themonth.

NHS Modernisation – special issue

20 June 2011 Gateway reference number 16236

news

Read David Nicholson's latest transition update, and see inside for more on current challenges facing the NHS, key conclusions of the Future Forum and a refreshed transition plan.

introduction

I am writing to update you following the publication of the report of the NHS Future Forum last week and in light of the detailed policy response being published by the government today. This special edition of The Month sets out:

- The current **delivery challenges** facing the NHS along with our plans for measuring success going forward;
- An overview of the **key conclusions of the Future Forum** and the resultant changes to the Government's plans for modernisation, and
- A **refreshed transition plan** and timetable, adjusted in light of the conclusions of the Future Forum.

The last few weeks have been a period of significant uncertainty for the NHS. However, it has also been a period of genuine and meaningful engagement resulting in important changes to the government's plans for modernisation. Subject to the passage of the Health and Social Care Bill, the future policy direction is now clearer than before, while the transition will be phased to allow us to build the new system over time. In particular, the importance of retaining skilled and experience staff from SHAs and PCTs in the new system has been recognised.

I am conscious that this is not the first time we have made changes to the timetable and details of the transition process. We do not take such changes lightly and I appreciate the additional uncertainty that it can cause for individuals when plans are adjusted. However, I am confident that the new approach to transition, which maintains an integrated delivery system and with regional oversight during 2012/13, will increase stability and provide greater flexibility going forward.

Our priorities for the coming period must be to maintain our grip on current performance, including quality, safety and financial control, while creating fresh momentum for change in preparation for the new system. I do not underestimate the scale of the challenge that that presents and we will be working over the coming weeks to ensure our approach allows us to achieve both of these goals. There has never been a more critical time for managerial and clinical leaders across the service to stand up and be counted.

Sir David Nicholson
NHS Chief Executive

update

Delivery for today

Although the attention of the commentariat has been firmly focused on the listening exercise over the last few weeks, the attention of the communities whom you serve has remained on the things that matter most to them; the provision of quality health services for them and their families – however and wherever they are accessed. Throughout this time the Government have been absolutely clear that this remains our number one priority.

I am very pleased to say that in 2010/11 the NHS has maintained a strong focus on finance and performance. The final accounts for 2010/11 will confirm the healthy financial surplus that has been forecast during 2010/11. Whilst the overall financial position remains healthy, we must continue to focus on the handful of organisations that are struggling to manage their finances.

In the face of rising demand, referral to treatment waiting times have remained broadly stable and we achieved our key commitments on A & E and cancer waiting times. We also made further reductions in Healthcare Associated Infections, with reductions of 22 per cent and 15 per cent respectively in MRSA Bacteremia and C.difficile infections.

All of this represents a fantastic achievement and is testament to the efforts of thousands of staff across the country, at a time when a number of people have also had to deal with uncertainty about their own futures.

Our operational priorities, from maintaining access to reducing healthcare associated infections have not changed since the Operating Framework for 2011/12 was published. The difference is that having talked about and planned for how we will meet the impending quality and productivity challenge for some time, we are now at the point where people are putting those plans into action. We will be setting out shortly how and when we will report on progress during the year.

Having been round the country in recent weeks talking to groups of leaders in every region, I have seen first hand the detailed and granular work that has gone in to agreeing plans locally. Overall, our operational performance over the last year and the underlying strength of our financial position means we are well placed going into this year, but there is no room for any complacency and there are three specific issues I want to particularly draw attention to.

Waiting times

During the last year, waiting times have remained broadly stable in the face of rising demand.

However, I can assure you, the need to maintain our focus on waiting times is as much a priority now as it has been at any point in the last 10 years. The Prime Minister himself could not have been clearer about this in recent weeks. More importantly though, our patients will not forgive us if we allow the transformative improvements we have made in recent years to slip.

Improving quality of care

This next period is a challenging one for everyone, but particularly for acute providers, with the combination of the new incentive structures around the tariff and the need to begin to shift activity into the community. Both of these things are absolutely necessary if we are to meet the quality and productivity challenges of the next few years, but both need careful managing. In our analysis of the plans for 2011/12, it is evident that some organisations have very ambitious cost improvement plans. Where this is the case, it is imperative that such plans are underpinned by rigorous quality impact assessments.

