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The NHS Listening Exercise

What's New?

A brief summary of the key changes and new proposals

A briefing on the key changes and new proposals for the reform of the NHS as a result of the Government's Listening Exercise on the NHS Reforms, with particular reference to issues of public and patient engagement and accountability and scrutiny.

By Mike Cooper

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The NHS listening exercise – new proposals

On 6 April 2011 the government announced that it would "pause, listen and reflect" on its NHS reform plans; the NHS Future Forum was established to lead the 8-week "listening exercise" and issued its report on 13 June. On 20 June 2011 the government made its full response to the report. This is a summary of the changes the Government has proposed to its reform proposals, focusing on issues of public involvement, accountability and governance. It should be read in conjunction with our briefing, *The Health White Paper – what it says,* and update paper, *The Health White Paper – What's changed?*, summarising the changes announced by the government following the consultation on the White Paper (for this and other comment and analysis see http://tamarindchambers.wordpress.com).

A national health service

The government has reaffirmed its commitment to maintaining NHS care free at the point of use and will take further steps to embed the NHS Constitution and to uphold the patient rights it contains; the NHS Commissioning Board and commissioning consortia will be required to actively promote the Constitution.

The Secretary of State will remain accountable for the NHS and responsible for promoting a comprehensive health service; and for overseeing and holding to account the national bodies such as the NHS Commissioning Board and the regulators, but not for direct operational management.

Local commissioning groups

Commissioning consortia, previously termed 'GP Commissioning Consortia', are to be renamed 'clinical commissioning groups', and whilst still being made up of groups of GP practices, will involve a wide range of health professionals as well as patients, carers and the public. They will be phased in more slowly, and may take on a commissioning budget from April 2013, but only when ready and willing to do so - some groups may be authorised in part or may operate in shadow form without commissioning responsibilities until fully authorised commissioning groups are established.

The boundaries of clinical commissioning groups should not normally cross local authority boundaries, and if they do they must demonstrate to the NHS Commissioning Board how that would be in the interests of patients and promote integration of health and social care. The proposed boundaries of clinical commissioning groups will have to be agreed by the NHS Commissioning Board, which will be required to seek the views of Health and Wellbeing Boards.

Clinical commissioning groups will be public bodies, with transparent and accountable governance consistent with the Nolan principles. They will each have a decision-making governing body, that will include at least 2 lay members and at least one registered nurse and secondary care doctor (who must not have a conflict of interest with the clinical commissioning group, ie not be employed by a local provider); and will have to meet in public and publish minutes and details of contracts with providers.

Clinical commissioning groups will be under a duty to:

- arrange emergency and urgent care and commission services for people who are not registered with a GP, within their boundaries;
- involve patients, carers and the public in commissioning decisions and to consult on their annual commissioning plans; and they will have to involve the public on any changes to patient services, not just 'substantial' ones (equivalent to current duties under section 242 of the NHS Act 2006);

- promote choice and promote integrated services for patients, both within the NHS and between health, social care and other local services; and
- secure professional advice from the full range of relevant health professionals, and to promote research and use research evidence.

Clinical commissioning groups will be able to work in partnership with other groups, local authorities and the NHS Commissioning Board; but will not be able to contract out their responsibility for commissioning decisions. The government will publish further details on the process for authorising clinical commissioning groups and their accountabilities and relationships with Health and Wellbeing Boards.

The NHS Commissioning Board

The NHS Commissioning Board will be set up in shadow form in October 2011; it will be established as an independent statutory body by October 2012 and start to carry out the authorisation of clinical commissioning groups, with input from emerging Health and Wellbeing Boards and local clinicians; and it will take on its full responsibilities from April 2013.

The NHS Commissioning Board will be under duty to involve patients, carers and the public in commissioning decisions and to consult on their annual commissioning plans. The Secretary of State's 'mandate' to the Board will set expectations about offering choice, and make it a priority to extend patient budgets including integrated budgets across health and social care.

Primary Care Trusts (PCTs) will be abolished in April 2013. Where a clinical commissioning group has not been authorised, the NHS Commissioning Board will carry out commissioning, based on the areas of PCT clusters, whilst it works to establish authorised clinical commissioning groups.

Strategic Health Authorities will be formed into a smaller number of clusters later in 2011 and will be abolished in April 2013.

Clinical senates

New 'Clinical senates', made up of doctors, nurses and other professionals including public health and social care experts, will give advice to clinical commissioning groups and advise the NHS Commissioning Board on local commissioning plans and major service changes, and have a role in advising the NHS Commissioning Board on the authorisation of clinical commissioning groups. Clinical networks, including patient and carer representatives will have a role in supporting commissioning groups.

Providers and competition

All NHS trusts will be required to become foundation trusts as soon as clinically feasible; most by April 2014, but there will not be a set deadline in the Bill. There will be a new requirement on foundation trusts to hold their board meetings in public, on all NHS providers to be open and transparent in admitting mistakes. Monitor will retain specific oversight powers over foundation trusts until 2016.

Monitor's core duty will be to protect and promote patients' interests. Monitor will not be given powers to 'promote competition' as an end in itself; but will only act to prevent abuses and unjustifiable restrictions on competition that act against patients interests.

Competition will be on the basis of quality not price; there will be safeguards against "cherry picking" and commissioners will be required to follow 'best value' principles, not just lowest price. Current rules governing competition in the NHS as introduced by the previous government will be retained.

The Government remains committed to 'any qualified provider', but phased in and delayed to start in April 2012, and limited to services covered by national or local tariff pricing.

Public Health

Public Health England will be established in April 2013 as an executive agency of the Department of Health, to ensure that it can give independent advice. Further details will follow in the government's response on the Public Health White Paper.

Health and Wellbeing Boards

The Health and Wellbeing Board will operate as an executive body of the local authority. The number of members who are councillors, and whether they make up a majority, will be up to the local authority.

Health and Wellbeing Boards will be involved throughout the process of clinical commissioning groups developing their commissioning plans, and there will be a statutory expectation that plans will be in line with the health and wellbeing strategy. The Health and Wellbeing Board will not have a veto over commissioning plans, but may refer them back to the clinical commissioning group or to the NHS Commissioning Board.

Health and Wellbeing Boards will be under a new duty to involve users and the public.

Health and Wellbeing Boards will have a formal role in advising the NHS Commissioning Board on the authorisation of clinical commissioning groups and the NHS Commissioning Board will have to take their views into account in their annual assessment of clinical commissioning groups.

Local authority scrutiny

The government has confirmed that clinical commissioning groups and Health and Wellbeing Boards will be subject to scrutiny by local authority overview and scrutiny bodies and the existing statutory powers of scrutiny will apply; and that local authorities will have greater flexibility over how to exercise scrutiny powers, in line with the Localism Bill.

Local authorities will continue to be able to challenge proposals for substantial variation to NHS services in accordance with current government and the four tests for assessing service reconfigurations (the proposal for 'designated services' has been dropped); but a referral will need to be triggered by an agreement of full council, not the health scrutiny committee.

Healthwatch

Local Healthwatch will be under a new requirement that its membership be representative of different users, including carers.

The Care Quality Commission will be required to respond to advice from HealthWatch England (which will, as previously proposed, be a sub committee of the CQC).