AGENDA

MAIDSTONE AND TUNBRIDGE WELLS JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE MEETING

Date: Tuesday 21 September 2010
Time: 10.30 am
Venue: Town Hall, High Street, Maidstone

Membership:

Councillors: Atwood, Crowhurst, Cunningham, Elliott (Chairman), Marchant (Vice-Chairman), D Mortimer, Paterson and Mrs Stockell

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1. The Committee to consider whether all items on the agenda should be web-cast

2. Apologies.

Continued Over/:

Issued on 13 September 2010

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Alison Broom

Alison Broom, Chief Executive, Maidstone Borough Council, Maidstone House, King Street, Maidstone, Kent ME15 6JQ

3. Notification of Visiting Members

4. Disclosure by Members and Officers:

a) Disclosures of interest
b) Disclosures of lobbying
c) Disclosures of whipping

5. To consider whether any items should be taken in private because of the possible disclosure of exempt information

6. Minutes of the Meeting held on 17 June 2010 1 - 8

7. Appointment of Co-optee.

To consider the co-option of Councillor Dr Basu, a retired consultant oncologist, as a non- voting member of the Committee for agenda item 8: Department of Health consultation on health reforms.

8. Department of Health consultation on health reforms 9 - 309

To consider whether, and if so how, to respond to the Department of Health White Papers issued under the overarching title 'Liberating the NHS'.

Interviews with:

a) Mr A Scarff, Head of Business & Corporate Planning, Maidstone and Tunbridge Wells NHS Trust; and
Mr J Thallon, Medical Director NHS West Kent.
(10:30 to 11:15)

b) Graham Hills, Operational Director, Kent and Medway Local Involvement Networks;
Mr C Wanstall, Kent and Medway Local Involvement Networks;
Mr M Fittock, Kent and Medway Local Involvement Networks; and
Dr R Bowes, Chair of the South West Kent PBC Group.
(11:15 to 12:00)

c) Helen Wolstenholme, Healthier Communities Manager, Tunbridge Wells Borough Council;
Ms T Gailey, Health Policy Manager KCC; and
Ms J Coombes, Maidstone Borough Council Healthy lifestyles coordinator.
(12:00 to 12:45)

d) Consideration of the White Papers.

MAIDSTONE BOROUGH COUNCIL

MINUTES OF THE MAIDSTONE AND TUNBRIDGE WELLS JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE MEETING HELD ON THURSDAY 17 JUNE 2010

PRESENT: Councillor Elliott (Chairman)
Councillors Crowhurst, Cunningham, Marchant, D Mortimer and Paterson

1. The Committee to consider whether all items on the Agenda should be web-cast

Resolved: That all items be web-cast.

2. Apologies.

Apologies were received from Councillors Atwood and Mrs Stockell.

3. Notification of Visiting Members.

There were none.

4. Notification of Substitute Members.

There were none.

5. a) Election of Chairman
b) Election of Vice-Chairman

Resolved: That:

(a) Councillor Elliott be elected Chairman for the municipal year 2010-11; and
(b) Councillor Marchant be elected Vice Chairman for the municipal year 2010-11.

6. Disclosure by Members and Officers:

a) Disclosures of interest

Councillor Mortimer declared a personal interest in Agenda items 8 and 9 'Maidstone and Tunbridge Wells NHS Trust: Quality Report 2009/10' and 'Department of Health consultation on registering with a GP practice of your choice' due to being employed in the Health care industry.

Councillor Cunningham declared a personal interest in Agenda item 8 'Maidstone and Tunbridge Wells NHS Trust: Quality Report

2009/10' by virtue of his wife working for Hospitals in Maidstone and Tunbridge Wells.

Councillor Crowhurst declared a personal interest in Agenda item 8 'Maidstone and Tunbridge Wells NHS Trust: Quality Report 2009/10' by virtue of the new Hospital at Pembury being in the Ward she represented.

b) Disclosures of lobbying

There were none.

c) Disclosures of whipping

There were none

7. To Consider whether any item should be taken in private because of the possible disclosure of exempt information.

Resolved: That all items be taken in public as proposed.

8. Maidstone and Tunbridge Wells NHS Trust: Quality Report 2009/10

Kat Hicks, Overview and Scrutiny Officer, introduced witnesses from the Maidstone and Tunbridge Wells NHS Trust :

- Glenn Douglas, Chief Executive
- Claire Roberts, Head of Quality; and
- Darren Yates, Head of Communications

Mr Douglas described the progress the Trust had made in a variety of different areas over the year and responded to Members' questions. It was explained that the publishing of Quality Accounts was a new process to the NHS. They set out the previous years performance and how the Trust will be judged over the coming year, and he welcomed input and feedback from the Committee on the progress made by the Trust. The Trust had achieved the majority of its targets in 2009/10, and 90% of patients in all specialities had been treated within 18 weeks of referral. Financially, in 2010 the Trust had balanced its budget for the second year in a row for the first time since 2001.

Mr Douglas said there had been a significant fall in Clostridium difficile ('C diff') infections in the Trust's Hospitals, which now had the lowest rates in the Strategic Health Authority's area. He explained the statistics for C diff infections included patients who were already infected at the time of admission. Although the overall number of cases for the year was low, there had been a sharp rise in the recorded number of patients with C diff throughout the winter. He attributed this to the high incidence of patients presenting with other viruses, such as the norovirus. During that period the hospital had tested all patients for infections on admission, leading to an increase in the number of recorded C Diff infections.

Mr Douglas said the rate of hospital acquired infection was very low. The Trust now routinely tested all patients for infection at the time of admission and would investigate whether they could set a separate target for hospital acquired infections. He added a survey of over 500 patients this year had shown that 95% of Hospital staff were using hand-cleaning gels before coming into contact with patients. The Committee was informed that the LINks report on infection control had found the Trust to be the best in Kent. But there were problems relating to hand hygiene at the entrance to the Pembury and Kent and Sussex Hospitals, partly due to the multiple entrances. Hand hygiene at the entrance to the wards was very good in all locations. He confirmed the Trust would issue a formal response to the LINks report.

Mr Douglas explained that, of the 23 cases of MRSA bacteraemia infection, 16 were acquired in hospital. Analysis had identified poor sampling procedures, resulting in cross contamination creating false positives, as a cause for the some of those cases. The Trust had introduced new procedures and training to address this and expected the rates to reduce in 2010/11. He stressed that, although the actual number of MRSA infections was quite small, it was important to eradicate avoidable hospital acquired infection. There had only been one case of MRSA infection in the last two months. Members suggested this should be explained in the report and he agreed to consider this.

The Committee heard that although The Trust could not explain the monthly variation in recorded patient trips slips and falls, the target was important. All incidents were reported and analysed and action taken to resolve any problems. There were relatively few instances of falls arising as a result of floor conditions, nevertheless a lot of thought had been given to the flooring in the new hospital to further minimise the risk of falls.

In response to questions, Mr Douglas explained that low rise beds were used when a patient was assessed as being at risk of falling out of bed. The beds were lowered to the floor when the patient was in it, thus negating the risk.

Mr Douglas informed the Committee that the Trust had implemented several measures to improve patient nutrition. These included ensuring meal times were not disturbed by visitors or ward rounds. Patients who needed help with eating were served meals on a red tray so that staff could easily identify and help those in need of assistance.

Mr Douglas acknowledged the Trust had, in his view justifiably, been criticised for not engaging enough with the public. The Trust had taken steps to improve this and had responded to patient concerns. The Committee was informed that patients were provided with hand-held electronic questionnaires so they could give feedback prior to discharge from hospital.

Mr Yates explained that the Trust had introduced processes to analyse patient's concerns, establish the cause, and identify ways to prevent the problem recurring. In addition, Matrons and ward Sisters were listening to patients and, where possible, dealt with problems at the time. He believed the Trust had improved significantly in this area and added the Royal College of Nursing had recently praised the Trust as a good example of listening and responding to patient's concerns.

The Committee was told that the new hospital at Pembury was on target for completion, with the first patients expected in early 2011. The hospital would be a significant improvement over the facilities previously available, with a large number of single occupancy rooms that would improve patient privacy. However Mr Douglas recognised that too many people still shared mixed sex facilities such as bathrooms in the Trust's other hospitals. He explained the Trust was investing in better toilet facilities and re-organising wards in those hospitals to improve patient privacy.

Mr Douglas said here had been significant investment in Maidstone Hospital, which now had a World leading Laparoscopic training centre. Laparoscopy [key-hole surgery] techniques reduced the length of hospital stay and improved the speed of patient recovery. RapidArc radiotherapy machines had also been installed in Maidstone and Canterbury Hospitals. They provided precise control of the dose of radio therapy administered, which improved the quality of care and patient outcomes. He said the Trust was now able to provide top quality radiotherapy services to patients.

The Committee heard that the Trust had a proposal for the location of a birthing centre at Maidstone, a midwife-led site adjacent to the main hospital site. Pembury Hospital had a midwife-led birthing facility as part of the main birthing centre.

The Committee was informed that work was underway on the new Histopathology laboratory [for examination of biopsy samples] in Maidstone Hospital. This would replace obsolete facilities at Preston Hall and Pembury and support cancer services.

Mr Douglas said the provision of stroke services had been a priority for the Trust over the last 12 months, and both Maidstone and Tunbridge Wells now had good services. He explained the Trust's performance against the Sentinel Stroke Audit, which had previously been poor, had improved significantly.

In response to questions, Mr Douglas confirmed the Trust intended to apply for planning permission for more parking spaces at Pembury Hospital.

In response to Members' questions, Mr Douglas confirmed there had been complaints regarding staff parking in streets near Maidstone Hospital. Managers had tried to deal with this, but there was a limit to what they could do to prevent staff parking legally on public roads. Although staff

had to pay for parking at the Hospital, the cost was £104 per year which the Trust considered to be reasonable.

Mr Douglas confirmed the Trust would work with partners to pursue development of duelling works for the A21. It was hoping to attract patients from Sevenoaks and believed improvements to the A21 would help this.

The Committee heard that the Trust's funding had been frozen for 2010/11, and was likely to remain frozen for the next few years. While confident it could meet its targets this year, this would have to be kept under review.

A Member asked about the measures the Trust took to cater for the needs of disabled or vulnerable people. Mr Douglas said this was high on his personal priorities. He said that generally the Trust managed this quite well, but there were examples where it had not performed as well as he would like. He believed the opening of Pembury Hospital was an opportunity to look again at how the Trust responded to their needs.

The Committee considered the format of the report and in response to questions, was informed that the term 'cum' in the tables on page 4 of the report meant 'cumulative', while 'breach' on pages 22, 25 and 26 of the report meant that a target had been exceeded.

Members suggested that, as the report contained acronyms and abbreviations, a glossary would be useful. Members also suggested that a summary of the report would make it more accessible to members of the Public. Mr Douglas said the Trust was required to follow a specific format for the report, but would consider producing a summary document.

Members noted that the Trust was reminding patients by text or telephone of their appointments, and noted this would be beneficial to both patients and the Trust.

The Chairman thanked the witnesses for attending and answering questions from the Committee.

Resolved: That the Committee write to the Trust, suggesting that:

a) A glossary should be included;
b) A summary should be produced to make the report more accessible to non health care professionals;
c) The term 'cum' in the tables on page 4 should be expanded or an explanation be included to show this referred to a cumulative total;
d) an explanation of why low-rise beds, referred to in page 6, reduce the incidence of patient slip, trips or falls, should be included;
e) An explanation of how the Red Tray system, referred to in page 21, improves patient nutrition would be helpful;

f) There should be a clearer explanation that a 'breach', referred to in pages 22, 25 and 28, meant a target had been exceeded;

g) The report should clarify that the rates of Hospital acquired infections of both Clostridium difficile and MRSA were lower than the recorded infection rates, due to the inclusion of patients with an existing infection on admission.

h) The report should explain why the rate of MRSA infections had not reduced in a similar proportion to that of C Diff infections, and why the measures proposed for 2010/11 were expected to reduce infection rates;

And the letter should:

i) Confirm the Committee believed the steps taken to remind patients by text or telephone of their appointments would prove to be beneficial to both patients and the Trust; and

j) Record that the Committee welcomed the agreement to publish a formal response to the LINks report on infection.

The web cast from this session is available at: http://clients.westminster-digital.co.uk/maidstone/Archive.aspx

9. Department of Health Consultation on registering with a GP practice of your choice

Les Smith, Overview and Scrutiny Officer, explained the background to the consultation document and the options identified in the document for patients to register with a GP practice of their choice. The Committee then discussed the document.

A Member informed the Committee he had discussed the document with a semi-retired GP, who had suggested the proposals were driven by politics rather than a clinical need for change. He said the GP had not seen a need to change the current system.

Members noted that continuity of care was important. They considered that the more services were fragmented, the more difficult it would be to properly treat the individual. They believed that most people would prefer to be treated by their local GP, who knew their history. A Member said that many GP practices offer some evening and / or Saturday morning appointments to cater for those who found it difficult to see the Doctor during normal working hours.

Members discussed the suggestion, in paragraph 2.12 of the consultation document, that a patient's record of home visits might be taken into account when considering which practice to register with. The Committee

noted that a home visit might be required at any time and concluded all practices should assume that home visits would be required.

Members noted the proposal to introduce new ways of defining practice boundaries. They believed the current system worked well and saw no need to make significant changes. They were concerned at the disclosure in paragraph 3.3 of the document, that over 800 practices are believed to have closed their lists to new patients without having first agreed this with the PCT. The Committee considered this reduced the choice that patients currently have in their choice of GP practice. Members noted that the PCT already had powers to deal with such practices and believed those powers should be used.

Members noted that both options A and B had a significant weakness in that a Doctor conducting a home visit for an out of area patient would not have access to their health information until the 'Summary Care Record' was in place. Members believed that a Doctor should have full access to a patient's history when treating and were concerned that a summary may cause confusion. They were also concerned that the Summary Record could be insecure and increase the risk of patient's data being lost, particularly if accessed through portable devices.

Members concluded that, for the majority of people, the current system of registering with a local GP worked well and provided continuity of health care. They recognised that for some people, the ability to register with a practice some distance away, for example close to where they worked, would give them better access to GP services. They noted the weaknesses identified in the document relating to dual registration, but concluded that this provided the best way of meeting that need.

The Committee concluded that a response should be sent to the Department of Health confirming that dual registration should be offered for those patients who regularly spend significant periods of time away from home.

Resolved: That a letter be sent in response to the consultation document, saying there was no need to amend the current system of practice boundaries but that dual registration should be available for those people who regularly spend significant periods of time away from their home.

The web cast from this session is available at: http://clients.westminster-digital.co.uk/maidstone/Archive.aspx

10. Joint Working Protocol

The Committee discussed the protocol for joint committees between Maidstone and Tunbridge Wells Borough Councils. Members agreed that the Chairman should be elected on the basis of being the best person for the job and voted in on an annual basis. Members also agreed that all Members of the Committee should have voting rights; that experts could be co-opted onto the Committee; and that due to the specialised nature of

the Committee substitute Members would not be permitted to attend Meetings.

The Committee also considered the Kent protocols for National Health Service Overview and Scrutiny and agreed that they were in need of review. Members also noted that the protocol prevented Overview and Scrutiny Committees adversely commenting on any individual officer of an authority or NHS body by name and therefore unduly restricted the role of the Committee.

Resolved: That the Committee would adopt the Joint Working Protocol on page 89 of the agenda with the following provisions:

a) The Chairman be voted in on an annual basis;
b) Substitute Members would not be permitted to attend; and
c) Experts could be co-opted on to the Committee to help with reviews.

11. Future Work Plan

The Committee was informed that the only item currently on the Forward Work Programme was a meeting with the MP for Tunbridge Wells, Greg Clark and the Primary care Trust to discuss the recent Mental Health Care Provision Review. This was expected to take place on 16 July, but the Committee would be informed as soon as a date was confirmed.

Resolved: That the Forward Work Programme be noted.

12. Duration of the Meeting

2:24 p.m. to 4:20 p.m.

MAIDSTONE AND TUNBRIDGE WELLS JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

21 September 2010

Report prepared by Andrew Goy & Les Smith

1. Department of Health White Papers: Liberating the NHS Consultation documents

1.1 Issue for Consideration

1.1.1 To consider the 'Equity and Excellence, Liberating the NHS', 'Liberating the NHS, Commissioning for Patients', and 'Liberating the NHS, Increasing Democratic Legitimacy in Health' consultation papers issued by the Department of Health and collect evidence from witnesses to produce a response from the Committee to the consultation.

1.1.2 The consultation papers form part of a raft of consultations currently being undertaken by the Department of Health and these other consultations, namely 'Liberating the NHS, Regulating Healthcare Providers', 'Liberating the NHS, Arms Length Bodies Review', and 'Transparency in Outcomes, a Framework for the NHS', have been included as background papers.

1.2 Recommendation

1.2.1 That Members:

- Interview witnesses about the proposed changes contained within the consultation papers to establish the likely effect upon local health services;
- Identify specific issues in the consultation papers that will impact upon both patients and the provision of services in the local area.
- Collate the evidence from the witnesses and discussion of the papers into clear points to be included in the Committee's response to the consultation; and
- Take account of the proposals in the background papers, in light of the evidence from witnesses, when forming its response.

1.3 Reasons for Recommendation

1.3.1 The changes proposed are far reaching and will have an impact on the delivery of health services in Maidstone and Tunbridge Wells. It is important that the likely local impact is established and taken account of by the Department of Health.

1.3.2 The witnesses will provide a diverse range of insights that, if used as evidence, will ensure that the interests of both patients and service providers are represented in the Committee's response.

1.4 Alternative Action and Why Not Recommended

1.4.1 The Committee could take no action and provide no response to the Consultation, but this would mean the Department of Health would not be able to take the impact on Maidstone and Tunbridge Wells into account when progressing these reforms.

1.5 Background

1.5.1 Equity and Excellence: Liberating the NHS

The consultation papers (**Appendix A**) seek views on a series of fundamental reforms to the way that health services will be delivered in future. The over-arching strategy is set out in the document 'Equity and Excellence: Liberating the NHS' which says the aim of the reforms is to:

- Put patients at the heart of the NHS, giving them more choice and control over their treatment;
- Measure success against clinical criteria such as improved cancer and stroke survival rates; and
- Empower health professionals to use their judgment about what is right for patients.

1.5.2 The paper sets out how these objectives will be delivered, by:

- Transferring responsibility for local health improvement from PCTs to local authorities;
- Giving patients access to comprehensive, easy to understand information from a range of sources on conditions, treatments, lifestyle choices and how to look after their own and their family's health;
- Creating a new independent consumer champion; HealthWatch England. Local Involvement Networks (LINks) will become the local HealthWatch;
- Devising funding mechanisms that ensures funding follows patients and reflects quality of care; and
- Devolving power and responsibility for commissioning services to local consortia of GP practices.

1.5.3 The Local Government Association has prepared a briefing note on the reforms which Members may find useful. That paper is enclosed as **Appendix B**. Witness A [redacted] a mental health service user, has submitted written evidence (**Appendix C)** on this paper which the Committee should consider before reaching

its conclusions. A briefing note on both this paper and on the consultation paper 'Liberating the NHS: Local Democratic Legitimacy in Health' is at **Appendix D**.

1.5.4 Liberating the NHS: Commissioning for patients

This paper (**Appendix E**) provides details of how GPs will be responsible for commissioning health services for their patients. In future, most commissioning decisions will be made in local consortia of GP practices, ensuring commissioning decisions are clearly informed by knowledge of local healthcare and clinical needs. A new NHS Commissioning Board will support GP Commissioners in developing guidelines, model contracts and tariffs. It anticipates PCTs will cease to exist from April 2013, following establishment of GP Consortia.

1.5.5 The paper sets out:

- The scope of services that GP consortia and the NHS Commissioning Board will be responsible for;
- The statutory form that GP Consortia will take, and the freedoms and flexibilities they will have to enable them decide how best to commission services and how they will be held accountable;
- How the consortia and the Commissioning Board will work with patients, the public, local government and other health care professionals to secure patient-centered and integrated delivery of care; and
- The timetable for the transition to practice based commissioning and the role PCTs will have to facilitate the transition.

1.5.6 Liberating the NHS: Local Democratic Legitimacy in Health

This paper (**Appendix F**) sets out more detail in the increased role of local government in health. Local authorities will bring the perspective of communities into commissioning plans. Local authorities will have responsibility for:

- Leading joint strategic needs assessments (JSNA)1 to ensure coherent and co-ordinated commissioning strategies;
- Supporting local voice, and the exercise of patient choice;
- Promoting joined up commissioning of local NHS services, social care and health improvement; and
- Leading on local health improvement and prevention activity.

1.5.7 Local authorities will fund HealthWatch and will be responsible for holding HealthWatch to account for delivering effective, value for money services. They will have an increased role in supporting partnership working in health and social care. Each upper tier local authority may have a statutory role to support joint working on health and well-being.

1.5.8 The paper suggests the establishment of a statutory partnership, which it describes as a 'health and wellbeing board', to act as a focal point through which partnership working would take place. The health and wellbeing board' would be an upper-tier local authority responsibility and would have four main functions:

- To assess the needs of the local population and lead the statutory joint strategic needs assessment;
- To promote integration and partnership across areas, including through promoting joined up commissioning plans across the NHS, social care and public health;
- To support joint commissioning and pooled budget arrangements, where all parties agree this makes sense; and
- To undertake a scrutiny role in relation to major service redesign

1.5.9 Health and wellbeing boards would have to ensure local needs are addressed and that democratic representatives of lower-tier authorities can contribute. Some of these functions could be delegated by the Health and wellbeing boards to districts or neighborhoods.

1.5.10 Because the Health and wellbeing boards would have a key role in promoting partnership working, and thus would have strategic oversight of health care, the paper suggests that the existing statutory health Overview and Scrutiny functions would transfer to the health and well-being board.

1.5.11 When PCTs cease to exist, responsibility and funding for local health improvement activity will transfer to local authorities. A national Public Health Service will be created to streamline health improvement and protection bodies and functions, with an increased emphasis on research, analysis and evaluation. Local Directors of Public Health will be jointly appointed by local authorities and the Public Health Service. The Director will have a budget to deliver national and local priorities in health improvement, and will be directly accountable to the local authority and ALSO, through the Public Health Service, to the Secretary of State.

1.5.12 <u>Liberating the NHS, Regulating Healthcare Providers</u>

1.5.13 The document (**Appendix G**) provides information on proposals for foundation trusts and the establishment of an independent economic regulator for health and adult social care. It proposes freeing foundation trusts from many of the constraints they operate under, so that they can innovate to improve care for patients. Within three years all NHS Trusts will be supported to become foundation trusts and the legislation relating to NHS Trusts will be repealed.

1.5.14 The paper sets out proposals, and seeks views on, the constitution, governance and regulation of foundation trusts.

1.5.15 Liberating the NHS: Report of the Arms Length Bodies Review

1.5.16 This document sets out more detail of how it proposes to reduce the number of 'arm's-length bodies' in the NHS (**Appendix H**). Arm's-length bodies are Government-funded organisations which work closely with local services and other arm's-length bodies. The Department has three main types of arm's-length bodies: Executive Agencies; Executive Non- Departmental Public Bodies; and Special Health Authorities.

1.5.17 In paragraph 2.13 the paper describes the criteria that will be applied in determining the role of arm's-length bodies and, in section 3, explains the proposals to retain, abolish or transfer the functions of 18 arm's-length bodies.

1.5.18 Liberating the NHS: Transparency in Outcomes – a framework for the NHS

This paper (**Appendix I**) provides information on developing an 'outcomes framework' - a focussed set of national outcome goals that will provide an indication of the overall performance of the NHS. Those goals would provide the means by which the Secretary of State would be held to account for the performance of the NHS. The expectation is that the framework would help to improve performance across the NHS, providing greater transparency about the quality of healthcare by giving better, and more locally relevant, information for use by patients, carers and the public.

1.6 Risk Management

1.7.1 There are no risks involved in responding to the consultation.

1.7 Other Implications

1.7.1

1.	Financial	
2.	Staffing	
3.	Legal	
4.	Equality Impact Needs Assessment	
5.	Environmental/Sustainable Development	
6.	Community Safety	

7. Human Rights Act	
8. Procurement	
9. Asset Management	

1.8 Relevant Documents

- **Appendix A**: Equity and Excellence – Liberating the NHS
- **Appendix B**: Local Government Association Briefing note on the White Paper "Equity and excellence: Liberating the NHS"
- **Appendix C**: Written evidence of Witness A [redacted]
- **Appendix D**: Analysis of the NHS White Paper and the consultation paper Local Democratic Legitimacy in Health
- **Appendix E**: Liberating the NHS, Commissioning for Patients
- **Appendix F**: Liberating the NHS, Increasing Democratic Legitimacy in Health

Background Papers:

- **Appendix G**: Liberating the NHS, Regulating Healthcare Providers
- **Appendix H**: Liberating the NHS, Arms Length Bodies Review
- **Appendix I**: Transparency in Outcomes, a Framework for the NHS

NHS

Equity and excellence:

Liberating the NHS

DH Department of Health

Equity and excellence: Liberating the NHS

Presented to Parliament
by the Secretary of State for Health
by Command of Her Majesty

July 2010

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Foreword

The NHS is a great national institution. The principles it was founded on are as important now as they were then: free at the point of use and available to everyone based on need, not ability to pay. But we believe that it can be so much better – for both patients and professionals.

That's why we've set out a bold vision for the future of the NHS - rooted in the coalition's core beliefs of freedom, fairness and responsibility.

We will make the NHS more accountable to patients. We will free staff from excessive bureaucracy and top-down control. We will increase real terms spending on the health service in every year of this Parliament.

Our ambition is to once again make the NHS the envy of the world. *Liberating the NHS* - a blend of Conservative and Liberal Democrat ideas - sets out our plans to do this.

First, patients will be at the heart of everything we do. So they will have more choice and control, helped by easy access to the information they need about the best GPs and hospitals. Patients will be in charge of making decisions about their care.

Second, there will be a relentless focus on clinical outcomes. Success will be measured, not through bureaucratic process targets, but against results that really matter to patients – such as improving cancer and stroke survival rates.

Third, we will empower health professionals. Doctors and nurses must to be able to use their professional judgement about what is right for patients. We will support this by giving front-line staff more control. Healthcare will be run from the bottom up, with ownership and decision-making in the hands of professionals and patients.

Of course, our massive deficit and growing debt means there are some difficult decisions to make. The NHS is not immune from those challenges. But far from that being reason to abandon reform, it demands that we accelerate it. Only by putting patients first and trusting professionals will we drive up standards, deliver better value for money and create a healthier nation.

Prime Minister

Deputy Prime Minister

Secretary of State for Health

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Our strategy for the NHS: an executive summary

1. The Government upholds the values and principles of the NHS: of a comprehensive service, available to all, free at the point of use and based on clinical need, not the ability to pay.

2. We will increase health spending in real terms in each year of this Parliament.

3. Our goal is an NHS which achieves results that are amongst the best in the world.

Putting patients and public first

4. We will put patients at the heart of the NHS, through an information revolution and greater choice and control:

    a. Shared decision-making will become the norm: *no decision about me without me*.

    b. Patients will have access to the information they want, to make choices about their care. They will have increased control over their own care records.

    c. Patients will have choice of any provider, choice of consultant-led team, choice of GP practice and choice of treatment. We will extend choice in maternity through new maternity networks.

    d. The Government will enable patients to rate hospitals and clinical departments according to the quality of care they receive, and we will require hospitals to be open about mistakes and always tell patients if something has gone wrong.

    e. The system will focus on personalised care that reflects individuals' health and care needs, supports carers and encourages strong joint arrangements and local partnerships.

    f. We will strengthen the collective voice of patients and the public through arrangements led by local authorities, and at national level, through a powerful new consumer champion, HealthWatch England, located in the Care Quality Commission.

    g. We will seek to ensure that everyone, whatever their need or background, benefits from these arrangements.

Improving healthcare outcomes

5. To achieve our ambition for world-class healthcare outcomes, the service must be focused on outcomes and the quality standards that deliver them. The Government's objectives are to reduce mortality and morbidity, increase safety, and improve patient experience and outcomes for all:

    h. The NHS will be held to account against clinically credible and evidence-based outcome measures, not process targets. We will remove targets with no clinical justification.

    i. A culture of open information, active responsibility and challenge will ensure that patient safety is put above all else, and that failings such as those in Mid-Staffordshire cannot go undetected.

    j. Quality standards, developed by NICE, will inform the commissioning of all NHS care and payment systems. Inspection will be against essential quality standards.

    k. We will pay drug companies according to the value of new medicines, to promote innovation, ensure better access for patients to effective drugs and improve value for money. As an interim measure, we are creating a new Cancer Drug Fund, which will operate from April 2011; this fund will support patients to get the drugs their doctors recommend.

    l. Money will follow the patient through transparent, comprehensive and stable payment systems across the NHS to promote high quality care, drive efficiency, and support patient choice.

    m. Providers will be paid according to their performance. Payment should reflect outcomes, not just activity, and provide an incentive for better quality.

Autonomy, accountability and democratic legitimacy

6. The Government's reforms will empower professionals and providers, giving them more autonomy and, in return, making them more accountable for the results they achieve, accountable to patients through choice and accountable to the public at local level:

    n. The forthcoming Health Bill will give the NHS greater freedoms and help prevent political micromanagement.

    o. The Government will devolve power and responsibility for commissioning services to the healthcare professionals closest to patients: GPs and their practice teams working in consortia.

    p. To strengthen democratic legitimacy at local level, local authorities will promote the joining up of local NHS services, social care and health improvement.

q. We will establish an independent and accountable NHS Commissioning Board. The Board will lead on the achievement of health outcomes, allocate and account for NHS resources, lead on quality improvement and promoting patient involvement and choice. The Board will have an explicit duty to promote equality and tackle inequalities in access to healthcare. We will limit the powers of Ministers over day-to-day NHS decisions.

r. We aim to create the largest social enterprise sector in the world by increasing the freedoms of foundation trusts and giving NHS staff the opportunity to have a greater say in the future of their organisations, including as employee-led social enterprises. All NHS trusts will become or be part of a foundation trust.

s. Monitor will become an economic regulator, to promote effective and efficient providers of health and care, to promote competition, regulate prices and safeguard the continuity of services.

t. We will strengthen the role of the Care Quality Commission as an effective quality inspectorate across both health and social care.

u. We will ring-fence the public health budget, allocated to reflect relative population health outcomes, with a new health premium to promote action to reduce health inequalities.

Cutting bureaucracy and improving efficiency

7. The NHS will need to achieve unprecedented efficiency gains, with savings reinvested in front-line services, to meet the current financial challenge and the future costs of demographic and technological change:

v. The NHS will release up to £20 billion of efficiency savings by 2014, which will be reinvested to support improvements in quality and outcomes.

w. The Government will reduce NHS management costs by more than 45% over the next four years, freeing up further resources for front-line care.

x. We will radically delayer and simplify the number of NHS bodies, and radically reduce the Department of Health's own NHS functions. We will abolish quangos that do not need to exist and streamline the functions of those that do.

Conclusion: making it happen

8. We will maintain constancy of purpose. This White Paper[1] is the long-term plan for the NHS in this Parliamentary term and beyond. We will give the NHS a coherent, stable, enduring framework for quality and service improvement. The debate on health should

no longer be about structures and processes, but about priorities and progress in health improvement for all.

9. This is a challenging and far-reaching set of reforms, which will drive cultural changes in the NHS. We are setting out plans for managing change, including the transitional roles of strategic health authorities and primary care trusts. Implementation will happen bottom-up.

Many of the commitments made in this White Paper require primary legislation and are subject to Parliamentary approval.

1. Liberating the NHS

Our values

1.1 It is our privilege to be custodians of the NHS, its values and principles. We believe that the NHS is an integral part of a Big Society, reflecting the social solidarity of shared access to collective healthcare, and a shared responsibility to use resources effectively to deliver better health.

1.2 We are committed to an NHS that is available to all, free at the point of use, and based on need, not the ability to pay. We will increase health spending in real terms in each year of this Parliament.

1.3 The NHS is about fairness for everyone in our society. It is about this country doing the right thing for those who need help. We are committed to promoting equality[2] and will implement the ban on age discrimination in NHS services and social care to take effect from 2012. The NHS Commissioning Board will have an explicit duty to address inequalities in outcomes from healthcare services.

1.4 We will uphold the NHS Constitution, the development of which enjoyed cross-party support. By 2012, the Government will publish the first statement of how well organisations are living by its letter and spirit.[3] The NHS Constitution codifies NHS principles and values, and the rights and responsibilities of patients and staff. It is about mutuality; and our proposals in chapter 2 for shared decision-making by patients, their carers, and clinicians will give better effect to this principle. It is also about NHS-funded organisations being good employers; and our plans in chapter 4 will give organisations and professionals greater freedoms, leading to better staff engagement and better patient care.

1.5 Current statutory arrangements allow the Secretary of State a large amount of discretion to micromanage parts of the NHS.[4] We will be clear about what the NHS should achieve; we will not prescribe how it should be achieved. We will legislate to establish more autonomous NHS institutions, with greater freedoms, clear duties, and transparency in their responsibilities to patients and their accountabilities. We will use our powers in order to devolve them.

The NHS today

1.6 At its best, the NHS is world-class. The people who work in the NHS are among the most talented in the world, and some of the most dedicated public servants in the country. Other countries seek to learn from our comprehensive system of general

practice, and its role as the medical home for patients, providing continuity of care and coordination. The NHS has an increasingly strong focus on evidence-based medicine, supported by internationally respected clinical researchers with funding from the National Institute for Health Research, and the National Institute for Health and Clinical Excellence (NICE). Other countries admire NHS delivery of immunisation programmes. Our patient participation levels in cancer research are the highest in the world.[5]

1.7 We will build on the ongoing good work in the NHS. We recognise the importance of Lord Darzi's work, in putting a stronger emphasis on quality.

1.8 Compared to other countries, however, the NHS has achieved relatively poor outcomes in some areas. For example, rates of mortality amenable to healthcare,[6] rates of mortality from some respiratory diseases and some cancers,[7] and some measures of stroke[8] have been amongst the worst in the developed world.[9] In part this is due to differences in underlying risk factors, which is why we need to re-focus on public health. But international evidence also shows we have much further to go on managing care more effectively. For example, the NHS has high rates of acute complications of diabetes and avoidable asthma admissions;[10] the incidence of MRSA infection has been worse than the European average;[11] and venous thromboembolism causes 25,000 avoidable deaths each year.[12]

1.9 The NHS also scores relatively poorly on being responsive to the patients it serves. It lacks a genuinely patient-centred approach in which services are designed around individual needs, lifestyles and aspirations. Too often, patients are expected to fit around services, rather than services around patients. The NHS is admired for the equity in access to healthcare it achieves; but not for the consistency of excellence to which we aspire. Our intention is to secure excellence as well as equity.

Our vision for the NHS

1.10 We can foresee a better NHS that:

- **Is genuinely centred on patients and carers;**
- **Achieves quality and outcomes that are among the best in the world;**
- **Refuses to tolerate unsafe and substandard care;**
- **Eliminates discrimination and reduces inequalities in care;**
- **Puts clinicians in the driving seat and sets hospitals and providers free to innovate, with stronger incentives to adopt best practice;**

- **Is more transparent, with clearer accountabilities for quality and results;**
- **Gives citizens a greater say in how the NHS is run;**
- **Is less insular and fragmented, and works much better across boundaries, including with local authorities and between hospitals and practices;**
- **Is more efficient and dynamic, with a radically smaller national, regional and local bureaucracy; and**
- **Is put on a more stable and sustainable footing, free from frequent and arbitrary political meddling.**

1.11 This is our vision. It is based on our commitment to NHS values and principles, and is about building on what is best in the NHS today, and striving for continual improvement, while being open and honest about shortcomings. Our strategy to implement this vision draws inspiration from the coalition principles of freedom, fairness and responsibility[13].

