Mike Cooper Consultancy

The Government's NHS Reforms

a briefing for health scrutiny practitioners

By Mike Cooper

Mike Cooper Consultancy

July 2011

The Government's NHS reforms

A briefing for health scrutiny practitioners

By Mike Cooper, July 2011

The Government has embarked upon major reforms to the NHS, originally set out in the Health White Paper, *Equity and excellence: liberating the NHS,* July 2010, and the Health & Social Care Bill, and amended by proposals announced following the NHS Future Forum 'listening exercise'. The Government is pressing ahead with a programme of pathfinders and early implementers to pilot and develop the new structures and functions, ahead of the Bill being enacted.

Health scrutiny continues to operate under existing legislation, and the current powers of health scrutiny and duties on commissioners and providers of health and social care services with regard to health scrutiny will continue to apply unless and until they are specifically replaced by new legislation.

1 The role and powers of scrutiny

The Government had originally proposed that the role of scrutiny be transferred from the health scrutiny committee to the Health and Wellbeing Board. However it has now confirmed that independent scrutiny of health and social care will remain, and that the new NHS commissioning groups and Health & Wellbeing Boards will be subject to scrutiny by local authority scrutiny committees.

The powers of health scrutiny will be extended to apply to all commissioners and providers of publicly funded health and social care services and the Government has said that the specific duties on local NHS bodies to respond to health scrutiny will be extended to all providers of publicly funded care, ie to include independent and private service providers.

The powers of health scrutiny that currently rest with the health scrutiny committee will in future be held by the local authority, and the authority will have flexibility over how it carries them out – whether through continuing to have a specific health scrutiny committee, or through a suitable alternative arrangement.

The power of health scrutiny to refer 'substantial variations in service' to the Secretary of State is to be changed so that in future a referral will need to be triggered by an agreement of full council, ie the health scrutiny committee would not make the referral itself, but would have to make a recommendation to Council. Local authorities will still be able to challenge any proposals for the substantial reconfiguration of services, and the Government's four tests continue to apply.

The Government also proposes that if local authorities establish a joint scrutiny committee, then the decisions of the joint scrutiny committee will be binding on all authorities.

2 NHS commissioning

The Health White Paper and the Health & Social Care Bill will transfer the bulk of the NHS commissioning role from PCTs to new clinical commissioning groups, and subsequently abolish

PCTs and SHAs.

Clinical commissioning groups will be made up of groups of GP practices. They will be public bodies with a board of governors that will include at least two lay members (like non-executive directors) and at least one registered nurse and one doctor who is a specialist in secondary care; and that will operate in accordance with Nolan principles and meet in public. Clinical commissioning groups will not normally cross local authority boundaries, and if they wish to they must demonstrate how that would be in the interests of patients and the integration of health and social care.

Clinical commissioning groups will be responsible for commissioning the majority of NHS services for their patients and for arranging emergency and urgent care; and they will be responsible for commissioning those services for people within their boundaries who are not registered with a GP. They will have a duty to work with and jointly commission services with local authorities; to secure advice from a full range of health professionals; and to involve patients, carers and the public in commissioning decisions and on any changes to patient services, not just 'substantial' ones (equivalent to the current duties on NHS bodies under section 242 of the NHS Act 2006). They will not be able to contract out their commissioning responsibility to a private company.

Clinical commissioning groups will be phased in more slowly – they may take on a commissioning budget from April 2013, but only when ready and willing to do so, and some groups may be authorised in part or may operate in shadow form without commissioning responsibilities until fully authorised commissioning groups are established. Where a clinical commissioning group has not been authorised the NHS Commissioning Board will carry out NHS commissioning, based on the areas of PCT clusters, whilst it works to establish authorised clinical commissioning groups.

