Government response to the NHS Future Forum report

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Foreword

The NHS will always provide free healthcare for all, based on need, not on ability to pay. This has never been in any doubt.

But if we want to keep our NHS that way, it must adapt to meet the challenges of the future.

With an ageing population and the development of more expensive drugs and treatments, the cost of healthcare is only going to rise.

People expect to be able to access the best possible treatments. They expect to have some say in how they are treated and where they are treated, and they expect to be treated with dignity and respect.

In many cases, the NHS not only meets these expectations, it exceeds them. But in some areas, it lags significantly behind the best health systems in Europe. And closer to home, there are even starker differences in the quality of care that people experience.

The last few weeks have shown that professionals, patients, the public and policy experts alike agree that there is an overwhelming case for a new kind of health system. A health system:

- that's led by frontline professionals;
- where patients and the public have a stronger voice and more control – "no decision about me without me";
- where people's health and social care needs aren't treated separately;
- where local councils have a real say over decisions in the NHS;
- that's focused on the causes of health problems as well as treating them;
- that's judged on the quality of care it provides – for example, whether we improve cancer survival rates, enable more people to live independently after having a stroke, or reduce hospital acquired infection rates.

But there has been considerable debate on how we get there and how fast we go. And while the majority of the public and healthcare professionals support these principles, many have raised serious questions about how we will implement them.

It was right that, in response to these concerns, we took the time to pause, listen, reflect on and improve our plans.

Over the last eight weeks, the NHS Future Forum, led by Professor Steve Field, has heard the views of thousands of people – patients, professionals and members of the public. They have listened to every professional group and toured every region in the country.

I would like to thank all the Forum members for their immense dedication to this task, and all those who have contributed to the listening exercise.

In their report, which we received on 13 June, the NHS Future Forum confirmed that there is considerable support for the principles of our reforms. But they also said that some of

the ways in which we were putting those principles into practice could be improved. The Government accepts all of their core recommendations, and believes the proposals are now much stronger, thanks to their contribution.

I am confident that the revised plans we set out today will build an NHS that's stronger, more efficient and more accountable. Where people have more choice and professionals have more power. And where everyone in the country can be confident that whether they're being admitted to hospital, visiting their local GP, trying to organise support in their home so they can live more independently, or getting advice on how to stay fit and healthy, they get the best care and support possible.

Andrew Lansley CBE
Secretary of State for Health

Summary of key changes

Overall accountability for the NHS

Some have raised concerns that the Health and Social Care Bill would weaken NHS principles or the Government's overall responsibility for the NHS. In response:

- we'll make sure the NHS Commissioning Board and clinical commissioning groups take active steps to promote the NHS Constitution, which enshrines the core principles and values of the NHS, including the 18 week limit on waiting times;
- we'll make clear in the Bill that Ministers are responsible for the NHS overall – the original duty to promote a comprehensive health service will remain.

Clinical advice and leadership

The Forum's report shows there is universal agreement that patient care is better if it is based on input from those closest to patients – doctors, nurses and other health and social care professionals – in discussion with patients and carers, the voluntary sector, and other healthcare partners.

But we have also heard that, to do this well, so it really makes a difference to patients and carers, we need to be more ambitious.
In response:

- GP consortia will be called "clinical commissioning groups". They will have governing bodies with at least one nurse and one specialist doctor;
- commissioners will be supported by clinical networks (advising on single areas of care, such as cancer) and new "clinical senates" in each area of the country (providing multi-professional advice on local commissioning plans) – both hosted by the NHS Commissioning Board.

Public accountability and patient involvement

The Future Forum agrees with us that patients and carers should be at the heart of the NHS, and that there should be "no decision about me without me."

But we have also heard from the Future Forum that there's more to do to make this second nature in the NHS. In response, we will:

- make sure there are clearer duties across the system to involve the public, patients and carers;
- improve governance for clinical commissioning groups: their governing bodies will have lay members and will meet in public;
- insist that foundation trusts have public board meetings;
- create a stronger role for health and wellbeing boards in local councils, with the right to refer back local commissioning plans that are not in line with the health and wellbeing strategy.

Choice and competition

Nearly everyone who contributed to the listening exercise felt patients should be given more choice and control over their care. Some felt that the competition that accompanies increased choice brought benefits for patients, but others had serious concerns about its impact on existing NHS providers and integrated services.

We are committed to giving patients greater choice and creating a level playing field, in which the best providers flourish, whether from the public, voluntary or private sector. We will make sure that what matters is the quality of care provided, not who owns the organisation providing it.

The NHS Future Forum said the Government should make its position clearer and guard against the dangers of competition being an end in itself. We have heard this message and we will improve our plans. In response:

- Monitor's core duty will be to protect and promote the interests of patients – not to promote competition as if it were an end in itself;
- there will be new safeguards against price competition, cherry picking and privatisation;
- there will be stronger duties on commissioners to promote (and Monitor to support) care that is integrated around the needs of users – e.g. by extending personal health budgets and joint health and social care budgets, in light of the current pilots;
- the NHS Commissioning Board will promote innovative ways to integrate care for patients.

Developing the healthcare workforce

We have some of the best health and care professionals in the world. They should be supported by a world class education and training system. And we need high quality management to help improve frontline care.

The NHS Future Forum said there was strong support for our proposals to improve education, training and development. But they also highlighted the need to keep focused on quality while we make these changes, and said that further work is needed to develop detailed proposals.

In response, we will:

- ensure a safe and robust transition for the education and training system, taking action to put Health Education England in place quickly to provide national leadership and strong accountability while moving towards provider-led networks in a phased way;
- ensure that, during the transition, deaneries will continue to oversee the training of junior doctors and dentists, and give them a clear home within the NHS family;
- improve the quality of management and leadership, for example by retaining the best talent from PCTs and SHAs and through the ongoing training and development of managers;
- further consider how best to ensure funding for education and training is protected and distributed fairly and transparently, and publish more detail in the autumn.

The timetable for change

While few have questioned the case for change, many during the listening exercise questioned the pace of change. Following the consultation on the White Paper, we have already made some amendments to the timetable. However, we recognise we can go further, and that the benefits of doing so outweigh the risks of any delay. In response:

- commissioning groups will all be established by April 2013 – there will be no two-tier system. They will not be authorised to take on any part of the commissioning budget in their local area until they are ready and willing to do so;
- where a commissioning group is ready and willing, it will be able to take on commissioning responsibility earlier. Where a group is not yet ready, the NHS Commissioning Board will commission on its behalf;
- Monitor will continue to have transitional powers over all foundation trusts until 2016 to maintain high standards of governance during the transition;
- there will be a careful transition process on education and training, to avoid instability – we'll publish further proposals in the autumn.

1 Modernising the NHS

Summary

The NHS will always be free at the point of need. But it needs to modernise to adapt to the challenges of the future. This is why we have put forward proposals for change, based on the principles of giving patients and carers more power and professionals more freedom. We introduced the Health and Social Care Bill to Parliament to make those changes that require legislation.

There have been concerns about the details of our proposals. So we announced a listening exercise, to pause, listen, reflect on and improve our plans. The listening exercise was led by the NHS Future Forum, a group of leading health professionals and patient representatives. The Future Forum reported back to the Government on 13 June, and we presented the Government's initial response on 14 June.

We welcome the Forum's report, and this document shows how we will act on their recommendations by changing our proposals. We will do this both by making significant amendments to the Bill and through changes that do not need legislation.

The case for change

1.1. This Government believes in the NHS. The NHS will always be free at the point of need, funded by taxation. We are committed to preserving and strengthening the NHS and the principles it is founded on.

1.2. But the pressures on the NHS are increasing. More of us are living longer. The number of people in the UK aged over 85 has almost trebled over the past 25 years. It is set to double again over the next 20. By 2034, one in 20 of us will be aged over 85. More people are living with at least one long-term condition; and the possibilities – and often the costs – of new technology are constantly increasing.

1.3. The Government has protected the NHS budget and will continue to increase it in real terms. But, because of the state of the public finances, this will still be amongst the tightest funding settlements the NHS has ever faced. Recent years have seen many improvements in services, and rising public satisfaction alongside growing budgets. In many ways, the NHS is providing the best service it ever has. But simply doing the same things in the same way will no longer be affordable in future, given the pressures.

1.4. Without change to get more value for what the NHS spends, there will be a rising and unsustainable gap between the cost of providing NHS services and the funding the country can afford. This requires the NHS to adapt to new ways of working that reduce cost pressures while delivering improved outcomes.

1.5. Besides these future challenges, many of the things the NHS does now need to improve.

1.6. Although the NHS at its best is world-leading, there are still important areas where NHS services fall behind the level of other major European countries, such as in treating respiratory disease and some cancers.

1.7. There are also unjustified variations in the quality of care across the country. The chances of receiving a diagnosis of dementia, recovering from a heart attack or major operation, or of beating cancer, can vary hugely depending on where you are treated. If all parts of the NHS performed closer to the level of the best, thousands of lives could be saved every year.

1.8. Similarly, the experience of care for too many patients is fragmented between different parts of the health service and between the NHS and social care or other services. There are huge opportunities to make services more integrated, building on the many examples of good practice that already exist.

1.9. And while good management is vital, too much money is currently spent on administration which could be better spent on frontline services.

1.10. Therefore we must modernise: both to tackle the problems of today and to avoid a crisis tomorrow.

The Government's proposals

1.11. We set out proposals for modernising the NHS to meet these challenges in a White Paper, *Equity and excellence: Liberating the NHS*. Our vision is to create a more efficient NHS that achieves some of the best healthcare outcomes in the world. Our proposals are rooted in the principles of:

- giving patients and carers more power – putting patients, carers and the public first;
- focusing on healthcare outcomes and the quality standards that deliver them, rather than on narrow process targets; and
- giving frontline professionals more freedom, and cutting the bureaucracy that can get in the way of their work.

1.12. Following a consultation and engagement process, we introduced the Health and Social Care Bill in January 2011, to make those changes that need legislation.

1.13. The aim of the Bill, subject to Parliamentary approval, is to create a coherent framework that will put the NHS on a financially sustainable footing and drive improvements in quality and outcomes. It is based on:

- **Clinical commissioning groups** (called "commissioning consortia" in the Bill as it stands) to organise services for their local populations, supported by a national NHS Commissioning Board. GPs and other frontline professionals already make the clinical decisions that determine how most NHS resources are used. Putting them in charge of shaping services will enable NHS funding to be spent more effectively to provide high quality care. Better commissioning can improve quality and save money at the same time, for example by helping people to manage their conditions at home and reducing the need to go to hospital.

- **More choice for patients**, with greater competition between providers where this helps drive up quality and efficiency. Coupled with more transparent information, this will make services more dynamic and responsive to patients. We want existing providers to be able to develop their services, and new providers to be able to introduce innovative ways of working. High quality providers will be able to expand, and poor quality or inefficient organisations will no longer be propped up with subsidies. A regulator, Monitor, will make sure that competition is fair and operating in the interests of patients.
- **A powerful new role for local councils** in helping join up the NHS with social care, public health and other local services. Too often, organisational boundaries get in the way of providing seamless care. We want local authorities to be able to work far more closely with the NHS to shape services around the needs of individuals. To boost local accountability, councils will also have extended powers to scrutinise NHS services, including those provided by private or voluntary sector providers.
- **A new way of organising public health**, to ensure that long-term investment in preventing future ill health is not sacrificed for short-term savings.

1.14. The Bill makes Ministers more clearly responsible for the things they should be responsible for. Ministers need to set direction, and hold the NHS to account for the way it treats patients. They need to remain accountable to Parliament and the public for the health service as a whole. But it is not the job of politicians to interfere in day-to-day operational management.

1.15. The ideas in the White Paper and the Bill – independent regulation, involving GPs in commissioning, extending choice and competition, limiting Ministers' powers of intervention – are not new; they are an evolution of reforms carried out under the last two administrations. The difference is that we are trying to carry out change in a single, coherent programme, rather than as a series of piecemeal initiatives. This recognises that the different parts of the NHS are inter-connected, and that change must be managed in an integrated way in order to drive up quality and value for money.

The NHS Future Forum

1.16. While there has been wide support for the principles of our proposals, there have been concerns about the details: both about specific policies and about our plan for implementing the changes. That is why, after the Bill finished its Committee stage in the House of Commons, we announced a listening exercise: to pause, listen, reflect on and improve our proposals.

1.17. The listening exercise was led by the NHS Future Forum, a group of 45 leading professionals from across health and social care, chaired by Professor Steve Field.

1.18. The Forum focused on the following four themes:

- how advice and leadership from a range of healthcare professions can improve patient care;
- how to ensure public accountability and patient involvement in the new system;

- the role of choice and competition in improving the quality of care; and
- how new arrangements for education and training can support the modernisation process.

1.19. Over the course of the listening exercise, Ministers and members of the NHS Future Forum attended over 250 events and meetings, in every region of the country, and over 8,000 people took part directly in providing their views. The events involved over 250 stakeholder organisations, including patient groups, professional bodies and unions, voluntary sector groups and local authorities, as well as patients and members of the public.

1.20. Besides the listening events, people were encouraged to air their comments and concerns online. The Department of Health's Modernisation of Health and Care web channel recorded over 2,400 public posts and a further 970 privately submitted comments.

1.21. The Forum's report was published on 13 June, and we announced our initial response on 14 June.

1.22. As Professor Steve Field said in his covering letter to the Forum's report, the Government's aim of making improvement in quality and healthcare outcomes the primary purpose of all NHS funded care is universally supported. However, there have been genuine and deep-seated concerns from NHS staff, patients and the public which must be addressed if the reforms are to be progressed. Professor Field made it clear that, if the Government accepted the substantial changes proposed by the Forum, he believed the resulting framework would place the NHS in a strong position to meet this objective and tackle the pressing challenges in the years ahead.

1.23. We welcome the Forum's conclusions, and we accept the core recommendations of their report. This document, which is largely structured around the Forum's four themes, explains how we will change our proposals.