1.12 The headquarters of the NHS will not be in the Department of Health or the new NHS Commissioning Board but instead, power will be given to the front-line clinicians and patients. The headquarters will be in the consulting room and clinic. The Government will liberate the NHS from excessive bureaucratic and political control, and make it easier for professionals to do the right things for and with patients, to innovate and improve outcomes. We will create an environment where staff and organisations enjoy greater freedom and clearer incentives to flourish, but also know the consequences of failing the patients they serve and the taxpayers who fund them.

1.13 The current architecture of the health system has developed piecemeal, involves duplication, and is unwieldy. Liberating the NHS, and putting power in the hands of patients and clinicians, means we will be able to effect a radical simplification, and remove layers of management. We will build on key aspects of the existing arrangements: for example, a number of GP consortia are likely to emerge from practice-based commissioning clusters and Monitor will become the economic regulator.

Improving public health and reforming social care

1.14 Liberating the NHS will fundamentally change the role of the Department. Its NHS role will be much reduced and more strategic. It will focus on improving public health, tackling health inequalities and reforming adult social care.

1.15 We will set out our programme for public health in a White Paper later this year. The forthcoming Health Bill will support the creation of a new Public Health Service, to integrate and streamline existing health improvement and protection bodies and

functions, including an increased emphasis on research, analysis and evaluation. It will be responsible for vaccination and screening programmes and, in order to manage public health emergencies, it will have powers in relation to the NHS matched by corresponding duties for NHS resilience.

1.16 PCT responsibilities for local health improvement will transfer to local authorities, who will employ the Director of Public Health jointly appointed with the Public Health Service. The Department will create a ring-fenced public health budget and, within this, local Directors of Public Health will be responsible for health improvement funds allocated according to relative population health need. The allocation formula for those funds will include a new "health premium" designed to promote action to improve population-wide health and reduce health inequalities.

1.17 The Department will continue to have a vital role in setting adult social care policy. We want a sustainable adult social care system that gives people support and freedom to lead the life they choose, with dignity. We recognise the critical interdependence between the NHS and the adult social care system in securing better outcomes for people, including carers. We will seek to break down barriers between health and social care funding to encourage preventative action. Later this year we will set out our vision for adult social care, to enable people to have greater control over their care and support so they can enjoy maximum independence and responsibility for their own lives. The Department will continue to work closely with the Department for Education on services for children, to ensure that the changes in this White Paper and the subsequent public health White Paper support local health, education and social care services to work together for children and families.

1.18 The Department will establish a commission on the funding of long-term care and support, to report within a year. We understand the urgency of reforming the system of funding social care. The Commission will consider a range of ideas, including both a voluntary insurance scheme and a partnership scheme. As a key component of a lasting settlement for the social care system, we will reform and consolidate the law underpinning adult social care, working with the Law Commission.

1.19 The Government will bring together the conclusions of the Law Commission and the Commission on funding of long-term care, along with our vision, into a White Paper in 2011, with a view to introducing legislation in the second session of this Parliament to establish a sustainable legal and financial framework for adult social care.

The financial position

1.20 We know that the reforms that we are proposing in this White Paper will take place against the backdrop of a very challenging financial position. In the Coalition Agreement, the Government said that the single greatest priority for the next Parliament will be to reduce the deficit. It is now even more pressing that we

implement the reforms set out here in order to increase productivity and efficiency in the NHS.

1.21 We will increase NHS spending in real terms in each year of this Parliament. Despite this, local NHS organisations will need to achieve unprecedented efficiency gains, if we are to meet the costs of demographic and technological changes, and even more so if we are to achieve quality and improve outcomes. Large cuts in administrative costs will provide an important but still modest contribution. In the next five years, the NHS will only be able to increase quality through implementing best practice and increasing productivity. This will be difficult work. Inevitably, as a result of the record debt, the NHS will employ fewer staff at the end of this Parliament; although rebalanced towards clinical staffing and front-line support rather than excessive administration. This is a hard truth which any government would have to recognise.

1.22 All of this means we have a responsibility to ensure that funding is used as efficiently as possible. The proposals laid out in this White Paper are a part of this. They are intended to put the NHS onto a sustainable footing, so that everyone in the system – from the Department to groups of GP practices – is accountable for the best use of funding. We are very clear that there will be no bail-outs for organisations which overspend public budgets.

Implementing our NHS vision

1.23 Our strategy is about making changes for the long-term; not just for this Parliament, but beyond. Experience in other sectors and abroad shows that embedding change takes time, and requires ongoing adaptation. The Department is committed to evidence-based policy-making and a culture of evaluation and learning.

1.24 Many will welcome our vision and clarity of intention, our insistence on transparency, and our sense of real urgency. Others may find it too challenging. Throughout, we will maintain constancy of purpose. This White Paper is our strategy for the NHS during this Parliamentary term, so that it is liberated to deliver the best quality care over the longer-term. In the next five years, the coalition Government will not produce another long-term plan for the NHS.

1.25 The NHS will face very significant challenges along the way. The new financial context will require difficult local decisions in the NHS, irrespective of this White Paper.[14] We will be open and honest about what this means.

1.26 These reforms will make the NHS more responsive and transparent, better able to withstand the funding pressures of the future. Once they are in place, it will not just be the responsibility of government, but of every commissioner, every healthcare provider and every GP practice to ensure that taxpayers' money is used to achieve the best possible outcomes for patients.

1.27 The following chapters set out how we will bring about this long-term transformation through:

- putting patients and the public first;
- focusing on improvement in quality and healthcare outcomes;
- autonomy, accountability and democratic legitimacy; and
- cutting bureaucracy and improving efficiency.

1.28 These plans are interconnected and mutually reinforcing. The final chapter sets out plans for making it happen. The Department will take forward work to manage the transition and flesh out further policy details in partnership with external organisations, seeking their help and expertise.

2. Putting patients and the public first

Shared decision-making: nothing about me without me

2.1 The Government's ambition is to achieve healthcare outcomes that are among the best in the world. This can only be realised by involving patients fully in their own care, with decisions made in partnership with clinicians, rather than by clinicians alone.

2.2 Healthcare outcomes are personal to each of us. The outcomes we experience reflect the quality of our interaction with the professionals that serve us.[15] But compared to other sectors, healthcare systems are in their infancy in putting the experience of the user first, and have barely started to realise the potential of patients as joint providers of their own care and recovery. Progress has been limited in making the NHS truly patient led.[16] We intend to put that right.

2.3 We want the principle of "shared decision-making" to become the norm: *no decision about me without me*. International evidence shows that involving patients in their care and treatment improves their health outcomes,[17] boosts their satisfaction with services received, and increases not just their knowledge and understanding of their health status but also their adherence to a chosen treatment.[18] It can also bring significant reductions in cost, as highlighted in the Wanless Report,[19] and in evidence from various programmes to improve the management of long-term conditions.[20] This is equally true of the partnership between patients and clinicians in research, where those institutions with strong participation in clinical trials tend to have better outcomes.

2.4 The new NHS Commissioning Board will champion patient and carer involvement, and the Secretary of State will hold it to account for progress. In the meantime, the Department will work with patients, carers and professional groups, to bring forward proposals about transforming care through shared decision-making.

An NHS information revolution

2.5 Information, combined with the right support, is the key to better care, better outcomes and reduced costs. Patients need and should have far more information and data on all aspects of healthcare, to enable them to share in decisions made about their care and find out much more easily about services that are available.

2.6 The Government intends to bring about an NHS information revolution, to correct the imbalance in who knows what. Our aim is to give people access to comprehensive, trustworthy and easy to understand information from a range of sources on conditions, treatments, lifestyle choices and how to look after their own and their family's health. The information revolution is also about new ways of delivering care,

such as enabling patients to communicate with their clinicians about their health status on-line. We will provide a range of on-line services which will mean services being provided much more efficiently at a time and place that is convenient for patients and carers, and will also enable greater efficiency.

2.7 Information generated by patients themselves will be critical to this process, and will include much wider use of effective tools like Patient-Reported Outcome Measures (PROMS), patient experience data, and real-time feedback. At present, PROMs, other outcome measures, patient experience surveys and national clinical audit are not used widely enough. We will expand their validity, collection and use. The Department will extend national clinical audit to support clinicians across a much wider range of treatments and conditions, and it will extend PROMs across the NHS wherever practicable.

2.8 We will also encourage more widespread use of patient experience surveys and real-time feedback. We will enable patients to rate services and clinical departments according to the quality of care they received, and we will require hospitals to be open about mistakes and always tell patients if something has gone wrong. We will also require that staff feedback around the quality of the patient care provided in organisations is publicly available. As in many other services, this feedback from patients, carers and families, and staff will help to inform other people with similar conditions to make the right choice of hospital or clinical department and will encourage providers to be more responsive.[21] The Department will seek views on how best to ensure this approach is developed in a coherent way.

2.9 Information will improve accountability: in future, it will be far easier for the public to see where unacceptable services are being provided and to exert local pressure for them to be improved. There is compelling evidence that better information also creates a clear drive for improvement in providers. Our intention is for clinical teams to see a meaningful, risk-adjusted assessment of their performance against their peers, and this assessment should also be placed in the public domain. The Department will revise and extend quality accounts to reinforce local accountability for performance, encourage peer competition, and provide a clear spur for boards of provider organisations to focus on improving outcomes. Subject to evaluation, we will extend quality accounts to all providers of NHS care from 2011 and continue to strengthen the independent assurance of quality accounts to ensure the content is accurate and fair. We will ensure that nationally comparable information is published, in a way that patients, their families and clinical teams can use.

2.10 More information about commissioning of healthcare will also improve public accountability. Wherever possible, we will ensure that information about services is published on a commissioner basis. We will also publish assessments of how well commissioners are performing, so that they are held to account for their use of public money.

Information to support choice and accountability

In future, there should be increasing amounts of robust information, comparable between similar providers, on:

- **Safety**: for example, about levels of healthcare-associated infections, adverse events and avoidable deaths, broken down by providers and clinical teams;
- **Effectiveness**: for example, mortality rates (this could include mortality from heart disease, and one year and five year cancer survival), emergency re-admission rates; and patient-reported outcome measures; and
- **Experience**: including information on average and maximum waiting times; opening hours and clinic times; cancelled operations; and diverse measures of patient experience, based on feedback from patients, families and carers.

2.11 We will enable patients to have control of their health records. This will start with access to the records held by their GP and over time this will extend to health records held by all providers. The patient will determine who else can access their records and will easily be able to see changes when they are made to their records. We will consult on arrangements, including appropriate confidentiality safeguards, later this year.

2.12 Our aim is that people should be able to share their records with third parties, such as support groups for patients, who can help patients understand their records and manage their condition better. We will make it simple for a patient to download their record and pass it, in a standard format, to any organisation of their choice.

2.13 We intend to make aggregate data available in a standard format to allow intermediaries to analyse and present it to patients in an easily understandable way. Making aggregated, anonymised data available to the university and research sectors also has the potential to suggest new areas of research through medical and scientific analysis. There will be safeguards to protect personally identifiable information. We will consider introducing a voluntary accreditation system, which will allow information intermediaries to apply for a kitemark to demonstrate to the public that they meet quality standards.

2.14 Patients and carers will be able to access the information they want through a range of means, to ensure that no individual or section of the community is left out. In addition to NHS Choices, a range of third parties will be encouraged to provide information to support patient choice. Assistance will be provided for people who do not access on-line health advice, or who would particularly benefit from more intensive support.

2.15 We will ensure the right data is collected by the Health and Social Care Information Centre to enable people to exercise choice. We will seek to centralise all data returns in the Information Centre, which will have lead responsibility for data collection and assuring the data quality of those returns, working with other interested parties such as Monitor and the Care Quality Commission. We will also review data collections with a view to reducing burdens, as outlined in chapter 5. The forthcoming Health Bill will contain provisions to put the Information Centre on a firmer statutory footing, with clearer powers across organisations in the health and care system.

2.16 Providers will be under clear contractual obligations, with sanctions, in relation to accuracy and timeliness of data. Along with commissioners, they will have to use agreed technical and data standards to promote compatibility between different systems. The NHS Commissioning Board will determine these standards but they will include, for example, record keeping, data sharing capabilities, efficiency of data transfer and data security. We will clarify the legal ownership and responsibilities of organisations and people who manage health data. This may require primary legislation and we will consult on arrangements later this year.

2.17 The Department will publish an information strategy this autumn to seek views on how best to implement these changes.

Increased choice and control

2.18 In future, patients and carers will have far more clout and choice in the system; and as a result, the NHS will become more responsive to their needs and wishes. People want choice,[22] and evidence at home and abroad shows that it improves quality.[23] We are also clear that increasing patient choice is not a one-way street. In return for greater choice and control, patients should accept responsibility for the choices they make, concordance with treatment programmes and the implications for their lifestyle.

2.19 The previous Government made a start on patient choice, but its focus was narrow, concentrating mainly on choice of provider. Although limited progress has been made on choice of provider for first elective appointment, the policy has not been implemented fully and momentum has stalled. It has remained the case for several years that just under half of patients recall that their GP has offered them choice.[24] The Department will increase that significantly. We will explore with the profession and patient groups how we can make rapid progress towards this goal.

2.20 However, we do not see choice as just being about where you go and when, but a more fundamental control of the circumstances of the treatment and care you receive.

Extending choice

The Government will:

- Increase the current offer of **choice of any provider** significantly, and will explore with professional and patient groups how we can make rapid progress towards this goal;

- Create a presumption that all patients will have choice and control over their care and treatment, and **choice of any willing provider** wherever relevant (it will not be appropriate for all services – for example, emergency ambulance admissions to A&E);

- Introduce **choice of named consultant-led team** for elective care by April 2011 where clinically appropriate. We will look at ways of ensuring that Choose and Book usage is maximised, and we intend to amend the appropriate standard acute contract to ensure that providers list named consultants on Choose and Book;

- **Extend maternity choice** and help make safe, informed choices throughout pregnancy and in childbirth a reality – recognising that not all choices will be appropriate or safe for all women – by developing new provider networks. Pregnancy offers a unique opportunity to engage women from all sections of society, with the right support through pregnancy and at the start of life being vital for improving life chances and tackling cycles of disadvantage;

- Begin to introduce choice of treatment and provider in some **mental health services** from April 2011, and extend this wherever practicable;

- Begin to introduce choice for **diagnostic testing**, and **choice post-diagnosis**, from 2011;

- Introduce **choice in care for long-term conditions** as part of personalised care planning. In **end-of-life care**, we will move towards a national choice offer to support people's preferences about how to have a good death, and we will work with providers, including hospices, to ensure that people have the support they need;

- Give patients more information on **research studies** that are relevant to them, and more scope to join in if they wish;

- Give every patient a clear **right to choose to register with any GP practice** they want with an open list, without being restricted by where they live. People should be able to expect that they can change their GP quickly and straightforwardly if and when it is right for them, but

equally that they can stay with their GP if they wish when they move house.

- Develop **a coherent 24/7 urgent care service in every area of England** that makes sense to patients when they have to make choices about their care. This will incorporate GP out-of-hours services and provide urgent medical care for people registered with a GP elsewhere. We will make care more accessible by introducing, informed by evaluation, a single telephone number for every kind of urgent and social care and by using technology to help people communicate with their clinicians; and

- Consult on **choice of treatment** later this year including the potential introduction of new contractual requirements.

2.21 In implementing proposals for extending choice, the Department will consult widely. We will need to tackle a range of issues, including: professional and patient engagement; reform to payment systems so that money follows the patient and enables choices to work; information availability and accessibility to enable choice of treatment, including decision aids, particularly in mental health and community services; support to patients with different language needs and patients with disabilities to ensure that they can exercise choice; ensuring that local commissioners fully support rather than restrict choice; and maximising use of Choose and Book. We will consult on choice of treatment later this year, including the potential introduction of new contractual requirements on providers, and collecting and publishing information on whether this is happening, to support patients.

2.22 The previous Government recently started a programme of personal health budget pilots. International evidence, and evidence from social care, shows that these have much potential to help improve outcomes, transform NHS culture by putting patients in control, and enable integration across health and social care. As part of personalised care planning, the Department will encourage further pilots to come forward and explore the potential for introducing a right to a personal health budget in discrete areas such as NHS continuing care. We also recognise that introducing personal budgets is operationally complex and the Government will use the results of the evaluation in 2012 to inform a wider, more general roll-out.

2.23 We expect choice of treatment and provider to become the reality for patients in the vast majority of NHS-funded services by no later than 2013/14. In future, the NHS Commissioning Board will have a key role in promoting and extending choice and control. It will be responsible for developing and agreeing with the Secretary of State guarantees for patients about the choices they can make, in order to provide clarity for patients and providers alike, ensuring the advice of Monitor is sought on any implications for competition. The Government will require the NHS Commissioning Board to develop an implementation plan as one of its first tasks, working with

patient and professional groups; and the Secretary of State will hold it to account for progress.

Patient and public voice

2.24 We will strengthen the collective voice of patients, and we will bring forward provisions in the forthcoming Health Bill to create HealthWatch England, a new independent consumer champion within the Care Quality Commission. Local Involvement Networks (LINks) will become the local HealthWatch, creating a strong local infrastructure, and we will enhance the role of local authorities in promoting choice and complaints advocacy, through the HealthWatch arrangements they commission.

2.25 We will also look at existing mechanisms, including relevant legislation, to ensure that public engagement is fully effective in future, and that services meet the needs of neighbourhoods.

2.26 All sources of feedback, of which complaints are an important part, should be a central mechanism for providers to assess the quality of their services. We want to avoid the experience of Mid-Staffordshire, where patient and staff concerns were continually overlooked while systemic failure in the quality of care went unchecked. Building on existing complaints handling structures, we will strengthen arrangements for information sharing. Local HealthWatch will also have the power to recommend that poor services are investigated.

The role of HealthWatch

At local level:

- Local HealthWatch organisations will ensure that the views and feedback from patients and carers are an integral part of local commissioning across health and social care;
- Local authorities will be able to commission local HealthWatch or HealthWatch England to provide advocacy and support, helping people access and make choices about services, and supporting individuals who want to make a complaint. In particular, they will support people who lack the means or capacity to make choices; for example, helping them choose which General Practice to register with;
- Local HealthWatch will be funded by and accountable to local authorities, and will be involved in local authorities' new partnership functions, described in chapter 4. To reinforce local accountability, local authorities will be responsible for ensuring that local HealthWatch are operating

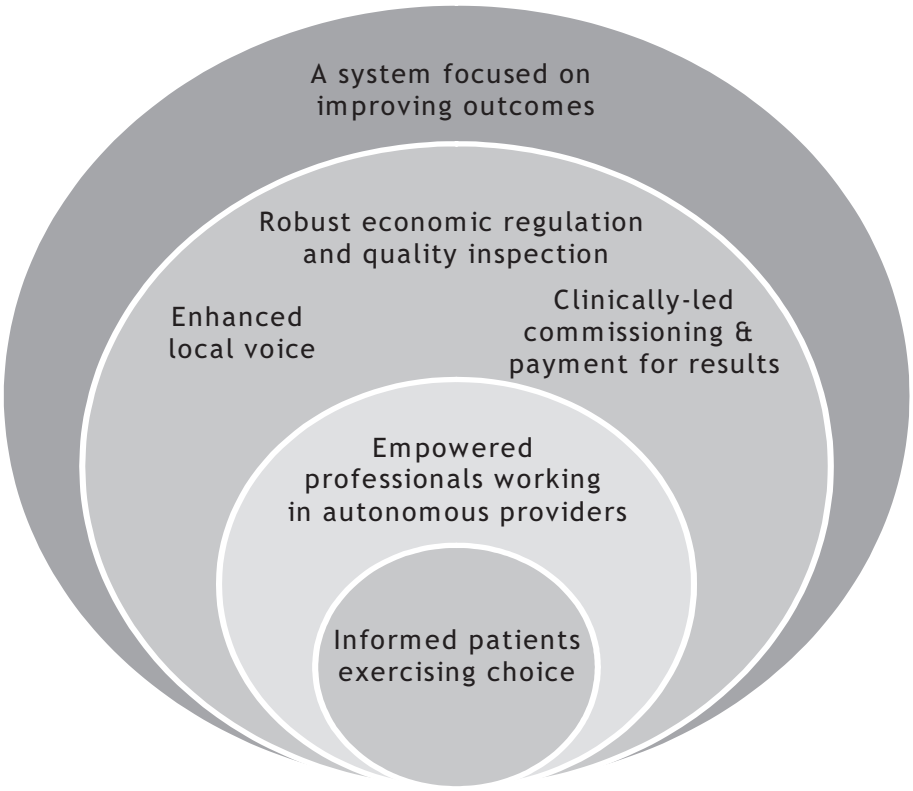
effectively, and for putting in place better arrangements if they are not; and

- Local HealthWatch will provide a source of intelligence for national HealthWatch and will be able to report concerns about the quality of providers, independently of the local authority.

At national level:

- HealthWatch England will provide leadership, advice and support to local HealthWatch, and will be able to provide advocacy services on their behalf if the local authority wishes;
- HealthWatch England will provide advice to the Health and Social Care Information Centre on the information which would be of most use to patients to facilitate their choices about their care;
- HealthWatch England will provide advice to the NHS Commissioning Board, Monitor and the Secretary of State; and
- Based on information received from local HealthWatch and other sources, HealthWatch England will have powers to propose CQC investigations of poor services.

Figure 1



3. Improving healthcare outcomes

3.1 The primary purpose of the NHS is to improve the outcomes of healthcare for all: to deliver care that is safer, more effective, and that provides a better experience for patients. Building on Lord Darzi's work, the Government will now establish improvement in quality and healthcare outcomes as the primary purpose of all NHS-funded care. This primary purpose will be enshrined in statute, the NHS Constitution, and model contracts for services, ensuring that the focus is always on what matters most to patients and professionals.

3.2 We will start by discarding what blocks progress in the NHS today: the overwhelming importance attached to certain top-down targets. These targets crowd out the bigger objectives of reducing mortality and morbidity, increasing safety and improving patient experience more broadly – including for the most vulnerable in our society. We have already revised the NHS Operating Framework for 2010/11, setting out how existing targets should be treated this year. Some targets are clinically justifiable and deliver significant benefits. Others, that have no clinical relevance, have been removed. In future, performance will be driven by patient choice and commissioning; as a result, there will be no excuse or hiding place for deteriorating standards and our proposals will drive improving standards.

3.3 This will help ensure that patient safety is placed above all else at the heart of the NHS, and that there are no longer any production line approaches to healthcare, which measure the volume but ignore the quality. There cannot be a trade-off between safety and efficiency. Our information revolution will play an important role in this, boosting transparency so that failings do not go undetected. It will help foster a culture of active responsibility where staff and patients are empowered to ask, challenge and intervene.

3.4 We will replace the relationship between politicians and professionals with relationships between professionals and patients. Instead of national process targets, the NHS will, wherever possible, use clinically credible and evidence-based measures that clinicians themselves use. The Government believes that outcomes will improve most rapidly when clinicians are engaged, and creativity, research participation and professionalism are allowed to flourish. In future, the Secretary of State will hold the NHS to account for improving healthcare outcomes. The NHS, not politicians, will be responsible for determining how best to deliver this within a clear and coherent national policy framework.

The NHS Outcomes Framework

3.5 The current performance regime will be replaced with separate frameworks for outcomes that set direction for the NHS, for public health and social care, which provide for clear and unambiguous accountability, and enable better joint working. The Secretary of State, through the Public Health Service, will set local authorities national objectives for improving population health outcomes. It will be for local authorities to determine how best to secure those objectives, including by commissioning services from providers of NHS care.

3.6 A new NHS Outcomes Framework will provide direction for the NHS. It will include a focused set of national outcome goals determined by the Secretary of State, against which the NHS Commissioning Board will be held to account, alongside overall improvements in the NHS.

3.7 In turn, the NHS Outcomes Framework will be translated into a commissioning outcomes framework for GP consortia, to create powerful incentives for effective commissioning.

3.8 The NHS Outcomes Framework will span the three domains of quality:

- the effectiveness of the treatment and care provided to patients – measured by both clinical outcomes and patient-reported outcomes;
- the safety of the treatment and care provided to patients; and
- the broader experience patients have of the treatment and care they receive.

For example, effectiveness goals might include how we compare internationally on avoidable mortality and morbidity across a range of conditions. The criteria used will ensure that we do not exclude outcomes for key groups and services such as children, older people and mental health.

3.9 The Department will launch a consultation on the development of the national outcome goals. We are committed to working with clinicians, patients, carers and representative groups to create indicators that are based on the best available evidence. Later this year, in the light of the Spending Review, the Government will issue the first NHS Outcomes Framework. We intend it will be available to support NHS organisations in delivering improved outcomes from April 2011, with full implementation from April 2012.

3.10 The NHS Commissioning Board will work with clinicians, patients and the public at every level of the system to develop the NHS Outcomes Framework into a more comprehensive set of indicators, reflecting the quality standards developed by NICE. The framework and its constituent indicators will enable international comparisons wherever possible, and reflect the Board's duties to promote equality and tackle inequalities in healthcare outcomes. It will ensure that clinical values direct

managerial activity and that every part of the NHS is focusing on the right goals for patients. The main purpose of the programme of reform set out in this White Paper is to change the NHS environment so that it is easier to progress against those goals.

3.11 It is essential for patient outcomes that health and social care services are better integrated at all levels of the system. We will be consulting widely on options to ensure health and social care works seamlessly together to enable this.

Developing and implementing quality standards

3.12 Progress on outcomes will be supported by quality standards. These will be developed for the NHS Commissioning Board by NICE, who will develop authoritative standards setting out each part of the patient pathway, and indicators for each step. NICE will rapidly expand its existing work programme to create a comprehensive library of standards for all the main pathways of care. The first three on stroke, dementia and prevention of venous thromboembolism were published in June. Within the next five years, NICE expects to produce 150 standards. To support the development of quality standards, NICE will advise the National Institute for Health Research on research priorities.

3.13 Each standard is a set of 5-10 specific, concise quality statements and associated measures. These measures act as markers of high quality, cost-effective patient care. They are about excellence, derived from the best available evidence and are produced collaboratively with the NHS and social care professionals, along with their partners, service users and carers. The standards will be developed in a way that makes sense for patients, and they will extend beyond NHS care, informing the work of local authorities and the Public Health Service. They will include information for clinicians and patients on relevant and ongoing research studies that are key to improving evidence for better outcomes.

3.14 With the increasing importance of coherent joint arrangements between health and social care, the standards will cover areas that span health and social care. We will expand the role of NICE to develop quality standards for social care. The Health Bill will put NICE on a firmer statutory footing, securing its independence and core functions and extending its remit to social care.

NICE quality standard for venous thromboembolism (VTE)

Quality statements:

- All patients, on admission, receive an assessment of VTE and bleeding risk using the clinical risk assessment criteria described in the national tool.
- Patients/carers are offered verbal and written information on VTE prevention

as part of the admission process.

- Patients provided with anti-embolism stockings have them fitted and monitored in accordance with NICE guidance.
- Patients are re-assessed within 24 hours of admission for risk of VTE and bleeding.
- Patients assessed to be at risk of VTE are offered VTE prophylaxis in accordance with NICE guidance.
- Patients/carers are offered verbal and written information on VTE prevention as part of the discharge process.
- Patients are offered extended (post-hospital) VTE prophylaxis in accordance with NICE guidance.[25]

3.15 Commissioners will draw from the NICE library of standards as they commission care. GP consortia and providers will agree local priorities for implementation each year, taking account of the NHS Outcomes Framework. NICE quality standards will be reflected in commissioning contracts and financial incentives. Together with essential regulatory standards, these will provide the national consistency that patients expect from their National Health Service.

Research

3.16 The Government is committed to the promotion and conduct of research as a core NHS role. Research is vital in providing the new knowledge needed to improve health outcomes and reduce inequalities. Research is even more important when resources are under pressure – it identifies new ways of preventing, diagnosing and treating disease. It is essential if we are to increase the quality and productivity of the NHS, and to support growth in the economy. A thriving life sciences industry is critical to the ability of the NHS to deliver world-class health outcomes. The Department will continue to promote the role of Biomedical Research Centres and Units, Academic Health Science Centres and Collaborations for Leadership in Applied Health Research and Care, to develop research and to unlock synergies between research, education and patient care.

Incentives for quality improvement

3.17 The absence of an effective payment system in many parts of the NHS severely restricts the ability of commissioners and providers to improve outcomes, increase efficiency and increase patient choice. In future, the structure of payment systems will

be the responsibility of the NHS Commissioning Board, and the economic regulator will be responsible for pricing. In the meantime the Department will start designing and implementing a more comprehensive, transparent and sustainable structure of payment for performance so that money follows the patient and reflects quality. Payments and the 'currencies' they are based on will be structured in the way that is most relevant to the service being provided, and will be conditional on achieving quality goals.

3.18 The previous administration made progress in developing payment by results in acute trusts. The mandatory scope has changed little since 2005/06, and has not incentivised results throughout the system. The Department will:

- implement a set of currencies for adult mental health services for use from 2012/13, and develop currencies for child and adolescent services;
- develop payment systems to support the commissioning of talking therapies;
- mandate in 2011/12 national currencies for adult and neonatal critical care;
- review payment systems to support end-of-life care, including exploring options for per-patient funding;
- accelerate the development of pathway tariffs for use by commissioners;
- accelerate the development of currencies and tariffs for community services;
- implement in 2011/12 further incentives to reduce avoidable readmissions and encourage more joined-up working between hospitals and social care for services following discharge; and
- link quality measures in national clinical audits to payment arrangements.

3.19 The Department will also refine the basis of current tariffs. We will rapidly accelerate the development of best-practice tariffs, introducing an increasing number each year, so that providers are paid according to the costs of excellent care, rather than average price. 2011/12 will see the introduction of best-practice tariffs for interventional radiology, day-case surgery for breast surgery, hernia repairs and some orthopaedic surgery. The Department will also introduce the latest version of the International Classification of Disease (ICD) 10 clinical diagnosis coding system from 2012/13, and explore the scope for developing a benchmarking approach, with greater local flexibility, including for local marginal rates.

3.20 If providers deliver excellent care in line with commissioner priorities, the commissioner will be able to pay a quality increment. The Department will extend the scope and value of the Commissioning for Quality and Innovation (CQUIN) payment framework, to support local quality improvement goals. The CQUIN framework will

be important for the implementation of NICE quality standards and improving patient experience and patient-reported outcomes. And in future, if providers deliver poor quality care, the commissioner will also be able to impose a contractual penalty. In particular, we will proceed with work to impose fines for an extended list of "never events", such as wrong site surgery, from October 2010.[26]

3.21 The principle of rewarding quality will also apply in primary care. In general practice the Department will seek over time to establish a single contractual and funding model to promote quality improvement, deliver fairness for all practices, support free patient choice, and remove unnecessary barriers to new provision. Our principle is that funding should follow the registered patient, on a weighted capitation model, adjusted for quality. We will incentivise ways of improving access to primary care in disadvantaged areas.

3.22 Following consultation and piloting, we will introduce a new dentistry contract, with a focus on improving quality, achieving good dental health and increasing access to NHS dentistry, and an additional focus on the oral health of schoolchildren. The community pharmacy contract, through payment for performance, will incentivise and support high quality and efficient services, including better value in the use of medicines through better informed and more involved patients. Pharmacists, working with doctors and other health professionals, have an important and expanding role in optimising the use of medicines and in supporting better health. Pharmacy services will benefit from greater transparency in NHS pricing and payment for services.

3.23 The Government will also reform the way that drug companies are paid for NHS medicines, moving to a system of value-based pricing when the current scheme expires. This will help ensure better access for patients to effective drugs and innovative treatments on the NHS and secure value for money for NHS spending on medicines. As an interim measure, the Department is creating a new Cancer Drug Fund, which will operate from April 2011; this fund will help patients get the cancer drugs their doctors recommend.

4. Autonomy, accountability and democratic legitimacy

4.1 The Government's reforms will liberate professionals and providers from top-down control. This is the only way to secure the quality, innovation and productivity needed to improve outcomes. We will give responsibility for commissioning and budgets to groups of GP practices; and providers will be freed from government control to shape their services around the needs and choices of patients. Greater autonomy will be matched by increased accountability to patients and democratic legitimacy, with a transparent regime of economic regulation and quality inspection to hold providers to account for the results they deliver.

GP commissioning consortia

4.2 In order to shift decision-making as close as possible to individual patients, the Department will devolve power and responsibility for commissioning services to local consortia of GP practices. This change will build on the pivotal and trusted role that primary care professionals already play in coordinating patient care, through the system of registered patient lists.

4.3 Primary care professionals coordinate all the services that patients receive, helping them to navigate the system and ensure they get the best care (of course, they do not deliver all the care themselves). For this reason they are best placed to coordinate the commissioning of care for their patients while involving all other clinical professionals who are also part of any pathway of care.

4.4 Commissioning by GP consortia will mean that the redesign of patient pathways and local services is always clinically-led and based on more effective dialogue and partnership with hospital specialists. It will bring together responsibility for clinical decisions and for the financial consequences of these decisions. This will reinforce the crucial role that GPs already play in committing NHS resources through their daily clinical decisions – not only in terms of referrals and prescribing, but also how well they manage long-term conditions, and the accessibility of their services. It will increase efficiency, by enabling GPs to strip out activities that do not have appreciable benefits for patients' health or healthcare.

4.5 GP-led purchasing has history. Practice-based commissioning was an attempt by the last Government to build on the successful parts of previous Conservative approaches, such as total purchasing pilots. There have been some examples of practice-based groups making progress, in spite of a flawed policy framework that confuses the respective responsibilities of GPs and PCTs, and fails to transfer real freedom and responsibility to GP practices. Our model is neither a recreation of GP

fundholding nor a complete rejection of practice-based commissioning. Fundholding led to a two-tier NHS; and practice-based commissioning never became a real transfer of responsibility. So we will learn from the past, and offer a clear way forward for GP consortia.

4.6 The Government will shortly issue a document setting out our proposals in more detail, and providing the basis for fuller engagement with primary care professionals, patients and the public. We will then bring forward legislation in the forthcoming Health Bill.

The role of GP commissioning consortia

- We envisage putting GP commissioning on a statutory basis, with powers and duties set out in primary and secondary legislation.
- Consortia of GP practices, working with other health and care professionals, and in partnership with local communities and local authorities, will commission the great majority of NHS services for their patients. They will not be directly responsible for commissioning services that GPs themselves provide, but they will become increasingly influential in driving up the quality of general practice. They will not commission the other family health services of dentistry, community pharmacy and primary ophthalmic services. These will be the responsibility of the NHS Commissioning Board, as will national and regional specialised services, although consortia will have influence and involvement.
- The NHS Commissioning Board will calculate practice-level budgets and allocate these directly to consortia. The consortia will hold contracts with providers and may choose to adopt a lead commissioner model, for example in relation to large teaching hospitals.
- GP consortia will include an accountable officer, and the NHS Commissioning Board will be responsible for holding consortia to account for stewardship of NHS resources and for the outcomes they achieve as commissioners. In turn, each consortium will hold its constituent practices to account against these objectives.
- A fundamental principle of the new arrangements is that every GP practice will be a member of a consortium, as a corollary of holding a registered list of patients. Practices will have flexibility within the new legislative framework to form consortia in ways that they think will secure the best healthcare and health outcomes for their patients and locality. We envisage that the NHS Commissioning Board will be under a duty to establish a comprehensive system of GP consortia, and we

envisage a reserve power for the NHS Commissioning Board to be able to assign practices to consortia if necessary.

- GP consortia will need to have a sufficient geographic focus to be able to take responsibility for agreeing and monitoring contracts for locality-based services (such as urgent care services), to have responsibility for commissioning services for people who are not registered with a GP practice, and to commission services jointly with local authorities. The consortia will also need to be of sufficient size to manage financial risk and allow for accurate allocations.

