

Government response to the  
NHS Future Forum report:  
*Briefing notes on amendments to  
the Health and Social Care Bill*

# Contents

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*This document follows the structure of the Government response to the Future Forum report. As chapters 1 and 6 of the Government response do not include changes to the Health and Social Care Bill, they are not included in this document.*

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# Introduction

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1. Following the listening exercise on the Health and Social Care Bill, the NHS Future Forum published its recommendations on the future for NHS modernisation. Our response, published on 20th June, set out the changes we intend to make in response to the recommendations.
2. As the response makes clear, many of these changes can be made within the flexibility of the Bill as it stands. However, a number of the changes require amendments to the Bill. For this purpose a set of Government amendments were tabled on 23<sup>rd</sup> June; these will be debated by the Public Bill Committee for the Health and Social Care Bill. This document provides briefing notes on those amendments.
3. This document is structured around the Government response to the NHS Future Forum report – including chapter heading, sub-headings, and paragraph numbers. The Government response is available at  
  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_127444](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127444)
4. The amendments themselves were tabled on 23<sup>rd</sup> June, and published by the House of Commons on 24<sup>th</sup> June. The amendment numbers in this document refer to the numbering used in the notices of amendments, available at:  
  
<http://www.publications.parliament.uk/pa/cm201011/cmbills/177/amend/psc1772306a.9-15.html>
5. These briefing notes have been produced and published by the Department of Health. They are not Explanatory Notes as published by Parliament, and do not have the formal status of Explanatory Notes. A revised version of the Explanatory Notes will be published when the Bill enters the Lords.

## Note on terminology

6. Please note that throughout this document we have used the term ‘clinical commissioning groups’ to describe commissioning consortia. In the amendments themselves, as in the Bill, these bodies continue to be referred to as ‘commissioning consortia’ or simply ‘consortia’.

## Chapter 2: Overall accountability for the NHS

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### The NHS Constitution

#### *Amendments 67 and 108. Government response paragraph 2.2.*

7. These amendments place a new stronger duty on the NHS Commissioning Board and on clinical commissioning groups actively to promote and raise awareness of the NHS Constitution when exercising their functions. This is in addition to their existing duty – in the Health Act 2009, as amended by paragraph 167 of Schedule 5 to the Bill – which requires them to "have regard" to the NHS Constitution.
8. The new duty means that when exercising all of their functions, the Board and clinical commissioning groups would have to act with a view to securing that health services were provided in a way that promotes the NHS Constitution and would be required to promote awareness of the NHS Constitution among patients, staff and members of the public. This means that not only would they need to act in accordance with the Constitution and ensure that people were made aware of their rights under it, they would also need to ensure that they contributed as far as possible to the advancement of its principles, rights, responsibilities and values, through their own actions and through facilitating the actions of stakeholders, partners and providers. For example, clinical commissioning groups and the Board could consider how to build the Constitution into their work on patient and public involvement.

### The role of the Secretary of State

#### *Amendments 54 to 56 and new clause 1. Government response paragraphs 2.8.*

9. This set of amendments make explicit that the Secretary of State will be responsible – as now – for promoting a comprehensive health service. They restate both the Secretary of State's core duty, as currently set out in section 1(1) of the NHS Act 2006 and the provision in section 1(3), which states that services must be free of charge. These principles remain unchanged since the founding NHS Act 1946.
10. The provision in section 1(2) differs from both the wording in the NHS Act 2006 and the current clause in the Bill. The changes clarify that the Secretary of State will retain accountability for securing the provision of services, though rather than securing services directly, the Secretary of State will do this in future by exercising his functions in relation to the NHS bodies. For example, the Secretary of State will set the mandate for the NHS Commissioning Board, report annually on the performance of the comprehensive health service, and hold the Arm's Length Bodies to account. He will have extensive powers to intervene in the event of significant failure.

11. Amendments 55 and 56 make changes which are consequential on the change to section 1(2), in particular a corresponding change to the Board's general functions in new section 1D.

***New clause 2. Government response paragraph 2.13.***

12. New clause 2 creates a new 'duty to keep health service functions under review' which makes clear that Ministers are responsible for overseeing and holding to account the national bodies (the Commissioning Board, Monitor, the Care Quality Commission, NICE, the Health and Social Care Information Centre and Special Health Authorities). The duty is backed by extensive powers of intervention in the event of significant failure. Subsection (3) also gives the Secretary of State explicit powers to report on the performance of all of the national NHS bodies, as part of the Secretary of State's annual report on the health service.

***Amendments 81 to 83, 157, 200 to 203, 218 to 223 and 225 and new clause 8. Government response paragraphs 2.11 and 4.31.***

13. This set of amendments clarifies the Secretary of State's powers of intervention over the NHS Commissioning Board (amendments 81 to 83), the Care Quality Commission (new clause 8), HealthWatch (amendments 200 to 203), NICE (amendments 218 to 220) and the Information Centre (amendments 221 to 223) to provide that they can be used in the event of a "significant" failure of those bodies to perform their functions. The amendments also require the Secretary of State to publish his reasons for every exercise of the power. The intention is to prevent political micromanagement of these bodies. The amendments closely reflect the position for Monitor as set out in clause 63, and amendment 157 makes a change to clause 63 to ensure consistency across the bodies.
14. In the case of the Care Quality Commission, and HealthWatch, the amendments provide that the Secretary of State would not be able to intervene in individual cases - he would need to demonstrate that there was evidence of a more widespread failure. This is to strengthen the position and independence of these regulators, whose functions to oversee individual providers are conferred upon them by Parliament through primary legislation.
15. In the case of the NHS Commissioning Board, it may be appropriate, in the case of a significant failure, for the Secretary of State to intervene in a particular case if he is to discharge his own duty to promote a comprehensive health service - for example if the Board failed to allocate funds to a particular clinical commissioning group, or if it failed to commission a particular service that it was required to commission under the Bill. For that reason, the 'particular case' limitation would not apply to Ministers' powers over the Board.
16. In the case of NICE and the Information Centre, the 'particular case' limitation is not relevant since they are focused predominantly on supporting the health and social care system, rather than on oversight of individual organisations.

