THE GOVERNMENT'S RESPONSE TO THE NHS FUTURE FORUM REPORT
Briefing for members 15 June 2011

This briefing is intended to help members make sense of the Government's announcements about changes to their NHS reforms on Tuesday 14 June. It highlights where the government has taken on board recommendations from the NHS Confederation in areas where our members wanted to see changes. It also highlights some key issues where the Government has chosen to take a different approach to that of the NHS Future Forum.

COMMENTARY

The Government has announced some significant changes to their health reforms in response to the NHS Future Forum's report. Many of these are in line with what the NHS Confederation has been calling for over the last few months. The key changes include:

- Making an explicit commitment that the **Secretary of State retains and is accountable for the overall responsibility of securing the comprehensive provision of health services** (the exact wording to be determined in the legislation). This will make clearer the means by which the Secretary will hold the new national bodies to account.

- Strengthening the **governance** of the clinical commissioning groups (note the change in title from GP commissioning consortia), with a requirement to meet in public and ensure lay input to their governing bodies, and introducing a requirement for Foundation Trust (FT) boards to meet in public.

- Widening the clinical input to commissioning by establishing **clinical senates** and **clinical networks** to advise commissioning groups and by requiring their governing bodies to include a specialist doctor and a nurse.

- Introducing **flexibility in the implementation timetable:**
  - Clinical commissioning groups will not be required to take on their responsibilities from April 2013 if not ready and willing. For groups in this position, the NHS Commissioning Board will take on some or all of their commissioning responsibilities and will be expected to develop the commissioning groups' capability and capacity to take full commissioning responsibility over time.
  - Primary care Trusts (PCTs) as previously stated continue to 2013 when the clusters will be reflected in the NHS Commissioning Board structure,

although the exact number and geography will be determined by the NHS Commissioning Board nearer the time.
    - Strategic Health Authorities (SHAs) will now continue until 2013 (although as clustered groupings as yet unspecified).
    - Removing the blanket deadline for all NHS trusts to become FTs by April 2014, although all will be required to move to FT status when 'clinically feasible'.

- Expecting Clinical Commissioning Groups to work very closely with **Health and Wellbeing Boards,** in particular to ensure that commissioning plans reflect local health needs and priorities and that joint commissioning of health and social care services is not undermined. Health and Wellbeing Boards will be able to raise concerns with the NHS Commissioning Board if this is not taking place.

- Removing the duty to promote **competition** from Monitor and replacing it with a core duty to protect and promote patients' interests and also to promote **integration.** Phasing the introduction of Any Qualified Provider and introducing a 'choice mandate' for the NHS Commissioning Board which will guide the actions of Clinical Commissioning Groups and Monitor in this regard.

- Setting out plans to publish details of the **transition to the new education and training system**, and consult on detailed proposals to change how it is funded in the autumn.

- Recognising explicitly that **good management** is essential in improving the quality of front-line services and that money invested in management is well spent.

We welcome most of these changes, but recognise that much of the detail of how they would work in practice remains unclear. There is an urgent need to move beyond policy debates to practical implementation on the ground as the real challenges for the NHS remain. These are delivering £20 billion of efficiencies over four years, addressing care being poor in too many places – particularly in the area of treating people with dignity – and services being fragmented for too many patients.

Next steps for the reforms

- A further detailed statement will be issued by the Government next week setting out the legislative changes and a more detailed explanation of the practical changes to the implementation of the reforms.
- The Government will publish a Command Paper, and David Nicholson will issue a detailed letter to NHS organisations with more detail about how the changes will work in practice.
- The Government will publish amendments to the legislation.
- The Bill will return to Committee stage in the Commons, allowing line by line scrutiny of the amendments. No dates for this have been announced but we expect this to happen during July.

- The NHS Future Forum will continue to lead on listening in the NHS. Among other areas they will focus on education and training; patients' rights; and public health.

DETAILS OF THE CHANGES

Role of the Secretary of State

The Secretary of State's role and responsibility to provide a comprehensive health service will remain unchanged. The Government will 'make clear' the Secretary of State's ultimate accountability for the provision of services in the new system, albeit through mandate to the NHS Commissioning Board, and his powers to report on the performance of national NHS bodies. The Bill will confirm the Secretary of State's mandate to the NHS Commissioning Board is multi-year. A new mandate will not be set every year.

Analysis

We welcome these clarifications.

Commissioning consortia

a. Role and remit of consortia

Consortia are to be referred to as clinical commissioning groups, not GP commissioning groups. Commissioning consortia will still consist of groups of GP practices, but commissioning will also involve patients, carers and the public and a wide range of doctors, nurses and other health and care professionals. Clinical commissioning groups will be expected to have a name that uses the NHS brand and has a clear link to their locality.