1.24. Many of our changes require legislation, and we will put forward significant amendments to the Bill for Parliament to consider. However, many other important changes can be made within the framework of the Bill as it stands, by adapting our approach to implementation and the design of secondary legislation. For example, no amendments to the Bill are needed to phase the introduction of clinical commissioning and choice of Any Qualified Provider, or for our proposals on clinical networks and clinical senates. We will publish briefing notes alongside our amendments to explain exactly how the policy changes outlined in this document have been translated into proposals for legislation.

1.25. We are very grateful to the Forum's members for their work, and we have asked them to continue to advise on the way that our proposals are developed and put into practice; we will set out further details on this. We will continue to listen and engage on the detail of our proposals, in a spirit of co-production.

2 Overall accountability for the NHS

Summary

Some have raised concerns that the Bill would weaken NHS principles or the Government's overall responsibility for the NHS. To make clear that this is not the case, we are tabling amendments which will:

- require the NHS Commissioning Board and clinical commissioning groups to take active steps to promote the NHS Constitution, which enshrines the core principles and values of the NHS;
- make explicit that the Secretary of State remains fully accountable for the NHS; and
- create explicit powers for the Secretary of State to oversee and assess the national NHS bodies, to ensure they are performing effectively, whilst respecting their operational independence.

The NHS Constitution

2.1. In response to the Future Forum's concerns, we will strengthen the role of the NHS Constitution. The Constitution, which was developed under the last administration, brings together the core values and principles of the NHS, alongside the rights and responsibilities of patients, the public and staff. It enshrines the principles that the NHS provides a comprehensive service, available to all, and that access to services is based on clinical need not the ability to pay. As we will make clearer in the Bill, NHS care must be free at the point of use, and patient charges could only be introduced through legislation. We commit not to introduce any new charges during this Parliament.

2.2. The last Government legislated in the Health Act 2009 to ensure that all NHS bodies and providers of NHS services had a duty to "have regard to" the NHS Constitution in carrying out their functions. In line with the Forum's recommendations, we now intend to go further. We will table amendments which will place an additional legal duty on the NHS Commissioning Board and on clinical commissioning groups **to "promote" the Constitution** and take active steps to ensure that patients, carers, members of the public and staff know about and make use of the Constitution. For example, this would include making patients aware of their right under the Constitution to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of alternative providers if this is not possible.

2.3. In this way, the Bill will reinforce and strengthen the enduring values and principles of the health service. It will fully embed the Constitution in the way the NHS works, empowering patients and the public.

2.4. The NHS Commissioning Board, Monitor, the Care Quality Commission and clinical commissioning groups will say in their annual reports how they have carried out their existing duty to have regard to the Constitution.

2.5. We will uphold all of the patient rights in the NHS Constitution. Where necessary, we will adapt the way these rights are given legal force, to ensure they have the same legal force under the new legislation. As Chapter 3 makes clear, this includes the right to drugs and treatments recommended by NICE.

The role of the Secretary of State

2.6. As the Future Forum's report highlights, some people are concerned that the Bill could weaken the Government's accountability for the health service. As a consequence of establishing a dedicated NHS Commissioning Board, the Bill currently removes the Secretary of State's current direct duty to "provide or secure the provision of services", and this has been interpreted by some as reducing Ministers' responsibility. There have even been some fears that the core principles of the NHS could be weakened.

2.7. This has not been our intention. We want to reinforce the principles and values of the NHS and strengthen overall Ministerial accountability. However, the Forum is right to point out that the current drafting of the Bill is not clear enough, and we will amend it.

2.8. Our policy is that the **Secretary of State will be responsible – as now – for promoting a comprehensive health service**. The wording of section 1(1) of the 2006 NHS Act will remain unchanged in legislation, as it has since the founding NHS Act of 1946. We will amend the Bill to make this clear.

2.9. We will also make clear that the Secretary of State will retain ultimate accountability for securing the provision of services, though rather than securing services directly, the Secretary of State will be exercising his duty in future through his relationship with the NHS bodies to be established through the Bill, for example the NHS Commissioning Board by way of the "mandate".

2.10. We will make clear that Ministers are responsible, not for direct operational management, but for overseeing and holding to account the national bodies – in particular, the NHS Commissioning Board and the regulators – backed by extensive powers of intervention in the event of significant failure.

2.11. Under the Bill as it stands, the Secretary of State will have powers of direction over the entire system in the event of an emergency, and powers to direct national bodies if they fail to perform their functions. As outlined in Chapter 4, to avoid political micromanagement, we will amend the Bill to make clear that intervention powers may only be used if the failure is "significant". Similarly, the NHS Commissioning Board will need to demonstrate reasonable grounds before intervening in a commissioning group's decisions.

2.12. In future, the role of the Department of Health will be to sponsor and oversee the national bodies. Each body will have a published framework agreement setting

out its relationship with the Department, and we will ensure there is a transparent assessment of how they have performed.

2.13. To strengthen this further, we will amend the Bill to give the Secretary of State **explicit powers to report on the performance** of all of the national NHS bodies, as part of the Department of Health's annual report on the health service.

2.14. These strengthened powers will be reinforced by the duties on the Secretary of State that the Bill creates for the first time, around improving the quality of services and reducing inequalities. We will translate these new duties into practical action using the Department of Health's full range of levers in the system, as the Future Forum recommended. We believe our proposals, strengthened by the changes we are making in response to the Forum, will be a powerful force for promoting equality, tackling inequalities and improving the health of the most vulnerable.

2.15. In addition, the Government will continue to have an important strategic role in the education and training system and in promoting research. We will table amendments to the Bill to make this clear, as set out in Chapters 3 and 6.

3 Clinical advice and leadership

Summary

The Forum's report shows there is universal agreement that patient care is better if it is based on input from those closest to patients – doctors, nurses and other health and social care professionals – in discussion with patients and carers, the voluntary sector, and other healthcare partners.

But we have also heard that, to do this well and really make a difference to patients and carers, we need to be more ambitious. So we will do more to improve our plans. This chapter shows how we will:

- make sure that a range of professionals play an integral part in the clinical commissioning of patient care, including through clinical networks and new clinical senates hosted by the NHS Commissioning Board and stronger duties on commissioners to obtain an appropriate range of clinical advice;
- ensure that at least one registered nurse and secondary care specialist doctor are appointed to clinical commissioning groups' governing bodies;
- embed clinical leadership throughout the new arrangements and support leadership skills to develop;
- support clinical commissioning groups to make high quality, evidence-based decisions, with information joining up to support integrated care; and
- provide more clarity around the proposed arrangements for supporting the development of clinical commissioning groups, authorising them to take on commissioning responsibilities and ensuring ongoing accountability for their role in improving the quality of care.

3.1. At the heart of our proposals is the principle that decisions about local services should be made as close to patients as possible, by those who are best placed to work with patients and the public to understand their needs. We remain committed to this vision, and the NHS Future Forum endorses it.

3.2. Doctors, nurses and other clinicians have told us from the start that they want more control over how local services look, and the freedom to design services around local needs. This is exactly what we want them to have. We want local groups of GP practices ("commissioning consortia" as they are described in the Bill as it stands) to have responsibility for bringing together a range of health and care professionals, together with patients and the public, to design services that provide the best quality of care and health outcomes.

3.3. The Forum's report shows that "there was universal agreement that people would be best served if care were designed around their needs and based on the input of the

public, patients and carers, health and social care professionals, the voluntary sector and specialist societies".

3.4. Empowering clinicians to take the lead on commissioning also means that we can remove layers of bureaucracy that are no longer needed, and which take money out of the NHS that could be better invested in improving frontline care.

3.5. The Forum's report also shows, however, that the proposals we had set out, and which are reflected in the Bill as it stands, did not fully mirror our ambition. The Forum's report recommends changes in three broad areas:

a. Multi-professional involvement in commissioning;

b. Clinical leadership at all levels, and leadership development; and

c. Information and evidence to support high quality integrated care.

3.6. These link to an important overarching theme: how we will make sure that clinical commissioning groups have the support they need to develop this multi-professional approach and how they will be held accountable for improving quality and health outcomes for patients.

3.7. We welcome the Forum's views and recommendations. We agree that these are essential issues, and we will make improvements to ensure we get them right. These are significant changes; for some of them, we will table amendments to the Bill, while we can bring about other improvements within the framework of the Bill as it stands.

Multi-professional involvement in commissioning

3.8. The Government's proposals for future NHS commissioning arrangements are designed to be rooted in, and build upon, the central role that general practice plays in coordinating patient care and acting as the patient's advocate. The Future Forum's report agrees that general practice has a unique role to play. When people need healthcare, general practice is often the first place they turn, giving GPs and other practice staff a strong relationship with their patients and a broad overview of their community's health needs.

3.9. GPs are central to the integration of patient care. They can link patients to other patients and carers and to a range of different clinicians, and can link those clinicians to each other and to other health and social care professionals.

3.10. At the same time, clinical commissioning is at its best when it is a collaboration of professionals, based on a shared drive for continuous quality improvement and greater integration of services. Everyone who can contribute to designing better, more integrated services for patients should have an opportunity to do so.

3.11. Commissioners will need advice and support to improve integration across health and care services: for instance, from the nurses, allied health professionals and pharmacists who have contact with patients day in and day out; from the hospital doctors who provide care for patients with the most serious needs; from the public health experts who plan how to improve our health and stop disease; and from the social care professionals who

make sure services are there to support the vulnerable.

3.12. The Forum's report reinforces this need for multi-professional involvement. It illustrates the strong feeling in the NHS that commissioning should involve a wide range of professionals, working in clinical, management and other roles across the NHS, public health and social care and at every stage of patients' care pathways. As the report states, "The full range of skills and clinical advice available from many different professional groups" must be "actively engaged in a meaningful and influential way in the design and commissioning of services for patients".

3.13. Our plans go some way towards achieving this – but we have heard that we need to do even more. We set out in this chapter a range of steps we will now take, both through improvements to the Bill and in other ways, to strengthen multi-professional leadership and involvement.

3.14. This stronger emphasis on wider professional involvement in commissioning decisions means that the **language we use when talking about local commissioning groups needs to change**. We have up until now talked about "GP consortia", reflecting the fact that they will comprise groups of GP practices. General practice remains at the heart of clinical commissioning groups; however we agree with the Forum's report that this phrase does not reflect the important involvement of a range of professionals. We therefore intend to use the term "clinical commissioning group" to describe these local NHS organisations.

An integral role for all professionals

3.15. We want the NHS Commissioning Board and clinical commissioning groups to have strong relationships with a range of health and care partners. This will provide them with access to information, advice and knowledge to help them make the best possible commissioning decisions: decisions based on evidence, after considering all the options, and aimed at improving the quality and efficiency of health services.

3.16. And we want **the full range of health and adult and child social care professionals** to be involved in the new commissioning arrangements, supporting the NHS Commissioning Board and clinical commissioning groups to design pathways of care and shape services.

3.17. In its national leadership role, the NHS Commissioning Board would provide a home for clinical advice, working closely with the National Institute for Clinical Excellence (NICE[1]) and other partners, to ensure that all health and care organisations know where to go for advice and support.

3.18. As recommended by the Forum, we are bringing about important changes through two distinct types of group, called **'clinical networks'** and **'clinical senates'**. Both will be hosted by the NHS Commissioning Board; they will not be organisations or new forms of bureaucracy, and they will not need to be provided for by amendments to the Bill.

3.19. There are already national clinical networks: groups of experts, including patient and carer representatives, brought

1 The Bill renames NICE as the National Institute for Health and Care Excellence, giving it a remit over social care as well as healthcare.

together around particular pathways or conditions, such as cancer care, which, as the Forum's report shows, are "working well to support multi-professional input to deliver improved outcomes for patients".

3.20. But the report highlights concerns about their future and the existing variability in their effectiveness. It recommends **embedding networks at all levels of the new system**, with further work to define them and review their range, function and effectiveness. We will retain and strengthen these networks so that they cover many more areas of specialist care. And we will give them a stronger role in commissioning, in support of the NHS Commissioning Board and local clinical commissioning groups.

3.21. As well as promoting effective clinical leadership and multi-professional collaboration around specific conditions and pathways, the Forum's report also recommends bringing together a range of professionals in **local clinical senates** to take an overview of health and healthcare for local populations and provide a source of expert support and advice on how different services fit together to provide the best overall care and outcomes for patients.

3.22. We will therefore also enable doctors, nurses and other professionals to come together in clinical senates to give expert advice, which we expect clinical commissioning groups to follow, on how to make patient care fit together seamlessly in each area of the country. To support the better integration of services, they should include public health specialists and adult and child social care experts.

3.23. Clinical senates will provide advice and support on a range of issues, and from a variety of health and care perspectives, including those of professionals who sometimes go unheard, such as allied health professionals.

3.24. The combination of clinical networks and senates will ensure that commissioners, health and wellbeing boards and others will have access to expertise on specific conditions and pathways, together with high quality advice and support on the overall local health and care landscape.

3.25. Clinical networks and senates' advice and support will help the NHS Commissioning Board and clinical commissioning groups to **improve the design and delivery of better patient care**. For example, the NHS Commissioning Board and national clinical networks will work together to develop the best pathways of care. And clinical senates will help clinical commissioning groups to make sure that improvements in patient care are made in an integrated way that supports more joined-up care and better population health outcomes.

3.26. Basing these clinical networks and senates in the NHS Commissioning Board will mean that the full range of health and care professionals play an important part in supporting the NHS Commissioning Board to **oversee the new commissioning arrangements**, for instance in the Board's function of supporting clinical commissioning groups, authorising them to take on commissioning responsibilities and holding them to account for quality improvement, which are discussed in more detail later in this chapter. Clinical senates will, for instance, be able to have a key role in advising the NHS

Commissioning Board on whether commissioning plans are clinically robust and on major service changes.

3.27. Clinical networks and senates will also be able to feed the needs of local commissioners up to the NHS Commissioning Board, to support the Board's national work to improve quality – whether it is developing service specifications, designing new tariffs for NHS prices, or working with NICE to design commissioning guidelines that reflect the best evidence.