## Chapter 3: Clinical advice and leadership

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### Multi-professional involvement in commissioning

#### Robust arrangements for involving professionals and a stronger duty to obtain their advice

*Amendments 71, 72, 112, 113, 114 and 135. Government response paragraphs 3.30 to 3.33.*

17. This set of amendments strengthens the duties on the NHS Commissioning Board and on clinical commissioning groups to obtain appropriate clinical advice.
18. These duties reinforce the principle that commissioners must obtain appropriate advice. They will do this through, among other means, clinical networks and clinical senates, which will be established as described in the Government response at paragraphs 3.18 to 3.24.
19. Amendments 71 and 112 change the wording of the duties on the NHS Commissioning Board and on clinical commissioning groups to obtain appropriate advice (new sections 13G and 14O, respectively). Rather than being required to “make arrangements with a view to securing that (they) obtain advice”, the Board and clinical commissioning groups are required simply to “obtain advice”: a clearer and stronger duty.
20. Amendments 72 and 113 place a more direct duty on the Board and on clinical commissioning groups to obtain this advice from a broad range of professionals with expertise in the “prevention, diagnosis or treatment of illness” and in the “protection or improvement of public health”, appropriate for enabling them to effectively discharge their functions. This would include for example obtaining advice when making commissioning decisions and, for the NHS Commissioning Board, when designing NHS pricing structures.
21. Amendment 114 introduces a power for the Board to issue guidance to clinical commissioning groups on the discharge of their duty to obtain advice. This parallels the power, already in the Bill in new section 14P subsection (3), for the Board to issue guidance to clinical commissioning groups on the discharge of their public involvement and consultation functions, as well as the new powers introduced by amendment 111 for the Board to issue guidance on the discharge of clinical commissioning groups’ duties on patient involvement. In each case, clinical commissioning groups are required to have regard to the Board’s guidance.
22. Amendment 135 requires the Board to include in its annual performance assessment of clinical commissioning groups an assessment of how effectively they have fulfilled their duty to obtain advice. The annual assessment would also be required to include an assessment of how well the clinical

commissioning group has discharged its patient and public involvement duties, under amendment 136.

***Amendment 152. Government response paragraph 3.35.***

23. In addition to the above amendments on the commissioning side, this amendment places a new duty on Monitor to secure appropriate clinical advice in carrying out its functions. This would provide consistency for Monitor with the strengthened duty on the NHS Commissioning Board described above.

**Clinical commissioning groups and their local communities**

***Amendments 57 to 59. Government response paragraph 3.45.***

24. These amendments make explicit on the face of the Bill that a clinical commissioning group has responsibility not only for patients registered with the GP practices that comprise its membership, but also for those who usually live in the clinical commissioning group's area but are not registered with a GP practice.
25. Amendment 59 specifies that a clinical commissioning group has responsibility for the provision of services or facilities for emergency care for everyone present in its area. This may for example include access to Accident and Emergency and ambulance services.

***Amendment 99. Government response paragraph 3.49.***

26. This amendment provides for a regulation-making power which would allow the Secretary of State to stipulate requirements for the naming of individual clinical commissioning groups. This would make it possible to ensure that clinical commissioning group names include the word 'NHS' and are clearly linked to their local area. The NHS Commissioning Board would have to be satisfied when authorising a clinical commissioning group that its proposed name met the requirements.

**Research and innovation**

***Amendments 115 and 116. Government response paragraph 3.89.***

27. This amendment places a duty on clinical commissioning groups, similar to that which is already on the NHS Commissioning Board in new section 13I, to have regard to the need to promote research on matters relevant to the health service, and promote the use of the evidence from research.
28. The amendment also imposes a duty on clinical commissioning groups, similar to that which is already on the NHS Commissioning Board in new section 13H, in the exercise of its functions to promote innovation in the provision of health services. This aims to ensure that clinical commissioning groups actively seek to innovate when exercising their functions as commissioners, and act as champions for innovation in their relationships with stakeholders and providers.

*New clause 3. Government response paragraph 2.15 and 3.90.*

29. This amendment places, for the first time, a specific duty on the Secretary of State to have regard to the need to promote health service research and the use of health service evidence obtained from research. This provides an explicit legislative basis to underpin the work of the Department of Health's research and development directorate and the National Institute for Health Research.

## **Chapter 4: Public accountability and patient involvement**

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### **Strengthening health and wellbeing boards**

#### ***Amendments 206 to 208 and 210. Government response paragraphs 4.8 and 4.41.***

30. These amendments place a requirement on local authorities and clinical commissioning groups (which in practice will be discharged by Health and Wellbeing Boards) to involve the Local HealthWatch organisation and the people who live or work in the local authority's area when preparing their Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies.

