Liberating the NHS – Legislative framework and next steps

Extracts of relevance to Eye Care

Foreword

'no decision about me, without me'

"liberates professionals at every level to take decisions in the best interests of patients"

How Government has modified its original proposals

- increased transparency in commissioning by requiring all GP consortia to have a published constitution
- we will extend councils' formal scrutiny powers to cover all NHS-funded services, and will give local authorities greater freedom in how these are exercised
- give GP consortia a stronger role in supporting the NHS Commissioning Board to drive up quality in primary care. 1.13

Health and Social Care Bill

The ….Bill proposes the legislative changes to underpin the White Paper's reforms and create a clear and stable legal regime. 1.26

The Government will introduce the Bill in Parliament in January 2011. 1.27

Building shared decision-making into commissioning

The Bill will place the NHS Commissioning Board under a duty, in exercising its functions, to have regard to the need to promote the involvement of patients and their carers in decisions about the provision of health services to them. The NHS Commissioning Board will also be under a duty to issue guidance on commissioning to GP consortia, which could include guidance about how to fulfil their duties in relation to public and patient involvement. 2.14

Health and Social Care Information Centre

….the Bill will establish the Health and Social Care Information Centre on a firmer statutory footing as a non-departmental public body. It will collect data that needs to be collected centrally to support the central bodies in discharging their statutory functions. It will have powers to require data to be provided to it when it is working on behalf of the Secretary of State or the NHS Commissioning Board. It will be able

to consider additional requests from other arm's-length bodies and carry out those data collections if specific criteria are met. It will also have a duty to seek to reduce the administrative burden of data collections on the NHS, with powers to support this. 2.29

Improving Healthcare Outcomes

The main objective of the Government's plans for reform across health and social care is to enable services to deliver those improved outcomes. 3.2

Integrating outcomes across health, public health and social care

The Government will therefore publish three separate frameworks for the NHS, public health and social care which are designed to incentivise collaboration and, in some cases, hold organisations to account for providing integrated services. 3.12

An NHS Outcomes Framework

The Government sees the first NHS Outcomes Framework as the first step in a cultural shift throughout the NHS away from performance management against targets and towards a whole=system focus on delivering better outcomes for people. 3.19

There will be a total of around 50 indicators……These….will track the progress of the NHS as a whole, in improving outcomes for people using its services. 3.22

Commissioning Guidance

Drawing on NICE quality standards, the NHS Commissioning Board will develop high-level commissioning guidance for GP consortia. This will contain evidence and good practice on pathways, standards, outcome measures, currencies and contracting to help consortia commission the best outcomes for the patients they serve. Under the provisions in the Health and Social Care Bill, GP consortia will be required to have regard to the commissioning guidance. 3.34

"The Freedom to make it work"

- Partnership working
- Freedom from political micro-management

The principle of GP commissioning

The transfer of power and responsibility to consortia and local government means that it is no longer necessary to keep the structures of existing PCTs……the need to increase productivity and reduce administration cost call for a significant simplification of administrative structures. 4.9

Robust governance arrangements

Where the Accountable Officer is not a clinician, we envisage that consortia would introduce other professional leadership roles, including responsibility for sustaining relationship between clinical colleagues both within the consortium and across local networks of care. 4.32

Other comments included the need to ensure clear systems for assuring the quality of general practice and avoiding conflicts of interest. 4.35

Local government will have a clear ability to scrutinise GP consortia, as well as stronger powers to scrutinise any NHS-funded services, including providers of primary care. 4.38

The Bill will provide that each consortium's constitution must include [amongst other things]

- arrangements for discharging their statutory functions (which will include public and patient engagement, and multi-disciplinary working);
- procedures for decision-making and managing conflicts of interest; 4.40

Multi-disciplinary working

…the strength of the new arrangements will draw primarily upon the leadership and behaviours demonstrated by leaders of GP consortia working together with patient groups, local authorities and other health and care professionals. 4.41

The forthcoming Bill will provide for consortia to make arrangements to ensure that they have appropriate advice from professionals with expertise in health. We propose, however, that consortia should have the freedom and flexibility to decide how best they exercise this duty, rather than rely on rigid prescribed structures. 4.44