3.28. These arrangements will not alter the essential responsibility – and the statutory accountability – that both clinical commissioning groups and the NHS Commissioning Board will have for deciding how best to improve quality and make best use of NHS resources. Clinical senates and networks will, however, provide a much more robust and reliable system for ensuring that commissioners are able to fulfil these statutory responsibilities in ways that draw on and take account of the very best clinical leadership, advice and support.

Robust arrangements for involving professionals and a stronger duty to obtain their advice

3.29. The Bill currently requires the NHS Commissioning Board and clinical commissioning groups, in carrying out their functions, to make arrangements with a view to securing appropriate advice from health professionals. We have heard from the Forum's report that these duties should be stronger, with more direct requirements to take advice from a range of professionals – and we agree.

3.30. We will therefore table amendments to the Bill to **strengthen the existing duties on the NHS Commissioning Board and clinical commissioning groups to secure professional advice** and ensure this advice is from a full range of health professionals where relevant. For example, commissioners will need to work with public health experts and in line with public health guidance.

3.31. We have heard that clinical advice should be an important factor in helping the NHS Commissioning Board design the pricing structure for NHS services. We agree: expert advice from health and care professionals will help the NHS Commissioning Board to make sure that pricing incentives are effective and drive the right kind of behaviour. We will make clear to the NHS Commissioning Board that it **must obtain appropriate clinical advice when it designs NHS pricing structures**.

3.32. We will put forward an amendment to the Bill to provide for the NHS Commissioning Board to issue guidance to commissioning groups on their duty to obtain appropriate professional advice, for example in relation to working with clinical senates and clinical networks.

3.33. The Forum's report also recommends that clinical commissioning groups should be able to demonstrate that they have robust arrangements for involving a range of professionals in the development and design of local services, and that this should be regularly assessed. We agree. The role of the NHS Commissioning Board in supporting the development of commissioning groups, authorising them and holding them to account is discussed later in this chapter.

3.34. We have also heard from many people that the Bill misses an opportunity to make sure that Monitor seeks appropriate advice to help it to carry out its functions.

3.35. Monitor will have a vital role in making sure that the system works together to give patients choices about their health and care. We entirely agree that, when assessing how well the system is supporting patient choice and what more needs to be done, Monitor will need advice from a range of appropriate professionals. We will therefore amend the Bill to **place Monitor under a new duty to obtain appropriate clinical advice**, which it could seek, for example, from the clinical networks and senates hosted by the NHS Commissioning Board.

Clinical commissioning groups' governing bodies

3.36. Chapter 4 discusses how the Bill will require each clinical commissioning group to have a governing body, and responds to concerns in the Forum's report about potential conflicts of interest. The report shows that there have been some calls for clinical commissioning groups' governing bodies to include a number of other health and care professionals.

3.37. We agree with the Forum's advice that a clear distinction should be made: the governance of clinical commissioning groups is not the same thing as clinical involvement in designing care pathways and shaping local services. However, we believe there is a case for ensuring that the governing bodies of commissioning groups include the voices of at least some other professions.

3.38. We will therefore seek to amend the Bill to allow regulations to be made specifying certain core requirements for governing bodies. We propose to require, through such regulations, that, in addition to GPs, there must be **at least two other clinicians** on every governing body: **at least one registered nurse and a doctor who is a secondary care specialist**. They must have no conflict of interest in relation to the clinical commissioning group's responsibilities.

3.39. Nurses are closely involved in delivering primary care in general practice settings and in the community, and we have heard from many during the listening exercise that it would be helpful for this expertise to feed into how clinical commissioning groups are run. We further heard that specialist doctors should have a strong voice within clinical commissioning groups, to help ensure robust arrangements for involving specialists at all levels in designing services.

3.40. The non-GP members of the governing body are there to provide an independent perspective, informed by their expertise and experience. While knowledge of local health services would be an asset, it is more important that the nurse and doctor on the governing body bring an understanding of nursing and of specialist care. Unlike primary care, which is commissioned by the NHS Commissioning Board, most local secondary and community services will be commissioned by clinical commissioning groups, so it will be important to ensure that these individuals do not have a conflict of interest.

3.41. The Forum's report states that it would be unhelpful for clinical commissioning groups' governing bodies to be representative of every group. We agree. The prime purpose of a governing body should be to take key decisions and make sure that clinical commissioning groups have the right systems in place to do their job well. It is these systems that will ensure they involve the full range of health and care professionals in commissioning. Requiring a very large group of professionals on the governing body itself would not mean that a broader range are involved in designing patient services – it would just lead to governing bodies that are too large and slow to do their job well.

3.42. Including the detail of core governance requirements in regulations will allow flexibility for the approach to evolve over time in the light of experience. Beyond the changes set out above, however, we do not intend to prescribe in detail the wider professional membership of commissioning groups' governing bodies.

Clinical commissioning groups and their local communities

3.43. Clinical commissioning, led by GPs and other local clinicians and involving a range of professionals, will ensure that local services are designed around the needs of the whole community. However, the Forum's report also reflects concerns that there has been insufficient attention given to the needs of some patients.

3.44. Some are worried that clinical commissioning groups will only commission services for patients who are registered with a GP practice belonging to that group. Some people with complex health needs may not be registered for local healthcare, such as some homeless people. We have also heard concern that clinical commissioning groups might not be responsible for people who need emergency care, regardless of where they live or which group is usually responsible for their care.

3.45. We will therefore make it explicit in the Bill and in regulations under the Bill that **clinical commissioning groups will be responsible for arranging emergency and urgent care services** within their boundaries, **and for commissioning services for any unregistered patients** who live in their area – in other words, they will be responsible for their whole population, not just registered patients, except in respect of those services that the NHS Commissioning Board is responsible for. They will need to work coherently with local partners to best serve local health needs – and in order to achieve that coherence, a significant majority of the registered patients that a clinical commissioning group is responsible for will have to live within the commissioning group's boundaries.

3.46. The Forum's report states that "Better integration of commissioning across health and social care should be the ambition for all local areas." We agree. As Chapter 5 discusses, clinical commissioning groups will have a **duty to promote integrated health and social care around the needs of service users**. And we accept the recommendation in the Forum's report that the **boundaries of clinical**

commissioning groups should not normally cross those of local authorities. Any departure from this will need to be clearly justified.

3.47. If a commissioning group wishes to be established on the basis of boundaries that would cross local authority boundaries, it will be expected to demonstrate to the NHS Commissioning Board a clear rationale in terms of benefits for patients: for example, if it would reflect local patient flows or enable the group to take on practices where, overall, this would secure a better service for patients. Further, they would need to provide a clear account of how they would expect to achieve better integration between health and social care services.

3.48. The NHS Commissioning Board would need to agree these proposed boundaries as part of the establishment process. Before establishing any clinical commissioning group, the Board will be required to seek the views of emerging health and wellbeing boards. Health and wellbeing boards may choose to object, and the NHS Commissioning Board will always have to satisfy itself that any such objections have been taken properly into account.

3.49. Clinical commissioning groups' names should also reflect their local community. It is important that they are recognisable, with a clear link to their local area and consistency across the country. Commissioning groups will therefore be expected to have **a name that uses the 'NHS' brand and demonstrates a clear link to their locality**. To bring this about, we will put forward an amendment to the Bill to give the Secretary of State the power to make regulations that specify requirements about commissioning groups' names.

3.50. Chapter 4 discusses how their involvement in health and wellbeing boards will further ensure that clinical commissioning groups have a meaningful connection with their local communities.

Collaborative commissioning and commissioning support

3.51. Local services need to work together to improve local health and wellbeing. As the report says, "People want to have joined up health and care services which are based on their needs rather than having to adapt to the way services are organised". To support integrated working, clinical commissioning groups will have the **flexibility they need to work in partnership with others when commissioning services**, for example with other commissioning groups, local authorities and the NHS Commissioning Board, to make sure the services they commission join up. But we can confirm that, as public bodies, they will not be able to delegate their statutory responsibility for commissioning decisions to private companies or contractors. This does not in any way preclude NHS commissioners from using external agencies to provide commissioning support, but ensures that statutory responsibility for decisions continues to rest with the responsible NHS commissioner.

Clinical leadership at all levels, and leadership development

3.52. The Forum's report notes that "strong and visible clinical and professional leadership at all levels, focused on increasing trust and encouraging positive behaviours, will be key to bring about better outcomes for patients". It shows that more needs to be done to embed clinical leadership and to support leadership skills to develop.

3.53. We entirely agree. Strong and visible clinical leadership throughout the system will encourage clinicians to drive improvements in patient care and health outcomes.

Leadership in the NHS Commissioning Board

3.54. The NHS Commissioning Board will have a pivotal role in providing national leadership for improving health outcomes and driving up the quality of care. The Forum's report reflects that people want to understand more about the culture, values and leadership of the Board – to know what kind of organisation this will be. In his role as Chief Executive designate of the NHS Commissioning Board, Sir David Nicholson will shortly publish a document setting out how the role of the Board is developing, although final decisions will be taken by the Board itself once formally established.

3.55. The Forum's report recommends that the NHS Commissioning Board's leadership reflects the broad spectrum of NHS care and professionals, with a significant role for the Royal Colleges. We agree that it will be vital for the NHS Commissioning Board to draw on the expertise of a range of healthcare professionals. The Board will establish close links with the Royal Colleges and other professional bodies, so that partnership working across a wide range of experts is firmly entrenched at a national level.

3.56. Clinical leadership will be at the heart of the NHS Commissioning Board's national role in leading on quality improvement. Hosting national clinical networks and local clinical senates will be an important part of this.

3.57. For example, networks will provide strong clinical leadership in specialist areas, such as care for vulnerable groups and those with less common conditions.

3.58. Clinical leadership will also be reflected in the senior leadership of the NHS Commissioning Board. It will be for the NHS Commissioning Board to determine its senior structures, which will not be set out in the Bill, but it should include a range of health and care professionals, and **it will have a Medical Director and Chief Nursing Officer on its board**.

3.59. We anticipate that the NHS Commissioning Board will be structured around the five outcome domains in the NHS Outcomes Framework, with national professional leads for each outcome area. Through these professional leads and their clinical advisory teams, the Board will work with clinical networks and senates to ensure that clinical leadership from all of the healthcare professions is embedded within the Board's ways of working. Beyond this we know that, as the Forum's report recommends, clear arrangements will be needed for key services or areas that may require dedicated professional and clinical leadership. This may include

children's services, older people's services, mental health services, services for people with learning disabilities, maternity services, primary care, and services for particular conditions such as dementia, cancer and diabetes.

3.60. Chapter 4 discusses further how the NHS Commissioning Board's leadership, governance and culture will also reflect a patient-centred approach.

Public health leadership

3.61. The Forum's report notes that many were concerned about the future of public health leaders. In particular, the report advises against establishing Public Health England fully within the Department of Health. Chapter 4 discusses our intention to create Public Health England as an executive agency of the Department.

3.62. The Forum's report also calls for "strong and visible public health leadership" to support commissioning, with public health advice available at every level. This chapter discusses how clinical senates will be created to bring together a range of health and care professionals, including public health professionals, to provide clinical leadership for commissioning high quality care.

3.63. We will also bring forward more specific, non-legislative proposals in response to the recent public health consultation on how to ensure that public health professionals, in partnership with NHS commissioners, play a key role in providing leadership to drive improvements in quality and patient outcomes and to reduce health inequalities.

Leadership for safeguarding

3.64. The NHS and other health organisations have a critical role in preventing and identifying abuse, neglect and exploitation of vulnerable adults and children, and we will ensure that the leaders of all health organisations recognise and fulfil their safeguarding responsibilities.

3.65. In particular, the Forum's report notes that people working with children are worried about the future of processes for safeguarding children. We believe that safeguarding children is of paramount importance, and expect the NHS to continue to improve processes for protecting children.

3.66. We will make sure that clinical commissioning groups and the NHS Commissioning Board are required to make arrangements to safeguard and promote children's welfare, and maintain providers' responsibilities for safeguarding. We will continue to explore with our key partners how best to ensure that professional leadership and expertise for safeguarding children are retained in the new system, including the continuing key role of named and designated safeguarding professionals, whose critical importance was recently highlighted in the Munro Review of Child Protection.

3.67. The Government has recently announced its intention to seek to put Safeguarding Adult Boards on a statutory footing. We intend that local authorities will retain the lead in matters of adult protection, but the NHS and police will be essential partners.

Leadership development

3.68. The Forum's report refers to the variation in the support given to NHS staff through continuing professional development. As Chapter 6 discusses, we agree that more work is needed to improve how continuing professional development is provided.

3.69. The report further recommends that all NHS organisations should ensure that leadership development support is in place, particularly noting the need to support those moving into new roles to build the skills they will need; for example, skills to help them meet their new financial responsibilities.

3.70. We agree that having the right support for developing leadership skills will be vital, not least for clinical commissioning groups. Good commissioning depends not only on high quality clinical advice, but on commissioners knowing how to translate that advice, together with all the other evidence and their own understanding of patients and communities, into workable plans that will deliver real results.

3.71. We will ensure that clinical leadership is strengthened, by building on the good work of the National Leadership Council and the NHS Institute. We will shortly provide more detail about new arrangements that will make regional and national leadership development opportunities for clinicians and others more coherent, better value and higher quality. They will also improve the diversity of our current leadership, as commented on in the Forum's report.

3.72. Finally, the Forum's report refers to the important role of responsible officers. In many organisations that provide NHS care or employ NHS medical staff, and also in each PCT and SHA, a senior doctor is nominated or appointed as a statutory 'responsible officer'. They make sure that each organisation has robust processes in place to ensure the fitness to practise of their medical practitioners and to underpin the process of medical revalidation – the process by which licensed doctors will, in future, regularly demonstrate that they are up to date and fit to practise throughout their career. The report recommends that the NHS Commissioning Board ensures that responsible officers are in place in the new system.