#### ***Amendments 125 to 133. Government response paragraph 4.10.***

31. These amendments make the duty on clinical commissioning groups to consult Health and Wellbeing Boards in relation to their commissioning plans part of a broader and stronger requirement on Health and Wellbeing Board involvement.
32. The current duty in new section 14Y requires clinical commissioning groups to consult Health and Wellbeing Boards on their views about whether commissioning plans have taken proper account of the most recent Joint Health and Wellbeing Strategy. The amendments create a new duty, in section 14YB, which requires clinical commissioning groups to involve Health and Wellbeing Boards in preparing or revising the plans and, in particular, to share drafts with the Board and consult it on whether the drafts take proper account of the Joint Health and Wellbeing Strategy. We would expect this to involve not a formal, one-off exercise but rather an ongoing dialogue with a view to producing a commissioning plan that is the result of a joint effort.
33. The new duty sits alongside the duty for Health and Wellbeing Boards to give their views to clinical commissioning groups on whether commissioning plans have taken proper account of the Joint Health and Wellbeing Strategy, and the power, where necessary, to make such views known by referring those views to the NHS Commissioning Board.

#### ***Amendments 138 to 140. Government response paragraph 4.12.***

34. These amendments place a requirement for the NHS Commissioning Board's annual performance assessment of clinical commissioning groups to include an assessment of how well the groups have discharged their duty to have regard to the Joint Health and Wellbeing Strategies. They also require the NHS Commissioning Board to consult Health and Wellbeing Boards on their views on clinical commissioning groups' contributions to the delivery of Joint Health and Wellbeing Strategies.

35. The amendments are designed to help reinforce the principle that effective joint working, which will be a key feature of the Joint Health and Wellbeing Strategy, is an essential element of the role of clinical commissioning groups – a given rather than an optional extra.

***Amendment 209. Government response paragraph 4.10.***

36. This amendment introduces a requirement for local authorities and clinical commissioning groups to have regard to guidance issued by the Secretary of State in preparing Joint Health and Wellbeing Strategies. This duty and the resulting power for the Secretary of State to issue guidance is equivalent to the duty to have regard to guidance in preparing the Joint Strategic Needs Assessments under section 116 of the Local Government and Public Involvement Act 2007 and the resulting power for Secretary of State to issue such guidance. This new statutory guidance on Joint Health and Wellbeing Strategies will be produced through close working with key stakeholders such as the Local Government Association, and will be part of the Government's approach to encourage lead commissioning, pooled budgets, and integrated provision.

***Amendment 134. Government response paragraph 4.12.***

37. This amendment requires that clinical commissioning groups' annual reports include a review of the extent to which they have contributed to delivering the Joint Health and Wellbeing Strategy, and that clinical commissioning groups consult Health and Wellbeing Boards when discharging this obligation.

**Strengthening governance arrangements of clinical commissioning groups**

***Amendments 95, 98, 100 to 101 and 104 to 106. Government response paragraphs 3.36 to 3.42 and 4.17 to 4.21.***

38. These amendments introduce a requirement that all clinical commissioning groups have a governing body. The main function of the governing body is to ensure that the group has in place appropriate arrangements to make sure that it exercises its functions effectively, efficiently and economically and that it complies with generally accepted principles of good governance. The governing body also has functions in relation to the determination of remuneration, fees and allowances. In addition, it may exercise other functions that are connected with the exercise of its main functions and that are specified in the group's constitution or in regulations made by the Secretary of State. Regulations may also require a group to obtain the approval of its governing body before exercising specified functions.
39. The amendments provide that the governing body must meet in public (except where it would not be in the public interest to do so). They also specify that the governing body must have an audit committee to assist with the discharge of the financial duties of the clinical commissioning group, and a remuneration committee to make recommendations to the governing body regarding the determination of the remuneration, fees and allowances paid to employees of the clinical commissioning group or to other persons providing services to it.

40. The amendments create a regulation-making power, which allows regulations to:
- make provision for the appointment of chairs and deputy chairs of the governing body or committees;
  - specify the categories of people who must be members of the governing body, and the maximum and minimum number of members from each category. The government intends that these powers would be used to specify that membership must include at least two lay members, one registered nurse and one doctor with secondary care experience;
  - provide that the group's Accountable Officer must be included in the membership of the governing body; and
  - specify arrangements for making appointments, the tenure of members, and circumstances in which an individual may be disqualified from being a member.

***Amendments 96 to 97 and 102.***

41. Clinical commissioning groups will also be required to publish their constitutions, which will set out for public scrutiny the arrangements in place to meet the group's statutory duties, including how they will manage potential conflicts of interest. The NHS Commissioning Board will have an express power to issue guidance to clinical commissioning groups about the publication of their constitutions. Building on this, these amendments provide that the constitution must specify the arrangements the clinical commissioning group will make for securing transparency about the clinical commissioning group's decisions and how they are made.

**Rewarding quality of commissioning**

***Amendments 143 to 146. Government response paragraph 4.25.***

42. This set of amendments makes a number of changes to the Bill's existing provisions on payments in respect of performance for clinical commissioning groups, in order to improve transparency and clarify the purpose of the payment. They clarify that these payments for clinical commissioning groups will be made based on performance against outcomes relating to the quality of services and reductions in inequalities. Clinical commissioning groups will be required to publish details of how the payments have been used.
43. The amendments also create regulation-making powers which could be used to establish key principles for such payments, to specify circumstances in which the Board may reduce or withhold a payment that would otherwise be made and to impose conditions about how the payment can be used. In addition, the facility for advance payments of the premium will be removed. Finally, the amendments will change the title of the clause to 'Payments in respect of quality' to reflect more accurately its effect.