The boundaries of clinical commissioning groups should not normally cross those of local authorities. If a commissioning group wishes to cross local authority boundaries, they will be required to demonstrate that this will secure a better service for patients.

The NHS Commissioning Board will need to agree proposed boundaries as part of the establishment process. Before establishing any clinical commissioning group, the Board will be required to seek the views of emerging Health and Wellbeing Boards.

It will be made clear that that commissioning groups must commission all urgent and emergency care within their boundaries, and that they will be responsible for their whole population not just patients registered with their constituent practices.

b. Governance

Commissioning groups will have a governing body including:

- 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
- at least one registered nurse and one doctor who is a secondary care specialist. These individuals 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.

These governing bodies will be required to meet in public and publish their minutes, as well as details of contracts with health service providers. Commissioning groups will be required to have governance arrangements consistent with Nolan principles, and will be held to account for this on an ongoing basis.

c. Accountability
The Government has clarified that as public bodies, clinical commissioning groups will be unable to delegate their statutory responsibility for commissioning decisions to private companies or contractors.

Further details on the processes for authorising and assessing clinical commissioning groups and on the accountabilities and relationships between the NHS Commissioning Board, commissioning groups and Health and Wellbeing Boards are to be published soon.

d. Quality premium
Provisions in the Bill relating to the quality premium will be revised to make clear that its purpose is to reward effective commissioning which improves the quality of patient care and health outcomes, including reducing inequalities in health outcomes, and manages this within available resources.

The Government acknowledges that the rules on how quality payments should be determined, including and when and why they can be withheld, need to be carefully designed. Such rules will be subject to regulations that have to be approved by Parliament. The Bill will also be changed so that regulations can make provisions for how commissioning groups can use any quality payment awarded to them.

Analysis
We welcome the focus on ensuring strong and transparent governance of commissioning groups. We are particularly pleased that both the Government and the Future Forum agreed that Nolan principles should be applied to commissioning groups and more widely, as we have argued consistently for this.

The requirement to include a nurse and secondary care specialist on the governing body of commissioning groups does not reflect the Future Forum recommendations. The Future Forum supported multi-professional professional and clinical advice and input, and the involvement of specialists in governance and decision-making but agreed with our argument that ‘clinical advice should not be confused with governance’. A requirement that these individuals are not be employed by a local provider will not eliminate conflicts of interest in a system where we have patient choice or Any Qualified Provider and robust mechanisms for managing conflicts of interest will be important. That said, we are pleased that a wider group of professionals will be engaged in commissioning.

Although there are benefits to alignment between the boundaries of NHS and local authority bodies, we would have concerns if the new approach has the effect of undermining or stalling progress where consortia that cross boundaries or are not geographically linked have already been established.

We agree the quality premium requires careful consideration and design to ensure there are sufficient incentives in the system but that these do not have unintended consequences, and clarity is required on how the quality premium is to be funded.

Role of the NHS Commissioning Board

The NHS Commissioning Board's role will be extended to include:

- Agreeing commissioning consortia boundaries including whether they are allowed to cross local authority boundaries.
- Holding commissioning groups to account for their compliance with robust governance requirements.
- Commissioning on behalf of shadow commissioning groups after April 2013.
- Working with GP practices and other local stakeholders to develop commissioning groups.
- Hosting clinical senates and clinical networks.
- Setting out guidance on how competition and choice should be applied to particular services, and how services should be bundled or integrated, in consultation with Monitor.
- Promoting innovative ways of demonstrating how care can be made more integrated.

Analysis

These extra responsibilities for the NHS Commissioning Board are largely as outlined in the Future Forum report, though going a little further in some cases (for example, delivering the Forum's recommendation of 'embedding' clinical advice in the NHS Commissioning Board by requiring it to host the clinical networks and senates). While we recognise and applaud the importance of a stable transition we also need to make sure that the new system is not over centralising and there is real momentum towards the important goal of pushing responsibility and decision making powers down to the local level.

Transition arrangements

Primary Care Trusts (PCTs) 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.

Those that are willing and have demonstrated they are ready by April 2013 could be authorised to take on full budgetary responsibility, but some will only be authorised in part, and others will only be established in shadow form.

'Shadow' commissioning groups will still be legally established bodies, but the NHS Commissioning Board will commission on their behalf until they are ready to take on their responsibilities. The NHS Commissioning Board will work with the GP practices and other stakeholders in these areas to develop fully operational commissioning groups as quickly as possible.

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.

Primary care trust “cluster” arrangements will be reflected in the local arrangements of the NHS Commissioning Board. Those local arrangements will be established before PCTs are abolished.