3.73. The introduction of responsible officers has been an important change in clinical governance arrangements, ensuring a high quality clinical workforce and putting in place the building blocks for medical revalidation. **We will make sure that there continues to be a responsible officer** where they are already present in organisations that provide NHS care. And we will consult shortly on how we can best ensure that the important responsibilities of responsible officers currently in PCTs and SHAs continue in the new system.

Information and evidence to support high quality integrated care

Information

3.74. Chapter 5 discusses the importance of integrated care, so that patients experience seamless and consistently high quality care as they move between professionals and around the system. We agree with the Forum's report that information flowing smoothly between

patients and all the professionals involved in their care will be key to this.

3.75. The Forum's report recommends that information systems are in place to support joined-up care across and within organisations. We are committed to moving towards an approach where the NHS, social care and other organisations that patients encounter **connect and join up information systems**, and we will set out how this will happen in our forthcoming Information Strategy.

3.76. The report emphasises that information about quality and patient outcomes is particularly important. We agree that it is vital that those working on improving patient care know what high quality care looks like and can track how their services are improving. We welcome the Forum's support for the important work of NICE in setting out Quality Standards that show commissioners what high quality care looks like, so they know what their commissioning decisions should achieve.

3.77. NICE works closely with leading clinicians and experts to provide independent advice and guidance. To guarantee that its advice remains independent, the Bill prevents the Secretary of State or the NHS Commissioning Board from interfering, making sure that advice such as the Quality Standards are informed and shaped by the clinical community.

3.78. The Forum further recommends that commissioners require that data about quality and the outcomes of care are collected and used transparently and in a way that supports continuous improvement. Our forthcoming Information Strategy will consider how commissioning can drive improved information collection and use, linking interventions to outcomes to support improvements in the quality of care.

3.79. In particular, the Forum's report notes the important work of Quality Observatories and Public Health Observatories and recommends that this is reviewed. We agree that data about quality and outcomes – particularly the information and intelligence collected by **Quality Observatories and Public Health Observatories** – is vital to support improved outcomes and efficiency and reduced inequalities.

3.80. Public Health Observatories' existing functions will therefore be brought together with information and intelligence roles of other bodies, such as the National Treatment Agency, in Public Health England. This will eliminate gaps and overlaps in public health evidence and support the development of a highly skilled information specialist workforce for public health. The independent National Quality Board is currently considering how to ensure that the Quality Observatories' work continues.

Pricing systems to support integration

3.81. The Forum's report also notes the important effect that the way that NHS services are priced and paid for has on the NHS's ability to provide integrated care. We agree. High quality patient care is not made up of just one episode of care – it is a series of treatments, tests and other interventions that can be provided by a number of professionals and in different settings. The prices (or tariffs) commissioners pay for these services should reflect this reality.

3.82. As outlined in Chapter 5, we are committed to ensuring that, wherever possible, NHS tariffs cover the whole set of services that make up a patient's care from start to finish, or over a longer period of time – not just service by service individually. We will encourage commissioners and providers to work together to agree these for local care. We already have some **tariffs based on best clinical practice** that show how they could look – and we will do more to develop these over a wider range of services, such as maternity care and care for children with diabetes.

Drugs and treatments recommended by NICE

3.83. NICE provides a key source of evidence for commissioning through its guidance. Once NICE has appraised drugs or treatments, it will make recommendations about their use. Through a funding direction, we currently require NHS commissioners in England to fund drugs and treatments in line with NICE's recommendations. We have committed to maintain this funding direction (translated into new regulations under the Bill) until January 2014, when we plan to introduce a system of value-based pricing for new drugs. This will link the price the NHS pays to the value that a new medicine delivers, considering the benefits that doctors and patients see from it.

3.84. A key aim of value-based pricing will be to ensure that NHS patients have consistently good access to effective, clinically appropriate drugs – which the current funding direction is also designed to achieve. We therefore intend to maintain the effect of the funding direction in the new value-based pricing arrangements to ensure that the NHS in England consistently funds medicines with a value-based price. The NHS will be required to fund drugs already recommended by NICE, as well as drug treatments subject to the value-based pricing regime. This means **patients will continue to have the legal right to clinically appropriate, cost-effective drugs and treatments** as set out in the NHS Constitution and accompanying handbook.

Research and innovation

3.85. The Forum's report also emphasises the important role of commissioners in supporting research and innovation. We agree that research and innovation (by academia, charities, businesses and the NHS) are vital to the continuous improvement of quality in the NHS. The NHS should drive innovation both in healthcare and across the wider economy, and high quality research will be essential to this.

3.86. As this chapter shows, expert advice from clinicians and other professionals is a core part of the evidence on which the NHS Commissioning Board and clinical commissioning groups should base their plans. But to achieve the best outcomes for patients, the latest clinical research and innovations must also be fed into the design and provision of local services. We will therefore ensure that **a culture of research and innovation is embedded in the arrangements for the new NHS Commissioning Board and Public Health England**.

3.87. In particular, we will make sure that the systems and processes for commissioning used by the NHS Commissioning Board and clinical commissioning groups ensure that research is promoted, supported and funded by the NHS. This will include the tariff, commissioning guidance and the processes for authorising and supporting development of clinical commissioning groups. We will also ensure that the systems and processes developed and used by Public Health England fully promote the conduct of research and the use of research evidence.

3.88. The Bill requires the NHS Commissioning Board to promote innovation in the provision of health services and to take full account of the need to promote research and the use of the evidence that research provides. The Forum's report recommends that clinical commissioning groups should be placed under the same duties, and also that commissioners fund the treatment costs of patients who are taking part in research.

3.89. We agree. Clinical commissioning groups' legal duties should reflect their key role in making sure that, at a local level, the need for good research, innovation and a strong evidence basis for clinical decisions is paramount. We will therefore amend the Bill to create a **new duty for clinical commissioning to promote research and innovation and the use of research evidence**, in line with the current duty on the NHS Commissioning Board. We will also make sure that clinical commissioning groups and the NHS Commissioning Board ensure that treatment costs for patients who are taking part in research funded by Government and Research Charity partner organisations are funded through normal arrangements for commissioning patient care, as set out in existing guidance (HSG(97)32).

3.90. As mentioned in Chapter 2, we also intend to amend the Bill to create a **new duty for the Secretary of State to promote research**, to reflect the important strategic role of government, together with the Department's ongoing responsibility for research and development policy and for the National Institute for Health Research.

Supporting clinical commissioning groups through authorisation and assessment

3.91. Better quality care is at the centre of the changes we are making to modernise the NHS. This chapter has discussed how commissioners should use all available expertise, evidence and skills to design services that aim to bring about improvements in quality and outcomes. The right incentives and support also need to be in place to help commissioners to do so, such as the quality rewards discussed in Chapter 4.

3.92. We still believe that clinical commissioning groups are better placed than politicians or civil servants to decide on how they carry out their work and how they make decisions. The Forum's report also shows that people feel we do not need to be too prescriptive about roles – getting the right skills is not dependent on people's job titles. Health needs vary widely across communities. The role that different professionals play within those

communities varies as well. The particular way in which commissioning groups carry out their duties and functions should therefore be decided locally, by those who know what is right for their area.

3.93. But we completely agree with the Forum's report that more should be done to check that clinical commissioning groups have the right skills, competencies and behaviours to do their job well, including the financial skills that they will need to be able to commission high quality care within their allotted resources. Chapter 7 discusses how we will ensure that clinical commissioning groups do not take on any part of the commissioning budget in their local area until they are ready and willing to do so.

3.94. As part of this, and as the Forum's report recommends, the NHS Commissioning Board will work with clinical commissioning groups seeking authorisation to support them to develop **the appropriate skills, capacity and capability to carry out their responsibilities**. Commissioning groups will then be authorised to commission services when both they, and the NHS Commissioning Board, consider that these are in place. And, through its ongoing assessment of commissioning groups, the NHS Commissioning Board will be able to identify where a group needs support to ensure that the right skills, capacity and capability remain in place.

3.95. The NHS Commissioning Board – and, during transition, PCT clusters – will work together with aspiring clinical commissioning groups to help them to get ready, helping to put in place the right skills, relationships and other arrangements that they will need to be able to commission high quality care, tailored to their communities' needs. The Board will also work closely with commissioning groups to develop the authorisation process that is then used to provide assurance that the right arrangements are in place before they take on statutory responsibilities for budgets and commissioning.

3.96. Once authorised, the Board and commissioning groups will continue to work together to identify any further support that the groups need to continue to be able to commission well. As part of this, the NHS Commissioning Board will review on an ongoing basis, and assess annually, the quality and outcomes they achieve, their stewardship of public resources, and fulfilment of their other statutory duties.

3.97. We will shortly publish details on the processes for assessing and authorising clinical commissioning groups and on the accountabilities and relationships between the NHS Commissioning Board, commissioning groups and health and wellbeing boards.

3.98. As part of these arrangements, the NHS Commissioning Board will need to draw on a range of professional views, just as it will need to draw on the views of patients, communities and local authorities. When considering whether clinical commissioning groups are ready to be authorised, the NHS Commissioning Board will work closely with the groups, and also seek views from emerging health and wellbeing boards and local

clinicians. Through their advice to the NHS Commissioning Board, clinical senates will have a formal role in the authorisation of clinical commissioning groups.

3.99. Likewise, when considering clinical commissioning groups' activities and achievements over the course of a year, the Board will work closely with the group and will be able to seek views from clinical senates and clinical networks, for instance to identify areas for further support. The Board will also have to take health and wellbeing boards' views into account in their annual assessment.

3.100. The Board will have powers to intervene to support commissioning groups where there is evidence that they are not meeting their statutory duties or there is a significant risk of failing to do so. We will work with the NHS, including emerging commissioning groups, to develop the more detailed criteria that should be used to determine when intervention and support are needed. As Chapter 4 discusses in more detail, it will be essential to have appropriate safeguards that ensure the Board operates in a way that is **fair, transparent and rules-based**, so as to prevent unnecessary interference in the day-to-day work of clinical commissioning groups.

4 Public accountability and patient involvement

Summary

The Future Forum agrees with us that patients and carers should be at the heart of the NHS, through shared decision making about their care and meaningful involvement in how health services are organised. We view these core strands of our modernisation plans as essential if we are to achieve healthcare outcomes that are among the best in the world.

But we have also heard from the Future Forum that if we are genuinely to achieve this, we must do more to ensure that shared decision making becomes the norm and that new organisations are sufficiently accountable for the decisions they make. In response to these recommendations, this chapter shows how we will:

- strengthen the accountability of new organisations, including clinical commissioning groups;
- ensure more joined-up local services by strengthening requirements for close working between health and wellbeing boards and clinical commissioning groups;
- strengthen the duties of organisations across the system with regard to patient, carer and public involvement;
- strengthen the definition of involvement to reflect better the principle of "no decision about me without me"; and
- ensure that commissioning groups receive a quality premium only where they can demonstrate good performance in terms of quality of patient care and reduced inequalities in healthcare outcomes.

4.1. Our aim is to put patients, carers and local communities at the heart of the NHS, shifting decision-making as close as possible to individual patients and carers by devolving power to professionals and providers and liberating them from top-down control.

4.2. The NHS Future Forum agreed that these principles were right. But their report says we need to strengthen our proposals, by making new organisations more transparent and accountable, and promoting greater public and patient involvement.

Strengthening health and wellbeing boards

4.3. We proposed to create statutory health and wellbeing boards in every upper tier local authority to improve health and care services, and the health and wellbeing of local people. Health and wellbeing boards will bring together locally elected councillors with the key commissioners in an area, including representatives of clinical commissioning groups, directors of public health, children's services and adult social services, and a representative of local HealthWatch. Health and

wellbeing boards will assess local needs (through the joint strategic needs assessment) and develop a shared strategy (in the form of a new joint health and wellbeing strategy) to address them, providing a strategic framework for commissioners' plans.

4.4. The Future Forum's report supports the idea of health and wellbeing boards, but recommends that we strengthen them, so they are truly the "focal point for decision-making about local health and wellbeing", enabling local authorities to work in partnership with clinical commissioning groups and other community partners to deliver meaningful joint health and wellbeing strategies and maximise opportunities for integrating health and social care. In response to the Forum's recommendations, we will make a number of changes designed to strengthen the role of health and wellbeing boards and increase public and patient involvement.

4.5. The boards will provide the vehicle for local government to work in partnership with commissioning groups to develop robust joint health and wellbeing strategies, which will in turn set the local framework for commissioning of health care, social care and public health. The creation of health and wellbeing boards will maximise opportunities for integrating health and social care, and for the NHS and local government to drive improvements in the health and wellbeing of their local population.

4.6. Health and wellbeing boards are not just about assessments and strategies. Health and wellbeing boards will have a **stronger role in promoting joint commissioning and integrated provision** between health, public health and social care. They can be **the vehicle for "lead commissioning"** for particular services, for example social care for people with long-term conditions – with pooled budgets and joint commissioning arrangements where the relevant functions are delegated to them. There could, for example, be a joint commissioning plan for specific services between the clinical commissioning groups and the local authority. They can also promote more integrated provision for patients, social care service users and carers – joining up social care, public health and NHS services with aspects of the wider local authority agenda that also impact on health and wellbeing, such as housing, education and the environment through Local Nature Partnerships.

4.7. The patient involvement and public accountability workstream of the Future Forum suggested that the Government "have a stated policy ambition that all local areas will undertake joint commissioning arrangements between the NHS and local authorities where appropriate". We recognise the contribution that joint commissioning can make to integrating care and improving the patient experience. We will therefore encourage lead and joint commissioning, and integrated provision, through the Government's mandate to the NHS Commissioning Board and in new statutory guidance on joint health and wellbeing strategies, which the Department will produce, working closely with key stakeholders such as the Local Government Association, representatives of NHS organisations, patients and the voluntary sector.

4.8. Second, we will give health and wellbeing boards a stronger role in leading on **local public involvement**. Health and wellbeing boards will be responsible for identifying local needs and developing a joint health and wellbeing strategy to meet those needs. But there is a gap in the Bill at the moment – the Bill is silent on the need to involve the public in both of these processes. We will now remedy this. This will be in addition to the existing requirement for a representative of local HealthWatch to sit on health and wellbeing boards.

