The structure of the new NHS

On 1 April 2013, the Health and Social Care Act 2012 came into force, bringing with it many new structures and arrangements for the NHS in England.

Primary care trusts (PCTs) and strategic health authorities (SHAs) have been abolished.

NHS England (formerly the NHS Commissioning Board) and clinical commissioning groups (CCGs) are now responsible for commissioning the vast majority of NHS services, with local authorities taking on new public health commissioning responsibilities.

Monitor has assumed the role of system regulator for all NHS-funded services and all remaining NHS trusts are expected to become NHS foundation trusts within the next few years.

NHS organisations and boards

NHS Trust Development Authority

Following the scrapping of strategic health authorities, this body will be responsible for overseeing the performance management and governance of NHS trusts that have not yet achieved foundation status. This will include clinical quality and managing trusts' progress towards foundation trust status. Ministers want all trusts to achieve foundation status.

Monitor

Monitor is the sector regulator for healthcare, responsible for licensing healthcare providers, regulating prices for NHS services and addressing restrictions on competition that act against patients' interests.

NHS England

NHS England (formerly The NHS Commissioning Board) is charged with improving the health outcomes for people in England, in line with the NHS mandate set by the government. It oversees the work of clinical commissioning groups (CCGs) and holds them to account, allocates resources, and commissions certain services such as primary care and highly specialised services that can be organised better and more efficiently at a regional or national level. It is accountable to the health secretary.

Health Education England

Health Education England (HEE) leads education, training and workforce development nationally. It will promote high-quality education and training that is responsive to the changing needs of patients and local communities. Professional regulators will still be responsible for setting and upholding standards. HEE has six professional boards. Its medical board is responsible for ensuring that training posts are filled by high-quality candidates, that curriculum-based training is delivered, that academic medicine's needs are recognised, and that there is enough capacity in the health service to deliver high-quality training.

Local authorities

Local government has a new set of duties to protect and improve public health. These include commissioning and providing public health services. The BMA has lobbied to ensure councils have adequate funding and that the independence of directors of public health, and public health doctors, in speaking out is protected. The BMA has also been working to ensure a smooth transition for public health doctors from primary care trusts, and ensured that Public Health England's code of conduct did not restrict their ability to raise issues of concern.

Local education and training boards

Local education and training boards (LETBs) will be responsible for workforce planning, education and training at a local level. They will bring together all healthcare and public health providers of NHS-funded services, education providers, professional bodies and local government and universities or research centres. They are accountable to Health Education England and will host postgraduate deaneries and their functions.

Public Health England

Public Health England is responsible for leading and managing an integrated public health delivery service. It will take over the roles of organisations including the Health Protection Agency, National Treatment Agency, public health observatories and cancer registries. It will have 15 centres across England, each of which will provide leadership and support across all three domains of public health - health protection, health improvement and healthcare public health.

- supporting local government in its leadership of the local public health system
- supporting directors of public health
- working with the NHS England (formerly the NHS Commissioning Board) on commissioning key specialist services and national public health programmes
- providing leadership in responding to emergencies.

Healthwatch

New patient and public bodies, known as local Healthwatch will be established. Local Healthwatch will act as a point of contact for individuals, community groups and voluntary organisations when dealing with health and social care and will have a representative seat on the health and wellbeing board.

Health and wellbeing boards

Health and wellbeing boards will be established in each upper tier local authority to promote integrated working across health and social care. With representatives from local authorities, health and social care, public health and patient groups, health and wellbeing boards will produce the Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS) identifying local priorities for commissioners.

Clinical commissioning groups

England's 211 clinical commissioning groups (CCGs) will take over from primary care trusts and be responsible for £65bn of the £95bn NHS commissioning budget. They will plan and commission hospital care and community and mental health services. All GP practices have to be members of a CCG, and every CCG board will include at least one hospital doctor, nurse and member of the public.

Commissioning support units

GPs and other clinicians involved in clinical commissioning groups (CCGs) will need support to commission effectively. Commissioning support encompasses a range of functions, from transactional services such as payroll and IT services, to equipping CCGs with the complex population level data required to inform commissioning decisions.

Primary care trust (PCT) clusters are currently developing commissioning support organisations, to be hosted by the NHS England (formerly the NHS Commissioning Board) until 2016. CCGs may choose to host their own, internal support services, or contract from the PCT-cluster developed bodies, private or third sector organisations.