Safeguarding quality is first and foremost the responsibility of the individual organisation's board, but it is also something which all parts of the system locally need to work together on to ensure, from PCTs, to SHAs, to the regulators. The recent appalling events at Winterbourne View as well as the ongoing Mid-Staffordshire Inquiry should serve as sharp reminders of why quality must remain our organising principle.

As a health service, we should judge ourselves against the service we provide for some of the most vulnerable groups. If we can get it right for them, we should be able to get it right for everyone. The Care Quality Commission's ongoing unannounced inspection reports on dignity and nutrition for older people are an important test of that and whilst the majority of these so far have not raised major concerns, it is important that where any problems are highlighted, local health systems respond swiftly to make the necessary improvements.

Emergency planning and resilience

Although the impact on our country has so far been minimal, the recent E coli outbreak in Germany should serve as a clear reminder that in this time of change we must continue to focus on emergency planning and resilience. We have shown before, in the case of pandemic influenza, that we can respond quickly and professionally as a health and social care system to these kinds of issues and we need to maintain a high level of preparedness, and absolute clarity on who is in charge of what as structures and accountabilities change.

update

The work of the NHS Future Forum

The NHS Future Forum delivered its reports last week and the government has published its detailed response today. As important as the content of the Forum's reports is the process of active listening and engagement that underpinned them. 6,700 people attended listening events and more than 25,000 sent their views: a remarkable level of involvement. Co-production must remain at the heart of our approach to change going forward and it is encouraging that the Forum will continue its work in areas such as education and training and public health.

The Forum's reports and the government's response provide a clear account of the changes to policy and legislation now planned. In addition, there are some significant themes beyond the specific policy changes which run through the Forum's work:

- Firstly, the Forum's report reminds us of what the NHS is for. It underlines the role of the NHS Constitution in underpinning the values of the NHS and setting out clearly what patients can expect from the service. And it confirms that the focus on outcomes at the heart of the reforms is widely supported.

- Secondly, it re-emphasises that the NHS cannot afford to stand still over the coming years. The combination of rising demand, demographic and technological change, and the tough financial climate mean the NHS must improve quality and productivity on a scale we have not previously achieved. In short, the Forum underlines the critical nature of the QIPP challenge.

- Thirdly, the Forum makes clear that the kinds of changes we are making to meet the QIPP challenge are the right ones. Smoother pathways of care for patients with long-term conditions; better integration between health and social care services, and more empowered patients taking control of their care are all strongly encouraged by the Forum. All are central to delivering the QIPP challenge. That is an important and powerful re-affirmation of our core operational purpose.

- Fourthly, the Forum's report supports the principles of the government's modernisation plans and makes clear that modernisation must support and enable the changes we need to make. Modernisation and QIPP must go hand in hand, mutually reinforcing each other. The changes recommended by the Forum will help to ensure that is the case. For example, wider clinical involvement in commissioning through clinical networks and clinical senates will support the development of better pathways for treating long-term conditions. Giving patients a stronger role in determining how choice is extended will ensure that choice and competition help to drive greater quality and efficiency. And better integration between different players through Health and Wellbeing Boards will support more joined-up care.

- Finally, the Forum's report emphasises that it is critical that we maintain our focus on quality, safety and financial control during the transition. The next section sets out how we intend to do this.

Transition: accountability arrangements

The Future Forum was clear on the need to quickly establish a revised timetable for the transition to the new system in order to provide clarity and direction for staff. This is set out below. We must remain mindful in planning and progressing the transition that the Health and Social Care Bill remains subject to ongoing parliamentary scrutiny and debate. We must therefore ensure that the actions we take represent reasonable preparatory steps which do not pre-empt the proper parliamentary process.

In revising the timing and approach to the transition, we need to balance a number of potentially conflicting priorities. First, and most important, is the need to maintain our grip on the system through clear accountability arrangements for delivering quality, safety and financial control. Second, we need to re-establish momentum for developing and testing the new arrangements. And third, we need to ensure that our transition plans are sufficiently flexible to respond to further developments.