4.9. Third, there will be a stronger expectation for NHS commissioning plans to follow the local health and wellbeing strategy, as well as the joint strategic needs assessment. As the Bill stands, NHS commissioning plans need to have regard to the health and wellbeing board's overarching joint health and wellbeing strategy, and there is a requirement for clinical commissioning groups to consult health and wellbeing boards on their commissioning plans. The Bill also requires clinical commissioning groups to include in their plan the view of the health and wellbeing board on whether they consider the plan to have had due regard to the joint strategy. As the Future Forum remarks in its report, however, health and wellbeing boards have a "lack of power" in the Bill as currently drafted, preventing them from driving cooperation and integration of services effectively at a local level.

4.10. We will therefore strengthen the Bill to make clear that **health and wellbeing boards should be involved throughout the process as clinical commissioning groups develop their commissioning plans**, and there will be a stronger expectation, set out in statutory guidance, for the plans to be in line with the health and wellbeing strategy. Though they will not have a veto, health and wellbeing boards will have a clear right to refer plans back to the group or to the NHS Commissioning Board for further consideration if they think that the plans are not taking proper account of the strategy. Where the commissioning plans vary significantly from the joint strategy, if challenged, the group will need to be able to amend or explain and justify why.

4.11. The Future Forum recommended that "the authorisation process for commissioning consortia should consider how consortia boundaries will support joint working with local authorities". We have already highlighted in Chapter 3 the role that emerging health and wellbeing boards will have in relation to clinical commissioning group authorisation. This will help ensure that local views are taken properly into account as part of the authorisation process, particularly in the consideration of how shared geographical boundaries between local authorities and clinical commissioning groups can support joint working.

4.12. The NHS Commissioning Board will also have to take health and wellbeing boards' views into account in their annual assessment of commissioning groups. As proposals currently stand, the NHS Commissioning Board will assess clinical commissioning groups annually, and publish the results. We will seek to amend the Bill so that the NHS Commissioning Board has to consult the health and wellbeing board for their views

on the group's contribution to the delivery of the joint health and wellbeing strategy. This will help reinforce the principle that effective joint working, underpinned by the joint health and wellbeing strategy, is a critical part of clinical commissioning groups' performance – a given rather than an optional extra. Clinical commissioning groups will also have to self-report in relation to their actions with regard to the joint health and wellbeing strategy, as an essential part of their annual reports. The views of the shadow health and wellbeing board will also be **taken into account by the NHS Commissioning Board** when they make decisions on establishment and authorisation of clinical commissioning groups.

4.13. We heard a number of concerns through the listening exercise about the requirements around core membership of health and wellbeing boards. Health and wellbeing boards discharge executive functions of local authorities, and should operate as equivalent executive bodies do in local government. We can confirm that it will be for local authorities to determine the precise number of elected members on a health and wellbeing board, and they will be free to insist upon having a majority of elected councillors. The requirements for other members of health and wellbeing boards will remain the same.

4.14. Members of health and wellbeing boards will be subject to oversight and scrutiny by the existing statutory structures for the overview and scrutiny of local authority or health functions. The existing statutory powers of local authority overview and scrutiny functions will continue to apply. In line with the principles of the Localism Bill, **local authorities will have greater discretion over how to exercise their health scrutiny powers**.

4.15. We are already taking action to extend local authority health scrutiny powers to facilitate effective scrutiny of any provider of any NHS-funded service, as well as any NHS commissioner. Local authorities will also **still be able to challenge any proposals** for the substantial reconfiguration of services, and we will retain the Government's four tests for assessing service reconfigurations. Proposals for reconfiguration will need to continue to demonstrate:

i) support from clinical commissioning groups;

ii) strengthened public and patient engagement;

iii) clarity on the clinical evidence base; and

iv) consistency with current and prospective patient choice.

Strengthening governance arrangements of clinical commissioning groups

4.16. The Future Forum's other major recommendation on public accountability was to improve the governance of commissioning groups. There have been significant concerns that our current proposals do not provide sufficient assurance that clinical commissioning groups will act transparently, manage conflicts of interest and have proper checks and balances for the stewardship of public money.

4.17. We have reflected on these concerns and are now strengthening our approach. As suggested by the Future Forum and noted in Chapter 3, we will make it a requirement in the Bill for every commissioning group to have a **governing body** with decision-making powers, to ensure that decisions about patient services and use of taxpayers' money are made in an open, transparent and accountable way.

4.18. In line with the recommendation set out in the Future Forum's report, the governing body will, in addition to GPs and two other clinicians, include at least two **lay members**, one with a lead role in championing patient and public involvement, the other with a lead role in overseeing key elements of governance such as audit, remuneration and managing conflicts of interest. One of the lay members will undertake either the role of Deputy Chair or Chair of the governing body. If Deputy Chair, the lay member would take the Chair's role for discussions and decisions involving a conflict of interest for the Chair. These arrangements, which will require amendments to the Bill and subsequent regulations, will ensure that there is independent oversight of these key governance arrangements, including systems for managing conflicts of interest.

4.19. As Chapter 3 also noted, we do not intend to prescribe in detail the wider professional membership of the governing body, but it will have to include **at least one registered nurse** and **one doctor who is a secondary care specialist**. They must have **no conflict of interest** in relation to the clinical commissioning group's responsibilities, for example they must not be employed by a local provider. Chapter 3 discusses the importance of ensuring that the governing body's non-GP members are there to provide an independent perspective, informed by their expertise and experience.

4.20. These members will be appointed on the basis of their professional expertise and knowledge and the additional perspectives this will bring to the governance of the commissioning group, rather than necessarily having close knowledge of the local health system. They are likely to play an important role in helping make sure that the commissioning group has effective systems in place for involving a range of healthcare professionals in decision-making.

4.21. To enhance transparency and accountability, governing bodies will be required to **meet in public** and publish their minutes, and clinical commissioning groups will have to **publish details of contracts** with health services.

4.22. In addition to these new requirements, governance will be an essential feature of the authorisation process for clinical commissioning groups. The **authorisation process** for clinical commissioning groups will ensure that they have robust governance requirements **consistent with Nolan principles** and are accountable and transparent. This will not be a one-off test: the NHS Commissioning Board will hold commissioning groups to account for this on an **ongoing basis**. These arrangements will ensure the organisation is properly run and has the right systems, processes and skills to meet all its duties, including the financial skills required to commission high quality care within their allotted resources.

Rewarding quality of commissioning

4.23. We have suggested that a payment, called a 'quality premium', should be made to reward commissioners for the quality of the services they commission for patients. However, we have heard from many people that the detail around these payments is not yet right.

4.24. We have heard that the Bill does not clearly underline the link between quality rewards and the performance of clinical commissioning groups on quality, improving healthcare outcomes and reducing inequality in healthcare outcomes. The patient involvement and accountability workstream of the Future Forum also suggested that clinical commissioning groups should be rewarded in part for their performance on "outcomes derived from the joint health and wellbeing strategy". We agree that this needs to change.

4.25. To ensure that quality rewards meet their purpose, we will **revise the provisions in the Bill on the quality premium**. We will make clear that its purpose is to reward clinical commissioning groups that commission effectively and so improve the quality of patient care and the outcomes this leads to, including reducing inequalities in health outcomes. Assessment of quality and outcomes will include consideration of a commissioning group's contribution to the outcomes prioritised in joint health and wellbeing strategies.

4.26. There will be circumstances where it would clearly not be appropriate to award a premium, for instance if a commissioning group has achieved high quality outcomes by spending more than the money allotted to it and thereby compromising the resources available to other parts of the country. We recognise, however, that great care will be needed to design rules on when a quality payment can be reduced or withheld to reflect factors such as these. We will therefore ensure that any such rules are subject to regulations that have to be approved by Parliament. We will also change the Bill so that regulations can be used to make provisions for how commissioning groups can use any quality payment awarded to them.

Public board meetings for foundation trusts

4.27. In their report the Future Forum also recorded concerns they had heard through the listening exercise about the openness of NHS provider organisations, in particular NHS foundation trusts. While currently all other NHS organisations are required to hold their board meetings in public, this does not apply to foundation trusts. Although many foundation trusts do hold their meetings in public, others do not. Requiring all foundation trusts to hold their board meetings in public would also help a foundation trust's governors to represent the public and staff and to hold the board to account more effectively.

4.28. The Bill as currently drafted strengthens the internal governance of foundation trusts. For example, governors elected by the public and staff will be able to call a special general meeting to question directors. However, we agree that more should be done. To ensure that the public can be fully confident in the openness, transparency and accountability of

foundation trusts and can better challenge and scrutinise the delivery of local healthcare provision, we will therefore amend the Bill to **require all foundation trusts to hold their board meetings in public**.

4.29. The NHS Future Forum suggested that we apply this requirement to "any and all organisations operating as part of the NHS". While requiring open board meetings is clearly something we can do for statutory NHS organisations, it is more complicated with voluntary and private sector organisations, for whom it would be difficult to try to impose such a requirement. We will explore further whether there are practical alternative ways of ensuring transparency which would be proportionate.

Respecting the autonomy of the new commissioning bodies

4.30. Another clear recommendation set out by the Future Forum in its report was the need to respect the autonomy of clinical commissioning groups and the NHS Commissioning Board. The Bill as it is currently drafted enshrines the principle of autonomy at the heart of the NHS, with the aim of freeing the system from political micromanagement. It limits the powers of the Secretary of State over the NHS Commissioning Board and sets an overarching principle of promoting local autonomy.

4.31. To further avoid political micromanagement, we will ensure that Secretary of State's powers of intervention over the NHS Commissioning Board and other bodies are only used in the event of a **significant failure**, and that any intervention is explained publicly.

4.32. Similarly, the NHS Commissioning Board would always need to demonstrate reasonable grounds before intervening in relation to a commissioning group. In certain circumstances and after consultation with the commissioning groups concerned, the Board might need to vary a group's membership or geographic area in order to ensure that all GP practices are members of commissioning groups and that there is comprehensive geographic coverage. In exceptional circumstances, the Board might also need to dissolve a commissioning group in the event of significant failure, subject to consultation with the group concerned, local authorities and other appropriate parties. In both cases, there will be regulations, approved by Parliament, to ensure that there are fair and transparent procedures used, and we will be engaging stakeholders on these. Regulations will also make provision for the procedures to be used in relation to any other types of intervention by the Board.

4.33. Finally, we intend to amend the Bill to clarify the frequency of the mandate. Under the Bill, the Secretary of State must set a mandate for the NHS Commissioning Board which includes all of the Government's requirements and expectations for the NHS. The Future Forum's report notes concern that the Bill as currently drafted, implies that a new mandate will be set every year. There are concerns that this could lead Ministers to take an overly prescriptive approach. This is not what we intended. Our aim is for

the Secretary of State to set the mandate as a whole over a three-year period, with the ability to make any necessary changes to it on an annual basis. This will provide the system with greater stability in the long term. While retaining the Secretary of State's ability to response to changing circumstances, we will therefore amend the Bill to set a clear expectation that the Secretary of State's **mandate to the NHS Commissioning Board is a multi-year document**, to avoid the impression that a new mandate would be set every year.

Enhancing the autonomy of public health advice

4.34. We are proposing a new approach to public health, to ensure that preventative services are given the priority they need. This will be led nationally by a new public health service, Public Health England, which will integrate and streamline existing health improvement and protection bodies and functions.

4.35. We originally proposed that Public Health England should be a core part of the Department of Health. However, there have been concerns that this could risk undermining the independence of expert advice. We have announced that we intend to establish **Public Health England as an executive agency** of the Department of Health, subject to completing the normal government approval processes for establishing new bodies. This will ensure that expert and scientific advice is independent, while at the same time integrating policy and action to allow a more joined-up approach to health protection and emergency planning.

4.36. We will make further announcements in the government response to the consultation on the Public Health White Paper, and we will continue to work closely with stakeholders on key issues, such as how best to ensure the continued independence of Directors of Public Health and the level of support they will need from Public Health England and other sources.

Maximising patient and public involvement

4.37. We proposed to strengthen the collective voice of patients and carers in the system at both a local and national level. Local Involvement Networks (LINks) would evolve to become local HealthWatch, creating a strong local infrastructure, and at a national level we would establish HealthWatch England as an independent patient champion within the Care Quality Commission.

4.38. The patient involvement and public accountability workstream of the Future Forum highlights the importance of ensuring that arrangements for patient, carer and public involvement are not only genuine and meaningful but are also built into "all levels of the health and wellbeing system". We agree: our plans are about putting patients and carers right at the heart of the NHS. However, we recognise that people want us to go even further with our proposals to ensure that local communities' views can have a real impact on services.

4.39. We will therefore table amendments to the Bill, which will:

- introduce a new requirement for the **Care Quality Commission to respond** to **advice from its HealthWatch England subcommittee**;
- require the **Secretary of State** to **consult HealthWatch England** on the **mandate** to the NHS Commissioning Board;
- place a **new duty on Monitor** to carry out appropriate **public and patient involvement** in the exercise of its functions;
- add an explicit requirement that **local HealthWatch** membership is **representative of different users**, including carers.

4.40. We will ensure that the NHS Commissioning Board has a national director-level role with responsibility for patient and public engagement.

4.41. We will also amend the Bill to strengthen local arrangements:

- We will give health and wellbeing boards a new duty to involve users and the public.
- Clinical commissioning groups will have to set out in their annual commissioning plans how they intend to involve patients and the public in their commissioning decisions.
- Clinical commissioning groups will be required to **consult on their annual commissioning plans** to ensure proper opportunities for public input.
- Clinical commissioning groups will have to involve the public on **any changes** that affect patient services, not just those with a "significant" impact. This point will also apply to the NHS Commissioning Board.
- The NHS Commissioning Board will assess how effectively clinical commissioning groups have discharged their duty to involve patients and the public as part of their annual assessment.
- Commissioners and providers will have a duty to have due regard to findings from local HealthWatch organisations.