We are currently in a transitional phase where most of the country is covered by 'pathfinder' commissioning groups operating under delegation from PCTs, that are themselves working in clusters, with the transition process being overseen by the SHA. Pathfinder commissioning groups have no legal status and their powers and duties are retained by the PCTs, so health scrutiny should still primarily operate through the PCT (or PCT cluster) that will continue to be subject to the current duties to respond to health scrutiny and to send a representative if requested. The current pathfinder commissioning groups may not end up as the authorised clinical commissioning groups that will take on formal responsibility for NHS commissioning from April 2013.

Some services currently commissioned by PCTs, and therefore subject to local health scrutiny, will not transfer to clinical commissioning groups, but to the NHS Commissioning Board:

- Services of GPs themselves.
- Primary dental, ophthalmic and pharmacy services.
- Specialised services, jointly commissioned, but currently PCTs still accountable. eg specialist cancer services.

It is not clear how these services will be subject to scrutiny, or what role, if any, there will be for health scrutiny committees.

Clinical commissioning groups will be accountable to the national NHS Commissioning Board (not directly accountable to the Department of Health in the way that PCTs are); the Government has stated that the NHS Commissioning Board would need to demonstrate 'reasonable grounds' before intervening in relation to a clinical commissioning group, but this could impact on their autonomy and local accountability to the Health & Wellbeing Board.

Monitor will have a new 'core duty' to protect and promote patients' interests and to promote integration of services. It will have a role in tackling abuses and unjustifiable restrictions to ensure a level playing field between providers, but will not have powers to promote competition 'as an end in itself'. Monitor will continue to oversee Foundation Trusts until 2016.

The government remains committed to extending patient choice to 'any qualified provider'; but will delay the start of this to April 2012, and limit choice to services covered by local or national tariff pricing so that competition is based on quality, not price. Some services, such as Accident & Emergency and critical care, will be excluded.

The existing 'direction of travel' with an increased diversity of providers is further promoted by the Government's NHS reforms, with the expectation that there will be an even greater range and number of providers operating with greater autonomy, whilst decision-making and public involvement will be more clearly focused on the commissioners – the local authority executive, clinical commissioning groups and Health & Wellbeing Boards.

3 Local authority – strategic and public health roles

The Government's NHS reforms give local authorities an increased strategic role promoting the integration of health and social care, and their integration with other services, and joining up the commissioning of local NHS services, social care and health improvement.

The Government's public health White Paper, *Healthy Lives, Healthy People* (November 2010), transfers responsibility for public health and health improvement from PCTs to local authorities, with a ring-fenced budget, from April 2013. This is intended to achieve greater coordination across the wider determinants of health, such as housing, education, transport and leisure, and, through local leadership in place of central NHS control, lead to more appropriate, flexible and effective local responses. The White Paper suggests that the new Health & Wellbeing Boards (see section 7.4 below) will play a key role in this.

A new national public health service, Public Health England, will be established as an executive agency of the Department of Health in April 2013, to coordinate action that is required nationally and to grant the ring-fenced budget to local authorities. Public health directors will sit in 1st tier local authorities, jointly appointed by the local authority and Public Health England. The White Paper also suggests that local authorities will be accountable for public health activity to the Department of Health, and it is not clear how this will impact on the stated desire for greater local accountability.

The Government will publish further details in its response to the consultation on the Public Health White Paper.

From April 2012 local authorities will be responsible for commissioning and funding local HealthWatch, and ensuring it is operating effectively in their area.

Local authorities will have new responsibilities to commission the following NHS advocacy, support and complaints services for their area:

- Advocacy and support services to enable NHS patients to exercise choice; that will be provided by local HealthWatch, from April 2012
- Mental health advocacy; that must be commissioned from bodies other than HealthWatch.
- NHS complaints services; that may be commissioned from HealthWatch or from other bodies, from April 2013.