- GP consortia will be responsible for managing the combined commissioning budgets of their member GP practices, and using these resources to improve healthcare and health outcomes. The Government will discuss with the BMA and the profession how primary medical care contracts can best reflect new complementary responsibilities for individual GP practices, including being a member of a consortium and supporting the consortium in ensuring efficient and effective use of NHS resources.

- GP consortia will need to have sufficient freedoms to use resources in ways that achieve the best and most cost-efficient outcomes for patients. Monitor and the NHS Commissioning Board will ensure that commissioning decisions are fair and transparent, and will promote competition.

- GP consortia will have the freedom to decide what commissioning activities they undertake for themselves and for what activities (such as demographic analysis, contract negotiation, performance monitoring and aspects of financial management) they may choose to buy in support from external organisations, including local authorities, private and voluntary sector bodies.

- We envisage that consortia will receive a maximum management allowance to reflect the costs associated with commissioning, with a premium for achieving high quality outcomes and for financial performance.

- GP consortia will have a duty to promote equalities and to work in partnership with local authorities, for instance in relation to health and adult social care, early years services, public health, safeguarding, and the wellbeing of local populations.

- GP consortia will have a duty of public and patient involvement, and will need to engage patients and the public in their neighbourhoods in the commissioning process. Through its local infrastructure, HealthWatch

will provide evidence about local communities and their needs and aspirations.

4.7 A number of PCTs have made important progress in developing commissioning experience which we will be looking to capitalise on during the transition period. Through the transitional arrangements, we will seek to ensure that existing expertise and capability in primary care trusts (PCTs) is maintained during the transition period where this is the wish of GP consortia.

4.8 Primary care trusts will have an important task in the next two years in supporting practices to prepare for these new arrangements. We want implementation to be driven bottom-up, with GP consortia taking on their new responsibilities as rapidly as possible, and early adopters promoting best practice.

4.9 The final shape of these proposals will depend upon our consultation findings and developing clear arrangements for managing financial risk. Our indicative timetable is for:

- a comprehensive system of GP consortia in place in shadow form during 2011/12, taking on increased delegated responsibility from PCTs;
- following passage of the Health Bill, consortia to take on responsibility for commissioning in 2012/13;
- the NHS Commissioning Board to make allocations for 2013/14 directly to GP consortia in late 2012; and
- GP consortia to take full financial responsibility from April 2013.

An autonomous NHS Commissioning Board

4.10 To support GP consortia in their commissioning decisions we will create a statutory NHS Commissioning Board. This will be a lean and expert organisation, free from day-to-day political interference, with a commissioning model that draws from best international practice. The NHS Commissioning Board will provide leadership for quality improvement through commissioning: through commissioning guidelines, it will help standardise what is known good practice, for example improving discharge from hospital, maximising the number of day care operations, reducing delays prior to operations, and enabling community access to care and treatments. It will play its full part in promoting equality in line with the Equality Act 2010. It will not manage providers or be the NHS headquarters.

4.11 The Board will promote patient and carer involvement and choice, championing the interests of the patient rather than the interests of particular providers. It will involve patients as a matter of course in its business, for example in developing

commissioning guidelines. To avoid double jeopardy and duplication, it will take over the current CQC responsibility of assessing NHS commissioners and will hold GP consortia to account for their performance and quality. It will manage some national and regional commissioning. It will allocate and account for NHS resources. It will have a role in supporting the Secretary of State and the Public Health Service to ensure that the NHS in England is resilient and able to be mobilised during any emergency it faces, or as part of a national response to threats external to the NHS. It will promote involvement in research and the use of research evidence.

The role of the NHS Commissioning Board

The Board will have five main functions:

1. **Providing national leadership on commissioning for quality improvement:**

    - setting commissioning guidelines on the basis of clinically approved quality standards developed with the advice of NICE in a way that promotes joint working across health, public health and social care;
    - designing model contracts for local commissioners to adapt and use with providers;
    - designing the structure of tariff and other financial incentives, whilst Monitor will set tariff levels;
    - hosting some clinical commissioning networks, for example for rarer cancers and transplant services, to pool specialist expertise;
    - setting standards for the quality of NHS commissioning and procurement;
    - making available accessible information on commissioner performance; and
    - tackling inequalities in outcomes of healthcare.

2. **Promoting and extending public and patient involvement and choice:**

    - championing greater involvement of patients and carers in decision-making and managing their own care, working with commissioners and local authorities;
    - promoting personalisation and extending patient choice of what, where and who, including personal health budgets; and
    - commissioning information requirements for choice and for

accountability, including through patient-reported measures.

3. **Ensuring the development of GP commissioning consortia:**

   - supporting and developing the establishment and maintenance of an effective and comprehensive system of GP consortia; and
   - holding consortia to account for delivering outcomes and financial performance.

4. **Commissioning certain services** that cannot solely be commissioned by consortia, in accordance with Secretary of State designation, including:

   - GP, dentistry, community pharmacy and primary ophthalmic services;
   - national specialised services[27] and regional specialised services set out in the Specialised Services National Definitions Set;[28] and
   - maternity services.

5. **Allocating and accounting for NHS resources:**

   - allocating NHS revenue resources to GP consortia on the basis of seeking to secure equivalent access to NHS services relative to the burden of disease and disability;
   - managing an overall NHS commissioner revenue limit, for which it will be accountable to the Department of Health; and
   - promoting productivity through better commissioning.

The Board would not have the power to restrict the scope of the services offered by the NHS.

Establishing the Board and managing the transition

4.12 The Board will be established in shadow form as a special health authority from April 2011. In 2011/12 it will develop its future business model, organisational structure and staffing. It will be converted by the forthcoming Health Bill into a statutory body, with its own powers and duties, and will go live in April 2012.

4.13 Changes in the way that strategic health authorities (SHA) operate will help pave the way for the NHS Commissioning Board. From this year SHAs will separate their commissioning and provider oversight functions. They will support the Board during its preparatory year, and have a critical role during the transition in managing finance

and performance. It will be for the NHS Commissioning Board to decide what, if any, presence it needs in different parts of the country. SHAs will be abolished as statutory bodies during 2012/13. From 2012 the Board will perform those national functions relevant to its new role that are currently carried out by the Department of Health. It will be subject to clear controls over management costs and consultancy spend.

A new relationship between the NHS and the Government

4.14 At present the Secretary of State enjoys extraordinarily wide powers over the NHS. It is intended that the forthcoming Health Bill will introduce provisions to limit the ability of the Secretary of State to micromanage and intervene. The forthcoming Health Bill will formalise the relationship between the government and the NHS, to improve transparency and increase stability, while maintaining the necessary level of political accountability for such large amounts of taxpayers' money.

The NHS role of the Secretary of State

The key NHS-related functions of the Secretary of State will include:

- **Setting a formal mandate for the NHS Commissioning Board.** This will be subject to consultation and Parliamentary scrutiny, and will include specific levels of improvement against a small number of outcome indicators.
- **Holding the NHS Commissioning Board to account.** In addition to delivery of improvements against the agreed outcome indicators, the Secretary of State will hold the Board to account on delivering improvements in choice and patient involvement, and in maintaining financial control. Clear financial controls and associated financial instructions will be set by the Secretary of State in line with the Department's continued Parliamentary accountability for expenditure and HM Treasury requirements.
- **Arbitration.** The Secretary of State will have a statutory role as arbiter of last resort in disputes that arise between NHS commissioners and local authorities, for example in relation to major service changes.
- **The legislative and policy framework.** Responsibility for Department of State functions will remain with the Secretary of State. This includes determining the comprehensive service which the NHS provides, and developing and publishing national service strategies which will enable the roles of NHS, public health services and social care services to be better coordinated.

- **Accounting annually to Parliament** for the overall performance of the NHS, public health and social care systems.

4.15 In future, the Secretary of State will be obliged to lay out a short formal mandate for the NHS Commissioning Board. This will be subject to public consultation and Parliamentary scrutiny, including by the Health Select Committee. The mandate is likely to be over a three year period, updated annually. The mandate will set out the totality of what the Government expects from the NHS Commissioning Board on behalf of the taxpayer for that period. This will comprise progress against outcomes specified by the Secretary of State, and objectives in relation to its core functions. Should the Government wish, by exception, to impose additional performance requirements on the Board in-year, it will on each occasion be obliged to lay a report in Parliament to explain why. The Secretary of State will also lose existing powers to intervene in relation to any specific commissioner other than in discharging defined statutory responsibilities. To ensure transparency, a public record will be made of all meetings between the Board and the Secretary of State.

Local democratic legitimacy

4.16 Following the establishment of the NHS Commissioning Board and a comprehensive network of GP consortia, PCTs will no longer have NHS commissioning functions. To realise administrative cost savings, and achieve greater alignment with local government responsibilities for local health and wellbeing, the Government will transfer PCT health improvement functions to local authorities and abolish PCTs. We expect that PCTs will cease to exist from 2013, in light of the successful establishment of GP consortia. Local Directors of Public Health will be jointly appointed by local authorities and the Public Health Service. Local Directors of Public Health will also have statutory duties in respect of the Public Health Service.

4.17 The Government will strengthen the local democratic legitimacy of the NHS. Building on the power of the local authority to promote local wellbeing, we will establish new statutory arrangements within local authorities – which will be established as "health and wellbeing boards" or within existing strategic partnerships – to take on the function of joining up the commissioning of local NHS services, social care and health improvement. These health and wellbeing boards allow local authorities to take a strategic approach and promote integration across health and adult social care, children's services, including safeguarding, and the wider local authority agenda.

4.18 We will simplify and extend the use of powers that enable joint working between the NHS and local authorities. It will be easier for commissioners and providers to adopt partnership arrangements, and adapt them to local circumstances.

4.19 These arrangements will give local authorities influence over NHS commissioning, and corresponding influence for NHS commissioners in relation to public health and social care. While NHS commissioning will be the sole preserve of the NHS Commissioning Board and GP consortia, our aim is to ensure coherent and coordinated local commissioning strategies across all three services, for example in relation to mental health or elderly care. The Secretary of State will seek to ensure strategic coordination nationally; the local authority's new functions will enable strategic coordination locally. It will not involve day-to-day interventions in NHS services. The Government will consult fully on the details of the new arrangements.

Local authorities' new functions

Each local authority will take on the function of joining up the commissioning of local NHS services, social care and health improvement.

Local authorities will therefore be responsible for:

- Promoting **integration and partnership working** between the NHS, social care, public health and other local services and strategies;
- Leading **joint strategic needs assessments**, and promoting collaboration on local commissioning plans, including by supporting joint commissioning arrangements where each party so wishes; and
- Building partnership for **service changes and priorities**. There will be an escalation process to the NHS Commissioning Board and the Secretary of State, which retain accountability for NHS commissioning decisions.

These functions would replace the current statutory functions of Health Overview and Scrutiny Committees.

As well as elected members of the local authority, all relevant NHS commissioners will be involved in carrying out these functions, as will the Directors of Public Health, adult social services, and children's services. They will all be under duties of partnership. Local HealthWatch representatives will also play a formal role to ensure that feedback from patients and service users is reflected in commissioning plans.

Freeing existing NHS providers

4.20 Autonomy in commissioning will be matched by autonomy for providers. Previous governments have tried to give greater freedom to providers, most recently through the introduction of foundation trusts. Yet the policy was flawed from the outset by the

controls imposed upon foundation trusts by Whitehall. Meanwhile, the drive to extend foundation status across the NHS has lost momentum, leaving reform half completed.

4.21 Our ambition is to create the largest and most vibrant social enterprise sector in the world. The Government's intention is to free foundation trusts from constraints they are under, in line with their original conception, so they can innovate to improve care for patients. In future, they will be regulated in the same way as any other providers, whether from the private or voluntary sector. Patients will be able to choose care from the provider they think to be the best. As all NHS trusts become foundation trusts, staff will have an opportunity to transform their organisations into employee-led social enterprises that they themselves control, freeing them to use their front-line experience to structure services around what works best for patients. For many foundation trusts, a governance model involving staff, the public and patients works well but we recognise that this may not be the best model for all types of foundation trust, particularly smaller organisations such as those providing community services. We will consult on future requirements: we envisage that some foundation trusts will be led only by employees; others will have wider memberships. The benefits of this approach will be seen in high productivity, greater innovation, better care and greater job satisfaction. Foundation trusts will not be privatised.

4.22 Ahead of bringing forward legislation, we intend to consult on options for increasing foundation trusts' freedoms – while ensuring financial risk is properly managed – including:

- abolishing the arbitrary cap on the amount of income foundation trusts may earn from other sources to reinvest in their services and allowing a broader scope, for example to provide health and care services;
- enabling foundation trusts to merge more easily; and
- whether we should enable foundation trusts to tailor their governance arrangements to their local needs, within a broad statutory framework that ensures any surplus and any proceeds are reinvested in the organisation rather than distributed externally.

4.23 Within three years, we will support all NHS trusts to become foundation trusts. It will not be an option for organisations to decide to remain as an NHS trust rather than become or be part of a foundation trust and in due course, we will repeal the NHS trust legislative model. A new unit in the Department of Health will drive progress and oversee SHAs' responsibilities in relation to providers. In the event that a few NHS trusts and SHAs fail to agree credible plans, and where the NHS trust is unsustainable, the Secretary of State may as a matter of last resort apply the trust administration regime set out in the Health Act 2009.[29] From April 2013, Monitor will take on the responsibility of regulating all providers of NHS care, irrespective of their status. Financial control will be maintained during the transition, with the Department, Monitor and SHAs taking any necessary steps.

4.24 The Government will apply a consistent approach across all types of NHS services. We will end the uncertainty and delay about the future of community health services currently provided within PCTs. We will complete the separation of commissioning from provision by April 2011 and move as soon as possible to an "any willing provider" approach for community services, reducing barriers to entry by new suppliers. In future, all community services will be provided by foundation trusts or other types of provider.

4.25 Special statutory arrangements will be made for the three high secure psychiatric hospitals (Broadmoor, Rampton and Ashworth), allowing them to benefit from the independence of foundation status while retaining appropriate safeguards to reflect their role in the criminal justice system.

Economic regulation and quality inspection to enable provider freedom

4.26 Providers will no longer be part of a system of top-down management, subject to political interference. Instead, they will be governed by a stable, transparent and rules-based system of regulation. Our aim is to free up provision of healthcare, so that in most sectors of care, any willing provider can provide services, giving patients greater choice and ensuring effective competition stimulates innovation and improvements, and increases productivity within a social market.

4.27 As now, the Care Quality Commission will act as quality inspectorate across health and social care for both publicly and privately funded care. In addition, we will develop Monitor, the current independent regulator of foundation trusts, into an economic regulator from April 2012, with responsibility for all providers of NHS care from April 2013. Providers will have a joint licence overseen by both Monitor and CQC, to maintain essential levels of safety and quality and ensure continuity of essential services.

The role of the Care Quality Commission

We will strengthen the role of CQC as an effective quality inspectorate by giving it a clearer focus on the essential levels of safety and quality of providers. In relation to the NHS, CQC's responsibilities will include:

Licensing - Together with Monitor, CQC will operate a joint licensing regime, with CQC being responsible for licensing against the essential safety and quality requirements. Where services fail to meet these essential levels, providers will be subject to enforcement action, including the possibility of fines and suspension of services.

Inspections - CQC will inspect providers against the essential levels of safety and quality. Inspection will be targeted and risk-based. CQC will carry out

inspections of providers in response to information that it receives about a provider. This information will come through a range of sources including patient feedback and complaints, HealthWatch, GP consortia and the NHS Commissioning Board. Where inspection reveals that a provider is not meeting essential levels of safety and quality, CQC will take enforcement action to bring about improvement.

The role of Monitor

Monitor will be turned into the economic regulator for the health and social care sectors, with three key functions:

- **Promoting competition**, to ensure that competition works effectively in the interests of patients and taxpayers. Like other sectoral regulators, such as OFCOM and OFGEM, Monitor will have concurrent powers with the Office of Fair Trading to apply competition law[30] to prevent anti-competitive behaviour;

- **Price regulation**. Where price regulation is necessary, Monitor's role will be to set efficient prices, or maximum prices, for NHS-funded services, in order to promote fair competition and drive productivity. In setting prices, Monitor will be required to consult the NHS Commissioning Board and take account of patients and taxpayers' interests including the need to secure the most efficient use of available resources; and

- **Supporting continuity of services**. Primary responsibility for ensuring continuity of services will lie with the NHS Commissioning Board and local commissioners. However, Monitor will also play a role in ensuring continued access to key services in some cases. Monitor will be responsible for defining regulated services that will be subject to special licence conditions and controls.

Monitor's levers to ensure that essential services are maintained will include:

- powers to protect assets or facilities required to maintain continuity of essential services;

- authorising special funding arrangements for essential services that would otherwise be unviable (with the agreement of the NHS Commissioning Board, and subject to rules on state aid);

- powers to levy providers for contributions to a risk pool; and

- intervening directly in the event of failure, including power to trigger a special administration and regime.

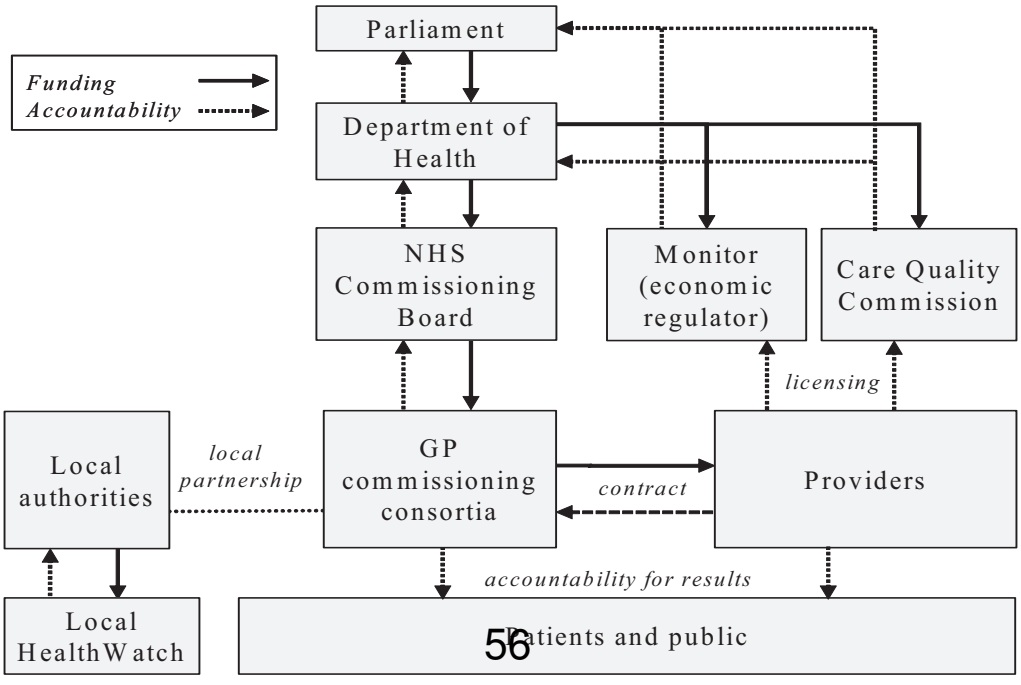
Monitor's scope and powers

4.28 Like other sectoral regulators, we propose that Monitor should have proactive, "*ex ante*" powers to protect essential services and help open the NHS social market up to competition, as well as being able to take "*ex post*" enforcement action reactively. *Ex ante* powers would enable Monitor, for instance, to protect essential assets; require monopoly providers to grant access to their facilities to third parties; or conduct market studies and refer potential structural problems to the Competition Commission for investigation. To minimise the risks of excessive regulation, the need for *ex ante* powers would be reviewed over time. In most regulated industries, the focus of competition regulation is on preventing anti-competitive behaviour by powerful suppliers. However, within the NHS social market, there is also scope for purchasers to act anti-competitively, for example by failing to tender services or discriminating in favour of incumbent providers. Monitor will be able to investigate complaints of anti-competitive purchasing and act as arbiter.

4.29 Monitor's powers to regulate prices and license providers will only cover publicly-funded health services. However, its powers to apply competition law will extend to both publicly and privately funded healthcare, and to social care.

4.30 The Government will shortly issue a document setting out our proposals on foundation trusts and economic regulation in more detail, for consultation, prior to bringing forward provisions in the forthcoming Health Bill.

Figure 2



Valuing staff

4.31 Staff who are empowered, engaged and well supported provide better patient care. We will therefore promote staff engagement, partnership working and the implementation of Dr Steve Boorman's recommendations to improve staff health and wellbeing.[31] We will also extend the principles of autonomy, not only by giving professionals more control of the way that NHS services are commissioned and provided, but also in our approach to staff training, education and pay.

Training and education

4.32 Each year several billion pounds are spent on central funding of education and training for NHS staff through the Multi-Profession Education and Training levy, in addition to investment by NHS organisations in their own staff. A top-down management approach led by the Department of Health does not allow accountability for decisions affecting workforce supply and demand to sit in the right place. It is time to give employers greater autonomy and accountability for planning and developing the workforce, alongside greater professional ownership of the quality of education and training.

4.33 In future, the Department will have a progressively reducing role in overseeing education and training. The system will be designed to ensure that education and training commissioning is aligned locally and nationally with the commissioning of patient care. Our vision is that:

- Healthcare employers and their staff will agree plans and funding for workforce development and training; their decisions will determine education commissioning plans.
- Education commissioning will be led locally and nationally by the healthcare professions, through Medical Education England for doctors, dentists, healthcare scientists and pharmacists. Similar mechanisms will be put in place for nurses and midwives and the allied health professions. They will work with employers to ensure a multi-disciplinary approach that meets their local needs.
- The professions will have a leading role in deciding the structure and content of training, and quality standards.
- All providers of healthcare services will pay to meet the costs of education and training. Transparent funding flows for education and training will support the level playing field between providers.
- The NHS Commissioning Board will provide national patient and public

oversight of healthcare providers' funding plans for training and education, checking that these reflect its strategic commissioning intentions. GP consortia will provide this oversight at local level.

- The Centre for Workforce Intelligence will act as a consistent source of information and analysis, informing and informed by all levels of the system.

4.34 The Department will publish proposals for consultation in due course. Reforms will be managed and introduced carefully to ensure that the changes do not de-stabilise individual providers.

NHS pay

4.35 Ministers currently exercise substantial control over pay levels and contractual arrangements for NHS staff. In the short term, the need for fiscal consolidation is paramount and this will require sustained pay restraint across the public sector. The NHS must play its part as the largest public service in the country. We will pursue the Coalition Agreement and policies announced in the Budget on 22 June in relation to public sector pay restraint.

4.36 Pay decisions should be led by healthcare employers rather than imposed by the Government. In future, all individual employers will have the right, as foundation trusts have now, to determine pay for their own staff. However, it is likely that many providers will want to continue to use national contracts as a basis for their local terms and conditions. In the short term, the Budget announced that pay will be frozen for two years for those earning more than £21,000 and the Government will ask the Pay Review Bodies to make recommendations on pay for those earning below this threshold, with a minimum increase of £250 for each year of the freeze. In the longer term, we will work with NHS employers and trade unions to explore appropriate arrangements for setting pay. However, while ministers will retain responsibility for determining overall resources and affordability, we would expect employers to take the lead in providing advice on staffing and cost pressures. Employers would also be responsible for leading negotiations on new employment contracts. In line with our aim of a decentralised system, the main incentives for financial management and efficiency will in future come from tariff-setting and a transparent regulatory framework – not from central government controls on providers' pay and internal processes.

NHS pensions

4.37 The Government has announced that Lord John Hutton will chair an independent review of public pensions, including those in the NHS. This wide ranging review will look not only at the affordability and sustainability of public service pensions but will also consider issues such as access, the impact on labour market mobility between the public and private sectors, and the extent to which pensions may act as a barrier to greater plurality of provision of public services. We will consider the findings of that review in due course but remain committed to ensuring that pension solutions are found that are fair to the workforce in the health service and fair to the taxpayer.

5. Cutting bureaucracy and improving efficiency

5.1 The Government has guaranteed that health spending will increase in real terms in every year of this Parliament. With that protection comes the same obligation for the NHS to cut waste and transform productivity as applies to other parts of the public sector.

5.2 This discipline is also required to meet the costs of demographic change and new technologies. Since its inception, the NHS budget has risen by an average of over 4% in real terms each year; so even with our spending commitment, the NHS will face a sustained and substantial financial constraint. We will not cut the NHS as happened in the 1970s in a previous financial crisis. Meeting this challenge will require difficult local decisions, and that would be true under any government. The scale of the NHS productivity challenge may prompt calls during this Parliament for even bigger increases in NHS resources; but the reality is that there is no more money.

Cutting bureaucracy and administrative costs

5.3 So our first task is to increase the proportion of resource available for front-line services, by cutting the costs of health bureaucracy. Over the past decade, layers of national and regional organisations have accumulated, resulting in excessive bureaucracy, inefficiency and duplication. The Government will therefore impose the largest reduction in administrative costs in NHS history. Over the next four years we will reduce the NHS's management costs by more than 45%.

5.4 Reduction on this scale cannot be met by cutting all organisations equally; instead, it can only be realised by radically simplifying the architecture of the health and care system. The Government's plans for decentralisation, set out in the previous chapter, will bring major savings. PCTs – with administrative costs of over a billion pounds a year – and practice-based commissioners, will together be replaced by GP consortia. The Department will radically reduce its own NHS functions. Strategic health authorities will be abolished.

5.5 The Department will shortly publish a review of its arm's-length bodies. Subject to Parliamentary approval, we will abolish organisations that do not need to exist. We will streamline those functions that need to remain, to cut cost and remove duplication and burdens on the NHS. In future, the Department will impose tight governance over the costs and scope of all its arm's-length bodies. For example, to prevent duplication and aid transparency, the Secretary of State will consider, for any particular arm's-length body, setting out an explicit list of functions that it is not to undertake, to complement the positive list of what it is expected to do. In future, quangos' independence will be about how they perform clear and agreed functions, not the freedom to assume new roles.

5.6 The Government does not embark upon these changes lightly. Taken together, they amount to a major delayering, which will cause significant disruption and loss of jobs, and incur transitional costs between now and 2013, even as we are cutting the management cost of the NHS. But it has rapidly become clear to us that the NHS simply cannot continue to afford to support the costs of the existing bureaucracy; and the Government has a moral obligation to release as much money as possible into supporting front-line care.

5.7 At present, there are over 260,000 data returns[32] to the Department of Health. Later this year, the Department will initiate a fundamental review of data returns, with the aim of culling returns of limited value. This will ensure that the NHS information revolution described in chapter 2 is fuelled by data that are meaningful to patients and clinicians when making decisions about care, rather than by what has been collected historically. We will consult on the findings prior to implementation.

5.8 The Government will cut the bureaucracy involved in medical research. We have asked the Academy of Medical Sciences to conduct an independent review of the regulation and governance of medical research. In the light of this review we will consider the legislation affecting medical research, and the bureaucracy that flows from it, and bring forward plans for radical simplification.

5.9 As a further measure to support front-line services, the Department of Health will apply cuts to its budgets for centrally managed programmes, such as consultancy services and advertising spend. NHS services will increasingly be empowered to be the customers of a more plural system of IT and other suppliers.

5.10 We are moving to a system of control based on quality and economic regulation, commissioning and payments by results, rather than national and regional management. Within that context, we are committed to reducing the overall burdens of regulation across the health and social care sectors. We will therefore undertake a wide-ranging review of all health and social care regulation, with a view to making significant reductions.

5.11 The reforms outlined in this White Paper will themselves have one-off costs. We will ensure these are affordable within the requirements of the wider Spending Review, while ensuring funding is focused on front-line patient care.

Increasing NHS productivity and quality

5.12 The reforms in this White Paper will provide the NHS with greater incentives to increase efficiency and quality:

- Patients will be more involved in making decisions about their own health and care, improving outcomes and reducing costs.
- Patient choice will reward the most efficient, high quality services, reducing expenditure on less efficient care.
- The NHS information revolution will also lead to more efficient ways of providing care, such as on-line consultations. Greater transparency will make it easier to compare the performance of commissioners and providers.
- Prices will be calculated on the basis of the most efficient, high quality services rather than average cost.
- Payment will depend on quality of care and outcomes, not just volume. Penalties for poor quality will encourage providers to get care right first time.
- The NHS will be freed from inefficient micromanagement of meeting targets like the 98% requirement for A&E waits, and associated performance management bureaucracy.
- Commissioners and providers will focus on implementing best practice to achieve improvements in outcomes, supported by a comprehensive library of NICE standards, the work of the NHS Commissioning Board, model contracts and continued research.
- GP consortia will align clinical decisions in general practice with the financial consequences of those decisions.
- Local authorities' new functions will help unlock efficiencies across the NHS, social care and public health through stronger joint working.
- Existing providers will be set free and will be in charge of their own destiny, without central or regional management or support. This will be supported by a system of economic regulation overseen by Monitor that will drive efficiency. It will include a rules-based special administration regime. Hidden bail-outs will end.

5.13 Taken together, these ten changes will bring about a revolution in NHS efficiency. In the long term, they will help put the NHS on a more sustainable and resilient financial footing. The Department recognises that full implementation will take time; in particular the migration away from current risk pooling arrangements across SHAs.

Enhanced financial controls

5.14 As well as providing incentives for greater efficiency, the new arrangements will provide for enhanced financial control:

How the NHS will manage its resources

- NHS services will continue to be funded by the taxpayer. The Department of Health will receive funding voted by Parliament, and will remain accountable to Parliament and HM Treasury for NHS spend.
- The NHS Commissioning Board will be accountable to the Department for living within an annual NHS revenue limit, and subject to clear financial rules. This arrangement will introduce greater financial transparency between the Government and the NHS. The NHS Commissioning Board will allocate resources to GP consortia on the basis of need.
- GP consortia will have a high level of freedom; but in return they will be accountable to the NHS Commissioning Board for managing public funds. They will be subject to transparent controls and incentives for financial performance, and will enjoy a clear relationship with their constituent practices. Consortia will be required to take part in risk-pooling arrangements overseen by the NHS Commissioning Board; the Government will not bail out commissioners who fail. Regulations will specify a failure regime for commissioners.
- Commissioners will be free to buy services from any willing provider; and providers will compete to provide services. Providers who wish to provide NHS-funded services must be licensed by Monitor, who will assess financial viability.
- Providers of essential services may be required to take part in risk-pooling arrangements to ensure that, if a provider becomes financially unsustainable, Monitor will be able to step in and keep essential services running, without recourse to the Department of Health. The Government will not provide additional funding for failing providers. Monitor will be able to allow transparent subsidies where these are objectively justified, and agreed by commissioners.

Making savings during the transition

5.15 We will implement the reforms in this White Paper as rapidly as is possible. But the NHS cannot wait for them all to be in place to begin to deliver improvements in

quality and productivity. Patients are rightly demanding the former, and the national economic position requires the latter.

5.16 The NHS has understood for some time the need to make extremely challenging improvements in productivity and efficiency. Work has begun to release £15-20 billon of efficiency savings for reinvestment across the system over the next four years whilst driving up quality. Achieving this ambition will be extremely challenging, but it is essential; and it will be given a boost by our reforms as they come on stream.

5.17 The existing Quality, Innovation, Productivity and Prevention (QIPP) initiative will continue with even greater urgency, but with a stronger focus on general practice leadership. The QIPP initiative is identifying how efficiencies can be driven and services redesigned to achieve the twin aims of improved quality and efficiency. Work has started on implementing what is required, for example by improving care for stroke patients, the "productive ward programme", increased self-care and the use of new technologies for people with long-term conditions.[33] Further efficiencies can, and need to, be made from improving energy efficiency and developing more sustainable forms of delivery across the NHS, for example through working with the Carbon Trust and similar bodies on carbon reduction programmes that reduce energy consumption and expenditure.

5.18 SHAs and PCTs have a current role in supporting QIPP. In discharging this, and to pave the way for the new arrangements, they should seek to devolve leadership of QIPP to emerging GP consortia and local authorities as rapidly as possible, wherever they are willing and able to take this on. The Department will require SHAs and PCTs to have an increased focus on maintaining financial control during the transition period, and they will also be supported in this task by Monitor. The Department will not hesitate to increase financial control arrangements during the transition, wherever that is necessary to maintain financial balance; in such instances, central control will be a necessary precursor to subsequent devolution to GP consortia.

6. Conclusion: making it happen

Engaging external organisations

6.1 This White Paper sets out the Government's strategy for liberating the NHS in the current Parliamentary term and beyond. It provides clarity of purpose: a more responsive, patient-centred NHS, which achieves outcomes that are among the best in the world. It provides certainty, through a clear policy framework to support that ambition, with increased autonomy and clear accountability at every level in the NHS.

6.2 Much work now needs to be undertaken over the next two to three years, both to manage the transition, as well as to flesh out the policy details. The Department will take this forward in partnership with external organisations, seeking their help and expertise in developing proposals that work in practice, for example on shared decision-making and choice.

6.3 The implementation of all these reforms, and the detailed approach we take, will be subject to broad consultation – with local government, patients and the public, as well as external organisations. The Government will formally consult wherever it is appropriate to do so, for example on strengthening the NHS Constitution, and on draft regulations.

6.4 The Government will shortly publish more detailed documents seeking views on commissioning for patients (the implementation of the NHS Commissioning Board and GP consortia); local democratic legitimacy in health; freeing providers and economic regulation; and the NHS outcomes framework. The report of the arm's-length bodies review will also be published shortly. Later this year, the Government will also publish for consultation a NHS information strategy, and a document on the move to a provider-led education and training system.

6.5 To support the ownership of the strategy within the NHS and to inform the implementation of this White Paper, the Department of Health will carry out a series of consultation activities with: patients, their representative groups and the public; NHS staff, their representative and professional bodies; local government; and the voluntary, social enterprise and independent sectors. This will run in parallel to the formal consultation on the proposals above.

6.6 We will need to ensure, through our consultation exercises and broader policy work, that the system is financially sustainable through the transition, as well as in the longer term. The proper management of financial risk will be of particular importance.

Proposals for legislation

6.7 Many of the changes in this White Paper require primary legislation. The Queen's Speech included a major Health Bill in the legislative programme for this first Parliamentary session. The Government will introduce this in the autumn. The principal legislative reforms will include:

- Enabling the creation of a **Public Health Service**, with a lead role on public health evidence and analysis;
- Transferring **local health improvement functions** to local authorities, with ring-fenced funding and accountability to the Secretary of State for Health;
- Placing the **Health and Social Care Information Centre**, currently a Special Health Authority, on a firmer statutory footing, with powers over other organisations in relation to information collection;
- Enshrining **improvement in healthcare outcomes** as the central purpose of the NHS;
- Making the **National Institute for Health and Clinical Excellence** a non-departmental public body, to define its role and functions, reform its processes, secure its independence, and extend its remit to social care;
- Establishing the independent **NHS Commissioning Board**, accountable to the Secretary of State, paving the way for the abolition of SHAs. The NHS Commissioning Board will initially be established as a Special Health Authority; the Bill will convert it into an independent non-departmental public body;
- Placing **clear limits on the role of the Secretary of State** in relation to the NHS Commissioning Board, and local NHS organisations, thereby strengthening the NHS Constitution;
- Giving **local authorities new functions** to increase the local democratic legitimacy in relation to the local strategies for NHS commissioning, and support integration and partnership working across social care, the NHS and public health;
- Establishing a statutory framework for a **comprehensive system of GP consortia**, paving the way for the abolition of PCTs;
- Establishing **HealthWatch** as a statutory part of the Care Quality Commission to champion services users and carers across health and social care, and turning Local Involvement Networks into local

HealthWatch;

- Reforming the **foundation trust** model, removing restrictions and enabling new governance arrangements, increasing transparency in their functions, repealing foundation trust deauthorisation and enabling the abolition of the NHS trust model;
- Strengthening the role of the **Care Quality Commission** as an effective quality inspectorate; and
- Developing **Monitor** into the economic regulator for health and social care, including provisions for special administration.