At the start of the listening exercise we confirmed that, as a result of the pause in the legislative process, the changes planned for April 2012 – including the abolition of Strategic Health Authorities and the full establishment of the NHS Commissioning Board – would need to be delayed until at least July 2012. Having given further consideration to this issue and to the Future Forum's advice, we have concluded that changing accountability arrangements during the financial year would present a significant risk to operational grip and financial control, particularly as 2012/13 is the second year of the QIPP period.

continued…

update

We have therefore determined that SHAs should remain in their current statutory roles for the whole of 2012/13 and, subject to the passage of the Bill, would be abolished alongside PCTs at the end of March 2013. The NHS Commissioning Board and the other new national bodies will take up their full accountability and financial responsibilities from 1 April 2013. This approach avoids changing accountability arrangements and altering financial allocation arrangements during the financial year. It therefore offers a more stable platform for transition.

Nevertheless, it is clear that maintaining the necessary capacity and capability across ten SHAs for the whole of this period will be a major challenge. There are growing numbers of people in interim posts and the need to reduce running costs over the transition period remains. We will therefore, mirroring the approach taken with PCTs, create four clusters of SHAs with single executive teams to consolidate leadership capacity whilst maintaining 10 separate statutory units. Our intention is for SHA clusters to be in place by October 2011.

The aim of clustering SHAs, as it has been with PCTs, is to ensure we have sufficient capacity in the system to maintain grip and momentum throughout the transition period. Alongside the extension of the period of transition, this should offer a more stable and durable set-up for the period up to April 2013. Moving to four SHA clusters will ensure the best fit between our transition arrangements and the future arrangement for the NHS Commissioning Board, which will be organised across the same geographical areas. Clustering will also help us to live within our running cost limits both now and in the future. In addition, clustering SHAs at an early stage will provide clarity for staff and avoids the need for operational changes during the winter period.

There are a number of detailed pieces of work we need to undertake in the coming weeks to make sure this new set-up is fit for purpose by:

- Finalising the geographical boundaries of the four SHA clusters, although we can confirm that the 4 areas will not cross existing SHA boundaries and that one of the four areas will be London,
- Agreeing governance arrangements, where a single model for all of the clusters is envisaged, and processes for making appointments,
- Setting out structural arrangements for the SHA clusters and a clear operating model between national leadership, SHA clusters and PCT clusters. This will build on the work that has already begun on a common operating model for PCT clusters,
- Agree a programme of development work to embed the new arrangements and ensure that there is sufficient leadership capacity in the system, and
- Establish broader national governance arrangements for the transition period that cover provider development, workforce and informatics as well as the commissioning system.

The NHS Management Board will take forward this work to develop the new transition arrangements and plans will be finalised by the end of July so that we can set a clear direction for the service.

Transition: commissioning development

Rapidly developing the new commissioning system – including clinical commissioning groups, commissioning support arrangements and the NHS Commissioning Board - is an urgent priority. We need to re-establish local momentum for clinical commissioning and begin to test the new aspects of the arrangements proposed in light of the Future Forum's report.

The pathfinder movement must remain at the heart of this process. Pathfinder groups are already playing a significant role in local commissioning arrangements and must remain at the forefront of modernisation. Many pathfinders are already actively testing some of the proposed new requirements, such as the development of governing bodies with independent and lay membership, membership for nurses and specialist doctors, and public meetings. Stronger governance, clearer public accountability and wider clinical involvement will all strengthen local commissioning groups, so we need to continue to test these changes across the country. Our overarching aim is still to support emerging clinical commissioning groups to be the very best they can be at the earliest opportunity. The emphasis on the importance of effective governance and independent membership on governing bodies also recognises the very important role that the Non-Executive community has played.

In line with previous plans, PCT clusters will remain in place until the end of March 2013. By April 2013, subject to the passage of the Bill, all GP practices will be members of either a commissioning group authorised to commission some or all services, or a 'shadow' commissioning group (legally established but with the Board carrying out some of its functions).

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update

The authorisation process will determine the pace and scale with which commissioning groups take on budgetary responsibilities. So, in line with the Future Forum's recommendations, there will be a phased approach to the assumption of new responsibilities by commissioning groups. Where clinical commissioning groups are not ready to take on their new responsibilities by April 2013, the local arms of the NHS Commissioning Board will commission some or all services instead.

The 50 PCT clusters are now in place and operational. The areas covered by PCT clusters will be reflected in the initial arrangements for the local arms of the NHS Commissioning Board. These local arms would be able to commission some or all care on behalf of those commissioning groups who are not yet ready to be fully authorised by April 2013. After April 2013, these local arms would oversee commissioning groups that have been authorised and would also commission some of those services, such as primary care, which are directly commissioned by the Board. Similarly, the areas covered by the 4 SHA clusters would be reflected in the sub-national arrangements of the Board and we will be working to align arrangements at this level with other key national bodies.