The NHS Commissioning Board

The headquarters of the NHS will be in the consulting room, not the NHS Commissioning Board. Innovation will come primarily from the leadership of liberated local commissioners and providers, supported by the NHS Commissioning Board, not the other way round. 4.51

The NHS Commissioning Board will have a vital role in providing national leadership for driving up the quality of care……,… supporting consortia in a number of ways:

- publishing commissioning guidance and model care pathways, based on the evidence-based quality standards that it has asked NICE to develop;
- developing model contracts and standard contractual terms for providers;
- designing the Commissioning Outcomes Framework and the new quality premium;

- designing the structure of price-setting, including best practice-tariffs and the CQUIN[1] framework;
- helping ensure that consortia have access to high-quality information; and
- providing a forum for consortia to share knowledge, and support collaboration. 4.54

Accountability for quality and outcomes

It will be for the shadow NHS Commissioning Board to take forward work on developing the Commissioning Outcomes Framework during 2011/12 with the support of NICE. To help maintain momentum, the Department will publish a discussion document early in 2011, seeking more detailed views on possible features of the framework, and we will ask NICE to engage with professional and patient groups on proposals for the design and testing of specific outcome indicators. 4.63

Accountability for fairness

Our proposed approach is based on ……

- proceeding on the basis of 'assumed responsibility' rather than 'earned autonomy', so that consortia are free, within the legislative framework, to make the decisions that they judge are right for patients and value for money, but with a clear duty on the NHS Commissioning Board or, if necessary, the economic regulator to intervene if there are concerns that a consortium has not met its duties in relation to fairness and choice or has engaged in anti-competitive behaviour. 4.76

… we will look to Monitor and the shadow NHS Commissioning Board to draw on these and other suggestions in drawing up proposed rules and guidance on how to ensure commissioning decisions are fair. 4.78

Commissioning primary care

We agree that the NHS Commissioning Board should retain the formal responsibility for ensuring that a practice is meeting its core contractual duties. It will also have responsibility for holding national lists of the GPs, dentists and other practitioners who are registered and fit to perform primary care services. 4.83

… there was general support for the principle that the NHS Commissioning Board rather than GP consortia should commission pharmacy, dental and ophthalmic services. 4.85

The Bill will enable consortia to be responsible for the costs associated with the prescriptions that are dispensed in the community by pharmacists and others. 4.85

[1] Commissioning for Quality and Innovation payment framework (part of World Class Commissioning)

Commissioning specialised and complex services

… the NHS Commissioning Board to have responsibility for health services for those in prison or custody. 4.90

Other statutory responsibilities of GP consortia

…consortia are subject to a number of important duties that apply to a range of public bodies : for instance, both consortia and the NHS Commissioning Board will be subject to the duties in the Children Acts 1989 and 2004 to discharge their functions in ways that safeguard and promote the welfare of children, and to be a member of Local Safeguarding Children Boards. 4.101

GP consortia pathfinders

Pathfinders in the programme will be:

- testing out design concepts for GP commissioning and exploring how emerging consortia will best be able to undertake their future functions. This will include the pathfinders having a key role in identifying what commissioning support GP consortia may require in future and how best this should be secured, including any functions that may need to be undertaken at scale. The Department, SHAs and PCTs will work with pathfinders to this end. It is important to note that it is GP consortia that will have the power to decide what commissioning support they want, and from whom. Transitional support arrangements from PCT clusters need to be set up with that clearly in mind, with emerging consortia acting as customers;

- exploring how consortia can develop effective relationships with constituent GP practices and local government, patient groups and secondary care clinicians. For example, we will support the GP consortia pathfinders in working with the shadow NHS Commissioning Board to explore how best to shape the relationship between the NHS Commissioning Board, consortia and practices in relation to primary medical care;

- embedding and reinforcing the importance of engagement with patients and the public and local partnership working with local authorities;

- exploring how consortia can best commission services at different geographical levels, and commission some of the more specialised and complex local services such as mental health, maternity and children's services. This will include looking at issues relating to size, such as how smaller consortia can best collaborate or how larger consortia can break down into smaller localities, where this makes sense;