Clinical networks

The networks will be hosted and funded by NHS England (formerly the NHS Commissioning Board), and will advise on specific conditions or patient groups where improvements can be made through an integrated, whole-system approach. The networks will advise local commissioners, help reduce variation in services, and encourage innovation.

Clinical senates

These will be led by clinicians to provide multidisciplinary input to strategic clinical decision-making. The groups, 12 of which are due to be established, should help ensure that clinical commissioning groups, local authorities and the NHS England (formerly the NHS Commissioning Board) have access to a broad range of clinical input to inform their decisions. Senates will include medical, nursing and allied healthcare professional representation as well as patients, volunteers and other groups.

Understanding the NHS reforms

Monitor and regulation

10 things you need to know...

1. Monitor will licence FTs from April 2013 and other providers of NHS healthcare services from April 2014. NHS trusts, primary care providers and providers that do not require a registration with the CQC are currently exempt from licensing.
2. Monitor has a range of powers to enforce its licensing regime, modelled on the powers available to other regulators. These include powers to suspend or revoke licences and to fine providers up to 10 per cent of their turnover for licence breaches.
3. Where services are subject to patient choice of provider, Monitor's licence requires that providers act transparently in setting and applying criteria for determining patient eligibility. Criteria have to be clinically-based and determine whether patients should receive treatment from a particular provider, rather than whether they should be able to access the treatment on the NHS. This is designed to ensure that patients cannot be rejected by providers on non-clinical grounds, to address potential 'cherry-picking' of simpler and more profitable cases.
4. Monitor is required to act with a view to preventing anti-competitive behaviour which is against the interests of people who use healthcare services. This applies to providers and commissioners of services, including the NHS Commissioning Board. Monitor has the power to investigate provider and commissioner behaviour and order remedies where it sees fit.
5. Monitor has concurrent functions with the Office of Fair Trading (OFT). This allows the application of existing competition rules and the investigation of infringements of these rules by Monitor, as a specific health regulator, rather than by the OFT, as a general regulatory body. Monitor's powers to apply the rules and investigate infringements will be the same as those currently exercised by the OFT.
6. Monitor is required to work with others, particularly commissioners, to remove any barriers and consider how to enable integrated care provision, where this is in the interests of patients. Monitor must also work with a view to enabling NHS services to be integrated with health-related services or social care services where this would achieve the same improvements.
7. Monitor has various responsibilities around setting and regulating prices, which it is expected to take on fully from the 2014-2015 tariff. It will collect data from providers to design a suitable pricing methodology, set prices, in agreement with the NHS Commissioning Board, and publish them in a document called the national tariff.
8. Monitor has various responsibilities in the failure regime which are outlined in the BMA's paper 'Understanding the reforms...failure regime'.
9. Monitor will retain specific oversight powers over all FTs to 2016, to try to provide continuity and enable FT governors to build capacity in holding their boards to account. Monitor also has 'enduring powers' to require an FT to remove directors or governors in cases of serious breach of licence conditions.
10. Monitor and the CQC are under a duty to work together to minimise bureaucracy, openly share information and create a single integrated process of licensing and registration for

providers. They have recognised the interaction between the regulation of quality and safety and the regulation of other aspects of healthcare for which they are responsible and are looking to develop a single failure and distress regime with the aim of increasing the consequences of quality failures for trusts. This may place greater emphasis on the judgements made by the CQC on quality than in the current compliance system.

Choice and any qualified provider

10 things you need to know...