It is important to be clear that the local outposts and other sub-national elements of the NHS Commissioning Board would require significantly less capacity than PCT and SHA clusters. So while aligning our geographical arrangements for the transition with our intentions for the Commissioning Board will secure opportunities for many staff, others in PCTs will still want to consider opportunities for moving to clinical commissioning groups or establishing commissioning support providers. Many current SHA staff will of course also prefer to consider opportunities in provider development, workforce and informatics functions.

Alongside these changes, we will press ahead with re-invigorating clinical networks and establishing clinical senates across the country. These groups, both to be hosted in due course by the NHS Commissioning Board, will have a critical role to play in ensuring there is broad clinical involvement in the commissioning process and particularly in the design of complex care pathways. We will also continue with the development of broader commissioning support arrangements.

The authorisation process for clinical commissioning groups will be overseen by the Commissioning Board but will include a 360 degree process, incorporating a range of different views. That means that local Health and Wellbeing Boards, clinical networks and senates and patient groups will all have a say in determining whether commissioning groups are ready to take on their new responsibilities. We will set out more detail about the authorisation process in July.

In line with the clear recommendation of the NHS Future Forum, we propose to establish arrangements for the NHS Commissioning Board quickly, aiming to have the Board in place in "shadow" form as a Special Health Authority during October 2011. Subject to the passage of the Bill, the Board will then be established and take on its statutory responsibility for authorising commissioning groups by October 2012 and its full statutory and financial roles from April 2013. The purpose of having the Board in place in shadow form for a long period is to provide clear leadership and capacity for the development of the new commissioning system. We will set out more detail on how the Board will operate next month.

This approach to the complex transition to the new commissioning architecture aims to maintain the strong early momentum for change whilst providing much greater assurance that commissioning groups will only take on their new responsibilities when they are ready to do so. By reflecting the arrangements for PCT and SHA clusters in the way the NHS Commissioning Board will be organised, our intention is to give all existing staff in commissioning organisations a potential pathway into the new system, subject of course to agreed people transition policies.

update

Transition: provider development

The Government's response to the Future Forum was clear that completing the Foundation Trust (FT) pipeline remains an absolute central priority for our provider development work. This is because the process of applying for FT status will equip providers more effectively to meet future challenges by testing both clinical quality and financial viability and a full FT sector is crucial to the overall reforms. Progressing the pipeline supports our efforts to meet the QIPP challenge and it therefore remains our strong expectation that the majority of the remaining NHS Trusts will achieve the 2014 deadline for FT status. The Tripartite Formal Agreements set out the journey for these organisations to achieve FT status on their own, as part of an existing FT or in another organisational form. Aspirant FTs will be accountable for their commitments already detailed in these crucial documents.

However, as the Government has recognised, there remains a small number of organisations which will not meet the 2014 deadline. We will therefore be making arrangements for a small minority of Trusts to continue beyond 2014 with a specifically agreed later date for moving to FT status.

Until April 2013, accountability for delivering the FT pipeline will remain with SHA clusters, with clear national leadership and governance through a significantly enhanced national team including a responsible director as well as nursing, medical, financial and commercial expertise. This team will develop and establish the NHS Trust Development Authority (NTDA) during 2012 which would assume its formal role in overseeing remaining NHS Trusts from April 2013.

Establishing the NTDA would be essential to maintain the momentum of the FT pipeline but also to offer a credible employment option for key provider staff. The transition between SHA clusters and the NTDA is crucial to maintain the positive progress with the pipeline, ensure robust governance procedures are in place for NHS Trusts until they become FTs and protect key staff. The specific timings of this proposed transition will be confirmed in the light of the broader work on national governance arrangements set out above.

To provide further stability for the FT sector, we also propose to extend the period during which Monitor can exercise transitional powers over FTs up to 2016, or for two years after an FT is authorised if that is later. This would allow FT governors more time to develop capacity and will increase stability during the transition.

The extension of patient choice of Any Qualified Provider will also now take place over a longer timescale, beginning in April 2012 with some community and mental health services where there is potential for clear improvements in quality and access. In line with the Future Forum's recommendations, we want to focus on developing AQP in service areas where there is evidence from patients that increasing choice and allowing new providers to enter the market will improve quality. We will be publishing guidance on how this will work in July as well as working with commissioners to support this process. Alongside the development of AQP, we will be looking at ways of contracting for integrated care packages for service, such as end of life care and long-term conditions, where this is the most appropriate model.