Associated with these changes, reducing the number of **arm's-length bodies** in the health sector, and amending their roles and functions.

6.8 We are clear about the coherent strategy, and we will engage people in understanding this and its implications. We are consulting on how best to implement these changes. In particular, the Department would welcome comments on the implementation of the proposals requiring primary legislation, and will publish a response to the views raised on the White Paper and the associated papers, prior to the introduction of the Bill. Comments should be sent by 5th October 2010, to:

NHSWhitePaper@dh.gsi.gov.uk

or:

White Paper team
Room 601
Department of Health
79 Whitehall
London SW1A 2NS

Managing the transition

6.9 *Liberating the NHS* involves change at every level of the NHS. The policy and legislative framework is just the start. Effective implementation will require a major and sustained implementation effort right across the NHS over a number of years. Change will happen bottom-up, for example by GP consortia having greater say and responsibility as rapidly as possible, and NHS trusts applying for foundation trust status at the earliest opportunity - rather than waiting until 2013. The pace of change will therefore vary across the country according to organisations' readiness to assume their new functions.

6.10 Alongside the White Paper, the Department is issuing a framework for managing the initial steps of the transition. This will include the principles and the values that the Department will hold itself to, to ensure that the transition is managed fairly and transparently, and in a way that respects staff and the contribution they make. Some organisations will disappear as we simplify NHS administration, and free resources to support front-line services. But the need for good managers performing essential functions, such as managing finance and contracts, will remain. There will be opportunities for managers to start new roles, and help build a more innovative and responsive NHS, for example supporting GP consortia, and within the NHS Commissioning Board.

Timetable for action

6.11 The high level timetable below outlines the Government's proposed timetable (subject to Parliamentary approval for legislation).

Commitment	**Date**
Further publications on: • framework for transition • NHS outcomes framework • commissioning for patients • local democratic legitimacy in health • freeing providers and economic regulation	July 2010
Report of the arm's length bodies review published	Summer 2010
Health Bill introduced in Parliament	Autumn 2010
Further publications on: • vision for adult social care • information strategy • patient choice • a provider-led education and training • review of data returns	By end 2010
Separation of SHAs' commissioning and provider oversight functions	
Public Health White Paper	Late 2010

Commitment	Date
Introduction of choice for: • care for long-term conditions • diagnostic testing, and post-diagnosis	From 2011
White Paper on social care reform	2011
Choice of consultant-led team	By April 2011
Shadow NHS Commissioning Board established as a special health authority	April 2011
Arrangements to support shadow health and wellbeing partnerships begin to be put in place	
Quality accounts expanded to all providers of NHS care	
Cancer Drug Fund established	
Choice of treatment and provider in some mental health services	From April 2011
Improved outcomes from NHS Outcomes Framework	
Expand validity, collection and use of PROMs	
Develop pathway tariffs for use by commissioners	
Quality accounts: nationally comparable information published	June 2011
Report on the funding of long-term care and support	By July 2011
Hospitals required to be open about mistakes	Summer 2011
GP consortia established in shadow form	2011/12
Tariffs: • Adult mental health currencies developed • National currencies introduced for critical care • Further incentives to reduce avoidable readmissions • Best-practice tariffs introduced for interventional radiology, day-case surgery for breast surgery, hernia repairs, and some orthopaedic surgery	2011/12
NHS Outcomes Framework fully implemented	By April 2012

Commitment	Date
Majority of reforms come into effect: • NHS Commissioning Board fully established • New local authority health and wellbeing boards in place • Limits on the ability of the Secretary of State to micromanage and intervene • Public record of all meetings between the Board and the Secretary of State • Public Health Service in place, with ring-fenced budget and local health improvement led by Directors of Public Health in local authorities • NICE put on a firmer statutory footing • HealthWatch established • Monitor established as economic regulator	April 2012
International Classification of Disease (ICD) 10 clinical diagnosis coding system introduced	From 2012/13
NHS Commissioning Board makes allocations for 2013/14 direct to GP consortia	Autumn 2012
Free choice of GP practice	2012
Formal establishment of all GP consortia	
SHAs are abolished	2012/13
GP consortia hold contracts with providers	April 2013
PCTs are abolished	From April 2013
All NHS trusts become, or are part of, foundation trusts	2013/14
All providers subject to Monitor regulation	
Choice of treatment and provider for patients in the vast majority of NHS-funded services	By 2013/14
Introduction of value-based approach to the way that drug companies are paid for NHS medicines	
NHS management costs reduced by over 45%	By end 2014
NICE expected to produce 150 quality standards	By July 2015

Glossary

Commissioning – the process of assessing the needs of a local population and putting in place services to meet those needs.

Commissioning for Quality and Innovation (CQUIN) framework – the CQUIN framework enables those commissioning care to pay for better quality care, helping promote a culture of continuous improvement.

Currencies – in a tariff-based payment system, payments are made for defined units of healthcare (such as an out-patient appointment with a consultant). These are known as currencies.

Foundation trusts – NHS providers who achieve foundation trust status have greater freedoms and are subject to less central control, enabling them to be more responsive to the needs of local populations.

Health Bill – proposals for a Health Bill were included in the Queen's Speech for the first Parliamentary session of the coalition Government. The Health Bill will bring forward the legislative changes required for the implementation of the proposals in this White Paper.

Law Commission – an independent body set up by Parliament to review and recommend reform of the law in England and Wales.

Local Involvement Networks (LINks) – LINks are local organisations in each local authority area set up to represent views of local people on health and social care services. These will become local HealthWatch. Further details are in paragraphs 2.23 to 2.25

National Clinical Audit – Assesses the quality of patient care across all NHS providers by measuring activities and outcomes, using that information to stimulate clinicians to improve their performance, to help patients choose providers, to guide commissioners, and to support regulation and performance management.

National Institute of Health and Clinical Excellence (NICE) – an independent organisation which provides advice and guidelines on the cost and effectiveness of drugs and treatments.

NHS Constitution – the NHS Constitution describes the principles and values of the NHS in England, and the rights and responsibilities of patients, the public and staff.

NHS Operating Framework – the Operating Framework sets out the priorities for the NHS for each financial year. The Government published a revised Operating Framework for this year on 21st June 2010.

Patient Reported Outcome Measures (PROMs) – PROMSprovide information on how patients feel about their own health, and the impact of the treatment or care they receive.

Pay Review Bodies - independent bodies which make recommendations on public sector pay in the light of evidence submitted by the Government, employers, staff and others.

Payment by Results – provides a transparent system for paying providers of healthcare services. By using the tariff and currencies to link payment to activity the system is designed to reward efficiency and support patient choice.

Personal health budget – an extension of personalised care planning, that gives people more choice and control over the services they receive by giving them more control over the money that is spent on their care.

Primary care trusts (PCTs) – the NHS body currently responsible for commissioning healthcare services and, in most cases, providing community-based services such as district nursing, for a local area.

Provider – organisations which provide services direct to patients, including hospitals, mental health services and ambulance services.

Quality accounts – a report on the quality of services published annually by providers of NHS care. Quality accounts are intended to enhance accountability to the public.

Spending Review – the Spending Review will set out the Government's priorities, and spending plans to meet these priorities, for the period 2011/12 to 2014/15.

Strategic health authorities (SHAs) – the 10 public bodies which currently oversee commissioning and provision of NHS services at a regional level.

Tariff – in relation to payment by results, the tariff it the calculated price for a unit of healthcare activity.

Value-based pricing – a mechanism for ensuring patients can get access to the medicines they need by linking the prices the NHS pays drug providers to the value of the treatment.

Venous thromboembolism (VTE) – a condition in which a blood clot (thrombus) forms in a vein. An embolism occurs if all or a part of the clot breaks off from the site where it forms and travels through the venous system.

Notes

[1] This White Paper applies only to the NHS in England. The devolved administrations in Scotland, Wales and Northern Ireland are responsible for developing their own health policies.

[2] European Union and domestic legislation prohibit discrimination on a number of grounds at work or in employment services, when providing goods, facilities or services to the public or disposing of or managing premises, in relation to education, when exercising public functions and by associations. The Equality Act 2010 which received Royal Assent on 8th April 2010 will replace existing anti-discrimination laws with one single Act and prohibit discrimination on a number of grounds such as sex, race, disability, age, religion or belief, sexual orientation, gender reassignment, pregnancy and maternity, and marriage and civil partnership.

[3] Section 6 Health Act 2009 places a duty on the Secretary of State to publish a report every three years on how the NHS Constitution has affected patients, staff, carers and members of the public, with the first report by 5 July 2012.

[4] For example, the Secretary of State has power in section 7 of the NHS Act 2006 to delegate functions to NHS bodies (other than NHS foundation trusts) and power in section 8 to direct those bodies as to the exercise of their functions. The Secretary of State also has powers to require information from NHS bodies, powers in relation to the allocation of their funding and various powers to intervene in certain NHS bodies.

[5] National Cancer Research Network, National Institute for Health Research, www.ncrn.org.uk

[6] Nolte, E., McKee, C.M, *Measuring the Health of Nations: analysis of mortality amenable to healthcare.* BMJ 2003; 327:1129; (2003).

[7] EUROCARE-4, www.eurocare.it

[8] OECD *In-hospital case-fatality rates within 30 days after admission for ischemic stroke (2007)*

[9] OECD, *Health at a Glance 2009,* (2009).

[10] OECD, *Health at a Glance 2009*, (2009).

[11] European Antimicrobial Resistance Surveillance System (EARSS) incidence of MRSA per 100,000 patient days (2008).

[12] House of Commons Health Committee. *The prevention of venous thromboembolism in hospitalised patients*. Second report of session 2004-5. (2007).

[13] *Freedom Fairness Responsibility: The Coalition: our programme for government,* www.cabinetoffice.gov.uk/media/409088/pfg_coalition.pdf

[14] Chote, R., Crawford, R., Emmerson, C., Tetlow, G., *Britain's Fiscal Squeeze: the Choices Ahead*, Institute for Fiscal Studies (2009).

[15] World Health Organization defines a high performing health system as one that should be "responsive to people's needs and preferences, treating them with dignity and respect when they come in contact with the system", *The Tallinn Charter: Health Systems for Health and Wealth Draft Charter*. WHO, (2008).

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[16]"There is a need for significant progress to improve issues such as the provision of information, noise in hospitals, and the engagement of patients in decisions about their care", Richards, N., and Coulter, A., *Is the NHS becoming more patient centred? Trends from the national surveys of patients in England 2002-2007,* Picker Institute (2007).

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[19] One of the three future scenarios modelled in the report was a "fully engaged" scenario where patients and the public were more engaged in their health, contributing to significantly lower demands on the health service in the longer-term. Wanless, D., *Securing our Future Health: Taking a Long-Term View*, (2002).

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[26] Department of Health, *Guidance on the NHS Standard Contract for Acute Services, 2010/11.*

[27] National services are defined each year in Regulations, currently there are 52. Examples include: heart and liver transplants. www.opsi.gov.uk/si/si2010/uksi_20100405_en_1

[28] Regional services (34 in all) are defined in the Specialised Services National Definition Set (SSNDS). Examples include spinal injuries, specialised cancer care, burn care and bone marrow transplantation. www.ncg.nhs.uk/index.php/key-documents/specialised-services-national-definitions-set/

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Local Government Group Briefing - Health White Paper: "Equity and excellence: Liberating the NHS"

13th July 2010

Introduction

The Government published its White Paper on the NHS yesterday afternoon (12 July 2010). This briefing summarises the key proposals and highlights the implications for local government.

LG Group Key Messages

- The White Paper represents a major restructuring, not just of health services but also of councils' responsibilities in relation to health improvement, and coordination of health and social care.
- The LG Group **welcomes the focus of the White Paper on removing unnecessary bureaucracy and devolving power to the local level.**
- The LG Group also **welcomes the transfer of public health responsibilities to local authorities.**
- The proposals represent only one part of the government's agenda for change in health and social care. The White Paper also announces that there will be five further publications over the next few months which will seek detailed views on particular aspects of its proposals.
- **The Government plans to publish a further White Paper on Public Health in the autumn and will bring forward proposals for the future funding of social care in October 2011.**
- Clearly, there are many aspects of the proposals that are not yet fully developed and we look forward to discussing with the sector and with central government how local government can contribute to joining up health improvement, health services and social care locally to achieve better outcomes and greater efficiency.

Summary of proposals

- Putting patients first through greater choice, involvement and control and a more important role for clinicians in deciding on health priorities.
- Greater focus on improved health outcomes to replace process-led targets.
- Greater accountability, local autonomy and democratic legitimacy through the development of GP commissioning consortia, working in partnership at local level with local authorities.
- Maintain NHS spending in real terms, though there will be efficiencies in the region of 45 per cent of total NHS management costs to offset rising demographic demands. There will be "no bail-outs for organisations which overspend public budgets".
- Creation of an independent NHS Commissioning Board to oversee commissioning and to champion improvement and patient involvement in health services. The development of GP commissioning consortia and the creation of the NHS Commissioning Board will pave the way for

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the abolition of Strategic Health Authorities (SHAs) in 2012/13 and Primary Care Trusts (PCTs) 2013.

- New roles and resources for local councils in public health, and a new statutory Health and Wellbeing Board to ensure coordination, integration and partnership working on social care, public health and health improvement.
- Abolition of the health oversight and scrutiny role for councils.
- Creation of a national Health Watch for England to be the national voice of patients and the public. Local involvement networks will become local Health Watch branches. Local authorities will retain their statutory duty to support patient and public involvement activity.
- New joint roles for both Monitor and the Care Quality Commission (CQC), with Monitor becoming the economic regulator for all health and social care providers and CQC becoming the quality inspectorate.

The Local Government Group is considering the White Paper through five key challenges:

1. **Do the proposals build on existing experience?** Deciding what is spent locally on health services needs to build on the innovative practice that already exists. In many areas, councils, PCTs and health practitioner-based commissioning consortia (including GPs, nurses, specialists and pharmacists) are already working together to improve services, efficiency and outcomes. We can use these areas as test-beds for new arrangements before they are rolled out nationally.
2. **Do they support an area-based budgeting approach?** The LG Group has developed an open and comprehensive offer to Government to help them achieve efficiency savings by adopting a place-based approach to deciding how public money is spent. Health resources will need to be included in this approach, in order to join up health and social care, and to invest in preventative and early interventions in order to reduce the need for health and social care.
3. **Do they promote a person-centred approach?** The proposals should support a person-centred approach to services, based on the needs and expectations of the individual rather than organisational considerations or convenience.
4. **Do they ensure accountability to local communities?** The proposals must include clear and transparent accountability arrangements to local communities, which build on existing accountability rather than creating new structures.
5. **Do they ensure that public resources are directed to the areas of greatest need?** In particular, they should address inequalities in health. We know that inequalities in health are, largely, avoidable and cost taxpayers many millions of pounds each year in spending on health and social care and loss of tax revenue through long-term ill-health.

Further Information

For further information on this briefing, please contact Ben Kind, LG Group Public Affairs and Campaigns Manager, at ben.kind@lga.gov.uk or 0207 664 3216

New roles and resources for local councils

- PCT public health improvement functions will be transferred to local councils after the abolition of PCTs in 2013.
- Local Directors of Public Health will be jointly appointed by local authorities and the national Public Health Service. Further clarity is required around the arrangements for the employment of public health teams and the accountability of the Local Director of Public Health
- A ring-fenced public health budget will be allocated to local authorities to support their public health and health improvement functions.
- Councils will be required to establish "health and wellbeing boards" to join up the commissioning of local NHS services, social care and health improvement. This will allow local authorities to take a strategic approach on promoting integration across health and adult social care, children's services (including safeguarding) and the wider local authority agenda.
- An extension and simplification of powers to enable joint working between the NHS and local authorities.
- Health Overview and Scrutiny Committees (HOSCs) will be replaced by the above functions.

LG Group view *– Local government has a central role to play in promoting public health and health improvement and we welcome the Government's recognition that councils are the most appropriate local bodies to co-ordinate and lead on health improvement. We also support the proposal to establish "health and wellbeing boards" in the knowledge that many councils and local partnerships already have very similar structures to improve co-ordination and collaboration on health improvement and addressing health inequalities.*

We are pleased the Government recognises that councils will require additional resources to undertake the public health role. However, the imposition of a ring-fence is completely at odds with the place-based approach advocated by the Local Government Group. Mainstream services such as housing, early years support, transport, leisure and recreation and social care make a far more significant contribution to public health and health improvement than the marginal resource in the ring-fence. ***Government must trust local councils to direct resources as they see fit and remove the ring-fence.***

With regard to the proposal to remove health oversight and scrutiny powers from councils, the LG Group believes that HOSCs have made a real difference in championing the public interest and challenging health commissioners and providers to deliver better health services. The scrutiny of health services must be transparent and have a strong element of democratically accountable oversight, independent of the health service, in order to ensure that it is responsive to the local public's needs.

Joint licensing role for Monitor and the Care Quality Commission

Providers will be subject to a twin licensing role. Monitor will become the economic regulator for all health and social care providers with responsibility for: promoting competition; regulating prices for NHS services; and supporting the continuity of services if services have become unviable or in protecting assets or facilities that are essential in maintaining the continuity of services.

The Care Quality Commission will focus on quality assurance for all health and social care, both public and private. Providers will have a joint licence overseen by both Monitor and the CQC.

Monitor will also have a role in ensuring competition and diversity of providers to ensure that neither commissioning nor providers use anti-competitive practices and will act as an arbiter to investigate complaints of anti-competitive practice.

The Government will be publishing more detailed proposals on economic regulation prior to the publication of the Health Bill.

Further proposals within the White Paper

Greater patient choice, information and control

People will be given greater choice of provider, including the right to choose to register with any GP, and greater involvement in decisions about their care. The NHS Commissioning Board will be a champion for patient and carer involvement.

There will be better information for patients and carers, a wider range of on-line services and new ways for patients and clinicians to communicate. All providers and commissioners will have a legal duty to provide accurate and timely data, and the Department of Health (DH) will publish an information strategy to seek views on how best to implement the changes.

Patients will have control over their health records and will be able to share them with other organisations, such as patient support groups and patient advocates.

There will be a further consultation on extending choice later in 2010. The White Paper reiterates the Government's commitment to extending choice through a roll-out of personal budgets for health. The NHS Commissioning Board will have a key role in extending choice and control, and Monitor will ensure that patients have a choice.

LG Group view *– The LG Group is committed to extending choice to people and sees this as the way forward in offering care and support that is tailored to individual needs. We support the intention of the White Paper and look forward to working with the Government to extend choice while seeking to achieve efficiencies.*

Greater focus on improved health outcomes

The NHS will focus on outcomes, rather than meet top-down targets. The first step towards this will be the new NHS Outcomes Framework which will include a set of national outcome goals, against which the NHS Commissioning Board will be accountable.

The outcomes will focus on clinical effectiveness, patient safety and patient experience of their care. The DH will be publishing a separate consultation document on the development of national outcome goals.

The outcome framework will be supported by quality standards developed by the National Institute for Health and Clinical Excellence (NICE). Within the next five years, NICE will develop 150 standards for all the main

pathways of care, covering both health and social care services.

LG Group View *– We welcome the focus on outcomes rather than targets and look forward to discussing with the Government how local areas, led by councils, can develop their own outcomes measures, based on the needs and expectations of local people*.

General practitioner-based commissioning consortia

Decisions on treatment and care will pass directly to groups of health practitioners who will be responsible for around £80 billion of NHS resources per annum. It is anticipated that there will be around 500-600 general practitioner commissioning consortia across England and all GPs will be required to join a consortium.

Each consortium will have to be of sufficient size to manage financial risk and to commission services jointly with local authorities. The NHS Commissioning Board will be responsible for holding consortia to account for their use of NHS resources. They will have the freedom to decide whether to undertake commissioning activities themselves or outsource commissioning activity to other organisations, including local authorities.

These consortia will have a duty to promote equalities, to work in partnership with local authorities and will also have a duty of patient and public involvement.

A consultation document giving more details on commissioning will be published shortly - the responses to which will inform the forthcoming Health Bill.

LG Group view *– Councils and PCTs are already working constructively with commissioning consortia in many areas to develop local services that directly address local needs. However, commissioning led by health practitioners is still in the early stages of development and not all practitioners have direct experience of this. We would recommend that the Government works with a few selected areas to "test-bed" this model of commissioning before it is rolled out nationally.*

Cutting bureaucracy and improving efficiency

There is an expectation that management costs will be cut by more than 45 per cent by abolishing PCTs and SHAs, a major reduction in the overall size of the Department of Health, and a major cull of health-related quangos which will be announced shortly.

PCTs will have an important but time-limited role in supporting health practitioners to develop their commissioning capacity and to ensure a smooth transition to the new model. It is planned that following the Health Bill in 2012/13, general practitioner-based consortia will take full financial responsibility from April 2013 when PCTs will be abolished.

LG Group view *– Councils know that cuts are necessary to reduce the budget deficit, however further reductions in public spending must go hand-in-hand with a radical reform of the way public money is spent. It is important that this includes an end to the ring-fencing of budgets in order to allow for efficiency savings through place-based budgeting.*

NHS Commissioning Board

An independent NHS Commissioning Board will allocate NHS resources to general practitioner-based consortia and support them in their commissioning decisions. It will also:

- provide national leadership on commissioning for quality improvement
- promote patient involvement and choice
- support the development of GP commissioning consortia
- commission national and regional specialist services and community services such as GP, dentistry, pharmacy and maternity services
- allocate and account for NHS resources.

The Board will be fully operational in April 2012, when Strategic Health Authorities will be abolished. A national Public Health Service will be created to promote public health, with responsibility for local delivery of public health transferred from PCTs to local authorities.

LG Group view *– The NHS Commissioning Board appears to represent a centralisation of decision making in the health service. It is essential for this Board to represent local decision making at the national level, whilst allowing local commissioners the flexibility to adapt services to local public needs.*

Patient and public voice

Health Watch England will be created as an independent consumer champion within the Care Quality Commission (CQC). Local involvement networks will be rebranded as Local Health Watch and will ensure that the voices of patients and carers are at the heart of the commissioning process. Local Health Watch will be funded by and accountable to local authorities and they will have a legal duty to ensure that Health Watch is operating effectively. Councils will have responsibility for commissioning Local Health Watch or Health Watch England to provide support and advocacy services.

At national level, Health Watch England will provide leadership to local branches and will provide advice to national bodies, including the NHS Commissioning Board, Monitor and the Secretary of State. It will also have the power to propose CQC investigations of poor services, based on local intelligence.

LG Group view *– We welcome the emphasis on greater public engagement at all levels of decision-making within the health service. However, we are concerned that Local Health Watch will carry the weight of responsibility in the public's eyes. The current system has had patchy success in putting patients and service users at the heart of commissioning plans and we will need to learn from best practice to improve effectiveness. Local decision making on public health must play a strong role in the delivery of any national public health service.*

The statutory responsibility to support public and patient involvement in health spending must go hand-in-hand with a radical reform of the way budgets are spent towards a system of place-based budgeting. It is also important that this includes an end to the ring-fencing of budgets in order to allow for the flexible provision of public services that are responsive to local needs.

Equity and Excellence: Liberating the NHS.

From A [redacted] (constituent, also mental health service user).

While the government has committed to reforming the NHS, it is important that during the reorganisations the present patient and public involvement is not lost. There is a danger that primary care trusts, strategic health authorities and GP practice based commissioning groups may turn inward, learning from management expertise and each-other but not from patients. Organisations may transfer their own responsibilities but then patients may not be part of the system until it is fully up and running in 2013. I think it will be hard too at a time when staff morale may be low among managers. Patients and public should be consulted during the next two years more than usual since we don't want the plans to be put in place without our being involved, there will also be tough calls on spending and we need to be part of these decisions, not just get a sense of them once there are fewer services.

I looked at the Equity and Excellence paper though so much is mentioned only to say that it will be consulted on at a later time. The plan refers to physical health eg cancer and stroke survival rates, but a different system of outcomes is needed for mental health. These outcomes may not be about life or death, except for suicides which are a concern, but the quality of life matters and someone getting enough support for their emotional health to become stronger. This can't always be achieved short term or with one treatment, many people have complex needs and need a range of help, possibly over some years.

The government should acknowledge that NHS services are already under pressure. The savings figure is huge and there's a risk that services will be cut, especially in mental health which is a less publicly visible target. As a patient I need to know that there will be enough resources and that I wouldn't be pushed out of my treatment early because of lack of funding. Mental health service users need face to face meetings, rather than going onto a computer or having brief phone calls. This may work in other services eg self testing for a long term condition, but the nature of mental health is different.

If you do cut out numbers of managers/'back room' staff you could be adding to the amount of work that the clinical staff need to do so they will not be able to see as many patients. They will depend on their administrators and receptionists (who are on low pay) but these roles seem lumped together with management costs.

The ideas around giving patients choice and control – no decision about us without us – do sound encouraging. But not all patients want to use that choice and still will rely on what the GP think is the best option. Patients shouldn't feel left to make decisions on their own. There is also a need for 'third parties' – to include trusted local organisations like citizens advice bureaux to help people get online to look up health information. Many people have problems with reading and writing or their first language isn't English, not everyone can grasp information either especially at times when they feel very distressed.

In mental health the concept of choice of provider (to be made available from April 2011) isn't necessarily what matters most. I would be unable to travel to see staff in a different mental health trust for treatment. I wouldn't want to go elsewhere, since I have built up a relationship with staff in the mental health team at [redacted], I am visited at home or have a short walk to this office. I want to choose the NHS rather than see private providers step in. Support needs to be close to home with good knowledge of the local community where I live. Choice can't be used when appointments are regular and continuity of care feels important. Where admitted to a mental health hospital, it also matters that it is in a location where friends or relatives can visit. Investing in mental health services – rather than this being a first area where spending is cut – means standards are good enough without needing to look outside the NHS or out of area NHS Trusts. Choice of a hospital for surgery is a different type of contact. I would though be for choice of care coordinator, psychiatrist, treatment and all other supports. Service users should be able to define what they want, and to this end also be involved in drawing up the government's planned 'clinical outcomes.' (and especially those in their own care) It shouldn't be down to professionals to define what patients should achieve as recovery, eg equating recovery only with getting into work.

Some patients are more assertive and informed, but there will be many who have difficulty in getting any kind of service (and don't have relatives or friends or even a good GP to advocate for them). The NHS plans shouldn't open up a division between those who ask for referrals based on information and others who have problems due to illness or personal disadvantage. There is also often a low response rate to patient surveys, so there needs to be more user involvement in the whole feedback process, as well as devising the questions that get asked.

The government should recognise that there is more to mental health services than talking therapies, which tend to be brief and limited to CBT only eg six sessions or a computerised version. This is unsuitable for many people with more complex problems who need a range of support and therapies. Secondary mental health services are essential in supporting people to live in the community –stepping in when crises happen - while living with a 'severe and enduring' mental illness.

Sometimes in mental health, the patient can lose the ability to make the most wise decisions and risks go up, eg when seriously depressed, or in psychosis. Advance directives drawn up ahead of such crises can be useful. But advocacy is also important, and professionals who know the patient working with the person in crisis. If Health Watch does take on advocacy work, there would still need to be separate mental health advocacy provision (to include independent mental capacity advocates).

Patients should be involved from the outset of planning future changes. At times consultations can happen with the outcome already decided and instead patients are only able to have a say in the general 'shape' of the service. Patients and carers should be able to have real input into the actual details of what is made available. In mental health there should be a stronger role for ex patients to be part of teams, helping others still in the service. There has already been frequent service redesign in mental health (including in the mental health trust, currently in community teams), with services and staff changed around in the name of

improving services – which does create uncertainty and anxiety for service users. There should be a period of stability for services, and a focus on what individual patients need.

Public involvement means that documents (such as this one) should be easier to read. Many people probably don't understand the different tiers of the NHS and what change will mean in their own lives. There should be people on hand, eg working in the health service, ready to explain changes rather than to say that they don't know what is happening themselves. PCTs have done work on public and patient involvement eg NHS West Kent, any new system could use good experience there, as well as not letting user involvement work stop until the new system is in place. The Kent LINK has also tried to involve different people from the local population and look at health treatment across a wide area. I would want more reassurance that new GP consortia would in future have patient involvement rather than closed meetings with no feedback or user representation there.

I worry about there being adequate mental health knowledge in the government's plans. GPs may vary in the amount training they have done, their interest and commitment to mental health. When GPs are new to commissioning they will need training in this too, so it will be a big learning curve. Mental health charity Rethink carried out a survey of GPs which showed that 'only 31% of GPs feel equipped to take on the commissioning role for mental health. While three quarters of GPs say they can take responsibility for diabetes and asthma services, less than a third felt the same for mental health services.'
http://www.rethink.org/how_we_can_help/news_and_media/press_releases/white_paper_to_hand.html

This does lead to the question of whether GPs will commission enough mental health services, and the best ones, if they don't all have expertise. Will GPs tender this commissioning out, and will other providers then try to reduce mental health spending more than it should be for local people. Could GPs also watch their own budgets so not make necessary referrals since they don't want to fail financially? Even if this was not true, patients may wonder if this is the motive when they are not referred to a service. I am also concerned about whether my GP would have enough time to see me? I look to this ongoing relationship with the same responsive and caring GP who knows my history. GPs should not lose patient time to become managers first (unless they want to change roles).

With NICEs role extending to social care I don't know whether they would be biased towards cost effectiveness. The Cancer drugs fund will need to mitigate the effects of their decisions not to fund some cancer drugs which are seen as too costly for the amount of life. Patients need to be able to trust that the standards for the NHS are not driven mainly by cost.

With Health Watch, it does sound like a greater role for the public/patient voice. LINKs across the country may not give enough focus to mental health since they have so many other health areas, which they may get more member/public reports on eg cleanliness in general hospitals. There is a risk in having a wide reach across all health areas so it would be essential that Health Watch prioritises mental health services. Members of Health Watch should also be recruited to make sure they have an interest in mental health. You should

though try to keep the loyalty of existing LINK members who do know already a lot about the local health services.

Arms length bodies are often not known or understood by public and patients. I think for those bodies that are kept there needs to be more chances to get involved. Perhaps with Monitor the time taken to authorise foundation trusts could be reduced, since potential foundation trusts seem locked into a long process before getting that status. I do think that the government are moving fast on changing the NHS eg the news on 28th August that NHS Direct will be scrapped. Consultation about all changes is due especially when experienced clinical staff will be lost to save money.

As patients we also want to be reassured that services are not due for cuts, and that mental health will be a priority area for the government. I worry the reforms will mean that any good work done (by the current organisations) is thrown out and we face a future of much more limited services, with uncertainty and instability for a long time, without the involvement of patients until it's too late.

APPENDIX D

Analysis of the NHS White Paper 'Equity and Excellence' and the consultation paper Local Democratic Legitimacy in Health

Key changes

1. **GP Consortia will commission directly from "any willing provider"**

Implications: All hospital trusts will need to become or be taken over by Foundation Trusts. MTWHT is not currently Foundation.

PCTs will be abolished by April 2013.

Private, community and voluntary sectors will be able to tender to provide services to GPs.

GPs will need to form consortia in order to secure providers. Some may choose to appoint managers/commissioners to do this. Consortia can be any size and could be based on existing Practice Based Commissioning Clusters. The consortia will need to work with LAs regarding adult social care etc. Consortia can form groups and may choose to appoint one group as the lead commissioner for one or more areas of work.

Opportunities: We have an opportunity here to strengthen our links with GPs and to be in a position to work closely with them regarding commissioning and public health in the future. We may be able to sell services to GPs or work with them via the new public health arrangements.

There may also be opportunities regarding shared premises and links to work relating to town centre regeneration.

2. Strengthened Patient Voice

Implications: LINks will become HealthWatch based within the Care Quality Commission. There will be local and national HealthWatch. This will act as consumer champions across health and care.

Health watch will also act as a 'CAB' for health and social care, providing signposting. They will also run NHS complaints advocacy services and support patients in making choice e.g. which GP.

Local HealthWatch will be able to report concerns to HealthWatch England to inform regulatory action independently of the LA.

LAs will have an increased role in promoting choice and complaints advocacy through the HealthWatch arrangements they commission. They will also need to hold HealthWatch to account for delivering effective and good value services. They will also ensure focus of HealthWatch is representative of the local community. They will intervene in under performance

Opportunities: It is not yet clear whether local HealthWatch will be, as LINk, county wide or become district level. There are opportunities to support HealthWatch in strengthening the local health economy and ensure it is meeting standards.
Both Councils could be in a position to support local residents in approaching a Kent wide HealthWatch or possibly in establishing local branches. They will need to ensure that the voices of patients in their Boroughs, particularly their more vulnerable residents, are not overlooked in favour of those in other areas of Kent.

3. LAs will be responsible for Health Improvement

Implications: From 2013, health improvement responsibilities will transfer to LAs following the abolition of PCTs. This is intended to 'unlock synergies with the wider role of LAs in tackling the determinants of ill health and health inequalities'[1].

The consultation paper sees funding for smoking, alcohol, diet and physical activity going to LAs. A full Public Health White Paper is expected later in the year.

LAs will also play an important role in the new Public Health Service (PHS) campaigns relating to screening programmes and delivering national campaigns at a local level.

Kent will need to appoint Joint Director of Public Health (KCC and new Public Health Service appointment). This director will hold a ring fenced budget allocated by the PHS. There will be direct accountability to both the LA and through the PHS to the Secretary of State. Local Directors of Public Health will have direct influence over the wider determinants of public health, advising elected members and as part of senior management at the LA.

Consequently, it is likely that districts will have a fundamental role to play due to their crucial role in the wider determinants such as housing, environmental health, legislation enforcement and health improvement. The implications of this are that the Councils' role in public health will increase rather than decrease and so every effort should be made to ensure consistency throughout this transitional period and into the new era from 2013.

[1] Local Democratic Legitimacy in Health consultation paper

Opportunities: Although the White Paper states that the PH budget for LAs will be ring fenced, this needs some clarification. There are significant opportunities to improve health via the wider determinants such as housing, education, transport and schools by returning the responsibility to LAs at both tiers.

Both Councils are in a strong position to maximise the benefit from these changes to Public Health owing to the well established Healthier partnership arrangements with NHS West Kent. The arrangements currently in place mean that we are able to enhance our existing role rather than accommodate a new responsibility. They are fortunate in being familiar with the public health strengths and weaknesses within the boroughs. This is not the case in other areas of Kent where the transition is likely to be more challenging.

However, both Councils need to ensure they secure the best possible investment for their residents and do not unduly suffer against areas of higher inequality and need within Kent. They will need to effectively direct resources to those areas which stand to benefit the most, thereby tackling our health inequalities.

4. National Public Health Service (PHS) to be established

Implications: This service will 'integrate and streamline health improvement and protection bodies and functions' and will carry an increased emphasis on research, analysis and evaluations. It will also co-ordinate national public health services.

The PHS will have powers in relation to NHS in order to manage public health emergencies as well as NHS resilience.

The Secretary of Sate through the PHS will agree with LAs the local application of national health improvement outcomes. LAs will then decide how best to secure those outcomes and this may include commissioning services. Local neighbourhoods will have the freedom to set local priorities within a national framework.

Opportunities: There is an opportunity for both Councils to take a leading role in the development and delivery of the PHS in Kent due to links with local universities, GPs and the local hospitals of excellence. There may be opportunities for training in relation to public health, including for GPs and commissioners, thereby strengthening the local health economies. The Boroughs could be positioned as centres of excellence for early intervention public health work within the new public health service and with regards to LA new health improvement responsibilities. There is also an opportunity to build on work to date with regards to SROI, mental health and Wellpoint. Again, the Councils need to ensure they are at the forefront by building on their existing strengths and not be overlooked in favour of other areas.