4.42. In addition, we will assess how well pathfinder clinical commissioning groups are involving patients and the public. In line with the recommendation made by the patient involvement and public accountability workstream, the NHS Commissioning Board will use this to inform the way they authorise and annually assess clinical commissioning groups.

4.43. We have considered carefully the recommendation that local HealthWatch should refer any disputes to HealthWatch England if local resolution is not possible. We agree with the Future Forum that, in line with the Government's localism agenda, there should be local resolution rather than top-down interference, wherever possible. We think this is particularly important for local HealthWatch, as the local champion for the public, and agree that it will be crucial for issues to be resolved locally to avoid undermining effective partnership working. The health and wellbeing board will need local HealthWatch to provide public and patient insight that will inform the assessment of needs and joint health and wellbeing strategy, so we would fully expect any concerns to be addressed in that local forum. This would also avoid creating unnecessary bureaucracy for local solutions. Arbitration would be inconsistent with the role that

HealthWatch England will have as a national consumer champion – as well as its role in providing advice to local HealthWatch and other bodies, including the NHS Commissioning Board and local authorities.

No decision about me without me

4.44. As we set out in the White Paper, patient involvement extends beyond collective discussions about service design and care pathways. Our White Paper declaration, 'no decision about me without me' aspires to an NHS where patients are involved fully in their own care, with decisions made in partnership with clinicians, rather than by clinicians alone.

4.45. In its report the Future Forum emphasised the importance of shared decision making in its report, and made suggestions for how we could better ensure that it better 'permeate[s] the culture throughout the health and care system'.

4.46. We agree with the patient involvement and public accountability workstream of the Future Forum that shared decision making must become the norm and not the exception. As suggested by the Future Forum, we will amend commissioners' duties to involve patients and carers in their own care to **better reflect the principle of 'no decision about me without me'**.

A duty of candour

4.47. We also heard through the listening exercise the suggestion that we could strengthen transparency of organisations and increase patient confidence by introducing a **"duty of candour"**: a new **contractual requirement on providers** to be open and transparent in admitting mistakes. We agree. This will be enacted through contractual mechanisms and therefore does not require amendments to the Bill. We will set out more details about this shortly.

Protecting the confidentiality of patient information

4.48. Another theme that emerged from the listening exercise was the importance of safeguarding confidential personal information.

4.49. We must make sure that information about patients' health and care history can safely follow them along their pathways, so that the professionals who treat them have all the information they need to know how to provide the right care. At the same time, we need to ensure that information is used appropriately to improve our knowledge about treatment and conditions so that we can improve health services for everybody.

4.50. We have already added safeguards to the Bill to keep patient-identifiable information safe and secure. For example, the Bill provides the NHS Commissioning Board with powers to publish guidance on information processing to which all registered providers must have regard. In addition, the Board or the Secretary of State have powers to publish information standards to which any publicly funded body providing health services or adult social care in England must have regard. However, we agree that we have not

done enough to reassure patients that their personal information will be safe or to explain how information will be used and protected.

4.51. In response to these concerns, and to ensure patients can be completely confident and clear about how we will use their information we will therefore use our forthcoming information strategy to set out how information will be collected, used and protected to improve our understanding of disease and outcomes while ensuring that patient confidentiality is completely protected.

4.52. We also heard concerns, from the BMA in particular, that the provisions in the Bill for the Information Centre are too broad in relation to patient identifiable information. Our intention is neither to undermine the existing legal position and practice, nor give the Information Centre new broad powers that appear to put patient confidentiality at risk. We will therefore **consider further how to amend the Bill to protect patient confidentiality** in a way that supports our plans to drive quality improvement through greater access to information; and to promote high quality research.

5 Choice and competition

Summary

Nearly everyone who contributed to the listening exercise felt patients should be given more choice and control over their care. Some felt that the competition that accompanies increased choice brought benefits for patients, while others were concerned about its impact on existing NHS providers and integrated services.

The NHS Future Forum said that, while competition has a role to play, the Government should make its position clearer and guard against the dangers of competition being an end in itself. We have heard this message and will improve our plans as follows:

- the Bill will rule out any deliberate policy to increase or maintain the market share of any particular sector of provider – private, voluntary or public;
- Monitor's core duties will be focused on protecting and promoting patients' interests, not on promoting competition as though it were as an end in itself;
- we will keep the existing rules on co-operation and competition in the NHS;
- there will be additional safeguards against cherry-picking and price competition;
- we will set limits on Monitor's powers to take action against commissioners;
- we will phase in the extension of Any Qualified Provider;
- Monitor will be required to enable integration of services for patients;
- we will strengthen the duties on commissioners to promote integrated services;
- the NHS Commissioning Board will promote innovative ways of demonstrating how care can be made more integrated, including exploring opportunities to move towards single budgets for health and social care;
- as recommended by the Forum, the Secretary of State's mandate to the NHS Commissioning Board will set clear expectations about offering patients choice: a "choice mandate"; and
- we will extend personal health budgets as a priority, subject to evidence from the current pilots.

5.1. One of the four key themes of the listening exercise was the role of choice and competition in improving the quality of care. As their report points out, this theme was the most controversial area of the Future Forum's work and prompted very strong views. Those who took part in the listening exercise, whether patients, members of the public, clinicians or others, felt that it was critical to get this right and many felt the Government needed to be clearer about its intentions for the role of competition in health services.

5.2. It is clear from the NHS Future Forum's summary report and the workstream report led by Sir Stephen Bubb that, while many of those who took part in the listening process recognised the benefits of increased choice for patients, many also expressed fears that, if left unchecked, greater levels of competition could destabilise the NHS. Some saw increased competition as synonymous with privatisation of the NHS. Some expressed concerns about the potential application of EU competition law to the NHS, worried that – combined with Monitor's role to "promote competition" – this could be used to impose tendering, break up integrated packages of care, and destabilise hospital services. Others were clear that competition was one of the tools commissioners could use to improve the quality of services.

5.3. The Future Forum rightly points out that the debate on choice and competition has become unhelpfully polarised, giving the impression that there are only two options: a system where there is neither choice nor competition; or full-blown marketisation, with all the excesses that can bring. In the same way, competition has often been interpreted as the opposite of integrated services. However, it is possible to have responsive, joined-up services working in patients' interests and competing for their choice, and this is what we are seeking to achieve.

5.4. Nevertheless, the concerns are not just an issue of presentation or communication. We need to ensure concerns are responded to, and that robust safeguards are built in.

5.5. And, as the Future Forum has pointed out, we need to avoid the risk of getting the wrong balance between incentivising quality through competition and safeguarding patients' expectations about service continuity and integration. We are therefore bringing forward a substantive package of changes, both legislative and non-legislative, to meet the recommendations of the Future Forum. These changes include:

- ruling out any question of **privatisation**;
- **using competition in the interests of patients**, not pursuing it as an end in itself;
- enabling **better integration** of services;
- strengthening the role of **patient choice and control**;
- safeguarding against **'cherry-picking'**;
- taking further measures to **rule out price competition** – so that providers compete on quality, not price; and
- **clarifying what happens if providers fail**.

5.6. Combined, these changes will put beyond doubt our commitment to maintaining the core values of the NHS: free at the point of use and available to all who need it. They will also mean that competition will be used for one purpose and one purpose alone: as a means of improving the quality and responsiveness of services. Competition is not, and will not be, used as an end in itself, and this Government is not ideologically bound to competition for its own sake. But there are clear benefits to be gained from increased competition and greater patient choice. We are committed to harnessing these and using

them as a driver for improvements in the quality of patient care and to empower patients and carers.

Ruling out privatisation

5.7. It is clear from the Future Forum's report that some people had genuine fears about the Government's long-term intentions for the NHS. Some questioned whether increased competition between NHS, private and voluntary providers could spell the end for the tax-funded, comprehensive service we all rely on. Others opposed on principle the involvement of private companies in the provision of NHS services.

5.8. To put our position beyond doubt, we will bring forward a series of amendments to our proposals and to the Health and Social Care Bill.

5.9. While the Bill in its current form does nothing to permit the privatisation of NHS services, it equally fails to prevent new functions and powers being used with the aim of increasing the market share of the private – or indeed any other – sector. Therefore, we will **outlaw any policy to increase or maintain the market share of any particular sector of provider**. This will prevent current or future Ministers, the NHS Commissioning Board or Monitor from having a deliberate policy of encouraging the growth of the private sector over existing state providers – or vice versa. What matters is the quality of care, not the ownership model. This change will complement the Government amendment already made to the Bill to prevent Monitor from setting different prices for providers because they are public or private sector.

5.10. This means that the Government, Monitor and the NHS Commissioning Board would be acting unlawfully if they exercised their functions with the aim of increasing or maintaining the market share of the private sector over public sector bodies, or vice versa. Instead, they will be required to remain neutral and even-handed.

5.11. We have heard concerns about our proposal to lift the cap on the amount of income foundation trusts can earn from treating private patients. Some fear that this could lead to NHS resources being used to cross-subsidise private care. Any cross-subsidy of this kind would breach the fundamental principles of the NHS, as set out in the NHS Constitution, which makes clear that "public funds for healthcare will be devoted solely to the benefit of the people that the NHS serves". To provide assurance and transparency, we will require foundation trusts to produce **separate accounts** for NHS and private-funded services.

Ensuring competition works in patients' interests

5.12. The Future Forum's report highlights the potential of greater patient choice to improve services, promote integration and increase citizens' rights. It stresses that competition should be used as one of the tools used to drive choice and efficiency. We will make a number of changes to ensure that competition always works in the interests of patients.

5.13. First, some people were fundamentally opposed to any degree of competition and, by implication, would prefer to undo the increases in competition made under the previous Government. Others did

not object to competition on ideological grounds, but instead were worried that competition would be put ahead of other important features of a health system, such as collaboration, or above patients' interests. The Bill as it stands has added to these concerns, by giving Monitor a duty of "promoting competition" which many have feared could be seen as putting competition before all other considerations.

5.14. We are clear that competition should only ever be seen as a means to an end and not an end in itself. We therefore agree with the Forum that **Monitor's core duties should be re-orientated away from promoting competition** as though it were an end in itself and focused instead on taking action in the interests of patients to tackle anti-competitive behaviour. We will amend the Bill accordingly. In carrying out its functions, Monitor's core duty will be to protect and promote patients' interests, by promoting value for money and quality in the provision of services.

5.15. We will remove Monitor's powers to "promote" competition **as if it were an end in itself**. Monitor will be limited to tackling specific abuses and restrictions that act against patients' interests, to ensure a level playing field between providers. For example, Monitor could take action against a provider seeking to frustrate patient choice, or colluding with another provider not to offer patients home-based treatments. As explained below, Monitor will also be required to support the delivery of integrated services for patients where this would improve quality of care for patients or improve efficiency.

5.16. Second, we recognise that many people thought we were promoting greater application of competition law in the NHS. To make clear that this is not our intention, we will **maintain the existing competition rules for the NHS** that were introduced by the last Government (the Principles and Rules for Co-operation and Competition), and give them a clearer statutory underpinning. The body that applies them, the Co-operation and Competition Panel will transfer to Monitor and retain its distinct identity. This will provide certainty and continuity for the NHS while ensuring that proper, independent regulation is in place.

5.17. We will retain our proposals to give Monitor concurrent powers with the Office of Fair Trading, to ensure that competition rules can be applied by a sector-specific regulator with expertise in healthcare. The Future Forum recommended that this was the best safeguard against competition being applied disproportionately. The Bill does not change EU competition law.

5.18. Alongside its role on competition, Monitor will retain its proposed new functions on price-setting and supporting the continuity of vital services in the event of failure, and its function of licensing providers.

5.19. Third, in reflecting on the points made during the listening exercise, we agree that we have not to date clearly described **the role of commissioners** in leading the choice and competition agenda. Because much of the Bill is about changing the role of Monitor, some people were understandably concerned that the regulator would have more control over local services than local commissioners.

But our intention is that the application of choice and competition should be driven by patients' needs and expectations, and may vary across different service areas.

5.20. In line with the Future Forum's recommendation, the NHS Commissioning Board, in consultation with Monitor, will set out guidance on how choice and competition should be applied to particular services, guided by the mandate set by Ministers, and following engagement with HealthWatch England. This includes guidance on how services should be bundled or integrated. For example, where it would be in patients' interests, it could be entirely legitimate for a commissioner to procure a whole care pathway from a single provider, as long as the process was fair, open and transparent.

5.21. To emphasise this, the regulations under the Bill setting out rules on procurement (which Monitor will enforce) will make clear that it is for commissioners to determine the shape of services, according to patients' preferences and needs. This was something that the Forum's report emphasised.

5.22. We will narrow Monitor's powers over anti-competitive purchasing behaviour by the NHS Commissioning Board or clinical commissioning groups, so that these are more proportionate and focus on preventing abuses rather than promoting competition as though it were an end in itself. Monitor will also ensure the application of UK and EU procurement law by commissioners, currently reflected in the Principles and Rules of Cooperation and Competition.

5.23. To give commissioners further reassurance, the NHS Commissioning Board will be expected to produce guidance on procurement. Commissioning groups should be at little risk of challenge if they work within the Board's choice offer and follow its guidance.

5.24. Fourth, we recognise that the proposed power for Monitor to open up competition by **requiring an existing provider to allow another provider access** to its facilities was potentially too disruptive. We will therefore remove this part of the Bill.

5.25. Finally, we will maintain our commitment to extending patients' choice of Any Qualified Provider, but we will do this in a **much more phased way**, and will delay starting until April 2012. Choice of Any Qualified Provider will be limited to services covered by national or local tariff pricing, to ensure competition is based on quality. We will focus on the services where patients say they want more choice, for example starting with selected community services, rather than seeking blanket coverage. There will be some services, such as A&E and critical care, where Any Qualified Provider will never be practicable or in patients' interests.