**Public board meetings for foundation trusts**

***Amendment 192. Government response paragraph 4.28.***

44. This amendment requires the constitution of a foundation trust to provide for meetings of the board of directors to be open to members of the public. It amends clause 149 (Directors) to insert this requirement into Schedule 7 of the NHS Act 2006. Subsection (2) provides that the board could have a closed part of the meeting for special reasons, for example to discuss confidential and sensitive matters. This amendment places the same requirement on foundation trust boards of directors as on boards of other NHS organisations and mirrors the existing requirement in the NHS Act 2006 on foundation trust boards of governors. It would strengthen transparent and accountable governance in foundation trusts and avoid NHS trusts, on becoming foundation trusts, shifting to closed board meetings.

**Respecting the autonomy of the new commissioning bodies**

***Amendments 60 and 62. Government response paragraph 4.33.***

45. These amendments to clause 19, new section 13A, amend the Secretary of State's duty to publish an annual mandate for the NHS Commissioning Board to make it clear that the objectives and requirements it contains should cover more than one year. The intention is to require the Secretary of State to provide the Board with a level of detail on objectives and requirements that will allow it to develop effective medium- and long-term planning assumptions. Where possible, the mandate will cover a three-year period, but this will be dependent on other factors, such as the Spending Review cycle. The mandate would be updated annually, and the Secretary of State would consult on revisions.

**Maximising patient and public involvement**

***Amendments 64, 150 and 199. Government response paragraph 4.39.***

46. This set of amendments introduces new requirements on the Care Quality Commission, the Secretary of State and Monitor in relation to strengthening the collective voice of patients and carers in the system.
47. Amendment 199 places a duty on the Care Quality Commission to respond formally in writing to any advice provided to it by its HealthWatch England committee. This places the Commission in the same position as the Secretary of State, the NHS Commissioning Board, Monitor and English local authorities, who are all required to respond in writing to advice from HealthWatch England. This amendment will both strengthen the transparency of the relationship between HealthWatch England and the Commission and provide greater reassurance to patients and the public that any issues brought to the Commission's attention by HealthWatch England would get a response.
48. Amendment 64 requires the Secretary of State to consult HealthWatch England prior to publishing the mandate to the NHS Commissioning Board.

49. Amendment 150 places a duty on Monitor to involve people who use health care services and other members of the public in decisions about the exercise of its functions.

***Amendments 76, 78, 118, 119, 123 and 136. Government response paragraph 4.41.***

50. This set of amendments places requirements on Health and Wellbeing Boards, clinical commissioning groups, the Board and providers relating to local involvement and consultation.
51. Amendments 76 and 118 amend the public involvement duty on the NHS Commissioning Board and clinical commissioning groups in new sections 13L and 14P to remove the word ‘significant’. The NHS Commissioning Board and clinical commissioning groups are currently required under new sections 13L and 14P to make arrangements for involving the public in (a) planning commissioning arrangements, (b) developing and considering proposals for changes in commissioning arrangements, and (c) decisions affecting the operation of commissioning arrangements. These sections are modelled closely on the existing duty on Primary Care Trusts and Strategic Health Authorities in section 242 of the NHS Act 2006 – with the exception that, as currently drafted, they limit the requirement relating to (b) and (c) so that the Board and clinical commissioning groups are only required to involve the public where proposals for change would have a ‘significant’ impact on the manner in which the services are delivered or the range of services available. The rationale for this was to avoid unnecessary or disproportionate burdens on commissioners. However, concerns have been voiced about the likelihood of more restricted public consultation on major service changes and about the difficulty of judging what counts as ‘significant’.
52. The existing section 242 duty, and the drafting of new sections 13L and 14P, already provides flexibility for commissioners to decide on a proportionate course of action in involving the public, depending on the significance of the proposed service change. The Bill also provides powers for the Board to issue statutory guidance to clinical commissioning groups in relation to this duty, which could be used to make clear the importance of proportionality and to provide examples of proportionality in action, in the same way that current guidance does in relation to the section 242 duty.
53. The amendment therefore removes the word ‘significant’ to bring the duty into line with the current section 242 duty.
54. Amendment 119 will require clinical commissioning groups to include in their constitutions a description of the arrangements they have made to fulfil their duties in section 14P in respect of public involvement and consultation and a statement of the principles that they will follow in implementing those arrangements. The Board would therefore need to be satisfied that a prospective clinical commissioning group’s proposed constitution complied with this requirement when considering its application for establishment (under section 14C). Amendment 123 will also require clinical commissioning groups to set out in their annual commissioning plans how they propose to

discharge their duty to involve and consult the public in relation to their proposals for the coming year.

55. The Bill also requires that a clinical commissioning group's annual report must, in particular, explain how it has discharged its duty to involve and consult the public. Amendment 136 now requires that, when the Board conducts a performance assessment of each clinical commissioning group in respect of each financial year, it must, in particular, consider how well the clinical commissioning group has discharged its duties under section 14P.
56. Amendment 78 requires the Board to explain how it proposes to discharge its own public involvement duties in its annual business plan, to bring this into line with the requirements on clinical commissioning groups.