5. Local Health and Wellbeing Boards (LHWB)

Implications: The Government believes that there is scope for stronger arrangements within LAs led by elected representatives, to support partnership working across health and social care and public health.

The Government prefers the establishment of a statutory role within upper tier LAs to support joint working on health and wellbeing – a Local Health and Wellbeing Board. However, they are consulting on this and welcome suggestions on how best to achieve partnership working and integrated commissioning. If these boards were developed requirements would be minimal with significant level of freedom for the LAs.

These would have four main functions:

- Assess the needs to the local population and lead JSNAs
- Promote integration and partnership across areas through joined up commissioning plans
- Support joint commissioning and pooled budgets
- Undertake a scrutiny role in relation to major service redesign

There would be statutory duty for LAs and commissioners to form part of this board. This board would give LAs influence over NHS commissioning.

The consultation paper states that although these boards would be at upper tier level, they would need to discharge their functions at the right level to ensure needs of diverse areas are at the core of their work and that elected members below tier one can contribute. Boards may choose to delegate the lead for some functions to districts or neighbourhoods. Neighbouring boroughs can also combine boards.

Boards would include Leaders or Mayors, Social Care, NHS Commissioners, local government, GP consortia and NHS commissioning

board representation, HealthWatch and patient champions. The DPH would also play a critical role.

HOSC would be abolished and the statutory powers transferred to Local Health and Wellbeing Boards.

Opportunities: Both Councils will have the opportunity to set up their own Health and Wellbeing Board, building on the existing LSP arrangements, if agreed by KCC or to contribute to the county board. Both officers and Members will need to be involved in the board at either level.

Representation will again be crucial in ensuring the boroughs are not overlooked against those areas with more noticeable health inequalities.

NHS

Liberating the NHS:

Commissioning for patients

A consultation on proposals

DH Department of Health

DH INFORMATION READER BOX

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Description	One of the central features in Liberating the NHS is to devolve commissioning responsibilities and budgets as far as possible to those who are best placed to act as patients' advocates and support them in their healthcare choices. This document sets out, and seeks views on, the intended arrangements for GP commissioning and the NHS Commissioning Board.
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1. Introduction

1.1 The White Paper *Equity and Excellence: Liberating the NHS* sets out the Government's strategy for the NHS. Our intention is to create an NHS which is much more responsive to patients, and achieves better outcomes, with increased autonomy and clear accountability at every level.

1.2 *Liberating the NHS* makes clear the Government's policy intentions and provides a coherent framework. Further work lies ahead to develop and implement detailed proposals. In progressing this work, the Department will be engaging with external organisations, seeking their help and wishing to benefit from their expertise. An analytical strategy published alongside *Liberating the NHS* sets out our plans to use the consultation and engagement activity to inform the development of Impact Assessments to be published later in the year. It also provides an initial indication of what benefits, costs and risks will be analysed.

1.3 This document, *Commissioning for patients,* provides further information on our intended arrangements for GP commissioning and the NHS Commissioning Board's role in supporting consortia and holding them to account. It seeks views on a number of specific consultation questions. Examples of existing practice and evidence that support respondents' views are encouraged.

1.4 This is part of a public consultation on specific aspects of the White Paper. The initial suite of supporting papers also includes:

- Regulating healthcare providers
- Local democratic legitimacy in health
- The review of Arm's-Length Bodies
- Transparency in outcomes: a framework for the NHS.

1.5 The Government will publish a response prior to the introduction of a Health Bill later this year.

Overview

1.6 When we think about the NHS, we often think of the individuals and organisations that provide care for patients, such as GPs, hospitals and community health professionals. But providers of NHS healthcare cannot exist in a vacuum. One of the most fundamental responsibilities in the NHS is to decide what services will best meet the needs of patients and local communities and to commission these services in ways that ensure high-quality outcomes, maximise patient choice and secure efficient use of NHS resources.

1.7 This is the central theme of NHS commissioning – understanding the health needs of a local population or a group of patients and of individual patients; working with patients and the full range of health and care professionals involved to decide what services will best meet those needs and to design these services; creating a clinical service specification that forms the basis for contracts with providers; establishing and holding a range of contracts that offer choice for patients wherever practicable; and monitoring to ensure that services are delivered to the right standards of quality.

1.8 One of the central features of the proposals in *Liberating the NHS* is to devolve commissioning responsibilities and budgets as far as possible to those who are best placed to act as patients' advocates and support them in their healthcare choices. Through our world-renowned system of general practice, GPs, practice nurses and other primary care professionals are already supporting patients in managing their health, promoting continuity and co-ordination of care, and making referrals to more specialist services. In empowering GP practices to come together in wider groupings, or 'consortia', to commission care on their patients' behalf and manage NHS resources, we are building on these foundations. We are also empowering them to work more effectively alongside individual patients and alongside the full range of other health and care professionals.

1.9 As set out in the parallel document *Local democratic legitimacy in health*, we plan to put in place robust oversight arrangements for local democratic accountability with local authorities playing a key role. They will lead the statutory joint strategic needs assessment, which will inform the commissioning of health and care services and promote integration and partnership across areas, including through joined up commissioning plans across the NHS, social care and public health. They will support joint commissioning and pooled budget arrangements, where parties agree this makes sense, and will undertake a scrutiny role in relation to major service redesign. One option for doing this is through the creation of statutory health and wellbeing boards within local authorities.

1.10 *Liberating the NHS* also sets out proposals to establish an independent NHS Commissioning Board. The Board will provide national leadership on commissioning for quality improvement and promote and extend public and patient involvement and choice. It will be responsible for ensuring a comprehensive system of GP commissioning consortia across the NHS, for holding consortia to account and for commissioning some services itself. It will allocate and account for NHS resources.

1.11 The forthcoming consultation document on *Regulating healthcare providers* will also set out a proposed role for a new independent economic regulator of health and social care, to act as a champion for patients, setting prices where needed, protecting patient choice, and helping to ensure continuity of services.

1.12 This document sets out our intended arrangements for GP commissioning and the NHS Commissioning Board's role in supporting consortia and holding them to account. It serves as the starting point for a programme of consultation and engagement with patients and the public, GPs and other health and care professionals, local government, and voluntary sector, social enterprise and independent sector organisations. We would like your views on how to deliver the greatest possible benefits from these new commissioning arrangements, on how to develop the partnerships on which their success will depend, on how GP consortia can best work with the NHS Commissioning Board, and on the other specific questions identified below.

Current commissioning arrangements

1.13 For the past decade, commissioning responsibilities have largely rested with primary care trusts (PCTs) and to some extent the primary care groups that preceded them. The previous Government made belated attempts to strengthen PCT commissioning through its programme of 'world class commissioning'. But the weaknesses of the system have lain much deeper than the capacity of staff working in PCTs. Commissioning has been too remote from the patients it is intended to serve. It has been divorced from GPs' clinical responsibilities, such as referral, with efforts to create 'practice based commissioning' lacking reality and not sufficiently empowering. It has been beset by political interference and micro-management, with a rhetoric of PCTs being free to reflect local health priorities but the reality of having to pursue targets and Ministerial demands.

Proposed commissioning arrangements

1.14 Our proposals for GP commissioning and the NHS Commissioning Board mark a fundamental break with this past. Most commissioning decisions will now be made by consortia of GP practices, free from top-down managerial control and supported and held to account for the outcomes they achieve by the NHS Commissioning Board. This will push decision-making much closer to patients and local communities and ensure that commissioners are accountable to them. It will ensure that commissioning decisions are underpinned by clinical insight and knowledge of local healthcare needs. It will enable consortia to work closely with secondary care, other health and care professionals and with community partners to design joined-up services that make sense to patients and the public.

1.15 Our proposed model will not mean all GPs, practice nurses and other practice staff having to be actively involved in every aspect of commissioning. Their predominant focus will continue to be on providing high-quality primary care to their patients. It is likely to be a smaller group of primary care practitioners who will lead the consortium and play an active role in the clinical design of local services, working with a range of other health and care professionals. All GP practices, however, will be able to ensure that commissioning decisions reflect their views of their patients' needs and their own referral intentions. It will be a requirement for every GP practice to be part of a consortium and to contribute to its goals, not least in ensuring that as a practice they provide services in ways that support high-quality outcomes and efficient use of NHS resources.

1.16 Nor will the practitioners who lead the consortia need to carry out all commissioning activities themselves. Whilst it is likely that they will coordinate most of the clinical aspects of commissioning themselves, consortia will be able to employ staff or buy in support from external organisations, including local authorities, voluntary organisations and independent sector providers, for instance to analyse population health needs, manage contracts with providers and monitor expenditure and outcomes. Consortia will have the freedom to decide which aspects of commissioning activity they undertake fully themselves and which aspects require collaboration across several consortia, for instance through a lead commissioner managing the contract with a large hospital or commissioning low-volume services not covered by national and regional specialised services.

1.17 GP consortia will also be supported by the role of the NHS Commissioning Board in developing commissioning guidelines, model contracts and tariffs.

1.18 Transferring commissioning functions to consortia and, in some cases, the NHS Commissioning Board, alongside the potential role for local health and wellbeing boards, means that PCTs will no longer have a role. We expect that PCTs will cease to exist from April 2013, in light of the successful establishment of GP consortia. A number of PCTs have made important progress in developing commissioning experience. We will be looking to capitalise on that existing expertise and capability in the transitional period, where this is the wish of GP consortia.

1.19 PCTs will have an important task in the next two years in supporting practices to prepare for these new arrangements. We want implementation to be bottom-up, with GP consortia taking on their new responsibilities as rapidly as possible and early adopters promoting best practice.

Purpose of this document

1.20 This document sets out in more detail:

- **responsibilities (Section 3):** the scope of the services for which consortia and the NHS Commissioning Board will be responsible, their responsibilities as commissioners of these services, and the relationship between the responsibilities of the NHS Commissioning Board, GP consortia and individual GP practices

- **establishment of GP consortia (Section 4):** the statutory form that consortia will take, the bottom-up way in which we will invite GP practices to form consortia and arrangements for authorisation by the NHS Commissioning Board

- **freedoms, controls and accountabilities (Section 5):** the freedoms and flexibilities that consortia will have to decide how best to commission services and how they will be held accountable, both to the patients and local communities they serve and to the NHS Commissioning Board, for the outcomes they achieve and for control of resources

- **partnerships (Section 6):** how we envisage that consortia and the NHS Commissioning Board will work with patients and the public, with local government, and with other health and care professionals to secure more patient-centred and integrated delivery of care

- **implementation and next steps (Section 7):** the timetable for the transition to GP practice commissioning and the establishment of the NHS Commissioning Board, and the practical steps we propose that PCTs should take with GP practices and current practice-based commissioning

groups to begin this transition, including action to help ensure that consortia will be supported by excellent clinical leadership and excellent information.

2. Summary of key points

Responsibilities of GP consortia

2.1 In order to shift decision-making as close as possible to individual patients, the Department will devolve power and responsibility for commissioning most healthcare services to groups of GP practices.

2.2 Consortia of GP practices will commission the great majority of NHS services on behalf of patients, including elective hospital care and rehabilitative care, urgent and emergency care (including out-of-hours services), most community health services, and mental health and learning disability services.

2.3 Consortia will not be responsible for commissioning primary medical services, which will be the responsibility of the NHS Commissioning Board, but consortia will become increasingly influential in driving up the quality of general practice. The NHS Commissioning Board will also commission the other family health services of dentistry, community pharmacy and primary ophthalmic services, as well as national and regional specialised services, maternity services and prison health services, but with the influence and involvement of consortia.

2.4 The NHS Commissioning Board will calculate practice-level budgets and allocate these resources directly to consortia. Consortia will be responsible for managing these combined budgets, which will be kept separate from GP practice income, and deciding how best to use resources to meet the healthcare needs of their patients. They will have a duty to ensure that expenditure does not exceed their allocated resources. They will enter into contracts with providers and hold providers to account for meeting their contractual duties, including required quality standards and patient outcomes.

2.5 Consortia will have a duty to promote equalities and to work in partnership with local authorities, for instance in relation to health and adult social care, early years services and public health.

2.6 Consortia will need to engage patients and the public on an ongoing basis as they undertake their commissioning responsibilities, and will have a duty of public and patient involvement.

Relationship between consortia and individual practices

2.7 The Government will discuss with the BMA and the profession how primary medical care contracts can best reflect new complementary responsibilities for individual GP practices, including a duty to be a member of a consortium and to support it in ensuring efficient and effective use of NHS resources.

The role of the NHS Commissioning Board

2.8 To support consortia in their commissioning decisions we will create a statutory NHS Commissioning Board, which will:

- provide national leadership on commissioning for quality improvement, for instance by developing commissioning guidelines based on quality standards and by designing tariffs and model NHS contracts
- promote and extend public and patient involvement and choice
- ensure the development of consortia and hold them to account for outcomes and financial performance
- commission certain services that are not commissioned by consortia, such as the national and regional specialised services
- allocate and account for NHS resources.

2.9 The NHS Commissioning Board will be accountable to the Secretary of State for managing the overall commissioning revenue limit and for delivering improvements against a number of measures of health outcomes. The Board will in turn hold consortia to account for their performance.

Establishment of GP consortia

2.10 The intention is to put GP commissioning on a statutory basis, with powers and responsibilities set out through primary and secondary legislation.

2.11 Every GP practice will be a member of a consortium, as a corollary of holding a list of registered patients. Within the new legislative framework, practices will have flexibility to form consortia in ways that they think will secure the best healthcare and health outcomes for their patients and locality. The NHS Commissioning Board will have a duty to ensure comprehensive coverage of GP consortia, and we envisage a reserve power for the Board to assign practices to consortia if necessary.

2.12 Consortia will be formed on a bottom-up basis, but will need to have sufficient geographic focus to be able to agree and monitor contracts for locality-based services (such as urgent and emergency care), to have responsibility for commissioning services for people who are not registered with a GP practice, to commission services jointly with local authorities, and to fulfil effectively their duties in areas such as safeguarding of children. The consortia will also need to be of sufficient size to manage financial risk effectively, notwithstanding their ability to work with other consortia to manage financial risk.

Freedoms and accountabilities

2.13 We envisage that consortia will receive a maximum management allowance to reflect the costs associated with commissioning. Consortia will have the freedom to decide what commissioning activities they undertake for themselves and for what activities they choose to buy in support from external organisations, including local authorities, private and voluntary sector bodies.

2.14 Consortia will have the freedom to use resources in ways that achieve the best and most cost-efficient outcomes for patients. At the same time, the economic regulator and the NHS Commissioning Board will ensure transparency and fairness in spending decisions and promote competition, for instance by ensuring wherever possible that any willing provider has an equal opportunity to provide services. The Department will discuss with the NHS the safeguards that will be needed to ensure these objectives, particularly with regard to consortia commissioning services from general practice (over and above the primary care services that they already have a duty to provide).

2.15 The NHS Commissioning Board will be responsible for holding consortia to account for the outcomes they achieve, for stewardship of NHS resources and for fulfilling duties such as public and patient involvement and partnership with local authorities. In turn, each consortium will develop its own arrangements to hold its constituent practices to account.

2.16 We propose that the NHS Commissioning Board, supported by NICE, will develop a commissioning outcomes framework so that there is clear, publicly available information on the quality of healthcare services commissioned by consortia, including patient-reported outcome measures and patient experience, and their management of NHS resources. The framework would also seek to capture progress in reducing health inequalities.

2.17 We propose, subject to discussion with the BMA and the profession, that a proportion of GP practice income should be linked to the outcomes that

practices achieve collaboratively through commissioning consortia and the effectiveness with which they manage NHS resources.

2.18 The NHS Commissioning Board will need powers to intervene in the event that a consortium is unable to fulfil its duties effectively or where there is a significant risk of failure. We propose working with the NHS to develop criteria or triggers for intervention.

Partnership

2.19 Consortia will need to work closely with the patients and local communities they serve, including through Local Involvement Networks (which will become local HealthWatch bodies) and patient participation groups, and with community partners.

2.20 The proposed new local authority health and wellbeing boards would enable consortia, alongside other partners, to contribute to effective joint action to promote the health and wellbeing of local communities, including combined action on health improvement, more integrated delivery of adult health and social care, early years' services and safeguarding of children and vulnerable adults.

2.21 We will work with the NHS and the health and care professions to promote multi-professional involvement in commissioning.

Implementation

2.22 Our proposed implementation timetable is:

In 2010/11

- GP consortia to begin to come together in shadow form (building on practice-based commissioning consortia, where they wish)

In 2011/12

- a comprehensive system of shadow GP consortia in place and the NHS Commissioning Board to be established in shadow form

In 2012/13

- formal establishment of GP consortia, together with indicative allocations and responsibility to prepare commissioning plans, and the NHS Commissioning Board to be established as an independent statutory body

In 2013/14

- GP consortia to be fully operational, with real budgets and holding contracts with providers.

3. Responsibilities

Scope of GP commissioning

3.1 The principle underpinning the scope of GP commissioning will be that commissioning responsibilities – and accompanying NHS resources – should be devolved as close to the patient as possible.

3.2 We intend that consortia will, therefore, be statutorily responsible for commissioning the great majority of NHS services, including elective hospital care and rehabilitative care, urgent and emergency care (including out-of-hours services), most community health services and mental health and learning disability services. Consortia will be responsible for meeting prescribing and associated costs. It will be for consortia to decide on a case-by-case basis whether to commission services themselves, or to make appropriate arrangements with another commissioning organisation (for instance a lead consortium).

3.3 There will, however, be some exceptions, where it makes sense for the NHS Commissioning Board to have responsibility – and the accompanying share of the NHS budget – for commissioning services. The proposed exceptions are:

- **primary medical care**: the Board will be responsible for holding contracts with individual GP practices in their role as providers of primary medical care, although we envisage a key role for consortia in driving up quality of general practice (see paras 3.14-3.22 below)

- **other family health services**: the Board will commission primary dental services, community pharmacy (and other dispensing services) and primary ophthalmic services. Consortia will, however, be able to commission services from primary care contractors, for instance if they wish to commission optometrists to help manage glaucoma

- **national and regional specialised commissioning**: the Board will have responsibility for commissioning certain highly specialised services, i.e. those covered by the Specialised Services National Definitions Set such as heart transplants, spinal injuries, burns and renal dialysis, which the Board will commission at the appropriate level. This will ensure that patients with rare conditions can be sure of high-quality and cost-effective treatment and are treated equitably with people who have more common conditions. It will also help ensure more effective implementation of Sir

David Carter's 2007 review of specialised commissioning. The Board will need to facilitate strong engagement of consortia in these arrangements and ensure a smooth interface between GP commissioners and specialised services

- **maternity services**: we propose that the Board plays the lead role in commissioning maternity and newborn care services, with a view to promoting choice across a range of settings and services

- **health services for those in prison or custody**: we propose that the Board works with criminal justice agencies and GP consortia to determine the most appropriate arrangements for prison health services.

3.4 There may of course be other services, such as low-volume services outside the scope of national or regional specialised commissioning, that are better commissioned for larger populations than those of individual consortia. We propose that consortia, in accordance with their duties of partnership and engagement, should have the freedom and the responsibility to decide for themselves at what level (for instance through a lead consortium) these services are best commissioned.

Questions

- In what practical ways can the NHS Commissioning Board most effectively engage GP consortia in influencing the commissioning of national and regional specialised services and the commissioning of maternity services?

- How can the NHS Commissioning Board and GP consortia best work together to ensure effective commissioning of low volume services?

- Are there any services currently commissioned as regional specialised services that could potentially be commissioned in the future by GP consortia?

- How can other primary care contractors most effectively be involved in commissioning services to which they refer patients, e.g. the role of primary care dentists in commissioning hospital and specialist dental services and the role of primary ophthalmic providers in commissioning hospital eye services?

Duties and responsibilities of GP consortia

3.5 The NHS Commissioning Board will calculate practice-level budgets and allocate these budgets directly to consortia. These budgets will need to reflect an appropriate share of healthcare resources to include both people registered with practices in the consortium and local residents who are not registered with any GP practice.

3.6 Consortia will be responsible for managing their combined budget and for deciding how best to use these resources to meet the healthcare needs of the patients for whom they are responsible. Just as PCTs are currently the responsible commissioner for people registered with a GP practice in their area (even if they live elsewhere), the consortium will be the responsible commissioner for any patients registered with its constituent practices. Cross-border arrangements with Scotland and Wales will be unaffected.

3.7 In addition to their responsibilities for registered patients, consortia will be responsible for ensuring the provision of comprehensive emergency services for any person in their area.

3.8 The specific accountabilities, responsibilities and duties of consortia will be set out through primary and secondary legislation. This will include accountability and responsibility for:

- determining healthcare needs, including contributing to the wider joint strategic needs assessment led by local authorities
- determining what services are required to meet these needs and ensuring the appropriate clinical and quality specification of these services
- entering into and managing contracts with providers
- monitoring and improving the quality of healthcare provided through these contracts
- providing oversight, with the NHS Commissioning Board, of healthcare providers' training and education plans.

3.9 The legislation will also set out a consortium's duties in relationship to financial management, including:

- ensuring that expenditure does not exceed its allocated resources
- requirements in relation to reporting, audit and accounts.

3.10 Consortia will have duties in relation to equality and human rights and in relation to data protection and freedom of information.

3.11 Consortia will have duties to work in partnership with local authorities, for instance in relation to health and adult social care, early years services, public health, safeguarding, services for carers, and to cooperate with local authorities and other agencies in relation to criminal justice.

3.12 Consortia will have a duty to inform, engage and involve the public in identifying needs, planning services and considering any proposed changes in how those services are provided. Where this is likely to result in changes in the configuration of services, consortia will be expected to report on the likely impact of those changes and the impact of public involvement on their commissioning decisions.

3.13 Section 5 of this document sets out proposals for how consortia are held to account for how they carry out their responsibilities and duties.

Relationship between consortia and individual GP practices

3.14 The duties and responsibilities set out above will apply to the consortium. In turn, each consortium will develop its own arrangements to hold its constituent practices to account.

3.15 We will discuss with the BMA and the profession how primary medical care contracts can best reflect specific new complementary responsibilities for individual GP practices, including being a member of a consortium and supporting the consortium in ensuring efficient and effective use of NHS resources.

3.16 With the exception of a management allowance (see para 5.2 below), the consortium's commissioning budget will be used exclusively for commissioning of patient care. It will be distinct from the income that GP practices earn under their primary medical care contract, from which they both meet their practice expenses and derive their personal income. However, health outcomes for patients will of course depend both on the quality of the services that GP practices provide and on the quality of GP commissioning. We therefore propose (as set out in para 5.17 below) that a proportion of GP practice income should be linked to the overall outcomes that practices achieve collaboratively through their role in a commissioning consortium.

3.17 We also propose to work with the BMA and the profession to reform the Quality and Outcomes Framework (QOF) so that it better reflects individual practices' contribution to health outcomes. The QOF made an initial

contribution to improving patient care when introduced in 2004, but it is now failing to deliver any significant degree of continuous quality improvement for patients. A large number of QOF indicators reward GP practices for the processes they carry out, such as keeping registers of patients with long-term conditions or measuring blood pressure, and reflect standards of care that one would routinely expect from any GP practice. We want the QOF to focus more on the health outcomes that are achieved for patients and to provide incentives for continuous improvements in quality of care.

3.18 By the same token, the performance of consortia as commissioners will be closely bound up with the quality of services provided by their constituent practices. The effective identification and management of long-term conditions, the accessibility and responsiveness of GP services, and decisions on referrals and prescribing all have a major impact both on the overall quality of patient care and on the efficient use of NHS resources. We therefore propose that consortia should play a key role in working with individual GP practices to drive up the quality of primary medical care and improve overall utilisation of NHS resources.

3.19 Whilst care will be needed to protect against conflicts of interest, the NHS Commissioning Board should have the power, where it judges it appropriate, to ask consortia to carry out on its behalf some aspects of the work involved in managing primary medical services contracts, for instance by promoting quality improvement, reviewing and benchmarking practice performance and ensuring clinical governance requirements are met. This would enable consortia to apply peer review and challenge in the first instance to areas where there appear to be unwarranted variations in practice or outcomes, for instance in relation to prescribing or the systems in place to support management of long-term conditions. The Board would retain overall responsibility for commissioning and contractual decisions.

3.20 The role of GP consortia in helping promote quality and review practice performance will also help ensure that action to ensure good financial management sits alongside and complements GPs' clinical responsibilities to patients and their role in supporting patient choice. This means promoting innovations that improve both quality and productivity, whilst challenging any behaviours that are inappropriate both for good clinical care and for efficient use of NHS resources.

3.21 The Government intends to work with the profession to move over time towards a single contractual and funding model for GP practices to promote quality improvement, deliver fairness for all practices, support free patient choice and remove unnecessary barriers to new providers. This model would

reflect the fundamental aspects of primary care services - those services that every patient should expect to be able to receive at their GP practice.

3.22 A consortium may need to arrange for some of its GP practices to provide primary care services over and above those that they already have a duty to provide, subject to safeguards (discussed in section 5) to ensure fairness, transparency and competition. We will take forward further work to identify the most suitable contractual framework for services of this kind.

Questions

- How can GP consortia most effectively take responsibility for improving the quality of the primary care provided by their constituent practices?
- What arrangements will support the most effective relationship between the NHS Commissioning Board and GP consortia in relation to monitoring and managing primary care performance?
- What safeguards are likely to be most effective in ensuring transparency and fairness in commissioning services from primary care and in promoting patient choice?

The role of the NHS Commissioning Board

3.23 To provide overall leadership on commissioning, we will create a NHS Commissioning Board with an appropriate infrastructure. The Board will be an independent statutory authority with a Chair, Chief Executive and both executive and non-executive board members and will be free to determine its own organisational shape, structure and ways of working. It will carry out some functions currently performed by the Department of Health, SHAs and PCTs, as set out below, but will be a lean organisation, performing those functions in a more streamlined way.

3.24 The NHS Commissioning Board will be accountable to the Secretary of State for managing the overall commissioning revenue limit and for delivering improvements against a number of measures of health outcomes. It will be responsible for reporting the consolidated financial position of consortia as part of its financial reporting obligations.

3.25 The Secretary of State will set the NHS Commissioning Board an annual mandate, based on a multi-year planning cycle, which will be subject to public

consultation and Parliamentary scrutiny. This will cover the totality of what the Government expects from the Board on behalf of the taxpayer, including progress against outcomes specified by the Secretary of State in the NHS Outcomes Framework, delivering improvements in choice and patient involvement and tackling inequalities in outcomes of healthcare. The Board will in turn hold consortia to account for their performance. The new system will be set out in primary and secondary legislation.

3.26 *Liberating the NHS* sets out five broad functions for the NHS Commissioning Board:

i) providing national leadership on commissioning for quality improvement

3.27 The NHS Commissioning Board will provide a framework to support GP consortia in commissioning services, including:

- setting commissioning guidelines on the basis of clinically approved quality standards developed with advice from NICE, in a way that promotes joint working across health, public health and social care. These will be used as the basis for developing the NHS Outcomes Framework into a more comprehensive set of indicators and making available accessible information on commissioner performance

- designing model NHS contracts for consortia to adapt and use with providers and setting standards for the quality of NHS commissioning and procurement

- designing the structure of tariff and other financial incentives whilst the economic regulator will set tariff levels

- having a role in determining technical and data standards to ensure there is consistency in the information that commissioners and providers are using, and compatibility between information systems

- where appropriate and by agreement with consortia, hosting some commissioning networks, for example for cancer, targeted health services for ill and disabled children, and coronary heart disease.

ii) promoting and extending public and patient involvement and choice

3.28 As well as involving patient and professional representative bodies in carrying out its work, the NHS Commissioning Board will take the lead in promoting and extending public and patient involvement and choice in the NHS by:

- championing effective patient and public involvement and engagement in commissioning decisions, and greater involvement of patients and carers in

decision-making and managing their own care, working with consortia, local authorities, patient groups and HealthWatch

- developing and agreeing with the Secretary of State the guarantees for patients about the choices they can make, taking account of advice from the economic regulator on the implications for competition, in order to provide clarity for patients and providers alike

- promoting and extending information to support meaningful choice of what care and treatment patients receive, where it is provided and who provides it, including personal health budgets

- commissioning information requirements for choice and for accountability, including patient-reported experience and outcome measures.

iii) ensuring the development of GP consortia and holding them to account

3.29 The NHS Commissioning Board will:

- support and develop the establishment and maintenance of an effective and comprehensive system of GP consortia; and

- hold consortia to account for delivering outcomes and financial performance.

iv) commissioning certain services that are not commissioned by consortia

3.30 The NHS Commissioning Board will have statutory responsibility for commissioning some services that it would be less appropriate for consortia to commission. These will include primary medical care, other family health services, maternity services, prison health services, and national and regional specialised services.

v) allocating and accounting for NHS resources

3.31 The NHS Commissioning Board will calculate practice-level budgets and allocate these budgets directly to consortia. The Board will allocate resources on the basis of seeking to secure equivalent access to NHS services for all, relative to the prospective burden of disease.

3.32 The Board will have overall responsibility for financial stability of commissioners and for accounting to the Secretary of State for NHS commissioning expenditure, underpinned by robust financial management measures at consortium level.

3.33 The Board will have limited powers, to be set out in legislation, to intervene where for example a consortium is failing to fulfil its statutory duties or there is a significant risk that a consortium will fail to do so.

Questions

- How can the NHS Commissioning Board develop effective relationships with GP consortia, so that the national framework of quality standards, model contracts, tariffs, and commissioning networks best supports local commissioning?
- Are there other activities that could be undertaken by the NHS Commissioning Board to support efficient and effective local commissioning?

4. Establishment of GP consortia

Organisational form

4.1 We intend that consortia, once established, will be statutory public bodies, with powers and responsibilities set out through primary and secondary legislation. By that time, each consortium would need to have chosen its own Accountable Officer and Chief Financial Officer (with the latter officer potentially discharging this role for more than one consortium).

4.2 We believe that consortia should be held to account for the outcomes they achieve and for their fulfilment of appropriate duties, rather than for the way in which they constitute themselves. We do not intend to set out detailed or prescriptive requirements in relation to the internal governance of a consortium, beyond essential requirements for example in relation to areas such as financial probity and accountability (e.g. statutory accounting as determined by the NHS Commissioning Board), reporting (e.g. to publish a commissioning plan and report on expenditure) and audit.

Questions

- What features should be considered essential for the governance of GP consortia?

Forming consortia

4.3 We intend, subject to discussion with the BMA and the wider profession, that every practice, i.e. every holder of a primary medical care contract (whether it be a GP partnership, nurse-led partnership, voluntary organisation, social enterprise or independent sector organisation), should be required to be a member of a consortium, as a corollary of holding a list of registered patients.

4.4 Consortia will need to have sufficient geographic focus to be able to agree and monitor contracts for locality-based services (such as urgent care), to have responsibility for commissioning services for people who are not registered with a practice, to commission services jointly with local authorities, and to fulfil effectively their duties in areas such as safeguarding. For these purposes, they will need to have boundaries that interlock so that taken together they cover the entire country.

4.5 We do not, however, propose to issue a Whitehall blueprint for the geography of consortia. We believe that GP practices should have the flexibility within the legislative framework, subject to having the geographic focus described above, to form consortia in ways that they think will secure the best healthcare and health outcomes for their patients and locality. This might include preserving groupings used for practice-based commissioning, where they have been successful. The NHS Commissioning Board will have a duty to ensure comprehensive coverage of GP consortia across the country. We envisage a reserve power for the Board to assign practices to consortia, if necessary, but only as a last resort.

4.6 Nor do we wish to be unduly prescriptive about the size of consortia. There have been widespread variations in the size and population coverage of PCTs, and there is no evidence to suggest a single 'right' size. The NHS Commissioning Board will nonetheless need to satisfy itself that consortia are of sufficient size to manage financial risk and allow for accurate allocations.

4.7 We would encourage consortia to begin to form on a shadow basis in 2010/11 (building on practice-based commissioning consortia, where they wish), and, where they are ready to do so, begin to take on some responsibilities from PCTs, in line with the vision set out in this document.

Questions

- How far should GP consortia have flexibility to include some practices that are not part of a geographically discrete area?
- Should there be a minimum and/or maximum population size for GP consortia?

Authorisation

4.8 We propose that the NHS Commissioning Board will have the duty and powers to authorise consortia, once it is satisfied that they have the necessary arrangements and capacity to fulfil their statutory duties and accountabilities and that there is clarity about the geographical area that they cover for the purposes set out above. There will need to be a rigorous process to ensure that consortia are able to fulfil duties in relation to financial accountability and control. Where a consortium does not fulfil any minimum requirements for authorisation, the Board will need to be explicit in setting out the steps that need to be taken and the interim arrangements.

4.9 There will also need to be flexibility to allow consortia to evolve in terms of the groups of practices that they bring together and to ensure that new primary care providers are able to join consortia.

5. Freedoms, controls and accountabilities

Freedoms

5.1 Within the scope of NHS services as defined by the Secretary of State, GP consortia will be free to decide commissioning priorities to reflect local needs, supported by the national framework of quality standards, tariffs and national contracts established by the NHS Commissioning Board. They will be able to adapt model contracts to include the quality dimensions that they judge will produce the best outcomes, subject to ensuring that patients have choice of any willing provider that can perform to these quality standards.

5.2 We propose that commissioning budgets will include a maximum allowance to cover management costs. Consortia will be free to decide how best to use this management allowance to carry out commissioning activities. Consortia are likely to carry out a number of commissioning activities themselves. In other cases, they may choose to act collectively, for instance by adopting a lead commissioner model to negotiate and monitor contacts with large hospital trusts or with urgent care providers. They may also choose to buy in support from external organisations, including local authorities and private and voluntary sector bodies. This could include, for instance, analytical activity to profile and stratify healthcare needs, procurement of services, and contract monitoring.

5.3 Consortia will also have the freedom to arrange for some commissioning activities to be undertaken at a sub-consortium or practice level, where that is appropriate and where the necessary internal controls are in place.

5.4 These freedoms are intended to ensure that GPs and other clinicians are able to focus their input on those aspects of commissioning that will most benefit from their clinical insight and expertise, alongside their core duties of care for patients.

5.5 In the transition to consortia taking on statutory commissioning responsibilities, we envisage that PCTs will provide many of these functions in support of shadow consortia, alongside the many organisations that already exist to provide commissioning support. We envisage that over time a more competitive market will develop for supplying some of these services.

Questions

- How can GP consortia best be supported in developing their own capacity and capability in commissioning?
- What support will GP consortia need to access and evaluate external providers of commissioning support?

Managing financial risk

5.6 Consortia will need to have sufficient freedoms to invest resources in ways that achieve the best and most cost-efficient outcomes for patients.

5.7 At the same time, consortia will need to manage resources in ways that control financial risk and enable them to meet their responsibility for breaking even on their commissioning budget. A key issue will be managing volume risk in the new system. There are two broad categories of risk in the system:

- risks from unavoidable and natural fluctuations in the healthcare needs of a population, which are often described as 'insurance risk'
- risks arising from controllable activities, such as poor prescribing or referral practices, sometimes known as 'service risk'.

5.8 The challenge for risk management is helping commissioners deal with the insurance risk through some form of risk pooling, while ensuring that commissioners are responsible for managing service risk. Empirically it can be difficult to separate out those risks. This means that the approach to managing financial risk will need to be carefully thought through and evolve over time as new evidence comes to light.

5.9 We envisage that the NHS Commissioning Board will have a significant role in managing financial risk, for example through oversight of risk pooling within and between consortia. Consortia should have a level of flexibility in deciding how best to manage financial risk within the overall regime set by the NHS Commissioning Board to encourage good financial management. The principles for managing underspends and overspends, including whether any planned and managed underspends may be carried over to future years to invest in services and whether any actual overspends will be deducted from the following year's allocation, will be agreed between the NHS Commissioning Board, the Department of Health and HM Treasury. Key criteria are likely to be:

- minimising exposure to uncontrollable 'insurance risk'
- allowing for the maximum proportion of funds to be allocated direct to patient services
- ensuring the right arrangements to manage the impact of over- or under-spending by consortia, without a disproportionate amount of money needing to be held back as contingency
- ensuring sufficient incentives and disciplines to manage financial risk properly, and service risk in particular, at the local consortium level.

