Department of Health

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11 AUG 2014

Dear Anna,

Thank you for your letter of 16 July, sharing your concerns about the potential impact of the Draft Legislative Reform (Clinical Commissioning Groups) Order 2014 (the LRO) and raising a number of issues.

I am also responding to your Advisory Note, in accordance with my duty under section 45A(7) of the Health and Social Care Act 2008.

Your letter and advisory note raise a number of concerns about the potential impact of the Draft LRO, using examples from recent experiences of local Healthwatch in Greater Manchester. Thank you for bringing these concerns to my attention and to the attention of Simon Stevens at NHS England.

It is important for all partners to consider how we most effectively support the system to work efficiently and, working in partnership, support all relevant organisations to develop open and accountable ways of working.

The Legislative Reform Order

It may help if I set out a brief summary of the LRO and the rationale for introducing it from 1 October 2014, subject to Parliamentary approval.

The Health and Social Care Act, when it established CCGs, did not make provision for CCGs to form joint committees with other CCGs. PCTs previously had this provision in legislation and many formed joint committees to progress partnership work.

Health organisations, including CCGs, have expressed concerns about CCGs' inability to form joint committees that are able to make binding decisions. This

inability has brought many practical challenges in working together on issues that cut across boundaries, such as continuing healthcare, patient specific funding requests and service change across a health economy.

In the absence of a specific power to form joint committees, CCGs have put in place legally robust arrangements that enable them to make progress with major joint projects, but these arrangements (termed "committees in common") are bureaucratic and complex. The purpose of making a LRO is to reduce the administrative burdens resulting from the current legislation.
The LRO will enable:

(a) two or more Clinical Commissioning Groups (CCGs) to form joint committees when jointly exercising their functions or

(b) one or more CCG and NHS England to jointly exercise the functions of a CCG and to form a joint committee when doing so.

The proposed amendments build upon the existing powers for CCGs to work jointly with each other and with NHS England, giving them greater flexibility and control in the way that they work. In any commissioning structure you have in place, there are always going to be some decisions that may need to be taken locally and some that span a wider population. The amendments made by the LRO will enable CCGs to work more effectively and efficiently together.

In addition to a targeted consultation with those affected by the changes, the LRO has also been scrutinised by the Regulatory Reform Committee (RRC) and the Delegated Powers and Regulatory Reform Committee (DPRRC). Both concluded that the Order should proceed under the affirmative procedure. This means it is not possible to amend the Order as it passes through Parliament.

Assurance arrangements

NHS England developed an assurance process for CCGs which was published in November 2013, along with further operational guidance in June 2014. This sets out the assurance process that is to be used by Area Teams. It outlines the Cabinet Office's principles of consultation and also includes reference to a role for local Healthwatch to support engagement with the local population. The guide includes, as an example of good practice, the test that patients and the public should be involved in major service change. The LRO will not change this.

Duties in relation to public engagement and consultation

The LRO will not compel CCGs to form joint committees. It will be for CCGs to decide whether they wish to form a joint committee. If they do so, they will be required to set out in their constitutions the form and scope that this committee would take. The formation of a joint committee, as is the case with the "committees

in common" model, will not circumvent any of the existing duties of an individual CCG including S14Z2 – the duty which covers public involvement and consultation.

CCGs are therefore expected to make suitable arrangements to ensure this duty was complied with when exercising their functions through a joint committee. For example, you will be aware of the statutory guidance published by NHS England in September 2013, *Transforming Participation in Health and Care.*

Response to Healthwatch England recommendations

Your advisory note sets out several recommendations for strengthening the reforms proposed in the LRO, and for enhancing transparency, accountability and public involvement in the operationalisation of the Order.

At this stage, I am not proposing further legislative change to amend the Order, subject to its Parliamentary approval in its current form.

I believe that the majority of the concerns you raise will be addressed by the move from complex "committees in common" to clearer joint committee structures, underpinned by legislation.

As "committees in common" will be superseded by these reforms, it is not possible to introduce a mandatory non-voting seat for local Healthwatch as you suggest. This would also be contrary to the permissive and flexible nature of the legislation in relation to CCGs, where it is right that local clinicians have the autonomy to determine the structures that will work best to deliver services for their local population (subject to CCGs meeting all relevant requirements and duties set out in the legislation).

As noted above, CCGs are still accountable as individual organisations, whether they are working individually or collaboratively with other commissioners, and their existing responsibilities will still apply.

However, in light of the proposed reforms driven by the LRO, I have asked my officials and NHS England to work with Healthwatch England to consider what additional material and good practice resources may be needed to support effective and accountable collaboration between CCGs.

I note the point you raise regarding the capacity of local Healthwatch to hold CCGs jointly to account, and that some local Healthwatch organisations may require

support to do this. Where local Healthwatch organisations have been able to work together to carry out their statutory role, it would be helpful to understand how this experience has been shared and what Healthwatch England is planning to do to further support the Healthwatch network. DH and NHS England officials would be happy to work with you to consider what short and accessible resources could be produced that might support local Healthwatch to work in these contexts.

You will be aware of the ongoing work led by the LGA, funded by the Department, to develop health and wellbeing boards, including a specific strand to support local Healthwatch as effective members of health and wellbeing boards. Again we would be happy to consider what further support might be offered to local Healthwatch through this programme to help them fulfil their accountability role when working with CCGs and joint committees.

Finally, I understand that NHS England have recently briefed your team on the CCG assurance process and would recommend that Local Healthwatch are supported by Healthwatch England and NHS England to understand and contribute to this process.

I have copied this response to Simon Stevens, David Sparks and Sarah Wollaston.

JEREMY HUNT