The ten Strategic Health Authorities (SHAs) will remain in place as statutory bodies until April 2013, but will be clustered later this year for management purposes, as has been done with PCTs.

The government predict the majority of remaining NHS trusts will be authorised as foundation trusts by April 2014. Remaining an NHS trust will not be an option but the Bill will not include a deadline. All NHS trusts will have an agreed deadline to become foundation trusts as soon as clinically feasible. To enable time for governors of Foundation Trusts to build capability, the government will further extend the transitional period where Monitor retains specific oversight powers over foundation trusts to 2016.

Reflecting the Future Forum's concerns that leadership development and wider continuing professional development is supported across the new system, steps are to be taken 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.

Analysis
A variable-speed approach to the new commissioning architecture is sensible, but there will need to be strong incentives for and support to local practices to form viable consortia by a specific end-point. We need to make sure that the new system is not over centralising and there is real momentum towards the important goal of pushing responsibility and decision making powers down to the local level. There may also be some legal issues to resolve if all groups are to be established as legal entities by April 2013 (for example, will consortia be able to delegate their statutory responsibility, as well as their commissioning activities, to the NHS Commissioning Board?). It will be necessary to ensure that there is clear process and accountability for local decision-making.

We await further clarification of the statement that PCT cluster arrangements will be reflected in the local arrangements of the NHS Commissioning Board, but welcome the acknowledgement of the need to retain the talent, expertise and experience from PCTs and SHAs.

The softening of the ‘drop dead’ date for FTs could mean a slower pace to achieving a whole FT sector. The Foundation Trust Network believes that the Government should keep the ‘drop dead’ date but allow an exceptions regime where NHS trusts can demonstrate that they could be viable for authorisation within a short time of the

final date through a vigorous business case agreed with the national provider agency.

Clinical networks and clinical senates

- Clinical networks will be retained and expanded to include a wider range of specialist areas as well as a stronger role in commissioning.
- Clinical senates will be established, and will include both public health specialists and adult and child social care experts.
- They will not be separate bodies or organisations and will be hosted by the NHS Commissioning Board.
- They will also have a formal role in the authorisation process of Clinical Commissioning Groups.
- Close links are to be established between the NHS Commissioning Board and the Royal colleges and other professional bodies.
- The NHS Commissioning Board will secure advice from a full range of health professionals where relevant.

Analysis

We welcome the involvement of a wide range of clinicians in commissioning at both a national and local level, having argued that setting up clinical advisory bodies to support consortia could represent a positive way forward.

The involvement of public health and social care professionals in the proposed clinical senates is also welcome, and healthcare professionals involved in the delivery of community health services should also be engaged in providing advice and support to commissioners.

However, the establishment and running of these multiple networks and senates alongside health and wellbeing boards, the National Institute for Health and Clinical Excellence (NICE) and Public Health England has the potential to become extremely complex and confusing, and could undermine local priority-setting and decision-making. It will be important to ensure this new system is coherent and streamlined, and more clarity is required on the status and authority of the advice and recommendations from these various entities.

Choice and competition

- The Bill will be amended to strengthen and emphasise commissioners' duty to promote choice in line with the NHS Constitution and this will be included in the Secretary of State's mandate to the NHS Commissioning Board.
- Subject to evidence from the current pilots, the mandate to the NHS Commissioning Board will also make it a priority to extend personal health budgets, including integrated budgets across health and social care.
- 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.
- The government will maintain its commitment to extending patients' choice of Any Qualified Provider but will use a more phased approach starting in April 2012. Choice of Any Qualified Provider will be limited to services covered by national or

local tariff pricing and will focus on services where patients say they want more choice, for example selected community services.

- The government will carry out further work on the feasibility of a citizens' 'Right to Challenge' poor quality services and lack of choice.
- The NHS Commissioning Board, in consultation with Monitor, will set out guidance on how choice and competition should be applied to particular services, guided by the mandate set by ministers. This includes guidance on how services should be bundled or integrated.
- To avoid 'cherry picking' of profitable cases, services will be covered by a system of prices that accurately reflect clinical complexity, except where this is not practical.
- Commissioners will be required to follow 'best value' principles when tendering for non-tariff services, rather than simply choosing the lowest price.

Analysis

We are pleased to see that the Government has recognised the importance of promoting integration but believe it is also important to recognise that for some services the use of choice and competition is also an essential route to deliver the best patient care. It is important to recognise that the independent and third sectors have an important role to play.

We believe decisions about applying choice and competition are best made locally, and support a phased approach in principle. We believe the NHS Commissioning Board's guidance on this should be in the form of a framework for local decision making rather than detailed, prescriptive guidance.