Transition: workforce planning, education and training

The Future Forum was clear on the need to proceed carefully with changes to the education system. The Forum will have an ongoing role in this area and will be involved in ongoing work ahead of the publication of further proposals in the autumn. The responses to the Government's consultation on Developing the healthcare workforce and the Future Forum offered broad support for the core elements of the new system, in particular:

- healthcare employers taking more accountability and responsibility for planning and developing their workforce;
- strong professional leadership working to clear national standards;
- effective partnership with the education and research sectors;
- protected funding for education and training; and
- a new national body – Health Education England – providing sector-wide oversight and leadership.

continued…

update

The consultation and Future Forum report both emphasised the importance of a safe transition which provides stability and continuity for education programmes and service delivery. In ensuring a well-managed transition:

- SHA clusters will continue to deliver their functions on workforce planning, education and training until end March 2013. We propose that Health Education England would be established in shadow form during 2012/13 (i.e. as a Special Health Authority, but without its full functions), so that it can develop its organisation and operating model prior to taking full operational responsibility from April 2013;
- The Department of Health will take forward further work with the range of stakeholders to develop arrangements for healthcare employers to work in partnership locally on planning and developing the healthcare workforce and commissioning education and training;
- Post-graduate Deans and SHA staff involved in developing the workforce will continue to manage and assure education and training, including the training and recruitment of junior doctors and dentists. They would continue to be part of SHA clusters until end March 2013, except where other local arrangements are already in place. Securing continuity for the work they do into the new arrangements will be a key part of the next stages of work;
- The Department of Health will work with the service and professional bodies to ensure that recruitment to post-graduate medical and dental programmes in 2012 is managed effectively. This will require focussed attention from SHA clusters, including post-graduate Deans, and
- SHA clusters should work with their local healthcare employers over the coming months in developing their plans for the commissioning of education and training for 2012/13. We expect plans to be able to demonstrate the support of healthcare employer representatives, engagement with the education sector and responsiveness to strategic commissioning intentions.

Transition: informatics

The work of the NHS Future Forum has confirmed that high quality informatics support will be vital to ensure the success of the new Health and Care system. To this end in the future system informatics support will be provided from four sources. These are:

- **Dedicated Teams:** Each national and local body in the health and social care landscape will have its own dedicated informatics team responsible for the effective use of informatics to deliver that organisation's objectives, though some local organisations such as clinical commissioning groups are likely to prefer to arrange these functions on a shared basis.
- **Inter-organisation Informatics Shared Services:** Where local organisations such as clinical commissioning groups wish to share resources they will be encouraged to do so.
- **The Information Centre for Health and Social Care (IC):** The IC will have a statutory role as the single body authorised to conduct national data collection.
- **A National Shared Informatics Function:** A specialised pool of informatics resources will be provided to support the dedicated informatics teams. This function will provide continued support for informatics infrastructure that is best provided on a national basis (e.g. Spine, Summary Care Record, Cancer Screening).

The size of each of these parts of the system will be determined as the transition process progresses. This structure will result in an overall system that is well positioned to use informatics effectively to involve patients in decisions about their care; to exchange and exploit information efficiently and to improve value for money in health and social care delivery. The work of the future forum particularly stressed the need to ensure effective information flows to support integrated care pathways and to link interventions with outcomes while protecting the confidentiality of individual patient records.

update

Transition: communications

In order to deliver the major changes that flow from both QIPP and modernisation, there is a vital role for all leaders in communicating these changes and listening to and understanding the views and concerns of our patients and public as we take them forward. It is important that all organisations have appropriate professional communications and engagement support. Given the reductions in the size of PCT and SHA communications and engagement teams as part of our planned management cost reductions, it is now imperative that we reorganise these functions in order to provide the level of support needed by PCT clusters and emerging commissioning groups.

SHA Directors of Communications and Engagement are therefore working with the Director of NHS Communications, pathfinders and PCT clusters to develop a locally focused, nationwide shared service for communications and engagement. The intention is to ensure continued capability during transition for locally focused communications and engagement advice and delivery, backed up with a nationwide infrastructure of specialist support. It would also provide support for the NHS Commissioning Board and, potentially, other national organisations. And it would form the basis of an offer that could continue to be used beyond transition by those commissioning groups that wished to use it. This arrangement, which we will start to put in place over the coming months, will form a key part of the single operating model for PCT clusters.