### **No decision about me without me**

#### ***Amendments 68 to 70 and 109 to 111. Government response paragraph 4.46.***

57. These amendments emphasise the importance of the NHS Commissioning Board and clinical commissioning groups' duties in relation to reducing inequalities and promoting patient choice and patient involvement by separating them out. This means that in the Board's and clinical commissioning groups' respective inequalities duties, the patient involvement duty and the patient choice duty are each contained within their own, separate section in the NHS Act 2006.
58. Amendments 70 and 111 amend the Board and clinical commissioning groups' duties relating to patient involvement (in new sections 13F(1)(c) and 14N(1)(c) in the existing drafting) to better reflect the principle of "no decision about me without me" in several ways. Firstly, they strengthen the duties, which had obliged the Board and clinical commissioning groups to "have regard to the need to" promote patient involvement, by replacing them with duties to promote patient involvement in the exercise of their functions. Secondly, they expand the range of people involved by referring to the involvement of patients' representatives, in addition to patients and carers. Thirdly, they clarify that these duties are about promoting patient involvement in decisions about patients' individual care (public involvement in decisions about service delivery generally is covered by the duties currently in new sections 13L and 14P in clauses 19 and 22 of the Bill). And finally, they give the Board the power to provide guidance to clinical commissioning groups about the patient involvement duty, to which the groups must have regard. This will enable further detail to be given about the meaning of 'involvement' and how commissioners can promote it.
59. Amendments 70 and 111 also strengthen the duties on the NHS Commissioning Board and clinical commissioning groups relating to patient choice. As currently drafted in new sections 13F(1)(d) and 14N(1)(d), the duties require the Board and commissioning groups to "have regard to the need to" enable patients to make choices with respect to aspects of their care. The amendments introduce revised duties, in new sections 13FB and 14NB,

which require the Board and clinical commissioning groups to “act with a view to enabling patients” to make those choices.

60. These amendments also remove an unintended difference between the wording of the patient choice duty on the Board in new section 13F(1)(d) and that on clinical commissioning groups in new section 14N(1)(d), by removing the unnecessary words “as part of the health service” from the latter.

## Chapter 5: Choice and competition

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### **Ruling out privatisation**

*Amendments 75, 153, 160, 171 and new clause 4. Government response paragraphs 5.9 to 5.11.*

61. These amendments prohibit Monitor, the NHS Commissioning Board and the Secretary of State from exercising their functions for the purpose of increasing or decreasing the market share of any particular type of provider - whether public or private sector - in the provision of NHS services.
62. This Government believes that what matters is the quality of services for patients, not the ownership model of the provider. These amendments would therefore prevent Monitor, current or future Ministers and the NHS Commissioning Board from pursuing any deliberate policy to encourage the growth of a particular sector of provider. For example, the amendments would prevent a future Secretary of State seeking to increase private provision of elective care. Equally, they would prevent him from deliberately promoting the growth of state providers over voluntary sector or private ones.
63. New clause 4 specifies that with respect to the Secretary of State, this duty applies to his core powers in the new system; that is, his powers to set the mandate to the Board, to establish “standing rules” imposing requirements on the Board and clinical commissioning groups, and to make regulations on procurement (which Monitor would enforce).
64. These amendments do not cut across local commissioners making their own decisions or seeking to develop integrated services; nor do they affect the role of Monitor and the Board in supporting innovation and enabling the development of new services, or prevent the provision of NHS services by new service providers.

### **Ensuring competition works in patients’ interests**

*Amendments 148, 149, 151, 154, 155, 158, 159, 161, 189 and 191 and new clause 5. Government response paragraphs 5.14 to 5.15.*

65. These amendments re-define Monitor’s core duty in regulating healthcare providers, and make changes to Monitor’s other general duties, provided for in clause 56.
66. Under the current drafting of clause 56, Monitor’s main duty is to exercise its functions to “protect and promote the interests of people who use health care services, by promoting competition where appropriate, and through regulation where necessary.” Amendment 148 changes that main duty so that Monitor must exercise its functions to protect and promote the interests of those using health care services “by promoting provision of health care services which is

economic, efficient and effective, and maintains or improves the quality of the services.”

67. This revised main duty therefore:

- removes Monitor’s duty to “promote competition”. Instead, amendment 149 requires Monitor to exercise its functions with a view to preventing anti-competitive behaviour which is against the interests of people who use NHS services. This means that Monitor’s role will be to tackle abuses and restrictions that act against patients’ interests, rather than to encourage competition as if it were an end in itself;
- makes clear that promoting value for money is part of Monitor’s main duty, by moving the requirement to promote economic, efficient and effective provision of services from subsection (3) into the description of the main duty in subsection (1); and
- explicitly requires Monitor to ensure quality in the provision of services.

68. Amendment 149 places a new duty on Monitor to exercise its functions with a view to enabling services to be provided in an integrated way, where this would improve their quality or the efficiency of their provision, or where it would reduce inequalities for patients. Subsection (2B) covers integration of healthcare services, while subsection (2C) covers integration of healthcare services with other relevant services (health-related services or social care services).