5.10 These arrangements will need to complement the incentives for consortia to manage risk, which will include benefits for good financial management such as the proposed quality premium (see para 5.17). The NHS Commissioning Board will have intervention powers in the event of poor financial management (see paras 5.18-5.21).

Questions

- Are these the right criteria for an effective system of financial risk management? What support will GP consortia need to help them manage risk?

Transparency and fairness in investment decisions

5.11 It is essential that consortia have the freedom to make commissioning decisions that they judge will achieve the best outcomes within the financial resources available to them. At the same time, the economic regulator and NHS Commissioning Board will need to develop and maintain a framework that ensures transparency, fairness and patient choice. We propose that, wherever possible, services should be commissioned that enable patients to choose from any willing provider.

5.12 This will be particularly important where a consortium proposes to commission services from one or more of its constituent practices. Consortia will be commissioning organisations and will not be able to provide services in their own right. It is essential, however, that individual practices or groups of practices have the opportunity to provide new services (over and above the primary care services that they already have a duty to provide), where this will provide best value in terms of quality and cost. This will not happen if the muddled and over-bureaucratised approach that has too often characterised

'practice-based commissioning' is allowed to continue. Further work will be taken forward with the NHS to develop a framework that allows commissioning of new services whilst guarding against real or perceived conflicts of interest.

5.13 This will require transparency over how commissioning decisions are made and the value of services commissioned from GP practices. Where services are commissioned on an 'any willing provider' basis, there are established protocols that can be used or adapted to report and audit the pattern of referrals from GP practices that are also themselves a provider or part of a provider consortium. We would also anticipate that, where GP practices wish to bid in a major procurement, the procurement could be managed by another party such as the NHS Commissioning Board or a local authority.

Questions

- What safeguards are likely to be most effective in demonstrating transparency and fairness in investment decisions and in promoting choice and competition?

Accountability to patients and the public

5.14 The NHS Commissioning Board will be responsible for developing an assurance process that enables consortia to be accountable for the outcomes they achieve, their stewardship of public resources, and their fulfilment of the duties placed upon them, for instance in relation to promoting equality and working in partnership.

5.15 We propose that the NHS Commissioning Board, supported by NICE and working with patient and professional groups, will develop a commissioning outcomes framework that measures the health outcomes and quality of care (including patient-reported outcome measures and patient experience) achieved by consortia, with an appropriate adjustment for patient mix. This would, for instance, assess the health outcomes achieved for people with long-term conditions, the quality of urgent care and acute hospital care, and health outcomes for people with long-term mental health conditions or a learning disability. It would include measures to reflect the consortium's duties to promote equality and to assess progress in reducing health inequalities.

5.16 This framework would allow the NHS Commissioning Board to identify the contribution of consortia to achieving the priorities for health improvement in

the NHS Outcomes Framework, against which the Secretary of State will hold the Board to account, whilst also being accountable to patients and local communities on a wider set of measures. It would also enable consortia to benchmark their performance and identify priorities for improvement.

5.17 GP practices already make a key contribution to the overall quality of patient care and to the effective use of NHS resources. Coming together in consortia to commission healthcare on behalf of patients will empower them to collaborate more effectively in pursuit of high-quality outcomes for patients. We therefore propose, subject to discussion with the BMA and the profession, that a proportion of GP practice income should be linked to the outcomes that they achieve collaboratively through commissioning consortia and the effectiveness with which they manage financial resources. We propose that this 'quality premium' should be paid in the first instance to the consortium and that the consortium would be free to decide how best to apportion it between its member practices. This premium would need to be funded from within existing resources.

Questions

- What are the key elements that you would expect to see reflected in a commissioning outcomes framework?
- Should some part of GP practice income be linked to the outcomes that the practice achieves as part of its wider commissioning consortium?
- What arrangements will best ensure that GP consortia operate in ways that are consistent with promoting equality and reducing avoidable inequalities in health?

Accountability for the use of public resources

5.18 The primary legislation will need to allow for the NHS Commissioning Board to intervene in the event that a consortium is unable to fulfil its duties effectively, for instance in the event of financial failure or a systemic failure to meet the healthcare needs of patients, or where there is a significant risk of failure. This could include powers for the Board to make continued authorisation dependent upon remedial action and, in the last resort, to take over the consortium's commissioning responsibilities or assign them to a third party (e.g. a neighbouring consortium).

5.19 We propose working with the profession and the NHS to develop criteria or triggers for intervention, which could be reflected in the consortium's terms of authorisation, and to consult on these at a later date. We envisage that any intervention would typically be a staged process so that, wherever possible, a consortium has the opportunity to take remedial action itself rather than have commissioning responsibilities withdrawn. Any process would need to be in accordance with a transparent statutory framework of rules.

5.20 We consider that GP practices, like any other provider of NHS services, have a responsibility to use public resources responsibly and in the public interest. We anticipate that enabling GP practices to work alongside other health and care professionals through commissioning consortia will enhance their ability to fulfil this responsibility.

5.21 In any circumstances where there are concerns that an individual practice is causing ineffective or wasteful use of NHS resources, the consortium of which it is a part would be expected to work with that practice to address the relevant issues. If problems persisted and there were concerns that a practice was not meeting its contractual duties, the NHS Commissioning Board would need to address this as part of its responsibility for managing primary care contracts.

6. Partnership

Patients and the public

6.1 One of the principal aims of GP commissioning is to make decisions more sensitive and responsive to the needs and wishes of patients and the public. Good communication and engagement with the public will, therefore, be vital. Both GP consortia and the NHS Commissioning Board will need to find and evolve efficient and effective ways of harnessing public voice so that commissioning decisions are increasingly shaped by people's expressed needs and wants.

6.2 As part of the development of GP commissioning and the NHS Commissioning Board, we will promote:

- patient, carer and public involvement in decision-making
- responsiveness to the views and feedback of patients, carers and the public
- accountability to local people for the decisions about their health services made by consortia on their behalf.

6.3 We are not starting with a clean sheet. Commissioners will need to establish and nurture new relationships with:

- local HealthWatch (currently Local Involvement Networks) and the national body HealthWatch England, the new independent consumer champion that we propose to establish as part of the Care Quality Commission
- the Patient Participation Groups that GP practices are increasingly using to help make their own services more responsive to patient wishes
- local authorities, who will have a new enhanced role in promoting public involvement in decisions about service priorities and changes to local services and in responding to any public concerns about inadequate involvement
- local voluntary organisations and community groups, who often work with, and represent, the most disadvantaged and marginalised patients and carers.

6.4 The NHS Commissioning Board will be expected to ensure that practices provide accessible information to the public on the range of services they provide and that GP consortia provide information on performance against their commissioning plans.

6.5 We want to ensure that the prime focus is on developing the behaviours and cultures that will encourage and facilitate public participation and patient voice, rather than being over-reliant on the legal framework.

Questions

- How can GP consortia and the NHS Commissioning Board best involve patients in making commissioning decisions that are built on patient insight?
- How can GP consortia best work alongside community partners (including seldom heard groups) to ensure that commissioning decisions are equitable, and reflect public voice and local priorities?
- How can we build on and strengthen existing systems of engagement such as Local HealthWatch and GP practices' Patient Participation Groups?
- What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they can promote equality of opportunity and outcome for all patients and, where appropriate, staff?

Local government and public health

6.6 Under the proposals set out in the parallel document *Local democratic legitimacy in health*, local government will have an enhanced responsibility for promoting partnership working and integrated delivery of public services across the NHS, social care, public health and other services. One way in which this could occur is through health and wellbeing boards which would include representatives from GP consortia and, where relevant issues are being discussed, representation from the NHS Commissioning Board.

6.7 Local government will also have an enhanced role in public health, with direct responsibility and funding (allocated to local Directors of Public Health) for improving the health of local communities, through areas such as reducing the incidence of smoking and alcohol misuse and promoting physical activity.

6.8 This enhanced role for local government will provide a framework through which GP consortia alongside other partners:

- contribute to a joint assessment of the health and care needs of local people and neighbourhoods
- ensure that their commissioning plans, and relevant joint commissioning plans, reflect the health needs identified in these assessments
- draw on the advice and support of the proposed health and wellbeing board in relation to population health
- identify ways of achieving more integrated delivery of health and adult social care, for instance through pooled budgets or lead commissioning arrangements (e.g. a local authority becoming the lead commissioner for some older people services)
- support improvements in children's health and wellbeing
- play a systematic and effective part in arrangements for safeguarding of children and protection of vulnerable adults
- cooperate with the criminal justice system, for instance in relation to tackling misuse of drugs and alcohol, offender health services and assessment of violent offenders.

6.9 We envisage that bringing GP practices together into consortia for commissioning purposes will also help provide a more effective conduit for the involvement of individual practices in these areas of partnership working.

6.10 Where there are currently Care Trusts that bring together responsibility for commissioning health and social care services, their healthcare responsibilities will need to transfer to GP consortia in line with the proposals set out in this document. The framework described above is designed to enable GP consortia to work with local government to ensure that the benefits achieved through Care Trusts can be sustained and built upon.

Questions

- How can GP practices begin to make stronger links with local authorities and identify how best to prepare to work together on the issues identified above?
- Where can we learn from current best practice in relation to joint working and partnership, for instance in relation to Care Trusts,

Children's Trusts and pooled budgets? What aspects of current practice will need to be preserved in the transition to the new arrangements?

Other health and care professionals

6.11 Given their key role in co-ordinating care, GP practices are well placed to lead on commissioning care for patients. However, we expect consortia to involve relevant health and social care professionals from all sectors in helping design care pathways or care packages that achieve more integrated delivery of care, higher quality, better patient experience and more efficient use of NHS resources.

6.12 Some of the most successful current examples of clinical commissioning have come when practice-based commissioning groups have engaged other health and care professionals in this way. This has often been driven by innovative use of data and information to throw a spotlight on the pattern of care received by patients with long-term conditions, particularly those with complex health problems. These types of analysis can show clinicians how the current system too often leads both to sub-optimal patient care and to inefficiency at the interfaces between primary care, community health services and specialist care. In time, we would expect to see this approach apply across the whole pathway, including health and social care.

6.13 We firmly believe that the GP practice and the registered patient list should form the essential building block of commissioning consortia, but successful commissioning will clearly also be dependent on the wider involvement of other health and care professionals. We will not fall into the trap of prescribing top-down processes or governance requirements to say how this should be achieved. We will, however, work with the NHS and professional bodies in the transition to the new arrangements to promote multi-professional involvement.

Questions

- How can multi-professional involvement in commissioning most effectively be promoted and sustained?

7. Implementation and next steps

7.1 PCTs will have an important task over the next two years in supporting GP practices to prepare for these new arrangements. Our indicative timetable is for:

2010/11

- GP consortia to begin to form on a shadow basis (building on practice-based commissioning consortia, where they wish) and, where they are ready to do so, begin to take on some responsibilities from PCTs, supported by indicative budgets

2011/12

- a comprehensive system of shadow GP consortia in place, taking on increased responsibility from PCTs, including increased responsibility for the leadership of the existing Quality, Innovation, Productivity and Prevention (QIPP) initiative
- the NHS Commissioning Board to be established in shadow form as a Special Health Authority from April 2011 and to have a role in supporting the development of GP consortia

2012/13

- formal establishment of GP consortia, together with indicative allocations
- the NHS Commissioning Board to be established as an independent statutory body
- the NHS Commissioning Board to announce (in the third quarter of 2012/13) the allocations that will be made directly to consortia for 2013/14

2013/14

- GP consortia to be fully operational, with real budgets and holding contracts with providers

Preparing for GP commissioning

7.2 There will be a number of practical next steps that PCTs will need to take with GP practices and existing practice-based commissioning groups during 2010/11, which we will discuss with the NHS and with the profession. This will include identifying the likely future shape of consortia and enabling them to start taking increasing responsibility for making commissioning decisions on behalf of PCTs. This will mean PCTs increasingly putting management resources at the disposal of shadow consortia and working with them during the transition to ensure that appropriate skills and knowledge are retained.

7.3 PCTs will also need to work alongside shadow consortia to forge relationships with patient and public groups and with the range of external partners identified in Section 6 of this document.

7.4 In addition to these practical steps, we think there will be a number of areas where it is essential that early progress is made in preparing for the challenge of future commissioning arrangements. These include:

- **clinical leadership**: we will work with the National Leadership Council and professional representative groups to explore how best to provide support and development for GPs and other clinicians who would like to take on leadership roles within commissioning consortia

- **information**: we will work with the profession and the wider NHS to identify how best to support consortia in the significant challenge of accessing accurate, real-time data that can be translated into information to support efficient and effective care along the patient pathway and to understand the relationship between patient needs, service provision, health outcomes and financial expenditure

- **financial transactions**: we will work with the profession and the NHS to ensure effective systems that enable consortia to track expenditure, reconcile activity and expenditure, and minimise transaction costs.

Engagement

7.5 Through *Liberating the NHS* and this document, we are setting out further detail on our plans for GP commissioning and the NHS Commissioning Board. We are inviting individuals and groups to engage with the policy design and are specifically asking for views on its implementation.

7.6 This engagement will be aligned with, and conducted in, close collaboration with the engagement activities for the broader White Paper to achieve a joined up and consistent approach.

7.7 Through this engagement, we will seek to build understanding, increase support, invite views, and prepare for the forthcoming changes in commissioning. Successful and effective engagement is an ongoing, two-way process and we will be using existing channels to take this forward.

7.8 Responses to the questions in this document should be sent to NHSWhitePaper@dh.gsi.gov.uk by 11 October.

Conclusion

7.9 Commissioning NHS services carries with it the responsibility to deploy public resources in ways that best improve health and healthcare for the public and local communities.

7.10 In future, people will have the confidence of knowing that their GP is not only their advocate in the healthcare system but part of a wider group of health and care professionals – a commissioning consortium – whose job it is to ensure that empowered patients have access to the right care, in the right place, at the right time.

7.11 The public will have the confidence that these commissioning decisions are being made within an overall framework that enshrines the principles and values of the National Health Service and promotes consistently high standards of quality.

7.12 Local communities will have the confidence that their locally elected representatives have the overarching responsibility for promoting joined-up health and social care services that are responsive to local patient and community voice.

7.13 We look forward to your active engagement in helping shape these new commissioning arrangements and helping deliver the maximum benefits for NHS patients.

Annex

Criteria for consultation

This consultation follows the 'Government Code of Practice'. In particular we aim to:

- formally consult at a stage where there is scope to influence the policy outcome;
- consult for at least 12 weeks - the policies in this document were included in the NHS White Paper, *Liberating the NHS*, which was launched on 12 July for a 12 week consultation period closing on 5 October;
- be clear about the consultations process in the consultation documents, what is being proposed, the scope to influence and the expected costs and benefits of the proposals;
- ensure the consultation exercise is designed to be accessible to, and clearly targeted at, those people it is intended to reach;
- keep the burden of consultation to a minimum to ensure consultations are effective and to obtain consultees' 'buy-in' to the process;
- analyse responses carefully and give clear feedback to participants following the consultation;
- ensure officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

The full text of the Code of Practice and related guidance is on the Better Regulation website at www.bis.gov.uk/policies/better-regulation/consultation-guidance

Comments on the consultation process itself

If you have concerns or comments which you would like to make relating specifically to the consultation process itself please contact:

Consultations Coordinator

Department of Health

3E48, Quarry House

Leeds

LS2 7UE

e-mail: consultations.co-ordinator@dh.gsi.gov.uk

Please do not send consultation responses to this address.

Confidentiality of information

We manage the information you provide in response to this consultation in accordance with the Department of Health's Information Charter (available at www.dh.gov.uk).

Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

Summary of the consultation

A response to this consultation will be made available on the Department of Health website by the end of this year.

NHS

Liberating the NHS:

Local democratic legitimacy in health

A consultation on proposals

Communities and Local Government

DH Department of Health

DH INFORMATION READER BOX

Policy	Estates
HR / Workforce	Commissioning
Management	IM & T
Planning /	Finance
Clinical	Social Care / Partnership Working

Document Purpose	Consultation/Discussion
Gateway Reference	14531
Title	Local Democratic Legitimacy in Health
Author	Department of Health & Communities and Local Government
Publication Date	22 Jul 2010
Target Audience	PCT CEs, Care Trust CEs, Directors of PH, Local Authority CEs, Directors of Adult SSs, PCT Chairs, GPs, Directors of Children's SSs
Circulation List	PCT CEs, Care Trust CEs, Directors of PH, Local Authority CEs, Directors of Adult SSs, PCT Chairs, GPs, Directors of Children's SSs, Voluntary Organisations/NDPBs
Description	The document sets out proposals to strengthen the role of local government in health by: i) local authorities taking on local public health improvement functions; ii) local authorities having a new role in promoting integration; and iii) Local HealthWatch organisations acting as independent consumer champions, accountable to local authorities.
Cross Ref	Equity and Excellence: Liberating the NHS (July 2010)
Superseded Docs	
Action Required	Interested parties should respond to the consultation
Timing	**Respond by 11 October 2010**
Contact Details	The White Paper Team - Consultation responses 6th Floor Richmond House 79 Whitehall London SW1A 2NS nhswhitepaper@dh.gsi.gov.uk www.dh.gov.uk/liberatingtheNHS
For Recipient's Use	

Foreword

A decade of centralising, controlling government has left our public services strangled with red tape, focused on processes not outcomes, and weakened by the need to account to bureaucrats instead of the public. Too many decisions have been made nationally, rather than locally, without enough public involvement. The NHS, like other public services, has suffered as a result. The creativity and innovation of health professionals has been stifled while the public are frustrated at the lack of opportunities to speak up and make a difference to their local health services.

Localism is one of the defining principles of this Government: pushing power away from Whitehall out to those who know best what will work in their communities. Our plans to make this happen in health are set out in the recent white paper: *Equity and Excellence: Liberating the NHS*. It will restore real decision-making powers to patients and GPs.

The NHS is one of Britain's greatest achievements, and a service of which we can all be proud. It will continue to be a national service, held to account by Parliament. But for the first time in forty years, there will be real local democratic accountability and legitimacy in the NHS. Elected councillors and councils will have a new role in ensuring the NHS is responsible and answerable to local communities. By commissioning HealthWatch - the new way for patients and the public to shape health services - councils will be responsible for ensuring local voices are heard and patients are able to exercise genuine choice. Councils will also take the lead in improving local public health.

In this new role, councils will be assessing local needs, promoting more joined up services, and supporting joint commissioning. This builds on the excellent work that is already being done by some councils in joining up services to improve local health and social care and will help ensure a closer working relationship between health and other council responsibilities, such as housing and environmental health. This means that patients who need the help of both health and social care services can expect to get much more coherent, effective support in future.

This short paper seeks your views on these important changes to establish local democratic accountability in the NHS. We look forward to hearing from you.

Rt. Hon. Andrew Lansley CBE MP
Secretary of State for Health

Rt. Hon. Eric Pickles MP
Secretary of State for Communities and Local Government

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Introduction

1. The White Paper *Equity and Excellence: Liberating the NHS* set out the Government's strategy for the NHS. Our intention is to create an NHS which is much more responsive to patients, and achieves better outcomes, with increased autonomy and clear accountability at every level.

2. *Liberating the NHS* makes clear the Government's policy intentions, and provides a coherent framework. Further work lies ahead to develop and implement detailed proposals. In progressing this work the Department will be engaging with external organisations, seeking their help and wishing to benefit from their expertise.

3. This short document, *Local democratic legitimacy in health,* provides further information on proposals for increasing local democratic legitimacy in health, through a clear and enhanced role for local government. Through elected members, local authorities will bring greater local democratic legitimacy to health. They will bring the perspective of local place - of neighbourhoods and communities - into commissioning plans. Local authorities can take a broader, more effective view of health improvement. They are uniquely placed to promote integration of local services across the boundaries between the NHS, social care and public health.

4. This consultation has been produced jointly by the Department of Health and the Department for Communities and Local Government.

5. It is part of a public consultation on specific aspects of the White Paper. The initial suite of supporting papers also includes:

    - *Commissioning for patients*
    - *Regulating healthcare providers*
    - *The review of arm's-length bodies*
    - *Transparency in outcomes: a framework for the NHS*

    The Government will publish a response prior to the introduction of a Health Bill later this year.

6. National accountability for the health service is critical. It currently receives about £100 billion of taxpayers' funding, and it is right that it is held to account for the stewardship of these finances and outcomes through Parliament. The reforms the Government set out in *Liberating the NHS* will remove ongoing political interference from the health service, through the creation of an independent NHS

Commissioning Board, but national accountability will remain. In the future, there will be a more transparent relationship between national government and the NHS, with less scope for day-to-day political interference.

7. One of the central features of the proposals in the White Paper is to devolve commissioning responsibilities and budgets as far as possible to those who are best placed to act as patients' advocates and support them in their healthcare choices. Through our world-renowned system of general practice, GPs and other primary care professionals are already supporting patients in managing their health, promoting continuity and coordination of care, and making referrals to more specialist services. In empowering GP practices to come together in wider groupings, or 'consortia', to commission care on their patients' behalf and manage NHS resources, we are building on these foundations. We are also empowering them to work more effectively alongside the full range of other health and care professionals.

8. Most commissioning decisions will now be made by consortia of GP practices, free from top-down managerial control and supported and held to account for the outcomes they achieve by the NHS Commissioning Board. This will push decision-making much closer to patients and local communities and ensure that commissioners are accountable to them. It will ensure that commissioning decisions are underpinned by clinical insight and knowledge of local healthcare needs. It will enable consortia to work closely with secondary care, other health and care professionals and with community partners to design joined-up services that make sense to patients and the public. It will not be appropriate for all commissioning decisions to be made at a local level and some specialist services, such as paediatrics, will need to be commissioned at a higher geographical unit, by the NHS Commissioning Board. *Commissioning for patients* - published alongside this document - gives further detail of how GP commissioning consortia and the NHS Commissioning Board will work.

9. Within this strong national system, the Government wants to strengthen local democracy. Giving people the opportunity to exercise their voices as individuals is an important part of this. The proposals build on the existing mechanisms, such as patients using information about a provider to exercise choice, or participating as an active member of a local foundation trust. We will strengthen the collective voice of patients and the public through arrangements led by local authorities, and at national level, through a powerful new consumer champion, HealthWatch England, located in the Care Quality Commission.

10. Within this new system, local authorities will have an enhanced role in health. The Government intends that they will have greater responsibility in four areas:

- leading joint strategic needs assessments (JSNA)[1] to ensure coherent and co-ordinated commissioning strategies;

- supporting local voice, and the exercise of patient choice;

- promoting joined up commissioning of local NHS services, social care and health improvement; and

- leading on local health improvement and prevention activity.

11. With the local authority taking a convening role, it will provide the opportunity for local areas to further integrate health with adult social care, children's services (including education) and wider services, including disability services, housing, and tackling crime and disorder. This has the potential to meet people's needs more effectively and promote the best use of public resources. The local authority will lead the process of undertaking joint strategic needs assessments across health and local government services and promote joint commissioning between GP consortia and local authorities. GP consortia and the NHS Commissioning Board will be responsible for making health care commissioning decisions, informed by the JSNA. We would encourage local authorities to take the NHS Constitution into account when influencing local commissioning decisions about NHS services.

12. The Government will work with the Local Government Association to understand the potential benefits of place-based budgets through the Spending Review period. We will look at the potential application of these approaches to cross-cutting areas of health spending that require effective partnerships with local authorities and other frontline organisations, for example older people's services, and substance misuse.

13. The Government is committed to ensuring that there is a strong local voice for patients through democratic representation in healthcare. The Coalition Programme proposed directly elected individuals on the primary care trusts (PCT) board as a mechanism for doing this. However, because of the proposed transfer of commissioning functions to the NHS Commissioning Board and GP consortia, the Government has concluded that PCTs should be abolished. Instead, we propose an enhanced role for elected local councillors and local authorities, as a more effective way to boost local democratic engagement. In this document, the Government is bringing forward practical plans that give stronger effect to its intentions for local democratisation in health.

[1] A joint strategic needs assessment is an assessment of the health and wellbeing needs of the population in a local area and since 2007 it has been a statutory duty for primary care trusts and local authorities to undertake one. They aim to establish a shared, evidence based consensus on key local priorities to support commissioning to improve health and wellbeing outcomes and reduce inequalities. In practice the JSNA falls to the Directors of Public Health, Directors of Adult Social Services and Directors of Children's Services to carry out, as set out in the JSNA guidance.

Strengthening public and patient involvement

14. *Liberating the NHS* set out plans to create a much more responsive NHS that is genuinely centred on the needs and wishes of patients, through increased choice, an information revolution, stronger voice, and commissioning by GP consortia. These changes will radically shift the power of the health service away from Whitehall and closer to the individual and the professionals that serve them.

15. Choice, control and better information are at the heart of these plans, but these need to be backed up by support for individuals and local voice. We want local people to have a greater say in decisions that affect their health and care and have a clear route to influence the services they receive. Since the *NHS Plan*, structures for leading local involvement have been subject to numerous changes. The Government intends to build on the current statutory arrangements, to develop a more powerful and stable local infrastructure in the form of local HealthWatch, which will act as local consumer champions across health and care. Local Involvement Networks (LINks) will become the local HealthWatch.

16. We propose that local HealthWatch be given additional functions and funding. Like LINks, they will continue to promote patient and public involvement, and seek views on local health and social care services which can be fed back into local commissioning. Also like LINks, they are likely to continue to take an interest in the NHS Constitution.

Q1 Should local HealthWatch have a formal role in seeking patients' views on whether local providers and commissioners of NHS services are taking account of the NHS Constitution?

17. We also propose that HealthWatch perform a wider role, so that they become more like a "citizen's advice bureau" for health and social care - the local consumer champion - providing a signposting function to the range of organisations that exist. We therefore propose that they are granted additional specific responsibilities, matched by additional funding, for:

- NHS complaints advocacy services. Currently, this is a national function for the NHS, exercised through a Department of Health contract for the Independent Complaints Advocacy Service. We propose that this responsibility is devolved to local authorities to commission through local or national HealthWatch, so that they can support people who want to make a complaint.

- Supporting individuals to exercise choice, for example helping them choose a GP practice. Giving patients and users the right to choice, and greater information, is essential, but it is not always sufficient to enable everyone to exercise it. Local HealthWatch will have a key role in offering support to those that need it.

Q2 Should local HealthWatch take on the wider role outlined in paragraph 17 with responsibility for complaints advocacy and supporting individuals to exercise choice and control?

18. Local authorities have a vital role in commissioning HealthWatch arrangements that serve their local populations well. They will continue to fund HealthWatch, and contract for their services. Local authorities have an important responsibility, set out in statute, for discharging these duties, and holding local HealthWatch to account for delivering services that are effective and value for money. They will also ensure that the focus of local HealthWatch activities is representative of the local community. In the event of under-performance, a local authority should intervene; and ultimately re-tender the contract where that is in the best interests of its local population.

Q3 What needs to be done to enable local authorities to be the most effective commissioners of local HealthWatch?

19. Local HealthWatch would still be able to report concerns about the quality of the provision of local NHS or social care services to HealthWatch England, in order to inform the need for potential regulatory action, independently of its host local authority. HealthWatch England will form a statutory part of the Care Quality Commission (CQC), the quality regulator for health and social care. This key role for local HealthWatch will be underpinned by continued rights to visit provider services.

Improving integrated working

20. People want services that feel joined up, and it can be a source of great frustration when that does not happen. Integration means different things to different people but at its heart is building services around individuals, not institutions. The Government is clear that joint, integrated working is vital to developing a personalised health and care system that reflects people's health and care needs. Services also need to be developed in ways that fit around the people who use them, and their families, and that they can understand and shape. We have an opportunity to strengthen integrated working across the health and social care agenda, from the point of providing services, to people understanding how services need to be commissioned to best meet the health and wellbeing needs of local populations. We can also improve integrated working right along the care pathway - from prevention, treatment and care, to recovery, rehabilitation and re-ablement.

21. *Liberating the NHS* has been designed to strengthen integration in many ways, for example:

- by giving people using services more choice and control about what matters most to them. Critically this includes choice of treatment and care not just choice of provider. People will have more power in the system to decide what matters most to them;

- by extending the availability of personal budgets in the NHS and social care, with joint assessment and care planning;

- quality standards will be developed systematically across patient pathways, for example the recently published NICE dementia standard;

- through the CQC as an effective inspectorate of essential quality standards, that span health and social care;

- through payment systems being used to support joint working, for example the proposals around payment by results and hospital readmissions, which should create opportunities for the full engagement of the wider health and care economy before discharging people from hospital; and

- through freeing up providers to innovate and focus on the needs of people using services rather than the needs of a top-down central bureaucracy. For example, the Government is proposing to remove the

constraints that currently exist for foundation trusts to enable them to augment their NHS role, by, for example, expanding into social care.

22. The existing framework provided in legislation[2] sets out optional partnership arrangements for service-level collaboration between local authorities and health-related bodies. The arrangements include:

- lead commissioning (with PCTs or local authorities leading commissioning services for a client group on behalf of both organisations);
- integrated provision (for example care trusts); and
- pooled budgets.

23. Take up of the current flexibilities to enable joint commissioning and pooled budgets has been relatively limited. It has tended to focus on specific service areas, such as mental health and learning disabilities. The full potential of joint commissioning, for example to secure services that are joined up around the needs of older people or children and families, remains untapped. The new commissioning arrangements will support this. GP commissioning consortia will have a duty to work with colleagues in the wider NHS and in social care to deliver higher quality care, a better patient experience and more efficient use of NHS resources.

Q4 What more, if anything, could and should the Department do to free up the use of flexibilities to support integrated working?

Q5 What further freedoms and flexibilities would support and incentivise integrated working?

24. The Government believes that there is scope for stronger institutional arrangements, within local authorities, led by elected members, to support partnership working across health and social care, and public health. Local authorities' skills, experience and existing relationships present them with an opportunity to bring together the new players in the health system, as well as to provide greater local democratic legitimacy in health.

25. One option is to leave it up to NHS commissioners and local authorities as to whether they want to work together, and should they so wish, to devise their own local arrangements. An alternative approach, which the Government prefers, is to specify the establishment of a statutory role, within each upper tier local authority, to support joint working on health and wellbeing.

[2] Section 75 of the NHS Act 2006

26. The advantages of having a statutory arrangement are that it would provide duties on relevant NHS commissioners to take part, and provide a high-level framework of functions. In this way it would offer clarity of expectation about partnership working.

Q6 Should the responsibility for local authorities to support joint working on health and wellbeing be underpinned by statutory powers?

27. One way in which respective roles and responsibilities could be enhanced further, is through a statutory partnership board - a health and wellbeing board - within the local authority. This would provide a vehicle and focal point through which joint working could happen. Alternatively, local partners may prefer to design their own arrangements. We would like your views on how best to achieve partnership working and integrated commissioning.

28. If health and wellbeing boards were created, requirements for such a board would be minimal, with Local Authorities enjoying freedom and flexibility as to how it would work in practice.

Q7 Do you agree with the proposal to create a statutory health and wellbeing board or should it be left to local authorities to decide how to take forward joint working arrangements?

Functions of health and wellbeing boards

29. The primary aim of the health and wellbeing boards would be to promote integration and partnership working between the NHS, social care, public health and other local services and improve democratic accountability. The local authority would bring partners together to agree priorities for the benefit of patients and taxpayers, informed by local people and neighbourhood needs.

30. The Government proposes that statutory health and wellbeing boards would have four main functions:

- to assess the needs of the local population and lead the statutory joint strategic needs assessment;
- to promote integration and partnership across areas, including through promoting joined up commissioning plans across the NHS, social care and public health;
- to support joint commissioning and pooled budget arrangements, where all parties agree this makes sense; and

- to undertake a scrutiny role in relation to major service redesign (as set out in paragraph 42 - 50).

Q8 ***Do you agree that the proposed health and wellbeing boards should have the main functions described in paragraph 30?***

Q9 ***Is there a need for further support to the proposed health and wellbeing boards in carrying out aspects of these functions, for example information on best practice in undertaking JSNAs?***

31. The health and wellbeing board would allow more effective engagement between local government and NHS commissioners. There would be a statutory obligation for the local authority and commissioners to participate as members of the board and act in partnership on these functions. Whilst responsibility and accountability for NHS commissioning would rest with the NHS Commissioning Board and GP consortia, the health and wellbeing board would give local authorities influence over NHS commissioning, and corresponding influence for NHS commissioners in relation to health improvement, reducing health inequalities, and social care.

32. The aim is to ensure coherent and coordinated local commissioning plans across the NHS, social care and public health, for example in relation to mental health, older people's or children's care, with intelligence and insight about people's wants and needs systematically shaping and commissioning decisions. These arrangements would also enable local authorities to engage more effectively via GP consortia, who would be making health care commissioning decisions. A significant benefit of the health reforms will be the removal of political interference in the day-to-day running of the health service. The local authority and its partners will only be able to ensure that the needs of their population are adequately assessed if they work together to ensure that national politics are not replaced by unconstructive local politics.

33. The health and wellbeing board could also be a vehicle for taking forward joint commissioning and pooled budgets, where parties agree this makes most sense and it is in line with the financial controls set by the NHS Commissioning Board.

Q10 ***If a health and wellbeing board was created, how do you see the proposals fitting with the current duty to cooperate through children's trusts?***

Operation of health and wellbeing boards

34. We anticipate that the statutory health and wellbeing boards would sit at the upper tier local authority level. However, the boards would want to put in place

arrangements to discharge their functions at the right level to ensure that the needs of diverse areas and neighbourhoods are at the core of their work, and that democratic representatives of areas below the upper tier can contribute. This would be particularly important in two-tier areas, where boards may want to delegate the lead for some functions to districts or neighbourhoods. Neighbouring boroughs may also choose to establish a single board covering their combined area, should that make most sense locally.

35. We anticipate that the health and wellbeing boards would have a lead role in determining the strategy and allocation of any local application of place-based budgets for health. The health and wellbeing boards would have an important role in relation to other local partnerships, including those relating to vulnerable adults and children's safeguarding. If the Local Children's Safeguarding Board became concerned that the local safeguarding arrangements were not working as they should, and in particular if there were concerns about the NHS partners, they could raise this with the health and wellbeing board, who would escalate it to the NHS Commissioning Board if they were unable to achieve local resolution.

36. To reduce bureaucracy, we anticipate that local authorities may want to use the proposed health and wellbeing boards to replace current health partnerships where they exist, and work with the local strategic partnership (at the upper tier) to promote links and connections between the wider needs and aspirations of local neighbourhoods and health and wellbeing.

37. If these proposals are taken forward, we will need to ensure that appropriate arrangements are made to support the full package of reforms in London with links between the borough boards and the Mayor. The Government would particularly welcome views on this point.

Q11 How should local health and wellbeing boards operate where there are arrangements in place to work across local authority areas, for example building on the work done in Greater Manchester or in London with the link to the Mayor?

Membership of health and wellbeing boards

38. If taken forward, the boards would bring together local elected representatives including the Leader or the Directly Elected Mayor, social care, NHS commissioners, local government and patient champions around one table. The Directors of Public Health, within the local authority, would also play a critical role. The elected members of the local authority would decide who chaired the board.

39. The board would include both the relevant GP consortia and representation from the NHS Commissioning Board (where relevant issues are being discussed). It may be relevant for the NHS Commissioning Board to attend when issues relating to the services that they commission are being discussed, for example family health services, specialised services and maternity services. We would specify both parties' duty to take part in the partnership in legislation.