Transition: local authorities and public health

The Future Forum's report fully supported the priority given to promoting joint commissioning and integration between health, public health and social services. It recommends a strengthened role for Health and Wellbeing Boards as the vehicle for local government to work in partnership with commissioning groups. Rapidly developing partnerships between local authorities and the new commissioning system therefore remain urgent priorities.

Local authorities and their partners are already playing a significant role in designing the new arrangements through the network of health and wellbeing board early implementers. 137 local authorities have already signed up to the early implementer network, and are already working with colleagues in SHAs, PCT Clusters and emerging pathfinders. Shadow health and wellbeing board arrangements should consider the following priorities;

- New governance arrangements – including relationships with Children's Trusts, local safeguarding arrangements, Crime and Safety Partnerships, Scrutiny Committees and District Councils
- Improving service provision for key groups – including Children, Young People and Families, Mental Health, learning disabilities, Older People, Offenders
- Arrangements for health Improvement, promotion and prevention and for tackling health inequalities
- Making best use of combined resources based on JSNA and Joint Health and Wellbeing Strategy
- Public engagement through and alongside HealthWatch

The Department, Local Government Group, SHAs and PCT Clusters will be working together with the early implementer network and pathfinders to ensure that support is available across the agenda. The Department will encourage lead and joint commissioning, and integrated provision, through the Government's mandate to the NHS Commissioning Board. It will set out new statutory guidance on joint health and wellbeing strategies, which the Department will produce, working closely with key stakeholders such as the Local Government Group, representatives of NHS organisations, patients and the voluntary sector.

The listening exercise highlighted that improving the public's health is everyone's business. It also sent a clear message about the importance of cooperation at every level. The NHS will continue to play a key role within the new public health system, and will need to build strong and cooperative relationships with local authorities and Public Health England. That includes robust arrangements for emergency preparedness and incident response.

Public Health England will be established as an executive agency of the Department of Health in April 2013. This will ensure that expert scientific advice is independent while allowing a more joined-up approach between policy and action in relation to health protection and emergency planning.

update

Transition: patient empowerment, choice and control

The Future Forum's report on Patient Involvement and Public Accountability fits well with our strategic approach to a new relationship with the citizen characterised by timely and clear information to support greater control, choice and convenience for patients, vulnerable communities and the wider public.

The Future Forum emphasised the importance of embedding 'No decision about me, without me' as core business throughout the service. We are drawing together existing work which supports this at an individual level (including shared decision models in long term conditions, decision support tools, and information prescriptions) to ensure a strategic approach, and will increasingly expect to see a partnership with the patient embedded in mainstream clinical practice across the service.

A personal sense of control is greatly enhanced by access to information about me and my condition; we are actively exploring how to enable on-line real-time access for more people to a greater range of health records held about them. This is part of our efforts to realise the government's vision for an information revolution to support choice and patient empowerment.

The Future Forum's report also 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. We are therefore planning to extend personal health budgets more widely, subject to the outcomes of the current pilots.

'No decision about me, without me' is also an important principle of accountability in public bodies. We are developing governance arrangements for both the NHSCB and local bodies which will embed good practice in transparency and participation, and enable us to be held to account for our activities.

We shall specifically address the concern expressed about accountability and responsiveness of a move to clinical commissioning groups through the development of robust authorisation processes which will pay particular attention to arrangements for governance and participation; we shall be looking for evidence that the core principles of greater control, choice and convenience are embedded in practice at local level.

This commitment to a new relationship with the citizen will be reflected in the structure of NHSCB through a dedicated national role for Engagement, Insight and Informatics to give leadership on these issues throughout the NHS.

As part of the QIPP challenge, we will draw on learning from the whole system demonstrator sites and other examples of using technology for safer, more responsive services to consider how to increase the range of channels routinely available for service delivery.

The Future Forum also 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 would take formal responsibility for NHS advocacy from April 2013.