- demonstrating how clinical leadership of commissioning can improve care, reduce waste and deliver value, including through developing and continuing effective partnerships with specialists, secondary care clinicians and other primary care clinicians;

- exploring good practice in governance arrangements;

- designing their new organisational structures and exploring how best to secure the skills and expertise they need, including the human resources issues involved in the transition from PCTs (on which Chapter 7 provides further detail);

- taking on increasing delegated responsibilities from PCTs (whilst PCTs retain statutory responsibility) and playing a leading role in tackling the NHS quality and productivity challenge, including, for example, through input into NHS contract negotiations with local providers; and

- providing a platform to share learning across the GP community. 4.125

The Department is ….providing support for leadership development through the National Leadership Council, which is working with national primary care organisations to develop a competency set for consortium leaders. 4.127

Managing the Transition

Building on the early findings of the pathfinders, during 2011/12 emerging consortia will work with PCTs to develop transition plans that include:

- identifying those posts within emerging consortia staffing structures that match existing posts within PCTs and therefore provide the basis for a transfer of staff from PCTs to consortia, with staff typically transferring from April 2012 onwards once consortia are statutorily established;

- identifying how they intend to fill other posts within their future staffing structures;

- enabling PCTs, SHAs and the shadow NHS Commissioning Board to identify the areas where there will be significant demand for external commissioning support, to encourage potential providers to develop support in these areas, and to consider how best to support consortia in accessing cost-efficient and effective support;

- agreeing a managed process for transferring any information and IT systems associated with these commissioning functions;

- identifying the individual contracts that will need to be transferred from PCTs to consortia;

- identifying partnership arrangements with local authorities, including pooled budget and lead commissioner agreements, that will transfer to consortia and working with local authorities to make future plans for these areas; and

- developing relationships with emerging health and wellbeing boards, with Local Involvement Networks (as they develop into local HealthWatch) and with other community partners and patient groups. 4.131

Once established as statutory bodies in their own right, consortia will be able to take on staff from PCTs. 4.133

We expect that many PCT staff will find roles within the new organisations, so some administration costs will be transferred around the system, including to GP consortia, the NHS Commissioning Board and local authorities. 4.137

[The NHS Commissioning Board's] main office will be in Leeds, with a small London base and representation at sub-national level in a range of locations to be decided. 4.143

Once the [NHS Commissioning Board's] top team is fully in place by the end of September 2011, the second phase is about executing the start-up plan designed iu the first phase, so that it is fit for purpose and ready to go live from 1 April 2012. It will focus on [amongst other things]…….

- establishing new commissioning relationships with GP practices, community pharmacists, dentists, prison healthcare services, and specialised services. 4.145

…we will be ensuring a clear transition path up to April 2013 including the rolling programme of pathfinders; we are strengthening the duties of consortia in relation to promoting quality improvement in general practice and multi-disciplinary working…… 4.148

Statutory health and wellbeing boards

The Health and Social Care Bill will…….require the establishment of a health and wellbeing board in every upper tier local authority. 5.6

Membership of health and wellbeing boards

… the Bill prescribes that there must be a minimum of at least one local elected representative……..The Bill provides that the other core members of the health and wellbeing board will be GP consortia, the director of adult social services, the director of children's services, the director of public health, and local HealthWatch. 5.13

[Health and wellbeing boards] will also want to ensure input from professionals and community organisations that can advise on and give voice to the needs of vulnerable and less-heard groups. Boards may also want to invite providers into discussions, taking care to adhere to the principles of treating all providers, existing or prospective, on a level playing field. 5.14

Enhanced joint strategic needs assessment (JSNA)

In the reformed system, the process and product of the joint strategic needs assessment takes on much greater importance. 5.19

…the Government is therefore introducing in the Bill a new legal obligation on NHS and local authority commissioners to have regard to the JSNA in exercising their relevant commissioning functions. 5.20

The new joint health and wellbeing strategy (JHWS)

The joint strategic needs assessment will be the primary process for identifying needs and building a robust evidence base on which to base local commissioning plans. 5.21