Designing prices that 'reflect clinical complexity' will be a complex task and depending on how it works, it could result in tariff inflation. It is unclear whether this is designed to prevent cherry picking within a procedure (for example, simple hip operations and hip operations with complications) or cherry picking of simpler treatment areas (for example, there is a view that some hospitals subsidise A&E through simpler elective procedures.) We agree with the Future Forum recommendation that further work is needed in this area.

We would like to see a commitment to more work to address the risks posed by price competition in non tariff services – including speeding up work to extend the tariff to more services including mental health.

Whilst we support extending personal health budgets, the timetable should be designed to allow the evidence base from the current pilots to be evaluated to give the best chance of success including widespread support from clinicians – five years may not be long enough.

While patients and citizens should have effective mechanisms for raising concerns about the choice and quality of services with local commissioners and ensuring these are addressed, we do not believe it would be appropriate to introduce a new 'right to challenge', as it is defined in the localism bill. We agree with the Future Forum that

further work is required to examine how patients and citizens can most effectively drive service improvement.

The role of Monitor

- Monitor's core duty will be "to protect and promote patients' interests" and that Monitor's powers to "promote competition as if it were an end in itself" will be removed. Monitor will instead "tackle specific abuses and unjustifiable restrictions that demonstrably act against patients' interests".
- Monitor's powers over anti-competitive purchasing behaviour will be narrowed to make them more proportionate and focused on preventing abuses rather than promoting competition.
- Monitor will not be able to force providers to open up their facilities to other providers.
- Monitor will be required to support the delivery of integrated services where this would improve quality of care or efficiency.
- The Labour government's Principles and Rules for Cooperation and Competition will be retained and given a clearer statutory underpinning. The Cooperation and Competition Panel will move to Monitor but retain its own identity. This goes beyond the Future Forum's recommendations.
- As proposed originally in the health bill and supported by the Future Forum, Monitor will have concurrent powers with the Office of Fair Trading to ensure competition rules can be applied by a sector-specific regulator with expertise in healthcare.
- It will not be possible for any politician to attempt to increase the market share of any particular type of provider (eg. independent sector or state run). This conflicts with the Future Forum's recommendations - particularly around social enterprise.

Analysis

Independent sector providers welcome the retention of the Cooperation and Competition Panel within Monitor, but the overall dilution of Monitor's role and the return to more centralised control and direction via the NHS Commissioning Board are unwelcome.

As Monitor is licensing all providers there will also be some apprehension around extending Monitor's jurisdiction over all FTs up to the end of 2016 as Monitor's special responsibility for FTs' success could give it a conflict of interest.

Integration

- Monitor will be required to support the delivery of integrated services where this would improve quality of care or efficiency;
- Clinical commissioning groups will have a new duty to promote integrated services for patients, both within the NHS and between health, social care and other local services; and the existing duty on the NHS Commissioning Board will be strengthened;
- The NHS Commissioning Board will promote and demonstrate how care can be made more integrated for patients, including developing tariffs for integrated pathways of care, and exploring how to achieve single budgets for health and social care.

Analysis
We welcome the greater focus on enabling integration, which we have argued for. We are also pleased that the Government has heeded our argument that innovative approaches such as single budgets for health and social care and integrated tariffs should be explored and look forward to contributing to this work.

Providers
- To end the culture of hidden bailouts and get the right incentives into the NHS the government assure there will be an effective failure regime;
- It will amend the Bill following concerns about the practicality of current proposals for an up-front system of designating services for additional regulation;
- The Government will amend the Bill to require foundation trusts to hold their board meetings in public;
- Foundation trusts will be required to produce separate accounts for NHS and private-funded services. This goes beyond the Future Forum's recommendations;
- The Government will introduce a "duty of candour": a new contractual requirement on providers to be open and transparent in admitting mistakes.

Analysis
We agree a failure regime is needed, but much more detail is needed and it is important that this is independent of government. More detail about the changes to designating services is also urgently required. Progress in both these areas should be a priority.

While we recognise it is important the NHS is transparent, we would want to analyse closely the practicalities of the proposed 'duty of candour'.

Health and wellbeing boards and local authorities
Health and well-being boards will:
- have a new duty to involve users and the public
- be involved throughout the process of developing clinical commissioning group plans which should be in line with the health and well-being strategy
- have a stronger role in promoting joint commissioning and integrated provision
- have a formal role in authorising clinical commissioning groups: the NHS Commissioning Board will have to take their views into consideration during group assessments
- operate as an executive body of local government. Local authorities will be able to determine the number of elected members to sit on the health and well-being board and are free to insist upon having a majority of elected councillors.
- be subject oversight and scrutiny by the existing structures in local authorities.