40. In addition to the strategic role, at a practical level, health and wellbeing boards could agree joint NHS and social care commissioning of specific services, for example mental health services, including prevention, or agree the allocation and strategy for place-based budgets on cross-cutting health issues. The precise role of place-based budgets should be a decision for the health and wellbeing board in light of local priorities. For the board to function well, it will undoubtedly require input from the relevant local authority directors, on social care, public health and children's services. We also propose a local representative from HealthWatch will have a seat on the board, so that it has influence and responsibility in the local decision-making process. We recognise the novelty of arrangements bringing together elected members and officials in this way and would welcome views as to how local authorities can make this work most effectively.

41. To ensure that the board is able to engage effectively with local people and neighbourhoods, local authorities may also choose to invite local representatives of the voluntary sector and other relevant public service officials to participate in the board. They may also want to invite providers into discussions, taking care to adhere to the principles of fairness, engaging providers in an equal and transparent manner.

Q12 Do you agree with our proposals for membership requirements set out in paragraph 38 - 41?

Overview and scrutiny function

42. In the current system, overview and scrutiny committees (OSCs) have the power to scrutinise major health service changes and the ongoing planning, development and operation of services. They are set up in local authorities and set their own priorities for scrutiny, reflecting the interests and concerns of the communities they serve. They are able to hold the NHS to account by:

- calling NHS managers to give information, answer questions and provide explanation about services and decisions and making recommendations locally;

- requiring consultation by the NHS where major changes to health services are proposed; and

- referring contested service changes to the Secretary of State for Health.

43. If a health and wellbeing board was created within a local authority, it would have a key new role in promoting joint working, with the aim of making commissioning plans across the NHS, public health and social care coherent, responsive and integrated. It would be able to exercise strategic oversight of health and care services. It would be better equipped to scrutinise these services locally. To avoid duplication, we propose that the statutory functions of the OSC would transfer to the health and wellbeing board.

44. This transfer would strengthen the overview that local authorities have on health decisions and bring in the voice of the local HealthWatch. Having a seat on the health and wellbeing board gives HealthWatch a stronger formal role in commissioning discussions than currently exists for LINks. This would provide additional opportunity for patients and the public to hold decision makers to account and offer scrutiny and patient voice.

45. Members of the health and wellbeing board, including elected councillors, would have the opportunity to identify shared goals and priorities and to identify early on in their respective commissioning processes how best to address these. This emphasis on proactive local partnership would minimise the potential for disputes. We will work with local authorities and the NHS to develop guidance on how best to resolve these issues locally, so that they are only referred on in the most exceptional circumstances.

Q13 What support might commissioners and local authorities need to empower them to resolve disputes locally, when they arise?

46. Within the scope of NHS services, as defined by the Secretary of State, GP consortia will be free to decide commissioning priorities to reflect local needs, consistent with the public sector equality duties and supported by the national framework of quality standards, tariffs and national model contracts established by the NHS Commissioning Board. GP consortia will also have a duty to engage and involve the public in planning services and considering any proposed changes in how those services are provided. In addition, the health and wellbeing board would have an important role in enabling the NHS Commissioning Board to assure itself that GP consortia are fulfilling their duties in ways that are responsive to patients and the public.

47. If health and wellbeing boards had significant concerns about substantial service changes, an attempt should first be made to resolve this locally, for example with local commissioners, through the health and wellbeing board itself. The boards

would be expected to take account of the need to deliver services more efficiently, and of the wider quality, innovation, productivity and prevention (QIPP) agenda. The board may choose to engage external expertise to help resolve the issue, for example a clinical expert, the Centre for Public Scrutiny or the Independent Reconfiguration Panel.

48. For a minority of cases, there will still need to be a system of dispute resolution beyond the local level. This should happen only in exceptional cases as local resolution should be the preferred course of action. Where the dispute is unable to be resolved, the health and wellbeing board would have a power to refer the commissioning decision to the NHS Commissioning Board. If the issue relates to a decision made by the NHS Commissioning Board (e.g. in relation to maternity services) the health and wellbeing board may choose to refer it directly to the Secretary of State.

49. If the NHS Commissioning Board is satisfied that the correct procedure has been followed and that the decisions are based on clinical evidence, but the health and wellbeing board still has significant concerns about the issue, the health and wellbeing board would have a statutory power to refer cases to the Secretary of State. The Secretary of State would then consider the NHS Commissioning Board's report alongside the reasons for referral, seeking advice from the Independent Reconfiguration Panel. In the context of the new regulatory framework, the Secretary of State for Health's involvement will be subject to independent decisions made by regulators - the economic regulator, and the Care Quality Commission - for example on the basis of patient safety.

Q14 Do you agree that the scrutiny and referral function of the current health OSC should be subsumed within the health and wellbeing board (if boards are created)?

Q15 How best can we ensure that arrangements for scrutiny and referral maximise local resolution of disputes and minimise escalation to the national level?

50. Public scrutiny is an essential part of ensuring that Government and public services remain effective and accountable. It helps to achieve a genuine accountability for the use of public resources. A formal health scrutiny function will continue to be important within the local authority, and the local authority will need to assure itself that it has a process in place to adequately scrutinise the functioning of the health and wellbeing board and health improvement policy decisions.

Q16 What arrangements should the local authority put in place to ensure that there is effective scrutiny of the health and wellbeing board's functions? To what extent should this be prescribed?

Local authority leadership for health improvement

51. In future, local authorities will have a stronger influence on the health outcomes of their local area. When PCTs cease to exist we intend to transfer responsibility and funding for local health improvement activity to local authorities. Embedding leadership for local health improvement activity within local authorities builds upon the existing success of the many joint Director of Public Health appointments between local authorities and PCTs. It is intended to unlock synergies with the wider role of local authorities in tackling the determinants of ill health and health inequalities.

52. Funding for health improvement includes that spent on the prevention of ill-health by addressing lifestyle factors such as smoking, alcohol, diet and physical exercise. So, for example, we envisage that smoking cessation services would be funded from the resources transferred to the local authority, but treatment for individuals with impaired lung function through smoking would be funded from resources allocated to GP consortia by the NHS Commissioning Board.

53. Local authority leadership for local health improvement will be complemented by the creation of a National Public Health Service (PHS). The PHS will integrate and streamline health improvement and protection bodies and functions, and will include an increased emphasis on research, analysis and evaluation. It will secure the delivery of public health services that need to be undertaken at a national level.

54. In order to manage public health emergencies, the PHS will have powers in relation to the NHS, matched by corresponding duties for NHS resilience. The NHS Commissioning Board will have a role in supporting the Secretary of State for Health and the PHS to ensure that the NHS in England is resilient and able to be mobilised during any emergency it faces, or as part of a national response to threats external to the NHS.

55. The local authority will also play an important role in PHS campaigns of national importance, which aim to protect public health or provide population screening; and it will have a role in national health improvement campaigns, tailoring programmes to meet the needs of its local population.

56. Local Directors of Public Health will be jointly appointed by local authorities and the PHS. They will have a ring-fenced health improvement budget, allocated by the PHS; and they will be able to deploy these resources to deliver national and local priorities. There will be direct accountability to both the local authority, and, through the PHS, to the Secretary of State. Through being employees of the local authority, local Directors of Public Health will have direct influence over the

wider determinants of health, advising elected members and as part of the senior management team of the local authority.

57. The Secretary of State, through the PHS, will agree with local authorities the local application of national health improvement outcomes. It will be for local authorities to determine how best to secure the outcomes and this may include commissioning services, for example, from providers of NHS care. Local neighbourhoods will have freedom and flexibility to set local priorities, working within a national framework.

58. In the Government's work to develop a public health White Paper, we will engage stakeholders on arrangements for the abolition of PCTs and the establishment of the public health ring-fenced health improvement budget. Arrangements for health improvement will also be aligned with future arrangements for outcomes in local government, and in particular with the approach to social care outcomes.

Conclusion and summary of consultation questions

59. This document has set out the Government's plans for increasing local democratic legitimacy in health, by giving local authorities a stronger role in supporting patient choice and ensuring effective local voice; promoting more effective NHS, social care and public health commissioning arrangements, through the proposed new health and wellbeing boards; and local leadership for health improvement. We will need to ensure, through this consultation exercise and broader policy work, that the health system is financially sustainable through the transition to the new structures that we lay out here, as well as in the longer term.

60. Implementation will be consistent with the new burdens doctrine. Subject to legislation, health improvement functions will transfer to local authorities from 2012. We propose that statutory partnership functions would also be established formally from 2012. However, if the idea receives positive support, the Departments of Health and Communities and Local Government will support local authorities to establish shadow arrangements with the PCT, emerging GP consortia and LINks in 2011. The Government proposes to make the changes through its forthcoming Health Bill, planned for introduction this autumn, subject to the responses received to this consultation.

61. The Government would welcome views on the following questions:

Q1 ***Should local HealthWatch have a formal role in seeking patients' views on whether local providers and commissioners of NHS services are taking account of the NHS Constitution?***

Q2 ***Should local HealthWatch take on the wider role outlined in paragraph 17, with responsibility for complaints advocacy and supporting individuals to exercise choice and control?***

Q3 ***What needs to be done to enable local authorities to be the most effective commissioners of local HealthWatch?***

Q4 ***What more, if anything, could and should the Department do to free up the use of flexibilities to support integrated working?***

Q5 ***What further freedoms and flexibilities would support and incentivise integrated working?***

Q6 ***Should the responsibility for local authorities to support joint working on health and wellbeing be underpinned by statutory powers?***

Q7 ***Do you agree with the proposal to create a statutory health and wellbeing board or should it be left to local authorities to decide how to take forward joint working arrangements?***

Q8 ***Do you agree that the proposed health and wellbeing board should have the main functions described in paragraph 30?***

Q9 ***Is there a need for further support to the proposed health and wellbeing boards in carrying out aspects of these functions, for example information on best practice in undertaking joint strategic needs assessments?***

Q10 ***If a health and wellbeing board was created, how do you see the proposals fitting with the current duty to cooperate through children's trusts?***

Q11 ***How should local health and wellbeing boards operate where there are arrangements in place to work across local authority areas, for example building on the work done in Greater Manchester or in London with the link to the Mayor?***

Q12 ***Do you agree with our proposals for membership requirements set out in paragraph 38 - 41?***

Q13 ***What support might commissioners and local authorities need to empower them to resolve disputes locally, when they arise?***

Q14 ***Do you agree that the scrutiny and referral function of the current health OSC should be subsumed within the health and wellbeing board (if boards are created)?***

Q15 ***How best can we ensure that arrangements for scrutiny and referral maximise local resolution of disputes and minimise escalation to the national level?***

Q16 ***What arrangements should the local authority put in place to ensure that there is effective scrutiny of the health and wellbeing board's functions? To what extent should this be prescribed?***

Q17 ***What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they can promote equality of opportunity and outcome for all patients, the public and, where appropriate, staff?***

Q18 ***Do you have any other comments on this document?***

62. Responses to the questions in this consultation document should be sent to nhswhitepaper@dh.gsi.gov.uk or to the White Paper Team, Room 601, Department of Health, 79 Whitehall, London SW1A 2NS by 11 October 2010.

Annex 1: The consultation process

Criteria for consultation

This consultation follows the 'Government Code of Practice', in particular we aim to:

- formally consult at a stage where there is scope to influence the policy outcome;
- consult for at least 12 weeks - the policies in this document were included in the NHS White Paper, *Liberating the NHS*, which was launched on 12 July for a 12 week consultation period closing on 5 October;
- be clear about the consultations process in the consultation documents: what is being proposed, the scope to influence and the expected costs and benefits of the proposals;
- ensure the consultation exercise is designed to be accessible to, and clearly targeted at, those people it is intended to reach;
- keep the burden of consultation to a minimum to ensure consultations are effective and to obtain consultees' 'buy-in' to the process;
- analyse responses carefully and give clear feedback to participants following the consultation;
- ensure officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

The full text of the Code of Practice and related guidance is on the Better Regulation

website at www.bis.gov.uk/policies/better-regulation/consultation-guidance

Comments on the consultation process itself

If you have concerns or comments which you would like to make relating specifically to the consultation process itself please contact:

Consultations Coordinator
Department of Health
3E48, Quarry House

Leeds
LS2 7UE
e-mail: consultations.co-ordinator@dh.gsi.gov.uk
Please do not send consultation responses to this address.

Confidentiality of information

We manage the information you provide in response to this consultation in accordance with the Department of Health's Information Charter (available at www.dh.gov.uk).

Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

Summary of the consultation

A response to this consultation will be made available at www.dh.gov.uk by the end of this year.

NHS

Liberating the NHS:

Regulating healthcare providers

A consultation on proposals

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DH Department of Health

DH INFORMATION READER BOX

Policy	Estates
HR / Workforce	Commissioning
Management	IM & T
Planning /	Finance
Clinical	Social Care / Partnership Working

Document Purpose	Consultation/Discussion
Gateway Reference	14550
Title	Liberating the NHS: Regulating healthcare providers
Author	Department of Health
Publication Date	26 Jul 2010
Target Audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs, Medical Directors, Directors of PH, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, PCT Chairs, NHS Trust Board Chairs, Special HA CEs, Directors of HR, Directors of Finance, GPs, Communications Leads, Emergency Care Leads
Circulation List	
Description	The White Paper, Liberating the NHS, sets out a vision for an NHS centred around the needs of patients. One of the key features of the plans is to free providers from political interference and to establish a stable, transparent regulatory environment. This document sets out proposals to liberate providers from central Government controls and to develop Monitor as an independent economic regulator for health and adult social care.
Cross Ref	Equity and Excellence: Liberating the NHS, and supporting documents
Superseded Docs	N/A
Action Required	Comments invited on the specific questions posed in the document
Timing	**Consultation closes 11 October 2010**
Contact Details	The White Paper Team Room 601 Department of Health 79 Whitehall SW1A 2NS www.dh.gov.uk/liberatingthenhs
For Recipient's Use	

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1. Introduction

1.1 The White Paper, *Equity and excellence: Liberating the NHS*, set out the Government's strategy for the NHS. Our intention is to create an NHS which is much more responsive to patients, and achieves better outcomes, with increased autonomy and clear accountability at every level.

1.2 *Liberating the NHS* makes clear the Government's policy intentions, and provides a coherent framework. Further work lies ahead to develop and implement detailed proposals. In progressing this, the Department will be engaging with external organisations, seeking their help and wishing to benefit from their expertise.

1.3 This document, *Regulating Healthcare Providers,* provides further information on proposals for foundation trusts and to establish an independent economic regulator for health and adult social care. It seeks views on a number of specific consultation questions.

1.4 This is part of a public consultation on implementation of proposals in the White Paper and supporting papers. The initial suite of supporting papers also includes:

- Commissioning for Patients
- Local Democratic Legitimacy in Health
- The Review of Arm's-Length Bodies
- Transparency in outcomes: a framework for the NHS

1.5 The Government will publish a response prior to the introduction of a Health Bill later this year.

1.6 With greater autonomy comes clearer accountability. Providers will be freed from control by hierarchical management. Instead they will be subject to effective quality and economic regulation, so that patients know the services are safe, and the taxpayer gets better value. Clinically-led commissioning, payment by results and choice will drive improvements in quality beyond essential regulatory standards.

1.7 Regulating Healthcare Providers considers potential additional freedoms for foundation trusts. It then considers the core purpose of Monitor in its changed

role as an economic regulator responsible for regulating prices, promoting competition, and supporting service continuity.

1.8 As an independent economic regulator, Monitor will carry out a range of regulatory functions currently delivered out, wholly or in part, by the Department of Health. The proposals aim to build on best practice in economic regulation. The Government is eager to receive comments on the proposed model of regulation as well as on the more detailed questions in this document. We intend to refine our proposals in light of responses to this consultation and further analysis of evidence from other sectors, working closely with the Department for Business, Innovation and Skills. We will consider development of Monitor as an economic regulator for healthcare in the wider context of the operation of sectoral regulation and concurrent application of competition law by different regulatory authorities.

2. Freeing Providers

2.1 The Government's intention is to free providers so that they can focus on improving outcomes, be more responsive to patients, and innovate. In doing this, we will build on the overall success of the foundation trust model, whilst recognising, through our plans for stronger quality regulation, and patient and public voice, that failings have occurred in some organisations.

2.2 The Coalition's belief is that the natural condition of organisations ought to be one of freedom rather than being shackled. In this way we will support organisations to develop and mature; they will be accountable but not infantilised. The Government's approach is that where specific control mechanisms are needed for providers, these should in general take effect through regulatory licensing and clinically-led contracting, rather than hierarchical management by regions or the centre. All providers of NHS care should be able to compete on a level playing field, so that they succeed or fail according to the quality of care they give patients and the value they offer to the taxpayer.

2.3 The White Paper set out our ambition to create the largest and most vibrant social enterprise sector in the world. The Government's intention is to free foundation trusts from constraints they are under, in line with their original conception, so they can innovate to improve care for patients. In future, they will be regulated in the same way as any other providers, whether from the private or voluntary sector. Patients will be able to choose care from the provider they think to be the best. For many foundation trusts, a governance model involving staff, the public and patients works well. But we recognise that this may not be the best model for all types of foundation trust, particularly smaller organisations such as those providing community services. As set out below, we are consulting on future requirements: we envisage that some foundation trusts will be led only by employees; others will have wider memberships. The benefits of this approach will be seen in high productivity, greater innovation, better care and greater job satisfaction. Foundation trusts will not be privatised.

2.4 This section seeks your views on options for increasing foundation trusts' freedoms while ensuring financial risk is properly managed.

2.5 As made clear in the White Paper, within three years, we will support all NHS trusts to become foundation trusts. It will not be an option for organisations to decide to remain as an NHS trust rather than become or be part of a foundation

trust and in due course, we will repeal the NHS trust legislative model. A new unit in the Department of Health will drive progress and oversee SHAs' responsibilities in relation to providers. In the transition period to the new system, Monitor will continue to apply its current standards to those organisations applying to become Foundation Trusts.

2.6 In the event that a few NHS trusts and SHAs fail to agree credible plans, and where the NHS trust is unsustainable, the Secretary of State may as a matter of last resort apply the trust administration regime introduced by the Health Act 2009. From April 2013, Monitor will take on the responsibility of regulating all providers of NHS care, irrespective of their status. Financial control will be maintained during the transition, with the Department, Monitor and SHAs taking any necessary steps.

2.7 As made clear in the White Paper, special statutory arrangements will be made for the three high secure psychiatric hospitals (Broadmoor, Rampton and Ashworth) allowing them to become foundation trusts and benefit from the independence of foundation status while retaining appropriate safeguards to reflect their role in the criminal justice system.

Continuity and additional potential freedoms for foundation trusts

2.8 We will keep the legislative framework for foundation trusts so they will continue to have a unique legal form. Their principal purpose will continue to be the provision of goods and services to the health service in England. As made clear in the White Paper, their broad statutory framework will continue to ensure that any surplus, and any proceeds from the sale of assets, are reinvested in the organisation or used to repay debt, rather than distributed externally, so that patients reap the benefits.

2.9 It is within this context that we are seeking views on liberalising the foundation trust regime. Foundation trusts are already effectively social enterprises – organisations with a social purpose that use any surpluses in pursuit of their purpose. They will continue to provide services to the NHS, with staff enjoying greater flexibility and freedom to deliver better services for patients.

Private income

2.10 In developing the model for foundation trusts the previous government imposed an arbitrary, ill-thought-through cap on their private income, fixed at the percentage of their income from private sources before the organisation

became a foundation trust. The perverse consequences include the inability in practice of an internationally respected organisation such as Great Ormond Street to expand the services it can offer for the benefit of patients; and the inability of the NHS to take proper advantage, for the benefit of this country, of the power of its brand abroad.

2.11 During the passage of the Health Act 2009, the House of Lords sought to rectify this anomaly. The previous government instigated a review of the cap and eased restrictions that had prevented mental health foundation trusts from providing services that are not directly funded by the NHS, including contributing to return-to-work programmes. This Government will bring forward provisions to address this anomaly for all foundation trusts by repealing the cap. This will allow foundation trusts to broaden the scope of their activities, whilst maintaining their primary purpose of providing NHS services.

Q1. Do you agree that the Government should remove the cap on private income of foundation trusts? If not, why; and on what practical basis would such control operate?

Statutory borrowing limits

2.12 Foundation trusts are already free to borrow from banks and other private sector lenders to improve the facilities and equipment available to patients. But they are subject to statutory controls – unlike voluntary or private providers – which give Monitor powers to set limits on the amount they can borrow. This was intended to prevent them from borrowing irresponsibly. However, since the first foundation trusts were authorised in 2004, none has taken a loan from the private sector for a significant capital investment as far as we are aware. And the new system of economic regulation, including price setting and failure, will provide strong incentives for financial discipline. In light of this, the Government is considering whether it will remain relevant in the future to maintain statutory controls over foundation trusts' borrowing limits.

Q2. Should statutory controls on borrowing by foundation trusts be retained or removed in the future?

Changing the constitution and configuration of a foundation trust

2.13 At the moment, foundation trusts need the specific consent of the regulator, Monitor, to amend their own constitutions. The Government does not see this

as necessary. We want to allow foundation trusts to change their constitutions with the consent of their boards of governors and directors, replacing the current requirement to obtain the consent of the regulator with more robust internal checks. In making any changes, foundation trusts will still need to ensure that their constitution is consistent with the legal form prescribed in legislation. Monitor, in its new role - described in this document - as the regulator for all of health and social care in England, will license all relevant providers of NHS services and will need to know that they are legally constituted and have clear governance arrangements. Foundation trusts would still, therefore, be required to notify Monitor of changes to their constitutions, although this would not be subject to regulatory approval.

Q3. Do you agree that foundation trusts should be able to change their constitution without the consent of Monitor?

2.14 We want to create a dynamic and innovative provider sector in which foundation trusts can choose how best to evolve and organise themselves and co-operate. They should be able to consider how they work with other foundation trusts and NHS trusts or indeed to reconfigure their organisation, and perhaps even be able to separate part of it, if they think that appropriate. Alongside joint ventures, alliances, federations and other forms of co-operation, we want to ensure it is possible for a successful foundation trust to acquire another organisation or to de-merge. We want these organisations, with their focus on providing services to the NHS, to be able to combine where they consider this will make them more effective. So we will legislate to remove any unnecessary barriers. We will make it easier for a foundation trust to merge with or acquire another foundation trust or NHS trust, or de-merge, ensuring the law allows this and that legal requirements about a foundation trust's legal status, elections and appointments do not get in the way inappropriately. Like other organisations, NHS Trusts and Foundation Trusts will be subject to merger controls to protect competition (see paragraphs 66 to 68 below).

Q4. What changes should be made to legislation to make it easier for foundation trusts to merge with or acquire another foundation trust or NHS trust? Should they also be able to de-merge?

Governance

2.15 The unique governance structure of foundation trusts seems to be working in many places. It requires all foundation trusts to adopt a three-tier model of members, governors and directors, with specific statutory requirements

regarding the make up of a foundation trust's membership, the composition of its boards of governors and of directors, and the relationships between them.

2.16 The Government has no intention of requiring or encouraging any existing foundation trust to change its governance model. It also wants NHS trusts to continue to prepare to take on the existing foundation trust model. However, we are interested in exploring whether there would be benefit in allowing some additional flexibility to foundation trusts, for example to increase staff influence.

2.17 Our assumption is that flexibility to adapt governance to suit an organisation's particular circumstances could be available for some foundation trusts, with the consent of their governors. Such flexibility could be available for all or only for some organisations such as more mature foundation trusts that have, through operating with the existing governance model for some time, adapted to looking outwards for their accountability. Allowing flexibility for foundation trusts that have existed for over, say, three years, would emphasise the need for them to build effective relationships with existing governors and make a convincing case for any change. We could consider limiting the scope of this flexibility, for example to ensure that the public can be members and have a seat amongst the governors.

2.18 In addition, *Liberating the NHS* said that some foundation trusts could be led only by employees, for example smaller organisations such as those providing community services. The strength of the case for the public (and patients) to form a majority on the board of governors at the outset may vary depending on the organisation involved. It may be possible to define a sub-group of providers that could be allowed to adopt a staff-only membership model from the start of their existence as foundation trusts. For example, this option could be available to organisations that only provide community services or to those that have few capital assets that were paid for by the taxpayer, below a specified threshold.

2.19 Strong governance is of key importance for corporate success, financial control, public accountability and stability. For these reasons well designed governance structures are important. There may be arguments for changing the governance arrangements of FTs, but we are also aware that there are risks. Given the regulatory controls we propose to remove, it may be helpful to increase the accountability of an organisation to its governors, for example by allowing them to call a special general meeting, ensuring they are invited to an annual general meeting which receives a report on executive pay and requiring a special general meeting to approve any significant transactions.

Q5. What if any changes should be made to the NHS Act 2006 in relation to foundation trust governance?

Taxpayer investment in foundation trusts

2.20 In addition to securing the continuity of provision, the taxpayer has an interest in foundation trusts through public dividend capital and loans owed to the Department of Health. Should foundation trusts fall into financial failure, this could necessitate writing off some element of this investment, which has an associated cost for the Department of Health. Therefore, it is important that the management of this stake in foundation trusts be undertaken in a way to minimize the risk and costs of any such failure. The future form of this investment and its management should as far as possible be conducted on a commercial basis to ensure that it does not lead to undue interference with foundation trust freedoms.

2.21 Under the current regime, Monitor has a role in managing these risks. However, as we move to a system where all providers are regulated on the same basis by Monitor, and not controlled by the Department of Health, it will be important for Monitor acting as economic regulator to avoid having a special interest in - or giving preferential treatment to – foundation trusts as a group of providers, compared with any other group of providers. In future, the role could be undertaken in the Department or a third party working on behalf of the Department - this could include Monitor if the independence of the regulator role is maintained.

Q6. Is there a continuing role for regulation to determine the form of the taxpayer's investment in foundation trusts and to protect this investment? If so, who should perform this role in future?

Further issues

2.22 This section of *Regulating Healthcare Providers* has described some of the options for increasing foundation trust freedoms, and potential changes to the foundation trust legislative framework given the introduction of economic regulation. It is by no means comprehensive and the Government would welcome additional comments and proposals.

Q7. Do you have any additional comments or proposals in relation to increasing foundation trust freedoms?

3. Economic regulation

3.1 *Liberating the NHS* made clear that the Government proposes to introduce a system of independent economic regulation to sit alongside independent quality regulation. As we move away from a system of top-down performance management, the rationale for economic regulation is to protect the public interest in the provision of services, particularly where communities are highly dependant on one, or very few, providers. Furthermore, as we seek to offer patients choice of 'any willing provider' for most services, the benefit of our approach is the ability to address potentially anticompetitive behaviour, through regulation where appropriate, rather than through costly legal proceedings. In developing this, we are learning from models in other countries and other sectors such as energy and water, whilst applying these models to the particular circumstances, values and principles of the NHS in England.

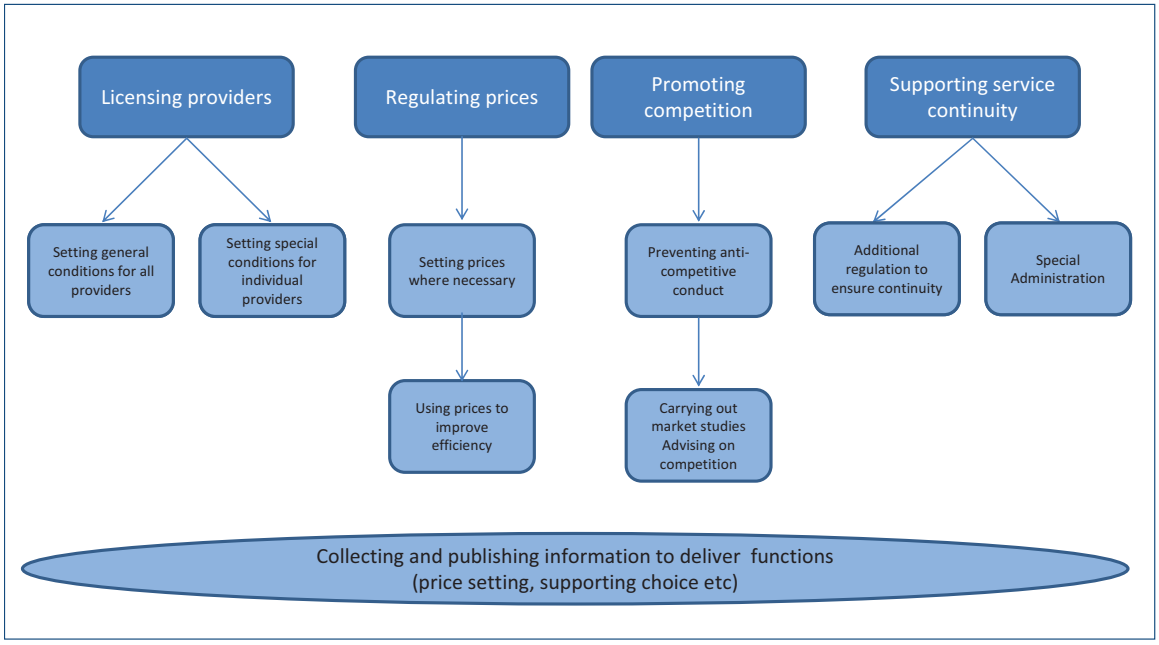
3.2 Our proposals will set providers free while at the same time protecting the public interest. Monitor will be developed into the economic regulator for all of health and adult social care in England. Monitor's principal duty will be to protect the interests of patients and the public in relation to health and adult social care services, by promoting competition where appropriate, and through regulation where necessary. Monitor will be required to exercise its functions in a manner consistent with the Secretary of State's duty to promote a comprehensive health service in England and have regard to the following objectives:

- maintaining the safety of patients and individuals accessing services
- securing ongoing improvements in quality of care
- providing equitable access to essential health and adult social care services
- supporting commissioners in maintaining continuity of essential services
- securing ongoing improvements in the efficiency of services
- promoting appropriate investment and innovation
- making best use of limited NHS and adult social care resources.

3.3 Monitor will license providers of NHS services in England and exercise functions in three areas: regulating prices, promoting competition and supporting service continuity. Its statutory remit will be limited to the provision of health and adult social care services. We do not envisage that it will extend to regulating supply of products or technologies such as equipment or pharmaceuticals.

3.4 In carrying out its functions, Monitor will need to balance multiple objectives, which may at times come into conflict. For example, the public interest in maintaining access to services in remote or rural areas may need to be considered against objectives to improve efficiency or promote competition. Monitor will be required to act transparently in determining its approach to regulation and in its decisions in individual cases. Where it appears to Monitor that any of its duties conflict with each other in a particular case, it will need to take a balanced judgement and set out a clear rationale for its decision. Building on established practice in other sectors, the rationale will need to set out where objectives come into conflict, the nature of the conflict, and Monitor's justification for prioritising between objectives in reaching its decision.

MONITOR'S CORE FUTURE FUNCTIONS



3.5 Monitor will continue to have the status of a non-departmental public body (NDPB), just like the Care Quality Commission and, in future, the NHS Commissioning Board. The Secretary of State will not have powers to direct Monitor in carrying out its functions; this maintains the current position and is

consistent with principles of effective regulation. We envisage that the Secretary of State will retain the power to appoint the Chair of Monitor for a term of four years and we propose that he should also have power to approve the appointment of a Chief Executive, who would be nominated by the Chair. Consistent with existing arrangements, the Secretary of State would have further powers to remove the Chair or Chief Executive, during their terms, for reasons of incapacity or misbehaviour.

3.6 As an NDPB, Monitor will be required to account to central Government for the use of its resources and to publish annual accounts. In addition, Monitor will be required to report annually to Parliament to demonstrate value for public money and will be accountable to the public through Parliamentary scrutiny, including through investigations by select committees. Monitor's funding position will be agreed with H.M. Treasury as part of the spending review process.

3.7 Monitor's regulatory decisions will be subject to a range of further checks and balances. These will include obligations to consult with interested parties – such as the NHS Commissioning Board and providers - and to carry out impact assessments of the costs and benefits of new regulation. Parties will also have the ability to appeal against Monitor's licensing and pricing decisions in particular circumstances.

3.8 We are committed to reducing the overall burdens of regulation across the health and adult social care sectors. In line with the principles of better regulation, Monitor will be under a duty ensure that its regulatory activities are transparent, proportionate, consistent and targeted only at cases where action is needed.

3.9 Before introducing new regulation (other than applying competition law), Monitor will be required to carry out a regulatory impact assessment and demonstrate that the new regulation is necessary. It will also need to demonstrate that it would not be able to protect patients and taxpayer's interests through less burdensome forms of intervention such as application of competition law on a case by case basis. Monitor will be required to review its activities as choice and competition develop and to reduce regulation wherever possible over time.

4. Licensing

4.1 This section sets out the role of Monitor in licensing providers of NHS services. In the new system, the CQC and Monitor will be jointly responsible for administering an integrated and streamlined registration and licensing regime.

4.2 The CQC currently registers providers of health and adult social care services to provide assurance that they meet essential levels of quality and safety. It will continue to play an important role in the new system, carrying out inspections in relation to its registration requirements and taking enforcement action where needed. The CQC will also continue to work closely with OFSTED, the lead inspectorate for children's social care, on matters relating to inspection of children's health services.

4.3 In future, Monitor will also need to license some providers of NHS services as a mechanism for delivering its regulatory functions. For example, it will need to license providers and set licence conditions to ensure that information is collected to set prices, promote competition, and safeguard the continuity of additionally regulated services. This will supersede and replace elements of Monitor's existing authorisation and compliance regime. It will be a requirement of Monitor's licence that organisations have gained CQC registration.

4.4 The CQC and Monitor will retain separate responsibilities for their parts of the regime. This means that the CQC will continue to register providers of health and adult social care. Meanwhile, Monitor will license providers of NHS healthcare services. Our aim is for a streamlined process that helps to minimise bureaucracy and ensures that regulation of providers is proportionate. Both regulators will need to work together to develop streamlined procedures.

4.5 As explained in the White Paper, Monitor's powers to regulate prices and license providers will only cover NHS services. Providers of other care services, including adult social care, would still be required to register with the CQC but would not be required to hold Monitor's licence. The rationale for this is that there is limited choice of alternative providers for many NHS services and some communities are highly dependent on one, or very few, providers. In adult social care and private healthcare, there are already mature markets with a range of choice between alternative providers.

Q8. Should there be exemptions to the requirement for providers of NHS services to be subject to the new licensing regime operated by Monitor, as economic regulator? If so, what circumstances or criteria would justify such exemptions?