69. Monitor would carry out its core duty through the exercise of its functions to regulate healthcare providers (including additional regulation, where necessary, to support the continuity of essential services), to regulate prices for NHS services, and to address restrictions on competition that act against patients’ interests. Monitor’s role is distinct from that of the Care Quality Commission, which registers health and adult social care services to ensure quality standards and maintains inspections to ensure that those standards continue to be met. Monitor’s role is also distinct from, but complementary to, the role of commissioners in securing healthcare services that meet patients’ needs and securing improved health outcomes, and the role of the NHS Commissioning Board in overseeing commissioning and allocating NHS resources.

70. The other amendments in this set make consequential changes throughout the Bill to reflect the re-definition of Monitor’s core duty. Amendment 151 removes a provision which is now incorporated into Monitor’s main duty. Amendment 158 amends provision about regulations on procurement applying to commissioners so that it relates solely to anti-competitive behaviour which is against the interests of patients. Similarly, amendments 159 and 161 replace provision for Monitor to exercise its functions to set or modify licence conditions for the purpose of “promoting competition” with provision for it to do so for the purpose of preventing anti-competitive behaviour which is against patients’ interests instead. Amendments 154, 155, 189, 191 and new clause 5 relate to the definitions of terms used.

***Amendments 162 to 163 and 190. Government response paragraph 5.24.***

71. These amendments remove provisions in the Bill that would give Monitor the power to require one provider to make its facilities available for use by another provider. This will ensure that Monitor could not use its licensing powers to address anti-competitive behaviour by requiring an NHS organisation to provide access to its facilities to a private provider or vice-versa.

### **Promoting better integrated services**

#### ***Amendment 156. Government response paragraph 5.30.***

72. Amendment 149 (see above) requires Monitor to exercise its functions with a view to enabling NHS services to be provided in an integrated way, where this is in the interests of patients and other users. Amendment 156 would complement this, by ensuring that Monitor should also have regard to the desirability of providers of health care services co-operating with one another to improve the quality of health care services. Together these changes would make sure that Monitor's role supports collaboration and integration where this is in the interests of patients. Monitor would not impede commissioners or providers integrating services to improve quality and would instead work alongside other organisations in the health and social care systems to enable integrated pathways of care.

#### ***Amendment 117. Government response paragraph 5.30.***

73. This amendment strengthens and expands the existing duty on the NHS Commissioning Board to encourage integrated working. Rather than simply requiring the NHS Commissioning Board to encourage clinical commissioning groups to work closely with local authorities, under this amendment, the Board is required to promote integration by taking specific action to secure that services are integrated where it considers that would be beneficial to the people receiving those services.
74. The duty requires the Board to exercise its functions with a view to securing that health services, health and social care services, and health and other health-related services (i.e. services such as housing that may have an effect on the health of individuals but are not health services or social care services) are provided in an integrated way where it consider that this would either improve the quality of health services and the outcomes they achieve, or reduce inequalities in access to and outcomes from health services.
75. This requirement would cover both integration between service types (eg between health and social care) and integration between different types of health services. Whatever the combination and however they are integrated, the practical effect should be that services are co-ordinated around the needs of the individual. This would apply to all the Board's functions, not just when exercising its commissioning functions, including when it exercises public health functions under arrangements with Public Health England.

#### ***Amendments 73 to 74. Government response paragraph 5.30.***

76. These amendments provide a new duty to promote integration on clinical commissioning groups similar to that which is being placed on the NHS Commissioning Board.
77. As members of Health and Wellbeing Boards, clause 192 already requires clinical commissioning groups to encourage integrated working between commissioners of NHS, public health and social care services for the benefit of the health and wellbeing of the local population. However, these amendments build on that requirement and takes it further, requiring clinical commissioning groups to promote integration by exercising their functions with a view to securing that health services, health and social care services and health and other health-related services (services such as housing that may have an effect on the health of individuals but are not health services or social care services) are provided in an integrated way, where the groups consider that this would either improve the quality of health services and the outcomes they achieve, or reduce inequalities in access to and outcomes from health services.
78. This requirement would apply to all of a clinical commissioning group's functions and would cover both integration between service types (eg between health and social care) and integration between different types of health services. Whatever the combination and however they are integrated, the practical effect should be that services are co-ordinated around the needs of the individual.

### **Safeguarding against cherry-picking and ruling out price competition**

#### ***New clause 6. Government response paragraph 5.42.***

79. This new clause requires Monitor to include standard conditions in the licence requiring that providers act transparently in the setting and application of criteria for determining patient eligibility for particular services, or for accepting or rejecting referrals, wherever services are subject to patient choice of provider. Such criteria would have to be clinically-based and would only determine whether it is appropriate for patients to receive a given treatment from a particular provider; they would not affect the ability of patients to access that treatment on the NHS.
80. It is appropriate that there should be clinical criteria to determine whether it would be clinically appropriate to refer a patient for a particular service - this is an integral part of good clinical practice and helps ensure that patients are treated in ways and in clinical settings that are most appropriate for their needs. This new clause would help to ensure that patients are not rejected by the providers of their choice on non-clinical grounds, and so help to address the potential risk of providers being able to restrict patient choice by 'cherry picking' the simplest, most profitable cases.
81. The increased transparency which would be brought about by this new clause would also provide a basis for Monitor to assess the impact of patient selection on variations in the cost of delivering services between different providers.

