Appendix 1

Additional Information on the Health and Social Care 'Command' Paper – Liberating the NHS: Next Steps and Legislative Framework

The recently published Health and Social Care command paper sets out the Government's legislative intentions for health (the Health and Social Care Bill will be presented to parliament in early 2011). In large part, these are a reiteration of the plans detailed in the white paper "Equity and Excellence". However, following a series of consultations on aspects of the white paper proposals, the Government has made some significant changes to its plans for NHS reform. Rather than re-brief members on the entire contents of Equity and Excellence, this paper focuses on those elements of the white paper plans which have been significantly amended.

The DH identifies the most significant amendments to its plans as being:

1 A longer transition period for provider reforms

In the white paper the Government proposed that all NHS trusts would become self-governing NHS Foundation Trusts by 2013. This deadline has now been extended until 2014, although the command paper reiterates the Government's commitment to all trusts becoming FTs (the Government plans to revoke NHS trust legislation by 2014, so that it will no longer be possible for organisations to exist as NHS trusts). This extension recognises the difficulty of transition to FT status, particularly given the current financial climate. The DH anticipates that a relatively small number of provider trusts will struggle to attain FT status within any time-scale, and sets out measures to support these trusts.

With the abolition of Strategic Health Authorities, Monitor (the FT regulator) was expected to take over performance management of any remaining NHS trusts in 2013. However this role will now be undertaken by a specialist organisation with particular skills in managing financial turnaround plans.

2 Strengthening the role of Health and Wellbeing Boards (HWBs)

Although the white paper introduced the concept of HWBs - partnership bodies bringing together social care, public health, patient representative bodies and GP commissioners– it was unclear on what HWBs would look like, whether they would be compulsory, or what their powers and duties would be. The command paper confirms that HWBs will be mandatory, with responsibility for the local Joint Strategic Needs Assessment (JSNA) and a Joint Health and Wellbeing Strategy (JHWS). GP commissioners will be required to take an active role in HWBs (as will local authority Directors of

Public Health, Adult Social Care and Children's Social Care). There will be places on each HWB for representatives of Healthwatch and for local Councillors. HWBs will be piloted via a number of early adopters in 2011-12 prior to being formally launched in 2013. (Subsequent guidance makes it apparent that all upper tier authorities will be expected to begin preparing for HWBs in 2011-12.)

3 Moving more quickly to GP commissioning consortia via pathfinder initiatives

In the command paper the Government reiterates its commitment to move to a system of GP commissioning. Indeed, the timetable has now been tightened, with pathfinder consortia already being launched. This change to the timetable seems partly to be a reaction to professional enthusiasm for GP commissioning, partly because there are concerns about the sustainability of many PCTs as staff leave to take up other posts etc.

4 Creating a distinct identity for Healthwatch

The command paper confirms the Government's intentions to create a new patient and public representative organisation called Healthwatch. It also confirms that Healthwatch will be part of the Care Quality Commission (CQC), operating as a formal sub-committee of the CQC. There had been some debate as to whether Healthwatch should be an entirely free-standing independent body, but the Government feels that there is considerable value in aligning Healthwatch with the CQC – the statutory independent assessor of health and social care. Administration for local Healthwatch organisations will be contracted by local authorities as per the white paper.

5 Requiring all GP consortia to publish a constitution

GP consortia will be statutory organisations and will be required to publish a constitution, annual reports and commissioning plans. Consortia will not be required to have public/patient representatives on their boards, as had been mooted, although they are free to do so if they wish. The DH intends for there to be a clear distinction between GP consortia and their member GP practices.

6 Maternity services to be commissioned locally rather than nationally

The white paper had proposed that maternity services be commissioned by the NHS Commissioning Board rather than by local GP consortia. The rationale for this was that GPs had relatively little involvement in or understanding of maternity services. However, this was challenged by many

respondents to the white paper consultation, and the position has now been reversed, with maternity becoming a GP consortia responsibility.

7 Retaining HOSCs and extending their powers

The white paper had effectively proposed the abolition of HOSCs, by planning to transfer their statutory powers to HWBs. This was challenged, both on the basis that HOSCs had made a valuable contribution to scrutiny of the NHS, and on the basis that the proposals would leave HWBs (or at any rate some HWB members) responsible for both executive decisions and scrutiny functions. The command paper therefore states that statutory health scrutiny powers will not be transferred to HWBs.

However, there are some changes to scrutiny arrangements proposed:

- Although health scrutiny powers may not be transferred to HWBs, they can be exercised by any other designated local authority body – i.e. not specifically a scrutiny committee as is currently the case.

- HOSCs currently have the statutory power to oblige NHS trusts and commissioners to report to them. The Health Bill will extend this power to cover all organisations which commission or provide NHS-funded services – this includes independent sector providers, GP practices etc. There is as yet no detail about these powers, and it should perhaps be noted that the current HOSC powers to compel attendance are actually relatively minimal: NHS organisations engage positively with HOSCs largely because they choose to rather than because of any statutory compulsion. It seems reasonable to anticipate that relationship building will continue to be more useful than statutory levers in terms of scrutinising commissioners and providers.

- It had originally been the Government's intention to involve Healthwatch directly in the scrutiny of health reconfiguration plans via the scrutiny functions of HWBs. Although HWBs will no longer exercise these functions, the Government is still committed to involving Healthwatch in scrutiny and expects HOSCs to develop strong partnership relationships with local Healthwatch organisations.

8 Phase in the transfer of complaints advocacy to Healthwatch

The white paper plans to transfer responsibility for complaints advocacy to Healthwatch have been slightly revised, with these services moving across to local authorities in 2013 rather than 2012 (when Healthwatch will 'go live'). This is in recognition of the specialist nature of these services and the need to plan carefully for them.

9 Give GP consortia a stronger role in determining local primary care policy

The white paper proposed that primary care services (e.g. GPs, dentists and community pharmacists) should be commissioned by the NHS Commissioning Board. Doing so removes the obvious clash of interests which would arise should GP commissioners be allowed to commission their own services. This position still stands; however, the Government has revised its plans slightly to give GP consortia a bigger role in improving quality amongst their constituent practices. The Health and Social Care Bill will therefore introduce a specific duty for GP consortia to support the NHSCB in improving the quality of primary medical care services.

10 Adding an explicit duty for NHS arms-length bodies to co-operate

The white paper adumbrated major plans to change NHS command structures, with the current Foundation Trust regulator, Monitor, becoming the NHS economic regulator, and the NHS Commissioning Board assuming a range of duties currently undertaken by the DH or SHAs. Some respondents to the white paper consultation expressed concerns that a situation could develop where these independent organisations ended up communicating with each other via quasi-judicial means – e.g. that Monitor would set the tariff price for various procedures and the NHSCB would then appeal against the tariff being set to high. To avoid this situation, the Bill will introduce a duty for Monitor and the NHSCB to informally co-operate on tariff-setting, only resorting to the formal resolution mechanisms when there is no possibility of reaching a mutually agreeable position.