5.26. Taken together, this would create a system where:

- Parliament would set the legislative framework for competition through the Bill and then secondary legislation;
- the Secretary of State would set the NHS Commissioning Board's mandate;
- the NHS Commissioning Board would produce guidance for commissioners,

based on the mandate. It would consult Monitor on the guidance to ensure consistency with the law, before issuing it;

- Monitor would respond to any anti-competitive commissioning activity

5.27. While meeting the concerns of those who queried the extent of Monitor's powers, these changes preserve the core tenet of the Health and Social Care Bill: that properly regulated competition, when used appropriately, has the potential to improve the efficiency, quality and responsiveness of public services, to the benefit of those who use them and the taxpayer. As the Future Forum's report points out, there is a growing body of evidence to support this, and harnessing these benefits remains a core pillar of the Government's ambition for a strengthened NHS better able to meet the demands of the future.

Promoting better integrated services

5.28. Closely linked to people's worries about the degree of competition were widespread concerns that a greater diversity of providers could prevent service integration. Sir Stephen Bubb's report emphasises that the health service now needs to drive integration in a way that has never happened before: in particular, to provide a better service for the growing number of people with long-term conditions. Too often, services have been fragmented and have failed to join up for the people who use them.

5.29. The Bill as it stands places a duty on the NHS Commissioning Board to encourage clinical commissioning groups to work closely with local authorities. Some people have criticised this as giving the impression that partnership working is an end in itself.

5.30. We will therefore create a new duty for clinical commissioning groups to **promote integrated services for patients**, both within the NHS and between health, social care and other local services; and we will strengthen the Bill's existing duty on the NHS Commissioning Board to mirror this. As mentioned above, Monitor will be required to support the delivery of integrated services for patients where this would improve quality of care for patients or improve efficiency. In doing so, Monitor will be expected weigh up the overall benefits to patients and taxpayers that could be delivered from integration as against competition, delivering the best trade-off between them.

5.31. In line with the Future Forum's recommendation, the NHS Commissioning Board will promote **innovative ways of demonstrating how care can be made more integrated for patients**: for example, by developing tariffs for integrated pathways of care, and exploring opportunities to move towards single budgets for health and social care, in line with the Government's wider proposals on Community Budgets. We will work with organisations such as the King's Fund and the Nuffield Trust to develop these ideas further.

5.32. Competition and integration do not need to be in conflict with each other, as the Forum argued persuasively. Indeed, our existing proposals give commissioners greater scope than before to develop integrated packages of care, for example for end-of-life care, from a lead provider where this makes sense.

And new health and wellbeing boards will promote integration across the NHS, social care and public health. These key components of the Government's original proposals, combined with the package of improvements, will ensure that increased competition supports, rather than detracts from, greater integration of services.

Strengthening patient choice

5.33. In line with the Future Forum's recommendations, we remain firmly committed to the presumption of choice as a key part of our vision of an NHS which puts patients first. We recently consulted on proposals for extending patient choice and for improving information and support, key companions of meaningful choice. We will respond to those consultations in the autumn. In our responses, we will set out which services will be prioritised for greater patient choice and how a revolution in the quality of information available to patients will enable them to exercise their ability to choose. In the meantime, and to strengthen our ambition further, we will act on the Future Forum's recommendations:

5.34. We will amend the Bill to strengthen and emphasise commissioners' duty to promote choice, in line with the right in the NHS Constitution for patients to make choices about their NHS care and to receive information to support those choices. As recommended by the Future Forum, the Secretary of State's mandate to the NHS Commissioning Board will set clear expectations about offering patients choice: a "choice mandate". In line with the Forum's proposal, this will **establish the parameters for choice and competition in all parts of the NHS** and will be used by the NHS Commissioning Board to develop its plans to make choice a reality for patients.

5.35. There will be clear accountability for this. The Bill requires the Board to publish a business plan at the start of each year setting out how it intends to achieve the objectives set in the mandate, then to report on its performance at the end of the year. The Secretary of State will be required to give a public assessment of how the Board has performed.

5.36. Subject to evidence from the current pilots, the mandate to the Board will also make it a priority to **extend personal health budgets**, including integrated personal budgets across health and social care. The Forum's report emphasises how personal budgets can help improve outcomes and join up services for users, especially when they are offered in an integrated way across health and social care. Our ambition is to use the powers in the Bill to introduce over time a right to a personal health budget for patients who would benefit from one, in line with the Forum's recommendation. We will consult further on the details.

5.37. As recommended by the Future Forum's report, HealthWatch England will have the power to establish a citizens' panel, or equivalent arrangement, to look at how choice and competition are working, and inform HealthWatch's annual report to Parliament. This does not require any further amendment to the Bill.

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

5.39. We agree with the Future Forum that there is potential in promoting the **'right to provide'** – the ability for staff to form social enterprises or mutuals to drive innovation and improve the quality of services. We are committed to removing the barriers to this and will work further with the Future Forum on making this a reality.

Safeguarding against cherry-picking and ruling out price competition

5.40. We fully agree with the NHS Future Forum's recommendation that we need to do more to guard against providers competing on price for NHS services and being able to cherry-pick the profitable, "easy" cases, as this could undermine quality, and potentially destabilise services.

5.41. The Government's position is unequivocal: competition should be on quality, not price. Ahead of the listening exercise, we took action by placing a new legal duty on the NHS Commissioning Board and Monitor to develop standardised pricing "currencies" for the national tariff. The more services are paid for at a fixed tariff, the less risk of the variations in price we see at the moment under competitive tendering.

5.42. However, the Forum recommended that additional precautions could and should be taken to minimise the risk of cherry-picking. We are therefore introducing a **suite of additional safeguards**, including:

- a specific duty on Monitor in setting the national tariff, to ensure that efficient providers are paid fairly, taking into account the clinical complexity of the cases that they treat;
- a duty on the NHS Commissioning Board to extend the use of standardised pricing currencies to services not yet covered by national prices;
- a fixed tariff (national or local) for each service offered under Any Qualified Provider;
- undertaking a piece of work with the Royal Colleges to identify the procedures most at risk of cherry picking and prioritising work on Payment by Results to ensure that fair prices are set for these procedures from 2013/14 onwards;
- requiring commissioners to follow "best value" principles when tendering for non-tariff services, rather than simply choosing the lowest price;
- strengthening safeguards to ensure providers are only able to turn away patients on clinical grounds if there are strong and legitimate reasons for doing so. Such grounds should normally be agreed in advance;
- requiring Monitor to include a standard condition in the licence to ensure transparency in the use of any patient referral or eligibility criteria;

- strengthening contractual terms to require providers to accept patients referred to them unless there are genuine and over-riding clinical concerns; and
- obliging commissioners to make public any variations to national tariff prices.

A fair and robust failure regime

5.43. The listening exercise has demonstrated widespread support for the principles of establishing a transparent failure regime: focused on protecting patients' access to essential services – irrespective of the type of provider – and avoiding bail-outs for poor services at the taxpayer's expense.

5.44. These principles are fundamental in getting the right incentives in place. Managers and clinicians expect to be held accountable for the outcomes they achieve and for the system to reward success. This won't work if we penalise successful organisations and simply 'bail-out' overspending. We will have an effective failure regime that ends the culture and practice of hidden bailouts and gets the right incentives into the NHS, whilst protecting essential services.

5.45. We have always made clear that regulation is needed to protect patients' interests. The listening exercise has demonstrated support for this principle, particularly, the importance of Monitor being able to intervene in 'distress' to support recovery and prevent failure before it happens. We have heard concerns about the practicality of our proposals for designating which services should be subject to additional regulation, and an overarching concern to ensure democratic legitimacy by maintaining local authority scrutiny rights.

5.46. We are responding to these concerns, whilst remaining true to the principles that the Health Select Committee and others have endorsed, and we will be amending the Bill accordingly. We will take an evolutionary approach, building on current legislation. This will mean withdrawing our proposal for commissioners to apply to Monitor to designate in advance which services would be subject to additional regulation. We will also maintain democratic oversight by reinstating local authority scrutiny rights.

6 Developing the healthcare workforce

Summary

We have some of the best health and care professionals in the world. They should be supported by a world class education and training system.

The NHS Future Forum highlighted that there was strong support for our proposals to improve arrangements for professional development. But they also said that further work is needed to develop detailed proposals following consultation.

This chapter shows how we will further develop and revise our plans to make sure we get them right. In particular, we will:

- ensure that Health Education England is in place quickly to provide national leadership and strong accountability, a whole workforce and multi-professional approach, with strong relationships with health, care and education partners;
- ensure a safe and robust transition for the education and training system. During transition, deaneries will continue to oversee the training of junior doctors and dentists, and we will give them a clear home within the NHS family;
- put in place a phased transition for provider-led networks to take on their workforce development responsibilities when they can demonstrate their capacity and capability;
- further consider how best to ensure funding for education and training is protected and distributed fairly and transparently, and publish more detail in the autumn; and
- ensure high quality management is valued across the NHS, with a commitment to retaining the best talent across the PCTs and SHAs.

6.1. The Forum's report emphasises the critical role that education and training will play in the continued improvement of healthcare services. The Forum found that everyone they spoke to wanted "a world class health care educational system", which is "essential" for world class health care. We agree. We rely on the skills, knowledge and values of frontline professionals, and we too want their training and education to be world class. To reinforce its importance, we will introduce **an explicit duty for the Secretary of State to maintain a system for professional education and training as part of the comprehensive health service**.

6.2. Through the listening exercise and our public consultation, *Liberating the NHS: developing the healthcare workforce*, we have heard broad support for the direction we set out for education and training, which the Forum's report also welcomes. People agree that healthcare employers should have more accountability and responsibility for planning and developing

their workforce. There should be strong professional leadership working to clear national standards; effective partnership with the education and academic, business and charitable research sectors; protected funding for education and training; and a new national body – Health Education England (HEE) – to provide sector-wide oversight and leadership.

6.3. But the Forum highlights that further work is needed to develop detailed plans. In particular, people want to understand more about:

- how the workforce will develop to meet the needs of patients and communities;
- multi-professional leadership and accountability within HEE and across the system;
- maintaining and improving quality;
- provider-led networks;
- avoiding the risk of over-regulation;
- funding for education and training.

6.4. We agree that there is much more work to be done to get these important arrangements right, building on the responses to the consultation and the Future Forum's report. Some further detail is set out in this chapter, and also in Chapter 7 considering the transition and timing for change, with more detail to follow as our plans continue to develop.

Developing the workforce to meet the needs of patients and communities

6.5. We heard strong support for our aim for education and training to be driven by the needs of patients and communities. The Forum's report, for example, refers to the "strong agreement that education and training needed to change and become more flexible and responsive to reflect changing health demands and new patterns of healthcare". It particularly noted the benefits of a system that is more responsive to the needs of services and employers, whilst being professionally informed and underpinned by strong academic links.

6.6. We therefore remain committed to **greater accountability and responsibility for employers to plan and develop their workforce**, held to account by HEE. In particular, healthcare providers should have a greater role in developing the professionals who provide frontline care, securing the right skills and investing in training to improve the quality of services they provide.

6.7. We have also heard that there are concerns that some providers will not be able to take this lead role straight away. But employers have reassured us that they are determined to step up and take on more responsibility for planning and developing their workforce, recognising that it is essential to the delivery of high quality care. And there was strong support for creating HEE to support providers in their new role, provide clear national direction and ensure effective commissioning of education for smaller professional groups.

6.8. We therefore propose to **ensure that HEE is in place quickly**, following the usual processes for setting up a special health authority, to provide sector-wide leadership and bring together the voices of patients, providers, the professions and staff. We intend to develop and test governance arrangements for HEE that reflect a balance of professionals, services, public and patients and educational expertise. Reflecting the new duty on Secretary of State, HEE would also be required to maintain the system for professional education and training and report to Secretary of State annually on the development of the healthcare workforce.

Multi-professional leadership and accountability

6.9. The Forum's report shows that there is "strong approval for a more collaborative multi-professional and multidisciplinary approach to workforce planning and all education, including continuing professional development". We agree that effective plans for workforce development need to reflect a broad range of views from patients and professionals working at all levels and across the NHS, public health and social care. They should be truly integrated across the professions, developing the values and skills that patients depend on from the whole workforce – not only clinical training.

6.10. In providing sector-wide and multi-professional leadership, HEE would draw expertise and support from **strong partnerships across health and care organisations**. HEE would need to work closely with the NHS Commissioning Board and the regulators, professional bodies and the education sector.

6.11. Further, HEE would establish the right relationships to make sure that those in smaller professions and specialties have a strong voice. As the Forum recommends, HEE would establish a framework setting out how education and training will be planned and provided for professions and specialties with a smaller number of practitioners – ensuring a strong input for providers and practitioners delivering small and specialist services.

6.12. Recognising, as the Forum's report notes, that education and training for healthcare is developed and regulated in a UK-wide context, HEE would need to build strong links with partners in Scotland, Wales and Northern Ireland to ensure consistency across the UK and better information for staff.

A focus on quality

6.13. The Forum's report makes clear that the quality of education and training is paramount: "Quality governance, the need for excellent quality assurance and management of education and training was considered essential". We agree: high quality education and training is critical for patient care. We accept the Forum's advice to **maintain quality and business continuity through a steady and phased transition** as employers take on greater accountability.

6.14. The post-graduate Deans and SHA staff involved in planning and developing the workforce play a vital role in planning,

commissioning and quality assuring education and training. The Forum's report reflects concerns about how their role will continue following abolition of the SHAs and recommends that we put in place interim arrangements for their functions. We will ensure there are effective arrangements to provide professional, educational leadership for all healthcare professions.

6.15. We agree that we have not made our plans clear enough. The **post-graduate Deans and SHA staff involved in planning and developing the workforce will continue to manage and assure education and training**, including the training and recruitment of junior doctors and dentists. Securing continuity for the work they do into the new arrangements will be a key part of safe transition. We will work with the service, deaneries, the proposed HEE and professional bodies to ensure that recruitment to post-graduate medical and dental programmes in 2012 and onwards is managed effectively.