…building on the enhanced JSNA, the Government is taking the important additional step of specifying that all health and wellbeing boards should have to develop a high-level "joint health and wellbeing strategy" (JHWS) that spans the NHS, social care and public health, and could potentially consider wider health determinants such as housing, or education. 5.22

The Bill will place GP consortia and local authorities under a new statutory duty to develop these health and wellbeing strategies together, in exactly the same way as they will the JSNA, through the health and wellbeing board. There will be no statutory guidance on the nature of these strategies, nor will the health and wellbeing board be required to submit them to the Department, the NHS Commissioning Board or any other central organisation, but they will be made public. To ensure that national and local strategies remain consistent, the health and wellbeing board will have a duty to have regard to the NHS Commissioning Board mandate in preparing the JHWS. 5.22

The strategy should provide the overarching framework within which commissioning plans for the NHS, social care, public health and other services which the health and wellbeing board agrees are relevant, are developed. 5.23

A comprehensive suite of duties and powers in the Bill will put beyond doubt the expectation of "*explicit council and consortium commitment*" to the JHWS: [including amongst other things]

- just as GP consortia and local authorities will be required to have regard to the joint strategic needs assessment, they will also be under a new statutory duty to have regard to the JHWS;
- the health and wellbeing board will be able to write formally to the NHS Commissioning Board and the GP consortia if, in its opinion, the local NHS commissioning plans have not had adequate regard to the JHWS;
- when GP consortia send their commissioning plans to the NHS Commissioning Board, they will be under an obligation to state whether the health and wellbeing board agrees that their plans have held due regard to the JHWS and send a copy of their plans to the health and wellbeing board at the same time. 5.24

…the NHS Commissioning Board will not have the authority to agree and sign off GP consortia commissioning plans; …Consortia will be accountable to the NHS Commissioning Board, and in turn, the Secretary of State for Health and Parliament; but this accountability will be for the results they achieve – improving outcomes and living within their cash-limit. 5.26

Joint commissioning and pooled budgets

Health and wellbeing boards will be able to look at the totality of resources in their local area for health and wellbeing. Within their health and wellbeing strategies they will be able to consider how prioritising health improvement and prevention, the management of long-term conditions, and provision of rehabilitation, recovery and re-ablement services can best deliver reductions in demand for health services, as well as the wider benefits to health and wellbeing. 5.28

The position of all existing pooled budgets will be an important part of local transition planning. As a backstop, the Bill will also make provision for any existing arrangements that have not been addressed as part of the transition, to continue, prior to GP consortia and local authorities entering into new arrangements. 5.29

Health and wellbeing boards as an open-ended vehicle

Where they feel it may improve commissioning, [GP consortia] will have the freedom to enter into voluntary arrangements with a local authority to perform any of [its statutory] functions on its behalf. 5.33

Local authorities' enhanced power of scrutiny

The Bill will enable the Government to extend the powers of local authorities to enable effective scrutiny of any provider of any NHS-funded service, including, for example, primary medical dental or pharmacy services and independent sector treatment centres, as well as any NHS commissioner. ... [The powers] will include the ability to require any NHS-funded providers or commissioners to attend scrutiny meetings, or to provide information. 5.47

Implementation framework

- we are asking all primary care trusts to ensure that their QIPP and reform plans are developed through collaboration with local government partners. It will be increasingly important throughout 2011/12 that local joint mechanisms have their QIPP and reform plan fully embedded in their discussions 5.51

The Department will shortly write to local authorities inviting interest in becoming an early implementer and to clarify the key transition milestones as they impact upon local government. Early implementers in 2010/11 will take the form of non-statutory partnership arrangements. 5.56

A new framework of regulation

The Government believes that, for providers to be able to exercise their freedoms to improve services, the environment they operate within must be fair, stable and transparent. Therefore, the White Paper announced our proposals for liberating providers from hierarchical management and creating a consistent framework of regulation across all types of provider. Monitor would become an economic regulator, while CQC would be strengthened as an effective quality inspectorate. 6.51

Strengthening the Care Quality Commission

All providers who are currently required to be registered by CQC will continue to need to be registered: and registration will be extended to primary care providers during 2011 and 2012. 6.52