***Amendments 168 and 170 and new clause 7. Government response paragraph 5.42.***

82. Building on new clause 6, new clause 7 places a duty on Monitor and the NHS Commissioning Board to deliver fair reimbursement for efficient services through the exercise of their tariff-setting functions. This would be an additional safeguard against the potential risk of providers being able to restrict patient choice by ‘cherry picking’ the simplest, most profitable cases. The new duty would mean that Monitor and the NHS Commissioning Board would have to have regard to the impact of variations in the range of services provided by different providers and variations in complexity of patients treated, when setting prices for NHS services (amendment 168 subsection (3B)). Monitor and the NHS Commissioning Board would need to consider how best to balance this with any increase in administrative burden brought about by increasing the complexity of the tariff.
83. The Bill would enable Monitor and the NHS Commissioning Board to fulfil this duty in a variety of ways. For example, a procedure could be specified in different ways, with different prices, depending on whether they were being provided as part of a group of services – as in an acute hospital – or as separate service lines as may be the case in a GP practice or treatment centre (amendment 168 and consequential amendment 170). Alternatively, Monitor and the NHS Commissioning Board may determine that the national tariff for particular services should be varied in defined circumstances (e.g. based on complexity of treatment), and/or set rules on the determination of prices for services outside the scope of the national tariff, as previously set out in the Bill. In fulfilling this duty Monitor and the NHS Commissioning Board would need to consider how best to balance the benefits to be gained from adjusting prices to reflect impact of variations in the range of services, and any increase in administrative burden brought about by increasing the complexity of the tariff.
84. Amendment 168 has additional effects which are described in the next section.

***Amendments 164 to 169 and 172 to 188 and new clause 7. Government response paragraph 5.42.***

85. This set of amendments relate to the roles of Monitor and the NHS Commissioning Board on pricing and the national tariff.
86. Amendment 166 is concerned with situations where commissioners could vary national tariff prices in line with the flexibilities set out in the tariff. This could take place only in accordance with rules included in the tariff. The amendment requires that commissioners make public any such variations. Monitor could issue guidance on the publication of these variations to the national tariff prices, which will be developed by the NHS Commissioning Board (Amendments 169 and 184). These amendments increase transparency, providing further assurance that there will be no price competition, and that other agreements could not be made between commissioners and providers that would be detrimental to patients’ interests. To improve the pricing system, amendment 169 requires that commissioners have regard to all guidance under

the national tariff and amendment 180, 183-188 provides that all guidance published must be agreed by Monitor and the NHS Commissioning Board.

87. Amendment 175 also works to prevent price competition, by ensuring that commissioners adhere to the national tariff. The amendment gives Monitor the power to direct commissioners to cease and make good any agreements they have made that do not comply with the national tariff. This amendment gives Monitor a similar power in relation to enforcing the national tariff as it has in relation to enforcing license conditions. Monitor's duty to act with a view to enabling integration, introduced by amendment 149, ensures that this power would not cut across innovative ways of developing more integrated services.
88. New clause 7 subsections (2)-(4), and consequential amendment 181, introduces a new duty on the NHS Commissioning Board and Monitor to act with a view to securing standardisation throughout England as to how services are specified for the purposes of the tariff, in the form of contract currencies, and as the basis of payment for NHS services. Increasing the scope of standard currencies would be a vital, incremental step towards increasing the proportion of NHS services covered by the national tariff. In exercising this duty, the NHS Commissioning Board and Monitor must consider any potential adverse impact of a proposed specification (New clause 7 subsection (4)). This is important for ensuring that standardisation is pursued not as an end in itself, but as an enabler for securing economy, efficiency and effectiveness in the provision of services.
89. To deliver standardisation of service specifications for those services not yet covered by national prices, amendment 168 provides that the rules for setting local prices clearly include the ability to set a national currency for services, with rules on setting prices for those services locally. Consequential amendments 172-174 allow for the same freedoms and safeguards for local price setting as those in the national tariff.
90. Amendments 164-165, 177-180 allow Monitor and the Board discretion to decide when the production of rules or guidance is necessary, rather than being obliged to include these in the national tariff document. This provision covers variations to the national price, rules governing when changes to the national tariff can be agreed by commissioners and providers, rules to be followed when setting local prices, and rules as to the payment of prices.
91. Amendment 176 is a minor amendment to clarify that where Monitor consults on the proposed national tariff it must include proposed national prices for the services which are specified. This has always been the intention.
92. Amendment 168 also has additional effects which are described in the previous section.

## Chapter 7: The timetable for change

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### *Amendments 198, 224 and 226. Government response paragraph 7.17.*

93. These amendments remove from the Bill the blanket deadline of 2014 for the repeal of NHS trust legislation and Monitor's authorisation powers, by removing subsections (3) and (4) of clause 176 (Abolition of NHS trusts in England). However, the Bill still repeals the legislation on NHS trusts using the usual legislative process of commencement order, so it would not be an option to stay as an NHS trust. The stringent tests set by Monitor will remain. All NHS trusts will continue to be expected to deliver their services through the foundation trust model as soon as clinically feasible, with an agreed deadline for every organisation.

### *Amendment 193. Government response paragraph 7.17.*

94. This amendment requires Monitor, before authorising a new foundation trust, to seek assurance from the Care Quality Commission that the applicant trust is currently complying with the requirements mentioned in section 12(2) of the Health and Social Care Act 2008 in relation to the regulated activity or activities carried on by the applicant. This amendment would create, through the new subsection (3)(a), a new requirement on Monitor, placing the onus on Monitor to seek such notification upon receipt of an application for foundation trust status. The amendment would create a statutory basis for the current voluntary arrangement outlined in a Memorandum of Understanding between the two regulators.