Transition: enabling workstreams

Quality and safety

Past experience and learning from other sectors demonstrate how periods of transition can pose risks to maintaining the quality of services. It is crucial that we take steps to mitigate these risks and the National Quality Board (NQB) recently produced: *Maintaining and Improving Quality during the transition: safety, effectiveness, experience*. This report finds that the NQB's *Review of early warning systems in the NHS* remains valid for transition and summarises that statutory roles and responsibilities for maintaining quality of services do not change during this period. The NQB will provide further advice later this year on how quality will be maintained and improved in the new system architecture.

Maintaining and improving quality during the transition provides practical suggestions for maintaining the focus on delivering high quality services and the NQB has also produced a guide for provider boards on governing for quality. The NQB rightly remind us that the most important constant

continued…

update

that unites the system during the period of change ahead is the continued focus on quality and the values and behaviours of all staff in the NHS need to remain focussed on putting patients first. I would urge boards to discuss this report and think about what steps your organisation needs to take to maintain and improve quality during the transition. For example, the report set out the need for 'legacy documents' as part of ensuring effective organisational handover.

Our people

The HR implications of the proposed health and social care reforms are significant. They have required the development of the most comprehensive suite of HR frameworks and policies that the NHS has ever produced. The forthcoming publication of the HR Transition Framework is a very important further building block. This overarching HR Transition Framework will be used to guide all transfer, selection and appointment activities relating to current ('sender') NHS, Arm's Length Bodies as well as Department of Health staff moving to new ('receiver') organisations. The framework has been developed and agreed with employers and union representatives from the NHS, the DH and the ALBs through the National Transition Forum.

The forum is now also collaborating on the production of two further pieces of HR work: People Transition Policies and a 'Concordat' between the NHS, DH, ALBs and Local Government. Each new organisation, including the NHS Commissioning Board, should apply the principles and guidance set out in the HR Transition Framework in their own People Transition Policy. The first People Transition Policy will be published in July and is essential reading for anyone in the NHS, DH and ALBs who think that their future employment may be in the NHS Commissioning Board. It will explain what working for the NHS Commissioning Board would be like, how transfers would be managed and how appointments would be made. The 'Concordat' will cover the principles relating to the transfer, selection and appointment processes affecting Public Health staff moving to Local Government.

All of the above documents share the common aim of helping to ensure that all staff affected by reforms are treated fairly and consistently and that we retain the best talent in the new system. In doing so I also want to ensure that the new organisations, including the NHS CB, are established as exciting and innovative places to work at the forefront of best practice in terms of the experience of staff.

Finance

There are a number of crucial financial issues that need to be comprehensively addressed as integral elements of the refreshed transition plan.

We are reviewing the magnitude of the costs generated by the transition process taking particular account of the announced changes to both the creation and abolition of organisations in the system and the HR Transition Framework. We also want to be able, as quickly as possible, to explain how future funding and financial management arrangements will operate with particular reference to allocations to clinical commissioning groups.

It is also important that we refresh our approach to setting the running cost limits for the new bodies proposed. This is crucial for the work taking place to design the NHS Commissioning Board but also to help emerging commissioning groups in their planning and preparation for authorisation.

Research and innovation

The Future Forum report emphasised the important role of commissioners in supporting research and innovation. It confirmed that research and innovation are vital to the continuous improvement of quality in the NHS. It made clear that the NHS should drive innovation both in healthcare and across the wider economy, and that high quality research will be essential to this.

As we move through transition, we need to:

- embed a culture of research and innovation throughout the NHS;
- ensure that all commissioners promote research and innovation, and the use of research evidence; and
- ensure that commissioners continue to fund treatment costs for patients who are taking part in research, through normal arrangements for commissioning patient care, as set out in existing guidance.

Estates

On 6 January 2011, the Department announced that the primary care trust-owned estate that is required to deliver the commissioned services will be made available to first and second wave aspirant community foundation trusts. Subject to the Health and Social Care Bill and abolition of PCTs:

- The Department is currently examining with NHS and professional groups the implications for the management and ownership of the remaining PCT estate and an announcement will be made when this has been completed;

The NHS Commissioning Board will in future directly take over Primary Care Trust responsibility for reimbursement of GP premises costs as set out in The National Health Service (General Medical Services - Premises Costs) England Directions 2004.

Transition: timetable for change

Planned date	Commitment
October 2011	• NHS Commissioning Board established in shadow form as a special health authority • SHA cluster arrangements in place
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
April 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 SHA responsibilities for the FT 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 not authorise groups to take on their responsibilities until 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)

First published June 2011