4 Health and Wellbeing Boards

Every upper tier local authority will be required to establish a 'Health & Wellbeing Board' that will operate as an executive body of the local authority. It is proposed that the Board will have a statutory core membership of at least one elected councillor, directors of adult social services,

children's services, and public health, representatives of relevant clinical commissioning group, and local HealthWatch; with membership beyond this being down to local determination. The number of members who are councillors, and whether they make up a majority, will be up to the local authority. The local authority may set up a joint board with neighbouring authorities.

The Health & Wellbeing Board will bring NHS commissioning groups together with the local authority, join up the commissioning of local NHS services with commissioning of social care and other local services, and make joint working and partnership arrangements easier. It will give local authorities influence over NHS commissioning, and NHS commissioners influence over public health and social care. Health and Wellbeing Boards will be under a new duty to involve users and the public.

The Health & Wellbeing Board will be required to develop a joint health and wellbeing strategy spanning the NHS, social care, public health and potentially other local services. The commissioning plans of local authority and NHS commissioners will be expected to be in line with the strategy. The 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.

Around 90% or local authorities are working as early implementers to establish 'shadow' Health and Wellbeing Boards, to develop their relationships and joint working arrangements with other existing and emerging partners, including health scrutiny. All local authorities should have shadow Health and Wellbeing Boards in place by April 2012, and they will take on their statutory responsibilities from April 2013.

5 Public engagement, LINks and HealthWatch

Under the Government's NHS reforms LINks will become HealthWatch; but their essential role and relationship with health scrutiny will stay the same.

Local HealthWatch will continue LINks' role in promoting and supporting public involvement in the commissioning, provision and scrutiny of local care services. Local Healthwatch will be under a new requirement that its membership be representative of different users, including carers.

Local HealthWatch will be established in October 2012, funded by and accountable to local authorities.

Local authorities will be responsible for commissioning local HealthWatch and for ensuring that local HealthWatch are operating effectively and for putting in place better arrangements if they are not, from April 2012; the budget will not be ring-fenced, but local authorities will get additional funding for the increased roles of HealthWatch in advocacy and support services to enable patients to exercise choice.

A new national body, HealthWatch England, will be established as a committee of the Care Quality Commission, in October 2012. It will provide leadership, advice and support to local HealthWatch, and will collate information from local HealthWatch and provide advice to the Care Quality Commission and other national agencies.

Local authorities will be required to consider how local HealthWatch relates to its scrutiny functions. The Government will set out proposals for HealthWatch governance and stakeholder engagement and the relationship between HealthWatch, the local authority and HealthWatch England.

In most of the country LINks are beginning to operate as pathfinder HealthWatch, to explore new

ways of working and develop their relationships with other existing and emerging partners, including health scrutiny, and to test models for their new role in advocacy and supporting patient choice.

6 Timescales

In response to the NHS Future Forum the Government announced that it would phase in its reforms more slowly. The timetable for the main changes impacting on health scrutiny (based on the latest information available) is as follows:

During 2011-12:
– Pathfinder commissioning groups rolled out across the country, working under delegation from PCTs
– Early implementer/pathfinder Health & Wellbeing Boards rolled out across the country
– LINks start operating as pathfinder local HealthWatch

Later in 2011:
– SHAs to be formed into a smaller number of clusters

October 2011:
– NHS Commissioning Board established in shadow form

April 2012:
– Local authorities take responsibility for commissioning local HealthWatch

By October 2012:
– NHS Commissioning Board established as an independent statutory body and starts to authorise clinical commissioning groups

October 2012
– HealthWatch England and local HealthWatch are established

April 2013:
– Public Health England established
– Health and Wellbeing Boards take on statutory responsibilities
– NHS Commissioning Board takes on full responsibilities
– Local authorities receive ring-fenced budget for public health
– Local authorities take on responsibility for commissioning NHS complaints advocacy
– All GP practices to be members of an authorised clinical commissioning group or a 'shadow' commissioning group
– Clinical commissioning groups take responsibility for NHS commissioning, where ready and willing and authorised
– PCTs abolished
– SHAs abolished

April 2014
– The majority of NHS trusts will have become Foundation Trusts