## Technical amendments

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95. In addition to the amendments following the Government response, a small number of technical amendments have also been tabled for consideration in Committee.

### *Amendments 61, 63, 65 to 66 and 79 to clause 19 (NHS Commissioning Board)*

96. These amendments amend clause 19 so as to change provisions relating to the NHS Commissioning Board's annual mandate and business plan.
97. Amendments 61 and 63 have the effect of changing the provisions of the mandate relating to finance. They amend subsections (3) and (4)(c) of new section 13A to the NHS Act 2006, and subsection (2) of new section 13B, so that the mandate must specify the capital and revenue resource allocations set for the Board by the Secretary of State under a new section 223DA (inserted by other amendments). In addition, they have the effect that if those allocations are varied the mandate must be revised. They also remove the requirement on the Secretary of State to set out the cash allotment under section 223B. The resource allocations to the Board are the primary means of controlling the finance to the Board and setting out its spending constraints for the year. The Board's cash allotments and the related limit on cash expenditure are calculated by reference to those resource allocations, and may be subject to technical adjustments, and so are not appropriate for the mandate.
98. Amendments 65 and 79 remove subsection (9) of new section 13A and subsection (5) of new section 13O. These subsections have the effect that in relation to the mandate and the business plan, the first financial year for the purposes of the mandate and the plan would be the year in which the Board is established, even if it is established part way through a year. The effect of these amendments is that the mandate and business plan will apply only to the first full financial year of the Board's operation and subsequent years. The policy intention is that although the Board would be established part way during the year 2012/13, the first mandate and business plan would relate to 2013/14.

### *Amendments 77, 80 and 120 to 122 to clauses 19 and 22 (Board and clinical commissioning groups – liability)*

99. These are minor and technical amendments to ensure that in various provisions relating to the Board and to clinical commissioning groups, arrangements under which functions of one body are delegated to another do not affect the liability of the first body.

### *Amendments 84 to 94, 107, 124, 137, 141 to 142 and 147 to clauses 20 and 23 and Schedules 2 and 3 (financial arrangements for the Board and commissioning groups)*

100. Amendments 84 to 94, 124, 137, 141 and 142 make changes to clauses 20 and 23 of the Bill which deal with financial arrangements for the Board and clinical commissioning groups. They amend these clauses to better reflect the system of resource accounting and the financial limits that apply to the Department of Health. The financial limits which the Secretary of State will set for the Board will apply to the total amount of resources used, or cash expenditure incurred, by NHS commissioners, including those used by clinical commissioning groups. It will be the responsibility of the NHS Commissioning Board, through exercising its functions in relation to clinical commissioning groups, to ensure that these are not exceeded. In addition, amendment 87 ensures that the system for allocating NHS funding to the Board and for the Board to make allocations to clinical commissioning groups will apply only to the first full financial year of the Board's operation (2013/14) and subsequent years, and not to the initial year in which the Board is established (2012/13).

101. Amendments 107 and 147 amend Schedules 2 and 3 (which relate to clinical commissioning groups). They are consequential on the amendments to clause 23.

***Amendment 103 to Schedule 2 (commissioning consortia)***

102. Amendment 103 is a minor change to improve the drafting of Schedule 2.

***Amendment 194 and 196 to clauses 165 and 166 (foundation trust merger and acquisitions)***

103. These amendments provide clarity around the Bill's requirement to secure governor approval to mergers and acquisitions, as set out in clauses 165(2) and 166(3). They would confirm that the requirement for governor approval would only apply to foundation trusts and not to NHS trusts, which do not have governors. Schedule 14 is consequentially amended

***Amendments 211 to 217 to clause 190 (joint strategic needs assessment and joint health and wellbeing strategies)***

104. These amendments correct the current clauses by requiring commissioners to have regard to the appropriate joint strategic needs assessment and joint health and wellbeing strategy when exercising functions. The clause as originally drafted required them to have regard to the most recent strategies prepared whereas it might be other strategies that are relevant. As such, the amendments require commissioners in exercising functions to have regard to those strategies that are relevant to the exercise of those functions.

***Amendment 205 to clause 179 (Local HealthWatch)***

105. This amendment adds Local HealthWatch to the list in Schedule 19 of the Equality Act 2010 of persons who are subject to the public sector equality duty under section 149 of that Act. Expressly listing bodies in the Schedule

provides clarity and ensures that any specific duties made under the Act can be applied to them. This amendment brings Local HealthWatch into line with other NHS bodies, which are either already listed in Schedule 19 or will be listed by virtue of provisions already in the Bill.

***Amendment 204 to Schedule 15 (Local HealthWatch)***

106. This amendment adds a procedural point to the power for the Secretary of State to give directions to Local HealthWatch organisations about the auditing of their accounts, in order to ensure consistency with other direction-giving powers in the Local Government and Public Involvement in Health Act 2007.

***Amendments 195 and 197 to clause 165 (foundation trusts and NHS trusts – mergers)***

107. These amendments require an NHS trust to obtain the support of the Secretary of State before it could either merge with, or be acquired by, a foundation trust. They remove subsection (3)(a) of clause 165, thereby retaining the current support provision for mergers, and add a new requirement to clause 166, which would bring the requirement for Secretary of State support for acquisitions in line with that currently in place for mergers. NHS trusts are accountable to the Secretary of State and these changes simply ensure this is reflected in requirements for a merger or acquisition.