health Commission) argued that it would be essential to prioritise early progress on GP consortia, and our pathfinder programme is designed with that in mind. Equally, our vision is for GP consortia to work in concert with local

government, so we are developing a parallel and connected programme of early implementer health and wellbeing boards, and a programme of local HealthWatch pathfinders. These programmes will expand during 2011/12, prior to the establishment of comprehensive arrangements in 2012/13, when there will be a first dry run of the new commissioning arrangements nationally. These early adopters will be modelling the new system and exploring key issues to inform wider national roll-out. The NHS Commissioning Board and the Department will be pulling together analysis of the lessons learnt and publishing these.

7.44 On the provider side, we are committed to completing the work to transform community services and extending choice of any willing provider; and it is vital that we make rapid and sustained progress in ensuring that existing NHS trusts are clinically and financially viable, as demonstrated through becoming authorised as a foundation trust. But equally, learning the lessons of other sectors, we recognise that full reform of the provider side and the introduction of greater competition where appropriate will take time to embed over many years.

7.45 Specific plans for implementing GP consortia, the NHS Commissioning Board, health and wellbeing boards, the foundation trust pipeline, and economic regulation, were set out in Chapters 4 to 6. These plans form part of an overall strategy, carefully designed to develop the new architecture and manage the transition from existing organisations across a four-year period, with nearly three years prior to the whole system going fully live. In this way there will be both opportunities for those who want to move more quickly, as well as time and space to plan for and test the new arrangements thoroughly. Phasing the reforms in this way will ensure that the parts of the system that need to move more gradually are not left behind. With the introduction of shadow bodies and early implementers, we are allowing nearly three years to consult, dry-run and put the reforms into practice on the ground, so that, collectively, the new organisations will have had time to secure capability by 2013.

7.46 There will be similar transitional arrangements for Public Health England. At a national level, Public Health England will start to operate in shadow form during 2011/12, with a dedicated leadership team in place. It will take on its formal powers and accountabilities at national level from April 2012. Shadow budgets will be allocated to local authorities for 2012/13, with local authorities taking on their full local role and financial accountability from 2013/14.

7.47 The high-level timetable of the key structural changes is set out below:

TRANSITION PHASED OVER FOUR CALENDER YEARS

2010/11 Design and early adoption

- The Department of Health confirms the design framework, subject to Parliamentary approval
- The Department of Health gives permission to pathfinders and early implementers to model the new arrangements and explore key issues for wider roll-out
- Refinement of HealthWatch following the choice and information consultations
- The Department of Health publishes transition plan setting out the role of LINks in influencing local services while local HealthWatch prepares to start exercising functions
- The Government begins working with local authorities as they prepare for their new role in commissioning support for choice and complaints advocacy

2011/12 Learning and planning for roll-out

- Shadow national arrangements progressively implemented for the NHS Commissioning Board, new Monitor, and the Public Health England programme
- Sharing lessons from the GP consortia pathfinder programme and early implementer health and wellbeing boards
- More pathfinders and early implementers, including local HealthWatch
- Plans drawn up for GP consortia, involving all GP practices
- Emerging consortia to lead the process for identifying which PCT-employed staff should be “assigned” to them
- Plans to be drawn up for health and wellbeing boards
- NHS trusts to apply for foundation trust status, or be planning to apply in 2012/13
- The new Provider Development Authority to be established by 1 April 2012
- SHAs to establish PCT cluster arrangements in preparation for the NHS Commissioning Board

2012/13 Full dry run

- From April 2012, NHS Commissioning Board and new

	Monitor come into effect, SHAs are abolished, PCT clusters are accountable to the Board, and the Department will have made substantial progress on its change programme and established Public Health England. The Provider Development Authority will oversee NHS trusts • More learning from GP pathfinders and health and wellbeing board early implementers • Authorisation process of comprehensive system of GP consortia begins, with all practices becoming members, acting under delegated arrangements with PCTs • Health and wellbeing boards are in place • Comprehensive local HealthWatch arrangements in place • From April 2012, local authorities to fund local HealthWatch to deliver most of their new functions • Consortia notified on 2013/14 allocations • By the end of the year, a significant number of NHS trusts have achieved foundation trust status • All applications for FT status to be made by end March 2013
2013/14	**First full year of the new system** • From April 2013, PCTs abolished and all consortia assume new statutory responsibilities • From April 2013, health and well being boards assume their statutory responsibilities • Consortia and health and wellbeing boards learning from their participation in the full dry run • From April 2013, Monitor's licensing regime is fully operational, and the Government aims to have the new special administration regime in place • From April 2013, local authorities to have responsibility for commissioning NHS complaints advocacy • At end March 2014, the Provider Development Authority ceases to exist • By 1 April 2014, all NHS trusts to have become FTs, and NHS trust legislation is repealed