1. AQP means that qualified providers go on a list of providers from which patients choose where they wish to go - it does not guarantee activity or income.
2. All local commissioning areas have already implemented AQP in at least three services. It will be for local commissioners to decide if and how to apply AQP from April 2013.
3. 105 private firms and 140 NHS organisations have been awarded AQP status. DH figures also state that 87 providers, of which 38 are private and 26 are from the NHS, have started treating patients.
4. The Supply2Health website gives support and information for commissioners, providers and patients.
5. One of the stated principles of AQP is that competition is based on quality, not price. Providers are paid a fixed price for a service which is either the national tariff or, where it is not covered by the national tariff, the price set by local commissioners. All providers in the area are paid the same price.
6. It is not yet clear how AQP will develop. If commissioners apply AQP to a substantial number of services, there could be a significant increase in the number of qualified non-NHS providers and a subsequent shift of work to these providers. Alternatively, if commissioners do not to extend AQP and patients choose to attend NHS providers, non-NHS providers could shrink back.
7. Under the Health and Social Care Act, Clinical Commissioning Groups, the NHS Commissioning Board and Monitor must all act with a view to enabling patients to make choices about their healthcare and the health services provided to them. This enshrines the duty to promote patient choice in legislation, ensuring that it is a priority throughout the new health service architecture.
8. The choice offer available to patients has grown and is likely to continue to grow. Key areas where choice has been extended include diagnostics, maternity services and choice of named consultant-led team.
9. Personal health budgets are a key plank of the Government's choice policy. All patients receiving NHS Continuing Healthcare will have a right to receive a personal health budget from April 2014. Clinicians will be able to offer budgets to other patients where they feel it would be beneficial.
10. There is uncertainty over how choice and personal health budgets will work together and whether patients who do not have a personal health budget will have the same choices available to them as patients who receive a budget. It could be the case that personal health budget holders are able to make significantly different choices to those made by other patients, due to the fact that they are budget holders and therefore have greater control over their care.

NHS England (formerly the NHS Commissioning Board)

10 things you need to know...

1. NHS England (formerly the NHS Commissioning Board) is central to the new commissioning architecture in the English NHS following the abolition of Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs), the establishment of Clinical Commissioning Groups (CCGs) and the transfer of the NHS' public health function to local authorities.
2. It will operate nationally, regionally and locally, with a central office in Leeds, 4 sectors and 27 local area teams (LATs).
3. It is legally obliged to pursue the objectives contained in the Secretary of State's mandate to the Board.
4. It has a concurrent duty with the Secretary of State to promote a comprehensive health service. Other legislative duties contained in the Health and Social Care Act 2012 include:
    - Promotion of the NHS Constitution, autonomy, integration and education and training;
    - Enabling patients to make choices; and
    - Not varying the proportion of public versus private-sector provided services intentionally.
5. It is responsible for commissioning £27.2bn worth of services directly and will hold around 35,000 contracts, including for:
    - Specialised and highly specialised services
    - Primary care at general practice level
    - Out-of-hours primary care for GP practices who have retained OOH responsibility
    - All dental services and community pharmacy
    - Immunisation and national screening programmes
    - Prison and military health services
6. It will negotiate the national General Medical Services (GMS) contract for GP services in the future and will hold Personal Medical Services (PMS) contracts.
7. It is responsible for the authorisation, oversight and performance management of CCGs. It calculates and allocates their commissioning budgets.
8. It currently hosts 23 commissioning support units, 12 clinical senates and 4 strategic clinical networks.
9. Together with NICE, it has developed the CCG Outcomes Indicator Set (CCG-OIS). Four of the measures included in the CCG-OIS plus three locally-agreed measures form the quality premium, a financial reward payable to CCGs for commissioning performance.
10. The NHS England is accountable to the Secretary of State, Parliament, the Department of Health and the Treasury.

Health and Social Care Act

10 things you need to know...

1. The Health and Social Care Act 2012 received Royal Assent on 27 March 2012, legislating for the NHS reforms first set out in the White Paper, 'Equity and Excellence: Liberating the NHS', published in July 2010. It came into force on 1 April 2013.
2. The Act abolishes Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs).
3. It creates a number of new statutory bodies including:

- NHS England (formerly The NHS Commissioning Board);
- Clinical Commissioning Groups; and
- Health and Wellbeing Boards (in each upper tier local authority).

4. It extends the role of Monitor to the system regulator for all NHS funded services.
5. It removes the CQC's responsibility for assessing the performance of NHS commissioners, which has been taken on by the NHS Commissioning Board.
6. It extends the role of NICE to include social care.
7. The Act places a duty on the Secretary of State for Health (SoS) to exercise his or her functions to secure an effective system for the planning and delivery of education and training for healthcare workers. It does not however establish the new Health Education England (HEE) or Local Education and Training Boards (LETBs).
8. The Act restructures public health services nationally and locally. Nationally, the SoS has a duty to protect the people of England, with central responsibility for health protection and response to emergencies. Locally, the Act grants local authorities responsibilities for health and stipulates that they must employ a Director of Public Health. It does not however establish the new national executive agency, Public Health England (PHE).
9. The Act does not enforce a legislative deadline for all remaining NHS trusts to become foundation trusts, but it makes provision for the Secretary of State to do so at a later date.
10. It establishes new patient and public bodies (not statutory) known as local HealthWatch at local authority level, with a national body, HealthWatch England, to support local HealthWatch.