To reinforce [the] core task of protecting safety and quality, the Bill will remove CQC's responsibility for assessing NHS commissioners (in future, this will be the responsibility of the NHS Commissioning Board) and for carrying out periodic reviews of NHS providers. 6.54

Economic regulation

As explained in *Regulating healthcare providers*, Monitor will become an economic regulator, with three core functions: promoting competition; setting or regulating prices; and supporting the continuity of services. As a mechanism to support these functions, Monitor will have the power to license providers of NHS-funded care. 6.55

The Government believes that economic regulation has the potential to protect the interests of patients and taxpayers by promoting efficiency, transparency and fairness in the way that resources are used. A robust regulatory regime will end unfair subsidies, create certainty over prices and offer incentives for the best providers to thrive, while safeguarding essential services. In addition, economic regulation is fundamental to our vision of putting patients first, by enabling innovative and flexible healthcare providers, which respond to the needs and choice of patients and commissioners. 6.56

Monitor's role and duties

The Bill will confirm the Government's proposals to keep Monitor's status as an independent non-departmental public body. The Bill will make clear that Monitor's overarching duty will be to protect the interests of patients (and other service users) in the provision of health and adult social care by promoting competition where appropriate and through regulation where necessary. 6.60

How economic regulation will work: licensing

There was general support for the proposal that the economic regulator's licensing regime should encompass all providers of NHS-funded services in England, whether foundation trusts or from the private or voluntary sector. Respondents also agreed with the idea of an exemption regime for providers that do not require regulation of prices, sector-specific competition powers and continuity of service provisions. 6.63

The Bill will therefore confirm the Government's proposals, creating powers for a licensing system. The details of the exemption regime would be set out in secondary legislation. 6.64

Enforcement of Monitor's licensing regime

The Government proposed giving Monitor a range of enforcement levers, including the power to fine providers for failing to comply with licence conditions and possibly

powers to suspend or revoke a licence for failing to comply with its conditions. … if licence conditions are breached, Monitor will be able to order a provider to remedy the breach (or commit to do so) or issue fines of up to 10% of turnover. 6.66

Under the Bill … if Monitor wishes to modify providers' licence conditions, it will need to consult with providers, who will have an opportunity to agree or object to the change. If the number of objections is above a threshold (to be defined in regulations, and weighted according to the market share of those complaining), Monitor would be required to respond to the objections or make a reference to the Competition Commission, which would have the power to make a binding decision. 6.68

Monitor's power to charge fees

… the licence fees gathered by Monitor will only be able to be used to support its licensing-related functions (for example, the issuing of licences, the assessment of providers and the undertaking of any related enforcement action); 6.69

Tackling anti-competitive behaviour by providers

The Bill will give Monitor concurrent powers with the Office of Fair Trading to apply the Competition Act 1998 in health and adult social care services. This would allow Monitor to investigate practices by individual providers or groups of providers which might restrict competition, such as actions to exclude competitors or agreements to restrict patient choice. 6.79

Patient choice and competition in the NHS are still at a relatively early stage and, as some respondents commented, it is not possible to tell at this point exactly what types of licence conditions will be needed to protect choice and competition in future. Therefore, the Government has decided for the Bill that Monitor should have power to set licence conditions wherever it can demonstrate that there is a need for regulation to protect competition. 6.82

As a check on this power, Monitor will need to carry out impact assessments demonstrating the benefits of any major new licence conditions and explain why it could not address the problem by applying concurrent competition powers. 6.83

Monitor's concurrent powers as a competition authority will include powers to apply for disqualification of directors for material breaches of competition law. This would be consistent with the concurrent powers of other sector-specific competition authorities such as Ofcom, Ofgem and Ofwat. 6.84

Tackling anti-competitive behaviour by commissioners

Like providers, commissioners can in some circumstances act in ways which undermine choice and competition, for example by failing to tender services where appropriate or discriminating against particular types of provider. 6.85

Pharmacists and other providers of community-based services were particularly concerned that "*GP consortia may use their new powers to commission their own practices to deliver services*", … and argued that procurement conditions "*that would*

favour the GPs who are part of a commissioning consortium must be outlawed" (Pharmaceutical Services Negotiating Committee). 6.86