7.48 As many respondents (for example, Norfolk and Sheffield PCTs) emphasised, it will be critical to ensure clear accountability during the transitional period. Strategic health authorities will be accountable for delivery and for overseeing the transition in their region up to April 2012.

The new NHS Commissioning Board will begin life as a special health authority during 2011 but will not take on its formal role and statutory accountabilities until 1 April 2012, when SHAs will be abolished. Its focus in 2011/12 will be on:

- developing its own capacity, including staffing and systems, to be ready to take on its full role in April 2012;
- building up the infrastructure of the new commissioning system – for example, the new systems for authorising consortia, holding consortia to account, and intervention, to be ready to ensure a comprehensive system of consortia by April 2013;
- agreeing with the Department a mandate for 2012/13, and overseeing key aspects of the planning process at national level. The Department will consult on the mandate in summer 2011; and
- developing relationships and detailed working arrangements with the Department of Health, Monitor and CQC nationally.

7.49 From 1 April 2012, the NHS Commissioning Board will take on all its statutory responsibilities and will be accountable on the commissioner side for delivery and overseeing the transition. PCTs will retain statutory responsibilities for commissioning healthcare services, for which they will be accountable to the Board, until 1 April 2013. PCTs will increasingly arrange for GP consortia to exercise on their behalf the functions that the consortia will be taking on. The Board will start to authorise consortia from April 2012 with the aim of having all consortia established as statutory bodies, subject to conditions if necessary, by the end of 2012/13. From 1 April 2013, statutory accountability will pass to GP consortia and PCTs will be abolished.

7.50 We agree with the many respondents who emphasised the need for capacity and capability to be sustained throughout the transition period. This will occur through identification of staff who will be involved in supporting the new GP consortia, and they will increasingly work to them albeit as PCT employees until the consortia are authorised. Equally, some PCT staff will find positions within local authorities, and some will find positions within the NHS Commissioning Board, commissioning primary care services and supporting GP consortia and holding them to account.

7.51 To pave the way for the NHS Commissioning Board to develop these roles, and maintain accountability and grip during 2011/12, and during 2012/13 once SHAs have been abolished, the Department has therefore

decided to expand the approach to managed consolidation of PCT capacity already taken in London and the North East. Here, sub-regional clusters have been formed by adopting single executive functions serving a number of statutory PCT bodies under existing legislative powers. These clusters will begin to oversee delivery during 2011 and continue to act as transition vehicles until at least April 2013; beyond that date, it will be for the Board to determine how it organises itself. It is envisaged that these sub-regional clusters will perform a common sets of functions for the transition period. Their core functions will comprise:

- overseeing in-year and medium-term QIPP delivery in 2011/12 and 2012/13. They will report to SHAs in 2011/12 and to the NHS Commissioning Board in 2012/13;

- direct commissioning of services for which responsibility will ultimately transfer to the NHS Commissioning Board, such as primary care, and nationally and regionally commissioned specialised services;

- ensuring GP consortia have access to commissioning support up until April 2013. As Chapter 4 made clear, consortia will have the power to decide what commissioning support they wish to access, and the clusters will be established with this in mind, with the emerging consortia acting as customers; and

- overseeing the development of GP consortia during 2011/12, ahead of their authorisation.

7.52 The NHS Operating Framework 2011/12 provides further detail on the shift to sub-regional clusters. It is important to note that only some PCT functions and staff will be clustered in this way; at the same time, many will be devolved to emerging consortia arrangements and to local authorities. There will, however, be clarity about where delivery responsibility and accountability lie for all functions.