Local accountability

10 things you need to know...

1. The NHS reforms in England introduced new functions for local authorities relating to local accountability within the health service.
2. Health and wellbeing boards and local HealthWatch have been set up by local authorities to perform these functions.
3. Health and wellbeing boards include representatives from local authorities, clinical commissioning groups (CCGs) and NHS England.
4. Health and wellbeing boards are responsible for leading on the Joint Strategic Needs Assessment (JSNA) and the new Joint health and wellbeing strategy, an overarching commissioning strategy for each area.
5. CCGs must engage with health and wellbeing boards when developing their commissioning plans. CCGs have a statutory duty to have regard to the JSNA and the Joint health and wellbeing strategy.
6. CCGs will have a representative on the Health and wellbeing board and, alongside other representatives from local authorities and NHS England, CCGs are jointly responsible for developing these plans.
7. New patient and public involvement groups, local HealthWatch are now operating within each local authority. They are community-led organisations, and accountable to the local community.

8. Local HealthWatch have a responsibility to find out what people think of their local healthcare services, look into the concerns of the local community as well as advise people to make healthcare choices by providing information to service users.
9. HealthWatch England is the national body to support local Healthwatch. It is tasked with representing people using health services at a national level.
10. HealthWatch England sits as a statutory committee of the Care Quality Commission (CQC) and has a role in identifying concerns about services that are underperforming and advising the CQC to review those services.

NHS trusts and foundation trusts

10 things you need to know...

1. The Health and Social Care Act 2012 set out the Government's expectation for all remaining NHS trusts to gain Foundation Trust (FT) status.
2. A new temporary organisation, the NHS Trust Development Authority (NTDA), now has responsibility for the supporting NHS trusts through the 'FT pipeline' following the abolition of Strategic Health Authorities (SHAs).
3. The NTDA has a fixed term of four years to achieve this work. This informally sets the deadline to achieve FT status by April 2016.
4. Each NHS trust has signed a Tripartite Formal Agreement (TFA), a formal business plan setting the date by which they believe they can achieve FT status and identifying the main challenges facing each organisation.
5. The main barriers to meeting FT status are the financial requirements.
6. There are two alternative options for NHS trusts that are unlikely to reach FT status. The first is to enter into a merger or acquisition with an existing FT.
7. A second option is to continue to operate under the management of another FT or private enterprise.
8. FTs can now generate a greater portion of their income from private patients. The Private Patient Income (PPI) cap is now set at 49 per cent, whereas previously, the cap varied from FT to FT, but was considerably lower.
9. FTs are now expected to hold all Board meetings in public.
10. FT Governors now have more responsibilities to agree activities including: significant transactions, mergers, acquisitions, separation or dissolution of the Trust, increases in the PPI cap, and changes to the Trust's constitution.

Failure regime

10 things you need to know...

1. There are now three different failure regimes for the different types of providers of NHS services.
2. NHS Trusts follow a Trust Special Administration (TSA) process for unsustainable providers, which has been in place since 2009 and is triggered by the Secretary of State.
3. Monitor oversees a new Trust Special Administration process for Foundation Trusts (FTs) similar to that for NHS Trusts.
4. Once FTs get into difficulties, they can now no longer revert to NHS Trust status.

5. Monitor will implement the FT failure regime through its new licensing regime, and can take proactive action to prevent failure of FTs.
6. In order to protect patients' interests, services that need to stay in the area will continue to be provided even when a provider enters the failure regime.
7. Clinical commissioning groups (CCGs) will have a role in deciding which services are continued; these will be termed ‘Commissioner Requested Services'.
8. In order to finance the continuation of these services during the failure regime process, a levy will be charged to all providers to generate a 'risk pool'.
9. A Health Special Administration (HSA) process for independent-sector providers is in development and will come into place in April 2014.
10. The HSA process will be similar to the process for FTs with the addition of insolvency procedures at the end of the process once any continuing services have been secured.