Local authorities will be able to challenge any proposals for the substantial reconfiguration of services.

Analysis
We are pleased to see the Government strengthening and outlining the role of health and well-being boards clearly, something we called for. They will perform a number

of functions relating to democratic legitimacy, operational decision-making and partnerships and they must be clearly accountable for these locally. We would prefer them to agree their membership locally to better support joint working.

The Government has taken up our recommendations to engage the NHS and local authorities in the health and well-being strategy and ensuring consortia plans are consistent with the strategy.

Patient and public involvement
Provisions for patient and public involvement will be strengthened:

- health and well-being boards will have a new duty to involve users and the public
- Monitor will have a new duty to involve patients and the public
- the duties for the NHS Commissioning Board and clinical commissioning groups to involve patients, careers and the public will be clarified. Commissioning groups will have to involve the public on any changes that affect patient services
- commissioners' duties will include involvement of patients and carers
- the CQC will be required to respond to advice from HealthWatch England and the Secretary of State will have to consult HealthWatch on the NHS Commissioning Board's mandate
- local HealthWatch will be required to represent different users including carers.

Analysis
We welcome the Government's plans to strengthen patient and public involvement. However detail is still required about how both complaints mechanisms and HealthWatch's role to involve and represent the public as well as patients will work in practice. We would also like to see commissioners and providers required to respond to HealthWatch findings.

We support the Future Forum's recommendations to:

- establish jointly accountable outcomes across health and social care
- set up joint commissioning demonstration sites
- strengthen the nature of patient involvement to include shared decision-making
- provide training and support for organisations engaging patients and the public

and we hope these are reflected in the reforms' detailed implementation.

Patient rights
The Government's response clarified patients' rights in a number of areas, to allay concerns, and set out some additional rights.

Government response:

- The NHS Commissioning Board and commissioning consortia will be required to actively promote the NHS Constitution.
- The Bill will uphold the legal force of the Constitution, including the right of patients to receive drugs and treatments recommended by NICE.
- The Bill will be amended to protect patient confidentiality in a way that supports plan to drive quality improvement

Analysis
We welcome promoting the NHS constitution and agree that appropriate patient confidentiality systems should be put in place. It is notable the Future Forum will have an ongoing role in consulting with stakeholders on this area.

Education and training
The Government set out relatively little detail on the future of the education and training reforms, allowing more time to get it right before consulting on additional details in the autumn.

The Government 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
- set out further details in the autumn on how to ensure a safe and robust transition for the education and training system. There was no specific response to the Future Forum's recommendation that Health Education England be established quickly
- give deaneries 'a clear home within the NHS family' - during the transition, deaneries will continue to oversee the training of junior doctors and dentists. The Future Forum said these functions should be transferred to a host organisation, a suggestion we made in our submission.
- ensure any changes to the funding of education and training are introduced in a careful, phased way that does not create instability. The Government will develop the proposals, working with health and social care partners and through further consultation, and publish more detail this autumn. The Forum report recognised the potential impact of changes to funding on workforce plans and the need for a level playing field between providers.

Analysis
The Future Forum's ongoing role in listening to the NHS includes education and training, so its recommendations on this issue are particularly relevant. As such, it is encouraging that the Future Forum report recognised the benefits of moving to a system that was more sensitive to the needs of the service and employers. We are also pleased they recognised the need for care in introducing changes to funding, reflecting our position. Whilst we recognise the need to allow enough time to get the new system right, we also need to maintain momentum towards a new system that will be more sustainable for the NHS. Read NHS Employers' briefing.

Public health
Government commitments:

- to make Public Health England (PHE) an executive agency
- to embed a culture of innovation and research in PHE
- commissioners to work with public health experts. Clinical senates will include public health specialists.

Analysis
We called for the Government to find robust solutions to maintain the independence from government of the scientific advice. We are pleased they have moved towards

this by establishing PHE as an executive agency, though it is unclear whether this status would allow it to generate funds through grants or contract work. We are pleased to see our recommendations regarding public health input into commissioning and the role of research being taken up. It is notable the NHS Future Forum will consult further with the NHS on public health.

Research

- A new duty will be created for the Secretary of State to promote research.
- There will be a new duty for clinical commissioning groups to promote research and innovation (in line with the NHS Commissioning Board).
- A culture of research is to be embedded for the NHS Commissioning Board and Public Health England.
- Clinical commissioning groups and the NHS Commissioning Board will ensure that treatment costs for patients who are taking part in research will be funded.

Analysis

We welcome these developments.