7.53 During 2011/12 we will establish the Provider Development Authority to begin work with the non-FTs. From April 2012, Monitor's new functions will start to come on stream, and the Provider Development Authority will be fully accountable to the Department directly for NHS trust performance, finance and delivery of the pipeline to foundation trust status.

7.54 The reforms set out in this document will result in a complex series of moves for staff across the whole system, as well as a significant reduction in management and administrative posts. However, until the functions of each organisation in the new system are fully defined and

cost envelopes set, it will not be possible to identify the broad numbers of posts required in each organisation.

7.55 As many respondents pointed out (for example, the chair of Peterborough PCT and South Staffordshire and Shropshire Healthcare NHS Foundation Trust), it will be essential that we provide staff with maximum clarity and ensure that those with scarce skills or real talent are not unnecessarily lost in the process. We recognise this and in January we will publish HR frameworks setting out guidance for managers and staff affected by the reforms. The frameworks will provide the basis for ensuring that necessary staff changes are efficiently delivered in line with the requirement to reduce management costs, while providing the new organisations with the freedom and flexibility to determine their future needs. We are working in partnership with staff and trades unions to ensure that the frameworks are in line with our pledges to treat staff in a transparent and fair manner, as set out in the NHS Constitution.

7.56 The issue of TUPE was raised in some responses (for example, the Southfields Group Practice, Sandwell Metropolitan Borough Council and Berkshire West PCT). It is important to emphasise that many functions performed by current organisations will continue to be performed by new organisations. Because of this, TUPE will apply to a significant proportion of the functions carried out by new organisations. We are currently developing a People and Functions Migration Map setting out the functions we expect to see performed by organisations in the future system.

7.57 Sir David Nicholson has today written a letter to all NHS staff providing an update on the reforms which includes further detail on the forthcoming human resources strategy.

Conclusion

7.58 The implementation of *Liberating the NHS* involves the management of a significant and complex set of interconnected changes. The Department and its NHS leadership team has set out a clear plan for achieving these in a managed way that actively supports the realisation of the QIPP challenge. Achieving greater devolution by 2013/14 requires tighter central control over quality, performance and money during the transition.

7.59 The NHS will face very significant challenges along the way and the new financial context will require difficult local decisions in the NHS,

irrespective of the White Paper. Some will oppose our plans, but the Government will maintain constancy of purpose in adhering to our vision and plans.

7.60 Whilst the structural transition will be completed over a four-year period, the Government fully recognises that embedding change will take many years and will not be complete until considerably beyond the lifetime of this Parliament.

NOTES

[i] This document is available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353.

[ii] The consultations are now closed, but copies are available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353.

[iii] The health service reforms outlined in this document generally apply to the health service for England only. The devolved administrations (DAs) in Wales, Scotland and Northern Ireland are responsible for developing their own health policies in respect of their health services. However, some changes to public bodies have a wider application requiring specific amendments to legislation, or references to legislation, that applies in the DAs: these amendments will be made through the Health and Social Care Bill. In addition, as a consequence of some of the reforms in England, the Health and Social Care Bill will make consequential amendments to legislation that applies in the territories of the DAs. These amendments will mainly concern the proposed changes to the Department of Health's public bodies, and references as appropriate to GP consortia and the NHS Commissioning Board. Where there are implications for the DAs, they have been consulted.

[iv] This document is available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_119449.

[v] These consultations are available at http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/index.htm.

[vi] This document is available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121508.

[vii] This document is available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121941.

[viii] *Future is great for evolutionary NHS reforms*: Letter to the Financial Times, 29 October 2010.

[ix] The Bill will deal primarily with health rather than social care; the Government intends to introduce legislation on social care reform in the second session of

Parliament. However, this Bill is titled a Health and Social Care Bill because some of its changes (in particular those to Monitor, the Care Quality Commission and the creation of health and wellbeing boards in local authorities) apply also to social care.

[x] The report is available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117691.

[xi] The consultation is available at http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/index.htm. Responses should be received by 14 January 2011. Details about how to respond are given in the consultation document.

[xii] This would include responsibility for health services for young people in prison and detained in the juvenile secure estate (including those detained on welfare grounds in secure children's homes).

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ISBN 978-0-10-179932-4

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