6.16. Protecting and improving quality at a national level will also be a key role for the proposed HEE, which will work with the professional regulators, Colleges and other professional bodies and the education sector to **maintain and improve national standards** for content and delivery of education and training.

6.17. The Forum notes that people are worried about accountability and potential conflicts of interest in the new framework. We accept their advice to establish HEE quickly, ensuring **clear lines of accountability and strong principles of good governance** throughout the system.

6.18. To ensure consistently high quality around the country, we will **develop a national education and training outcomes framework**, setting out the outcomes that HEE would expect providers to meet. These outcomes will be designed to help health and care professionals to meet the clinical outcomes set out in the NHS, public health and social care outcomes frameworks. We will also emphasise the importance of the right investment in education and training to ensure that we develop the right values, behaviours and team-working to provide person-centred care.

6.19. An important element of high quality education and training is continuing professional development. As the Forum states, "To deliver the NHS of the future requires all staff, not just professional staff, to have access to continuing professional development". We agree. The NHS Constitution commits all employers supplying NHS funded services to provide staff with personal development and access to appropriate training for their jobs. As the Forum's report recommends, we will consider the way in which continuing professional development is provided, and ways of ensuring greater transparency for the investment in continuing professional development. This includes the **ongoing training and development of managers**, whose skills are essential to improving the quality of frontline services and ensuring that resources are well spent.

Joining up through networks

6.20. We have heard from many about the importance of strong partnerships between education and training providers and the wider health sector. We agree: the system needs to join up better, so that plans for the workforce match plans for how health and care services are delivered and improved.

6.21. Strong partnerships between healthcare providers, commissioners, universities, researchers and other education providers will be needed to develop high quality plans for education and training. We intend HEE to provide national leadership, but local support and, as the Forum's report recommends, robust mechanisms for jointly developing curricula will be just as important.

A phased transition towards provider-led networks

6.22. In the consultation we proposed to establish networks, led by healthcare providers and bringing together organisations and professionals from across health and care, to plan and develop their workforce. We have heard from the Forum's report that this is the right way forward – but the report also notes that "time is needed to establish these properly". We agree that the sort of networks we want to see – strong and effective partnerships – cannot be created overnight. That is why we have built into our transition plans sufficient **time for local partnerships to grow and embed**. We will work with a range of stakeholders over the coming months to develop arrangements of the right scale for healthcare employers to work in partnership locally on planning and developing the workforce and to commission effectively and efficiently. SHAs will now be able to support their development through to April 2013.

6.23. The **transition will be phased** so that provider-led partnerships can take on their responsibilities as they are able to demonstrate their capacity and capability. HEE will develop and put in place **a rigorous authorisation process**.

A core part of the NHS

6.24. The Forum's report also considers the position of provider-led networks as a part of the NHS. They note that "education is core NHS business" – and we completely agree. That is why we will ensure that the **networks will be required to have regard to the NHS Constitution and NHS values** and that their name and constitution reflect how central they are to the NHS.

Regulation

6.25. The Forum's report refers to the risk of too many regulatory bodies, requirements and inspections, and recommends that regulators work together to ensure that the burden of regulation is kept to a minimum. There needs to be strong regulation to safeguard quality and patient safety that is effective but does not prevent professionals and providers improving their services for patients. We have asked the Law Commission to review how the legislative framework for professional regulation might be simplified, and to consult widely.

Funding

6.26. Many have called for **education and training funding to be protected**. We agree, so we will establish transparent systems to make sure that organisations in receipt of education and training money are held to account for using it for the education and training of the NHS workforce.

6.27. We expect overall investment in education and training to continue to reflect the requirements of the NHS workforce. We will look to employers to maintain appropriate levels of investment in the education, training and continuing professional and personal development that they fund directly. We will explore ways to provide **greater transparency about the overall level of investment** across the system, including for continuing professional development.

6.28. The Forum and others welcome our proposals to bring **fairness and transparency to how resources are distributed** for professional education and training, so that funding follows the student and trainee as they move throughout the system. In designing the new system we will keep a sharp focus on running costs to improve efficiency.

6.29. We have set out **broad proposals for ensuring all providers contribute** to the costs of education and training. However, it is vital that any changes to the funding of education and training are introduced in a careful, phased way that does not create instability. The Forum recommends more work on this, and we agree. We will therefore take the time to develop our proposals, working with our health and care partners and through further consultation, and we will **publish more detail this autumn**.

7 The timetable for change

Summary

The NHS Future Forum emphasised the need to get the pace of change right, in the best interests of quality and safety. We aim to strike a balance between maintaining momentum and allowing more time to recognise that some organisations may not be ready to take on their full responsibilities on the current timetable. We will make a number of changes to our proposals:

- Primary Care Trusts will cease to exist in April 2013. However, clinical commissioning groups will not be authorised to take on any part of the commissioning budget in their local area until they are ready and willing to do so;
- by April 2013, GP practices will be members of either an authorised clinical commissioning group, or a 'shadow' commissioning group, i.e. one that is legally established but operating only in shadow form;
- where a commissioning group is ready and willing, it will be able to take on commissioning responsibility earlier. Where a group is not yet ready, the local arms of the NHS Commissioning Board will commission on its behalf;
- the NHS Commissioning Board will be established by October 2012 to start to authorise clinical commissioning groups, but will only take on its full responsibilities from April 2013;
- choice of Any Qualified Provider will be phased in gradually from April 2012;
- our expectation is that the remaining NHS trusts will be authorised as foundation trusts by April 2014. But if any trust is not ready by then, it will continue to work towards foundation trust status under new management arrangements. We will further extend, to 2016, the transitional period where Monitor retains specific oversight powers over foundation trusts; and
- we will ensure a safe and robust transition for the education and training system, and will set out further details in the autumn.

7.1. One of the main themes that emerged from all four of the NHS Future Forum's workstreams was the pace of change.

7.2. As the Forum pointed out, some people felt that the changes were proceeding too quickly, with others concerned that the pace of change was not fast enough. The Forum recommended further changes to phase the transition, in order to strike the right balance. Their report supports the case for a single, integrated transition programme, so that changes can be aligned across the different interconnected parts of the NHS, public health and local government. And the current financial challenge makes it more important to maintain overall momentum: there is no delay in the need to find efficiency savings.

7.3. But, drawing on concerns they heard, we accept the need for **more flexibility**, to recognise that some organisations may not be ready to take on their full responsibilities, or perform at full capability, on the current timetable – while allowing those who are ready to make faster progress, in line with the current pathfinder programme.

A phased introduction of clinical commissioning groups

7.4. The greatest concerns were about the timetable for moving to the new system of commissioning. We have heard concerns that some commissioning groups will not be ready to take on all their responsibilities from 2013 – or in some cases may not be ready at all. On the other hand, we have heard and seen examples of areas where it is likely that emerging commissioning groups would in practice be ready to commission services before this date. Therefore we will change our approach, in line with the Future Forum's suggestion of following the principle of "earned autonomy" during the transition. Although these are significant changes, they can be made within the framework of the Bill as it stands, without further amendments, through the NHS Commissioning Board's existing powers of authorisation.

7.5. Subject to the passage of the Bill, our plans are now as follows. As we originally proposed, Primary Care Trusts will cease to exist in April 2013. However, clinical commissioning groups will not be authorised to take on any part of the commissioning budget in their local area **until they are ready and willing** to do so. Where groups are ready and willing, they will be able to **take on commissioning responsibility earlier** through delegated budgets and delegated decision-making, building on the current arrangements for 'pathfinders'.

7.6. By April 2013, GP practices will be members of either an authorised clinical commissioning group, or a 'shadow' commissioning group, i.e. one that is legally established but operating only in shadow form, with the NHS Commissioning Board commissioning on its behalf. This is required so that there is clarity about how different clinical commissioning groups cover the whole country without gaps. It will always be clear to patients and the public which GP practices are members of which local group.

7.7. Whilst all GP practices will be a part of a commissioning group from April 2013, whether shadow or authorised, no individual GP will need to get involved in the work of a commissioning group if they don't want to. All GP practices will be expected to work collaboratively to improve the quality of primary care and support the objectives of their commissioning group. This builds on the existing role that GPs play in commissioning, for instance through the day-to-day decisions they take in relation to referrals and prescribing.

7.8. Clinical commissioning groups that are ready and willing by April 2013 could be authorised to take on full budgetary responsibility. Some will only be authorised in part. Others will only be established in shadow form. This will be determined

through a robust process of authorisation, run by the NHS Commissioning Board, with input from emerging health and wellbeing boards and local clinicians.

7.9. Where a clinical commissioning group is not able to take on some or all aspects of commissioning, the local arms of the NHS Commissioning Board will commission on its behalf, and in this role will be subject to the same duties of transparency and engagement. **All groups will have the right to take on full responsibility, once they have demonstrated they are ready**. The NHS Commissioning Board will work with the GP practices and other stakeholders in these areas to develop fully operational commissioning groups and hand over commissioning responsibility to them as they become ready, so that we move, over time, to avoid a two-tier system of commissioning in the NHS.

7.10. The PCT "cluster" arrangements will be reflected in the local arrangements of the NHS Commissioning Board. Those local arrangements will be established before PCTs are abolished.

A more flexible timetable

7.11. Again subject to legislation, we have also decided to take a more flexible approach in a number of other areas:

7.12. First, as recommended by the Future Forum, we propose to establish the **NHS Commissioning Board** as soon as possible, to ensure focused leadership for improving quality and safety as well as meeting the financial challenge during the transition. The Board would be set up in shadow form as a special health authority in October 2011, following the usual processes for setting up a special health authority. It will be established formally as an independent statutory body by October 2012 to start to authorise clinical commissioning groups and carry out preparatory functions, but will only take on its full responsibilities from April 2013. This will create a smoother transition.

7.13. The ten **Strategic Health Authorities** will remain in place as statutory bodies until April 2013, but we will form them into a smaller number of clusters later this year for management purposes, as we have done with PCTs. They will support the transitional work both of the Board and of the NHS Trust Development Authority, which would operate in shadow form during 2012-13 before being fully operational in 2013-14.

7.14. Sir David Nicholson will retain his current role as NHS Chief Executive for the whole of 2012-13, alongside his role as chief executive-designate of the NHS Commissioning Board. This will help ensure that all parts of the system are fully aligned during the shift to the new structures.

7.15. As mentioned in Chapter 5, rather than being introduced in a "big bang", as many feared, we will extend the **choice of Any Qualified Provider** in a much more phased way and will delay starting until April 2012. We will focus on the services where patients say they want more choice.

7.16. The Future Forum recommended that **HealthWatch** England should be established as soon as possible in order to provide focused leadership for putting patients at the heart of local reforms. We intend to establish HealthWatch

England and local HealthWatch from October 2012. This will allow local HealthWatch the opportunity to play a full role in clinical commissioning groups and health and wellbeing boards when they are set up. Local Authorities and local HealthWatch will take formal responsibility for commissioning NHS complaints advocacy from April 2013.

7.17. We strongly expect that the majority of remaining NHS trusts will be authorised as **foundation trusts** by April 2014. The NHS Trust Development Authority will support this process and maintain the momentum, which will be essential for overall delivery. It will not be an option to stay as an NHS trust, but there will no longer be a blanket deadline in the Bill for abolishing NHS trusts as legal entities. All NHS trusts will be required to become foundation trusts as soon as clinically feasible, with an agreed deadline for every trust. The stringent tests set by Monitor will remain, and Monitor will continue to obtain assurance from the Care Quality Commission as part of the authorisation process.

7.18. To enable time for foundation trusts' governors to build capability in holding their boards to account, we will further extend, to 2016, the transitional period where **Monitor retains specific oversight powers** over foundation trusts. Monitor's oversight will last until two years after a foundation trust is authorised, if that is later. To provide continuity during a challenging period, and in recognition of concerns about the readiness of foundation trusts' governors, these powers will initially apply to all foundation trusts, and they will be reviewed in 2016.

7.19. As outlined in Chapter 6, we will ensure a safe and robust transition for the **education and training system**. In line with the Future Forum's recommendation, we will establish Health Education England quickly, ready for it to be fully operational from April 2013. We will set out further details in the autumn.

7.20. We believe these changes will significantly reduce the risks around implementation. They will allow greater flexibility for those organisations than need it, while maintaining overall momentum.

7.21. As Chapter 6 highlights, good management is essential in improving the quality of frontline services and ensuring that money is well spent. We will take steps to boost the quality of management and leadership: for example, by retaining the best talent from PCTs and SHAs in the new system, and through a commitment to the ongoing training and development of managers.

7.22. We have asked the NHS Future Forum to continue to advise the Government on how the transition can be managed successfully.

7.23. Sir David Nicholson is writing separately to the NHS with a more detailed update on the timetable for transition.

Timetable for change

Planned date	Commitment
October 2011	• NHS Commissioning Board established in shadow form as a special health authority
During 2012	• Health Education England and the NHS Trust Development Authority are established as special health authorities, but in shadow form, without full functions
April 2012	• The next step in extending the choice of Any Qualified Provider, which will be phased in gradually
By October 2012	• NHS Commissioning Board is established as an independent statutory body, but initially only carries out limited functions – in particular, establishing and authorising clinical commissioning groups
October 2012	• Monitor starts to take on its new regulatory functions • HealthWatch England and local HealthWatch are established
1April 2013	• SHAs and PCTs are abolished and the NHS Commissioning Board takes on its full functions • Health Education England takes over SHAs' responsibilities for education and training • The NHS Trust Development Authority takes over SHAs' responsibilities for the foundation trust pipeline and for the overall governance of NHS trusts • Public Health England is established • A full system of clinical commissioning groups is established. But the NHS Commissioning Board will only authorise groups to take on their responsibilities when they are ready
April 2014	• Our expectation is that the remaining NHS trusts will be authorised as foundation trusts by April 2014. But if any trust is not ready, it will continue to work towards FT status under new management arrangements
April 2016	• Monitor's transitional powers of oversight over foundation trusts will be reviewed (except for newly authorised FTs, where Monitor's oversight will continue until two years after the authorisation date if that is later)

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