In the light of consultation responses, the Government has decided to include a power in the Bill for the Secretary of State to issue regulations to govern commissioners' procurement activities and ensure they protect choice and competition. We will need to do further work, and consult in due course, regarding the precise contents of these regulations. However, they are likely to include requirements relating to:

- when to competitively tender services …
- the governance of tendering processes;
- managing conflicts of interest;
- protecting competition and choice in the delivery of services. 6.87

Parties with a legitimate interest will have a right to complain to Monitor if they believe commissioners have breached the rules. If it finds a breach, Monitor will have powers to direct the commissioner, including requiring it to modify its procurement approach or re-tender a contract. Commissioners and providers will be able to seek judicial review if they are dissatisfied with Monitor's decision. 6.88

In addition, the Bill will ensure that NHS commissioners will be subject to comparable prohibitions of anti-competitive conduct as those for providers under national competition law. 6.89

The rules governing procurement and competition will apply to the NHS Commissioning Board and GP consortia when commissioning NHS services. 6.90

Trust mergers

The OFT and the Competition Commission will be the sole organisations with responsibility for investigating mergers in health and social care services. For the avoidance of doubt, the Bill will make clear that mergers between [Foundation Trusts] should be subject to the OFT and the Competition Commission's merger controls from April 2012 onwards. 6.92

Market investigations and reviews

Like other sectoral regulators, Monitor will have the ability to carry out market studies and to refer markets for health or adult social care services to the Competition Commission for investigation if it suspects that features of the market restrict or distort competition. When it receives a reference, the Competition Commission must carry out an investigation and has powers to impose remedies to address adverse effects on competition. 6.98

… the Bill will require the Competition Commission to carry out a review of the development of competition and regulation in public healthcare services every seven years, with the first review to be completed no later than 2019. We believe this is a

reasonable interval, which reflects the likely time for significant changes to take place in the structure of provision or regulation. 6.99

Price setting and regulation

The Bill will create a joint process for setting prices, with Monitor and the NHS Commissioning Board each having primary responsibility for specific aspects of the process, as well as the duty to reach agreement at key stages. 6.106

The NHS Commissioning Board will have primary responsibility for developing the pricing structure for NHS services. 6.107

"Designated services" for additional regulation

… local councils will have the power to require any provider of any NHS-funded services to account to a scrutiny session, enhancing the level of local democratic oversight. This is irrespective of whether they are or are not designated for additional regulation. 6.117

We expect that the guidance notes to be issued by Monitor will focus on the contribution of each provider to its local health economy and the possibilities for alternative supply, rather than the ownership status of the provider. Therefore any provider of NHS-funded care, whether public or independent sector, could provide designated services. 6.118

Shared values and the NHS Constitution

… the Government also believes that an important national leadership role remains in raising consciousness of what the NHS Constitution means for patients and for staff. We intend to locate that leadership role within the NHS Commissioning Board and we intend that the Board should have an obligation to promote awareness of the NHS Constitution across all NHS-funded services. 7.6

The Department will therefore consult on changes to the NHS Constitution during 2011, prior to a revised version coming into being by April 2012. 7.9

Commissioning will be clinically-led, with groups of GP practices working together far more effectively – and also in concert with other community-based professionals and clinicians in secondary care. 7.12

Freeing up commissioning and provision will not only increase innovation, choice and competition – it will also enable greater integration of services, for example around out-of-hospital care. 7.13

Cutting the cost of administration

- where appropriate, arm's-length bodies will be expected to exploit commercial opportunities and maximise commercial discipline across the sector. 7.36

It is expected that significant numbers of PCT staff will transfer to roles in the new organisations. 7.40

Timetable (Attached)

…it will be critical to ensure clear accountability during the transitional period. Strategic health authorities will be accountable for delivery and for overseeing the transition in their region up to April 2012. The new NHS Commissioning Board will begin life as a special health authority during 2011 but will not take on its formal role and statutory accountabilities until 1 April 2012, when SHAs will be abolished. 7.48

From 1 April 2013, statutory accountability will pass to GP consortia and PCTs will be abolished. 7.49

To pave the way for the NHS Commissioning Board to develop these roles, and maintain accountability and grip during 2011/12, and during 2012/13 once SHAs have been abolished, the Department … has decided to expand the approach to managed consolidation of PCT capacity already taken in London and the North East. Here, sub-regional clusters have been formed by adopting single executive functions serving a number of statutory PCT bodies under existing legislative powers. These clusters will begin to oversee delivery during 2011 and continue to act as transition vehicles until at least April 2013; beyond that date, it will be for the Board to determine how it organises itself. It is envisaged that these sub-regional clusters will perform a common sets of functions for the transition period. Their core functions will comprise:

- overseeing in-year and medium-term QIPP delivery…
- direct commissioning of services for which responsibility will ultimately transfer to the NHS Commissioning Board, such as primary care, and nationally and regionally commissioned specialised services;
- ensuring GP consortia have access to commissioning support up until April 2013.
- overseeing the development of GP consortia during 2011/12, ahead of their authorisation. 7.51

TUPE

….many functions performed by current organisations will continue to be performed by new organisations. Because of this, TUPE will apply to a significant proportion of the functions carried out by new organisations. We are currently developing a People and Functions Migration Map setting out the functions we expect to see performed by organisations in the future system. 7.56

Implementation and Transition

Achieving greater devolution by 2013/14 requires tighter central control over quality, performance and money during the transition. 7.58

Whilst the structural transition will be completed over a four-year period, the Government fully recognises that embedding change will take many years and will not be complete until considerably beyond the lifetime of this Parliament. 7.60

Optical Confederation
January 2011

TRANSITION PHASED OVER FOUR CALENDER YEARS

2010/11 Design and early adoption

- The Department of Health confirms the design framework, subject to Parliamentary approval
- The Department of Health gives permission to pathfinders and early implementers to model the new arrangements and explore key issues for wider roll-out
- Refinement of HealthWatch following the choice and information consultations
- The Department of Health publishes transition plan setting out the role of LINks in influencing local services while local HealthWatch prepares to start exercising functions
- The Government begins working with local authorities as they prepare for their new role in commissioning support for choice and complaints advocacy

2011/12 Learning and planning for roll-out

- Shadow national arrangements progressively implemented for the NHS Commissioning Board, new Monitor, and the Public Health England programme
- Sharing lessons from the GP consortia pathfinder programme and early implementer health and wellbeing boards
- More pathfinders and early implementers, including local HealthWatch
- Plans drawn up for GP consortia, involving all GP practices
- Emerging consortia to lead the process for identifying which PCT-employed staff should be “assigned” to them
- Plans to be drawn up for health and wellbeing boards
- NHS trusts to apply for foundation trust status, or be planning to apply in 2012/13
- The new Provider Development Authority to be established by 1 April 2012
- SHAs to establish PCT cluster arrangements in preparation for the NHS Commissioning Board

2012/13 **Full dry run**

- From April 2012, NHS Commissioning Board and new Monitor come into effect, SHAs are abolished, PCT clusters are accountable to the Board, and the Department will have made substantial progress on its change programme and established Public Health England. The Provider Development Authority will oversee NHS trusts
- More learning from GP pathfinders and health and wellbeing board early implementers
- Authorisation process of comprehensive system of GP consortia begins, with all practices becoming members, acting under delegated arrangements with PCTs
- Health and wellbeing boards are in place
- Comprehensive local HealthWatch arrangements in place
- From April 2012, local authorities to fund local HealthWatch to deliver most of their new functions
- Consortia notified on 2013/14 allocations
- By the end of the year, a significant number of NHS trusts have achieved foundation trust status
- All applications for FT status to be made by end March 2013

2013 **2013/14 First full year of the new system**

- From April 2013, PCTs abolished and all consortia assume new statutory responsibilities
- From April 2013, health and well being boards assume their statutory responsibilities
- Consortia and health and wellbeing boards learning from their participation in the full dry run
- From April 2013, Monitor's licensing regime is fully operational, and the Government aims to have the new special administration regime in place
- From April 2013, local authorities to have responsibility for commissioning NHS complaints advocacy
- At end March 2014, the Provider Development Authority ceases to exist •
- By 1 April 2014, all NHS trusts to have become FTs, and NHS trust legislation is repealed