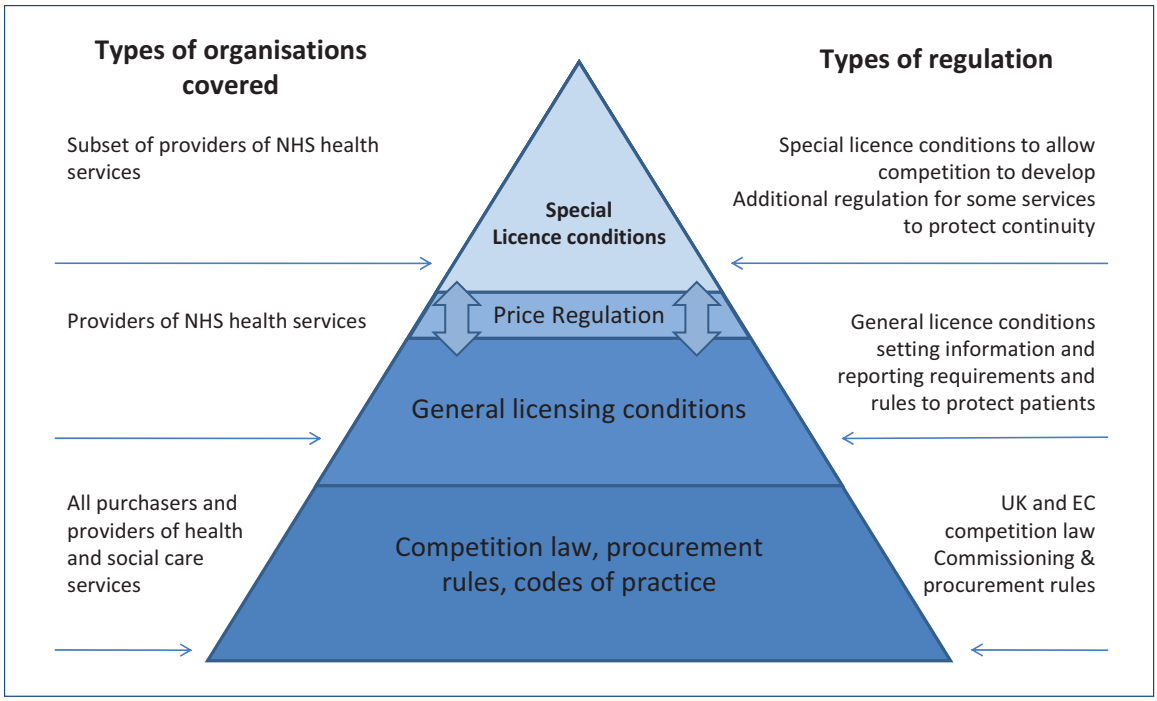
4.6 Monitor will be responsible for developing a general licence setting out conditions for all relevant providers of NHS services. The general licence conditions are likely to include a requirement that an organisation is a fit and proper body to provide NHS services - for example that it is a recognised legal body, with a properly constituted board, clear governance arrangements and a business plan. We envisage this replacing Monitor's current role in authorising foundation trusts. However, Monitor is likely to continue to act as the registrar for foundation trusts, to ensure that foundation trusts are legally constituted (in line with statutory requirements) and to maintain basic information such as membership of their boards.

4.7 The general licence conditions are also likely to include: requirements to provide Monitor with details on provision of NHS services, to notify proposed changes to services, and to report information (for example data on costs and volumes needed to set prices for some services). (In practice this information may be collected by the Health and Social Care Information Centre on behalf of Monitor.) The licence may also include other rules to protect patients' and taxpayers' interests (for example rules on advertising and mis-selling).

4.8 In addition, Monitor will be able to set special licence conditions for individual providers in certain cases. Monitor will be able to set special licence conditions either because a provider enjoys a position of market power in a local area or because there is a need for additional regulation to protect service continuity. The special licence conditions could include additional requirements on providers to promote choice (for example requirements to provide certain services to competitors) or requirements to protect continuity of services (for example requirements to pre-notify the regulator of plans to stop providing the service).

Q9. Do you agree with the proposals set out in this document for Monitor's licensing role?

THREE TIERS OF ECONOMIC REGULATION FOR HEALTH AND SOCIAL CARE



Enforcement powers

4.9 Monitor will have a range of powers to ensure that providers comply with their licence conditions. These will include the power to fine providers for failing to comply with licence conditions. They may also include the power to suspend or revoke a licence for failure to comply with its conditions.

Appeals against licence modifications

4.10 Monitor will have an obligation to review the need for and functioning of the general and special licence conditions on a periodic basis. It will also have powers to modify general licence conditions or individual providers' special licence conditions either to address new problems or reduce regulation. We envisage that groups of providers will have the right to appeal to the Competition Commission if a significant proportion oppose Monitor's proposed changes to the general licence conditions. Individual providers will have the right to appeal regarding proposed changes to their special licence conditions.

Q10. Under what circumstances should providers have the right to appeal against proposed licence modifications?

Fees

4.11 Monitor will need appropriate resources in order to carry out its functions. Monitor currently receives funding in the form of grant-in-aid from central Government. However, it also has statutory powers (as yet unused) to raise funds from the foundation trusts it regulates by charging fees.

4.12 In general, it is good practice for regulators to raise the majority of their funding from their industries rather than receiving funding in the form of grants from central government. This ensures that the regulator has true independence from central Government. It also ensures that the providers subject to regulation pay directly for that oversight, and that the regulator has an incentive to ensure that regulation is proportionate and avoids imposing unnecessary burdens. We therefore propose that Monitor should fund its regulatory activities for licensed providers by charging fees and receive grant-in-aid from if needed to support other activities.

Q11. Do you agree that Monitor should fund its regulatory activities through fees? What if any constraints should be imposed on Monitor's ability to charge fees?

5. Price regulation and setting

5.1 In our healthcare system, prices are set for a range of services under national tariffs. Up until now, the Secretary of State has been responsible for setting these prices on an annual basis. In other sectors, Government has delegated responsibility for price setting to independent economic regulators. Such bodies can create a more stable environment and greater regulatory certainty so that providers have the confidence to make long-term investments in services. Independent regulators can also develop strong technical skills in setting prices at the right levels.

5.2 As explained in the White Paper, Monitor will be responsible for setting efficient prices, or maximum prices, for NHS-funded services, in order to promote fair competition and drive productivity. Monitor and the NHS Commissioning Board will need to work closely together in deciding which services should be subject to national tariffs, and in developing appropriate currencies for pricing and payment purposes. Currencies will identify units of services for payment purposes and may have a direct impact upon incentives. For example, where currencies and payments are based on throughput of diagnostic or surgical procedures this may create financial incentives for providers to increase volumes of those procedures. As set out in the White Paper, we envisage the Board having primary responsibility for determining appropriate currencies. There may also be a role for Monitor, in setting tariff structures, to ensure that currencies do not restrict or distort competition against the public interest.

5.3 Monitor's role will be to set prices or price caps for services subject to national tariffs. Monitor will be responsible for devising a pricing methodology. It will be required to run a public consultation process, engaging with both the NHS Commissioning Board and providers. The tariff-setting methodology should be made transparent and fully open to scrutiny. As at present, the methodology will need to take account of inflation and, over time, the tariffs will be adjusted on a bottom-up basis to reflect increases in provider efficiency. In addition, Monitor will be under a duty to have regard to the need to make best use of limited NHS and social care resources, although primary responsibility for managing within the limits of these resources will be for the Board and local commissioners.

Q12. How should Monitor have regard to overall affordability constraints in regulating prices for NHS services?

5.4 It is important that both purchasers and providers are able to challenge aspects of Monitor's pricing decisions. The NHS Commissioning Board will be able to appeal to the Competition Commission if it opposes Monitor's methodology for setting tariff prices. Providers will also have the right to appeal to the Competition Commission, although it will be important to avoid perverse incentives to make vexatious or trivial complaints.

Q13 Under what circumstances and on what grounds should the NHS Commissioning Board or providers be able to appeal regarding Monitor's pricing methodology?

5.5 In exceptional circumstances, it may be necessary to modify the tariff price to sustain the provision of services. In rare cases, a provider might unavoidably have higher costs than other organisations, for example because it operates in a rural location and provides key services to a small, isolated population. We therefore propose that Monitor should have powers to modify tariffs for individual providers on rare occasions. For example, Monitor might set higher prices for a provider where it was the only provider of key services in an area, where it had unavoidably higher costs, and where there were no other providers able to enter the market and offer the service within the tariff price.

5.6 In carrying out this function, Monitor would need to have regard to its duties to protect the interests of patients and the public, through competition where appropriate and through regulation where necessary. It would also need to have regard to its duty to promote efficiency. In particular, it would need to ensure that any modifications to the tariff did not give recipient providers an unfair competitive advantage or constitute unlawful state aid under EU rules.

5.7 Commissioners and providers will be able to apply to Monitor to set a differentiated price or arbitrate in some pricing disputes. Monitor will need to consult the Board on proposed variations to tariff prices in individual cases.

5.8 Monitor and the NHS Commissioning Board will need to work closely together when developing tariffs and prices. They will be under an obligation to consult with each other on the services subject to national tariffs, contract currencies and funding models. Monitor will need to consult with the Board on its proposed methodology and prices for services under national tariffs. It will also need to consult with the Board on proposals to agree variations to the tariff in individual cases and in relation to some pricing disputes. The Department of Health, given the overall accountability of the Secretary of State for the NHS, and acting as sponsor of both the Board and the regulator,

will have a responsibility for promoting effective working behaviours between the Board and the regulator.

Q1. How should Monitor and the Commissioning Board work together in developing the tariff? How can constructive behaviours be promoted?

6. Promoting competition

6.1 In future, patients will have more clout in the system, more control over their care and the ability to choose between any willing provider for most services. Choice will spur providers to become more responsive to patients' needs, stimulating innovation, improvements in the quality of care and increases in productivity. It will be necessary to take proactive steps to make patient choice a reality. This needs to include providing patients with information to make informed decisions and making it easier for new providers to offer services. There will be a need for ongoing regulatory oversight to promote competition and ensure that it delivers the intended benefits for patients and taxpayers.

6.2 The Government will create a presumption that all patients will have choice and control over their treatment and choice of any willing provider, wherever relevant. In the new system, the NHS Commissioning Board will have a duty to promote patient choice, including developing the NHS choice offer in accordance with its mandate from the Secretary of State. The Board will also maintain guidance to commissioners on the procurement of health services.

6.3 As explained in the White Paper, we propose that, in carrying out its functions, Monitor would have a duty to promote competition, where appropriate. Specifically, Monitor would have powers to impose remedies and sanctions to address restrictions on competition, through its licensing regime, and through concurrent powers with the Office of Fair Trading (OFT) to enforce key aspects of competition law.

ROLES OF MONITOR AND NHS BOARD IN PROMOTING COMPETITION

Role of NHS Commissioning Board	Role of Monitor	Role of other organisations
• Promoting patient choice • Deciding how to introduce choice of any willing provider • Developing standard NHS contracts • Establishing guidance on commissioning and procurement • Assessing complaints on commissioning / procurement	• Setting licence conditions to prevent anti-competitive behaviour / facilitate development of competition • Investigating anti-competitive conduct under Competition Act 1998 • Carrying out studies and referring malfunctioning markets to the Competition Commission • Investigating complaints about commissioning after referral to NHS Board • Providing advice to Government and NHS Board on barriers to competition / level playing field	• Secretary of State sets mandate for NHS Board • OFT has concurrent powers to investigate anti-competitive conduct under Competition Act 1998 • Competition Commission investigates barriers to competition in markets following reference • OFT and Competition Commission investigate and prevent anti-competitive mergers

Preventing anti-competitive behaviour

6.4 The OFT currently has powers to enforce the Competition Act 1998 in health and social care. It also has the ability to carry out studies of health and social care services and to refer them to the Competition Commission. Given that Monitor will play a key role in promoting competition, we propose that it should have concurrent powers with the OFT to apply the Competition Act in addressing restrictions on competition in the health and adult social care sectors.

6.5 We propose that Monitor should also be able to carry out 'market studies' to investigate markets where competition is not functioning properly, for example because there are structural problems or other barriers to effective competition. It will be able to advise Government and the NHS Commissioning Board on changes to allow competition to function effectively. It will also have powers to refer dysfunctional markets or barriers to competition to the Competition Commission for investigation.

6.6 Application of Monitor's powers to enforce competition law within the health and social care sectors will not be limited to providers required to hold a licence. The rationale for this is that providers may deliver a mix of NHS and private healthcare, as well as other care services. The regulator would not be

able to police the system effectively if there were arbitrary distinctions preventing it from investigating issues spanning these different activities. This means that Monitor will have powers to enforce competition law and impose sanctions and remedies in relation to providers of health or adult social care services irrespective of whether they are required to hold a licence.

6.7 Monitor will have the power to set general licence conditions for all licensed providers. These may include provisions to protect patients' and taxpayers' interests such as rules to prevent misleading advertising or selling.

6.8 In some local areas, incumbent providers may be in a powerful position and have the ability to prevent choice and plurality developing. We therefore propose that Monitor should also have powers to set special licence conditions for some individual providers to protect competition. These special licence conditions might include: requirements to accept services such as diagnostic tests from other providers where clinically appropriate; requirements for providers to publish their terms and conditions for providing services to other providers; or requirements covering a provider's capital expenditure in certain circumstances.

Q15. Under what circumstances should Monitor be able to impose special licence conditions on individual providers to protect choice and competition?

Ensuring a level playing field

6.9 Where there is competition, this will be on a level playing field that rewards the highest-quality, most efficient providers that continuously improve services in line with the needs and the preferences of the patients they serve. The regulator will be able to consider factors that may put particular providers at a relative disadvantage and make proposals to the Government or the NHS Commissioning Board to move over time to ensure that any differences are fair.

Q16.. What more should be done to support a level playing field for providers?

Joint working with the NHS Commissioning Board

6.10 Monitor and the NHS Commissioning Board will need to work closely together to promote patient choice and plurality. The Board will have a duty to promote and extend choice and patient control and involvement in services. It will be responsible for developing and agreeing with the Secretary of State

guarantees for patients about the choices they can make and for setting out its strategy for delivering these. There will be a requirement to consult Monitor on this. Monitor will also give public advice to the NHS Commissioning Board on wider issues relating to choice and competition.

Anti-competitive behaviour by commissioners

6.11 In the current system, the Department of Health has issued guidance to commissioners on the procurement of health services and rules to prevent anti-competitive conduct. The Department's Cooperation and Competition Panel is able to investigate complaints regarding commissioners' procurement decisions and anti-competitive conduct. It can advise the Secretary of State or Monitor on these cases but has no enforcement powers.

6.12 For the future, we propose to set out in legislation the duties of the NHS Board and commissioners to promote choice, to act transparently and non-discriminatorily in all commissioning activities, and to prohibit agreements or other actions to restrict competition against patients' and taxpayers' interests. Monitor will have powers to investigate and remedy complaints regarding commissioners' procurement decisions, or other anticompetitive conduct, acting as arbiter.

Q27. How should we implement these proposals to prevent anti-competitive behaviour by commissioners? Do you agree that additional legislation is needed as a basis for addressing anticompetitive conduct by commissioners and what would such legislation need to cover? What problems could arise? What alternative solutions would you prefer and why?

Regulation of mergers

6.13 As well as preventing anti-competitive behaviour, it will be important to regulate mergers to maintain sufficient competition in the public interest. The OFT and Competition Commission are responsible for regulating mergers in all sectors under the Enterprise Act 2002. They can already assess mergers in health and social care under the Act and the OFT has done so on a number of occasions. In the future, we envisage that the OFT and Competition Commission will be the sole organisations with responsibility for investigating mergers in health and social care services. We expect Monitor to offer the OFT and Competition Commission any assistance and advice in investigations in the sector, as they may reasonably require.

6.14 We may need to legislate to ensure that the full range of providers of NHS services are subject to appropriate merger controls. We are considering the need for modifications to the Enterprise Act 2002 to take account of the specific characteristics of mergers in healthcare, including whether there is a case for:

- Any modifications to ensure that the full range of providers of NHS services, including NHS trusts and foundation trusts, are subject to merger controls; and
- Powers for the Secretary of State for Business Innovation and Skills to intervene in mergers on public interest grounds

6.15 Over the last two years, alongside this statutory regime, the Department of Health's Cooperation and Competition Panel has also provided expert advice to the Secretary of State and Monitor on mergers involving NHS Trusts and foundation trusts. The Panel will continue to provide expert advice on these mergers during the transition to the new system.

7. Supporting continuity of services

7.1 Ensuring the continuity of essential public services is vital to individuals and communities. There will be a range of safeguards in the new system to ensure the continuity of care, even when the providers of services may change. The objective of these measures is to ensure that there is a smooth transfer if commissioners wish to replace existing services with better alternatives, or to ensure service continuity should a provider become insolvent. This section sets out how this will work under the proposed reforms.

The role of commissioners

7.2 In future, consortia of GP practices will commission the vast majority of NHS services for their patients, including elective hospital care, rehabilitative care, urgent and emergency care, most community services, and mental health services. As in the current system, commissioners will retain primary responsibility for ensuring the continuity of service provision. This can be achieved through a variety of approaches including: seeking to commission services from a broad range of providers; encouraging the development of new and innovative types of provision; and, where necessary, negotiating contractual arrangements with providers that ensure the continuity of services, such as notice periods that are sufficiently long to allow for alternative provision to come on-line.

Additionally regulated services

7.3 Although commissioners will have the lead responsibility for ensuring continuity of services, Monitor may also need to intervene to ensure continued access to key services in some limited circumstances. At present, Monitor has power to define ‘mandatory services’ obligations within the Terms of Authorisation for foundation trusts. Foundation trusts are not allowed to withdraw ‘mandatory services’ without Monitor’s permission. We propose to build on this approach in the new system, providing further protection, over and above that given by commissioners, to services that are vital to local populations. Under the proposed new approach, Monitor will be able to classify services which require additional regulation as additionally regulated

services and set conditions in providers' licences to protect the continuity of those services.

7.4 The purpose of defining additionally regulated services is to identify where it would be reasonable and proportionate for Monitor to impose additional regulation to support commissioners in maintaining access to essential public services. It will be for Monitor to set out the criteria for defining additional regulated services. These criteria are likely to focus on identifying where a provider is the only provider or one of very few providers of services in a local area. The justification for additional regulation in these circumstances is the need to maintain access to those services in the absence of alternative providers.

7.5 We envisage that Monitor would have powers to impose special licence conditions for providers delivering additionally regulated services, as an evolution of its current approach to regulating foundation trusts and taking a consistent approach irrespective of the type of provider. For example, we envisage Monitor having powers to impose special licence conditions to protect the assets needed to provide those services (such as controls on disposal of these assets). Special licence conditions could also include requirements on providers to give notice of planned changes to additionally regulated services. Providers would be obliged to continue to provide additionally regulated services during the notice period. This could be an extensive period, particularly if the services are difficult to replace. In addition, Monitor would be able to trigger application of a special administration regime to ensure the continuity of additionally regulated services and protect the assets used to deliver them in the event of insolvency.

Q18. Do you agree that Monitor needs powers to impose additional regulation to help commissioners maintain access to essential public services? If so, in what circumstances, and under what criteria, should it be able to exercise such powers?

Special Administration, insolvency and risk pooling

7.6 In certain areas of the economy, for example the water, transport and energy sectors, special administration arrangements have been put in place to ensure the continued supply of key services where a provider becomes insolvent. We propose to establish a similar special administration regime for additionally regulated health services in England. This will build additional protections, on top of those outlined above, to ensure the continued, safe provision of additionally regulated services in the exceptional event that a provider becomes insolvent. The special administration regime will work as in other

sectors, providing an alternative to ordinary insolvency procedures. It will build upon aspects of the unsustainable provider regime in the Health Act 2009, without some of the bureaucracy and ability for political interference. In the event of insolvency, Monitor will have 14 days to trigger special administration to protect additionally regulated services, before the start of any other insolvency process.

7.7 In these cases, a special administrator will be appointed with responsibility for securing the continued provision of additionally regulated services. The administrator will be required to develop plans to ensure the continuity of those services. Possible outcomes include transfer or rescue.

7.8 Monitor will be responsible for establishing funding arrangements to finance the continued provision of services in the event of special administration. It will have the freedom to decide on the best approach, which may change over time. However, it is likely that it will initially do this by establishing a 'funding risk pool', raised from levies on the providers of regulated services. These levies will be based both on the size of such providers and the level of risk that they may need to access the risk pool. Monitor will be responsible for determining an appropriate approach to risk assessment.

Q19. What may be the optimal approach for funding continued provision of services in the event of special administration?

8. Conclusion

8.1 This document supplements the White Paper, *Equity and excellence: Liberating the NHS*, by providing some further detail on freeing providers and economic regulation, and asking a number of specific questions. It does not attempt to be comprehensive in addressing all issues and the Department would welcome further comments and proposals. Following the introduction of the Health Bill later this year, we will undertake more work over the next two years to develop the detail of proposals, working with external organisations.

Q20. Do you have any further comments or proposals on freeing foundation trusts and introducing a system of economic regulation?

Q21. What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they can promote equality of opportunity and outcome for all patients, the public, and where appropriate, staff?

8.2 Our proposals for freeing providers and economic regulation form part of a coherent strategy for NHS reform. We are consulting on how best to implement these changes. In particular, the Department would welcome comments on the implementation of the proposals requiring primary legislation, and will publish a response to the views raised on the White Paper and the associated papers, prior to the introduction of the Bill.

8.3 The government has produced an analytical strategy for the White Paper and associated documents to expand and seek views on the detail behind key elements of the planned reforms. We will be issuing a full impact assessment on these proposals before publication of the Health Bill in the autumn.

8.4 Comments should be sent by 11 October 2010 to: NHSWhitePaper@dh.gsi.gov.uk

8.5 This document seeks views on the following consultation questions:

Q1. Do you agree that the Government should remove the cap on private income of foundation trusts? If not, why; and on what practical basis would such control operate?

Q2. Should statutory controls on borrowing by foundation trusts be retained or removed in the future?

Q3. Do you agree that foundation trusts should be able to change their constitution without the consent of Monitor?

Q4. What changes should be made to legislation to make it easier for foundation trusts to merge with or acquire another foundation trust or NHS trust? Should they also be able to de-merge?

Q5. What if any changes should be made to the NHS Act 2006 in relation to foundation trust governance?

Q6. Is there a continuing role for regulation to determine the form of the taxpayer's investment in foundation trusts and to protect this investment? If so, who should perform this role in future?

Q7. Do you have any additional comments or proposals in relation to increasing foundation trust freedoms?

Q8. Should there be exemptions to the requirement for providers of NHS services to be subject to the new licensing regime operated by Monitor, as economic regulator? If so, what circumstances or criteria would justify such exemptions?

Q9. Do you agree with the proposals set out in this document for Monitor's licensing role?

Q10. Under what circumstances should providers have the right to appeal against proposed licence modifications?

Q11. Do you agree that Monitor should fund its regulatory activities through fees? What if any constraints should be imposed on Monitor's ability to charge fees?

Q12. How should Monitor have regard to overall affordability constraints in

regulating prices for NHS services?

Q13 Under what circumstances and on what grounds should the NHS Commissioning Board or providers be able to appeal regarding Monitor's pricing methodology?

Q14. How should Monitor and the Commissioning Board work together in developing the tariff? How can constructive behaviours be promoted?

Q15. Under what circumstances should Monitor be able to impose special licence conditions on individual providers to protect choice and competition?

Q16. What more should be done to support a level playing field for providers?

Q17. How should we implement these proposals to prevent anti-competitive behaviour by commissioners? Do you agree that additional legislation is needed as a basis for addressing anticompetitive conduct by commissioners and what would such legislation need to cover? What problems could arise? What alternative solutions would you prefer and why?

Q18. Do you agree that Monitor needs powers to impose additional regulation to help commissioners maintain access to essential public services? If so, in what circumstances, and under what criteria, should it be able to exercise such powers?

Q19. What may be the optimal approach for funding continued provision of services in the event of special administration?

Q20. Do you have any further comments or proposals on freeing foundation trusts and introducing a system of economic regulation?

Q21. What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they can promote equality of opportunity and outcome for all patients, the public, and where appropriate, staff?

Annex: The consultation process

Criteria for consultation

This consultation follows the 'Government Code of Practice', in particular we aim to:

- formally consult at a stage where there is scope to influence the policy outcome;
- consult for at least 12 weeks - the policies in this document were included in the NHS White Paper, *Liberating the NHS*, which was launched on 12 July for a 12 week consultation period closing on 5 October;
- be clear about the consultations process in the consultation documents, what is being proposed, the scope to influence and the expected costs and benefits of the proposals;
- ensure the consultation exercise is designed to be accessible to, and clearly targeted at, those people it is intended to reach;
- keep the burden of consultation to a minimum to ensure consultations are effective and to obtain consultees' 'buy-in' to the process;
- analyse responses carefully and give clear feedback to participants following the consultation;
- ensure officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

The full text of the Code of Practice and related guidance is on the Better Regulation website at www.bis.gov.uk/policies/better-regulation/consultation-guidance

Comments on the consultation process itself

If you have concerns or comments which you would like to make relating specifically to the consultation process itself please contact:

Consultations Coordinator

Department of Health

3E48, Quarry House

Leeds

LS2 7UE

e-mail: consultations.co-ordinator@dh.gsi.gov.uk

Please do not send consultation responses to this address.

Confidentiality of information

We manage the information you provide in response to this consultation in accordance with the Department of Health's Information Charter (available at www.dh.gov.uk).

Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

NHS

Liberating the NHS:

Report of the arm's-length bodies review

DH Department of Health

DH INFORMATION READER BOX

Policy	Estates
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EXECUTIVE SUMMARY

1. Our arm's-length bodies (ALBs) have made a significant contribution to improvements in health and care. Given the wider system reforms outlined in the White Paper - *Equity and excellence: Liberating the NHS*[1] - and the current economic climate, we must now act decisively to ensure that our arm's-length body sector remains fit for purpose and affordable.

2. Over the next four years the Government is committed to reducing NHS administrative costs by more than 45% and to simplifying and reducing radically the number of NHS bodies, including the Department's arm's-length bodies.

3. This report sets out in more detail the work on reducing bureaucracy and improving efficiency outlined in chapter 5 of the White Paper. It explains how we propose to abolish arm's-length bodies that do not need to exist, streamline the functions of those that do, and transfer functions that can be better delivered by other organisations.

4. Overall, we intend to simplify the national landscape, removing duplication and better aligning the arm's-length bodies sector with the rest of the health and social care system by:

    - ensuring that functions related to quality and safety improvement are devolved closer to the frontline;
    - integrating and streamlining existing national health improvement and protection bodies and functions within a new Public Health Service;
    - creating a more coherent and resilient regulatory system with clarity of responsibilities and reduced bureaucracy around licensing and inspection;
    - centralising data returns in the Health and Social Care Information Centre;
    - maximising opportunities for outsourcing of functions and shared business support functions across the sector to reduce overall costs and seek to realise assets through the commercialisation of activities.

[1] www.dh.gov.uk

5. In future:

    - functions will only be carried out at national level where it makes sense to do so;
    - the number of arm's-length bodies will be kept to a necessary minimum and the scope of each arm's-length body will be clearly defined to avoid mission creep;
    - arm's-length bodies will be expected to collaborate and co-operate to avoid duplication of activities and minimise unnecessary burdens and costs to health and social care organisations;
    - arm's-length bodies will have less freedom to determine how they spend their money on pay, expenses, travel, consultancy, communications and IT, and they will be expected to publish information and benchmarking data online;
    - where appropriate, arm's-length bodies will be expected to exploit commercial opportunities and maximise commercial discipline across the sector.

6. We will engage on these proposals with the arm's-length bodies and other interested parties, and where necessary we will bring forward legislative proposals within this Parliament.

1. INTRODUCTION

1.1 The Government has guaranteed that spending on health will increase in real terms in every year of this Parliament and is committed to increasing the proportion of resource available for front-line services to meet the current financial challenges and the future costs of demographic and technological changes. To achieve this we will need to achieve unprecedented efficiency gains, with savings reinvested in frontline services. Over the next four years the Government is committed to reducing NHS administrative costs by more than 45% and to radically reducing and simplifying the number of NHS bodies, including the Department's arm's-length bodies.

1.2 Reduction on this scale cannot be achieved by year-on-year efficiency savings alone. It also requires simplifying and rationalising the administrative infrastructure of the health and social care system.

1.3 *Equity and excellence: Liberating the NHS* set out the Government's strategy for the NHS. Our intention is to create an NHS that is much more responsive to patients, and achieves better outcomes, with increased autonomy and clear accountability at every level.

1.4 *Equity and excellence: Liberating the NHS* makes clear the Government's policy intentions, and provides a coherent framework. Further work lies ahead to develop and implement detailed proposals. In progressing this work the Department will be engaging with external organisations, seeking their help and wishing to benefit from their expertise.

1.5 This report on the review of our arm's-length bodies is part of a suite of papers published on specific aspects of the White Paper. The initial suite of supporting papers also includes:

- *Commissioning for Patients*
- *Regulating Healthcare Providers*
- *Transparency in Outcomes*
- *Local Democratic Legitimacy in Health*

1.6. A network of organisations has been created at national level, but at "arm's length" from the Department of Health, to regulate the system, improve

standards of care, protect public welfare, support local services and provide specialist advice. The work these organisations undertake ranges from back office administrative functions to complex ethical or clinical-related work. Arm's-length bodies are Government-funded organisations which work closely with local services and other arm's-length bodies. The Department has three main types of arm's-length bodies: Executive Agencies; Executive Non-Departmental Public Bodies; and Special Health Authorities.

1.7 Our arm's-length bodies form a significant component of the national health and social care landscape. In 2009/10, the sector as a whole spent in the region of £1.6 billion on business operations, including baseline revenue funding from the Department of about £800 million, and our arm's-length bodies employ around 18,000 staff.

1.8 The Department has already gone a long way to rationalise and reduce costs across this sector. The last review of our arm's-length bodies, which took place in 2003/04, reduced the number of organisations from 38 to 18. Annex B sets out the changes in our arm's-length body sector from 2003/04 – 2012/13.

1.9 However, six years on, we now need to take stock and assess how fit for purpose the sector is in light of the current financial climate, the cross-government drive to reduce the number of quangos and the strategy for the NHS set out in *Equity and excellence: Liberating the NHS,* which was published on 12 July 2010. This set out a coherent policy framework to support increased autonomy and clear accountability at every level in the NHS.

1.10 We have undertaken a review of our arm's-length bodies which includes an Executive Agency of the Department of Health, the Executive Non-Departmental Public Bodies (set up in primary legislation with their own powers) and Special Health Authorities.

1.11 This report sets out the result of the review within the context of the wider changes envisaged for the NHS set out in *Equity and excellence: Liberating the NHS* and the cross-government agenda to increase accountability and transparency and to reduce the number and costs of public bodies. We will engage with stakeholders around the implementation of the changes outlined in this report.

1.12 Part 2 of this report outlines our plans to streamline the sector and ensure that only those functions that need to be undertaken at a national level and at arm's length remain in the sector. Part 3 sets out the new configuration of arm's-length bodies. Part 4 sets out how we will tighten accountability, reduce bureaucracy and increase efficiencies across the arm's-length bodies. Part 5 describes how we will make the changes happen.

2 OUR STRATEGY FOR THE ARM'S-LENGTH BODY SECTOR

2.1 The Government's reforms of the NHS will establish more autonomous NHS institutions, with greater freedoms, clear duties, transparency in their responsibilities to patients and their accountabilities, with power devolved to the front-line. Liberating the NHS will fundamentally change the role of the Department and those bodies accountable to it.

2.2 In future, the arm's-length bodies sector needs to mirror these reforms. It will carry out only those functions that should be done at a national level to support the Department's clear objectives. Those functions that are better delivered by other parts of the system should be devolved to the right level of the system and those organisations that carry out functions that no longer need to be carried out by the state should be abolished. The sector will be streamlined to deliver its functions more effectively, reduce management costs and remove duplication and unnecessary burdens on the front-line.

2.3 The Department will impose tight governance and accountability over the costs and the scope of its remaining arm's-length bodies. To prevent duplication and aid transparency, the Secretary of State will consider, for any organisation, setting out an explicit list of functions that it is expected to perform. In future, arm's-length bodies' independence will be about how they perform clear and agreed functions, not the freedom to assume new roles.

2.4 Arm's-length bodies will be required to deliver their functions effectively and efficiently, and minimise the burden on the front-line. Our arm's-length bodies will be expected to take full advantage of commercial opportunities to improve value for money in the delivery of their services.

2.5 There will need to be a step change in the drive for efficiency including driving down the cost of operational delivery as well as simply cutting waste. The challenge for the sector will be how it can best exploit the potential synergies between different bodies. The more that can be achieved in these areas, the more we can protect spending on front-line services.

2.6 The proposals set out in this document should be seen as an integral component of the Government's wider plans for rationalisation set out in *Equity and excellence: Liberating the NHS* to radically reduce the Department's NHS

functions, abolish the ten Strategic Health Authorities and replace Primary Care Trusts and practice-based commissioners with GP commissioning consortia. Taken together, these measures will create more autonomous institutions, with greater freedoms, clear duties and transparency. They will free up resources, devolve decision making and reduce bureaucracy.

Scope of the review

2.7 The Department's review covered its 18 arm's-length bodies. Annex A sets out the full list of those public bodies covered by the review.

2.8 *Equity and excellence: Liberating the NHS* sets out the changes across the wider health and social care system and the rationale for the changing roles for Monitor, the Care Quality Commission, the National Institute for Health and Clinical Excellence and the Health and Social Care Information Centre. In addition, the desire to create a shift of power to patients and clinicians has implications for the future role of information. Similarly, the creation of an NHS Commissioning Board and the system changes to the regional and local NHS management tier pose questions about whether functions currently in the arm's-length bodies sector might be better delivered elsewhere.

2.9 The main changes proposed in the White Paper which will have an impact on the current role and function of the arm's-length bodies sector are:

- the establishment of an NHS commissioning board, leading to opportunities to consolidate functions currently carried out in arm's-length bodies, such as the Care Quality Commission NHS commissioner assurance function and providing its role of national leadership on commissioning for quality improvement;
- the establishment of an economic regulator, leading to an expanded role for Monitor across health and social care;
- a strengthened and streamlined role for the Care Quality Commission as an effective quality inspectorate across both health and social care, with a role in strengthening the collective voice of patients and service users by the creation of Healthwatch England, a new independent champion within the Care Quality Commission;
- an expanded role for the National Institute for Health and Clinical Excellence and putting it on a firmer statutory footing, securing its independence and extending its remit into social care;
- the creation of a Public Health Service, to integrate and streamline existing health improvement and protection bodies and functions; and

- the centralisation of all data returns in the Health and Social Care Information Centre, leading to streamlining information and data collection functions across the arm's-length bodies sector; and putting the Health and Social Care Information Centre on a firmer statutory footing.

2.10 These wider changes provided us with an opportunity to undertake a detailed review of the functions of each arm's-length body to determine whether in the future health and social care system the functions are essential and whether they:

- are sufficiently technical that there is a scarcity of capability and expertise for the function to be provided by other means;
- need to be performed independently of Ministers to ensure political impartiality;
- provide accountability and assurance to patients, service users and taxpayers by independently establishing facts.

2.11 These criteria are consistent with those issued by the Cabinet Office for use in developing policy for the Public Bodies (Reform) Bill, announced in the Queen's Speech in May 2010. The aim of the cross-government work on public bodies is to increase accountability and transparency, as well as reduce the numbers' costs of public bodies. In addition, other factors might give preference to retaining functions at a national level, such as economies or scale of the need for consistency and standardisation.

2.12 From the work carried out it is clear that:

- some national functions are vital to safeguard the health and welfare of the public;
- some functions overlap and could be integrated to build on synergies and reduce overheads.
- some functions no longer need to be provided at a national level by the state.
- change is required to achieve greater alignment with the wider system changes and to deliver a more responsive service.
- real efficiencies have yet to be delivered across business support functions, including cost efficient estate utilisation.
- commercial opportunities have not been fully exploited.

Key principles for the arm's-length bodies sector

2.13 The following principles will be applied to the sector:

- devolution to the frontline: functions will only be exercised at a national level where it makes sense to do so.
- the number of arm's-length bodies will be kept to a necessary minimum. The scope of each arm's-length body will be clearly defined and each arm's-length body will be subject to triennial reviews to provide a regular assessment of the need for functions to continue and to ensure the organisations deliver value for money for the taxpayer.
- arm's-length bodies will be expected to collaborate and co-operate to ensure that duplication of activities, for example licensing and inspections, and data collection is minimised and unnecessary burdens and costs to the NHS are reduced.
- setting policy is the role of the Department of Health not arm's-length bodies, although arm's-length bodies will often have a role in policy development and implementation determined by the Department of Health.
- business support functions will maximise economies of scale while meeting the support needs of individual arm's-length bodies. Budgets will be benchmarked and managed down to ensure efficiency.
- in the interests of greater transparency and accountability, arm's-length bodies will be expected to publish performance information and benchmarking data online.
- where appropriate, arm's-length bodies will be expected to exploit commercial opportunities, for example outsourcing or divestment, to maximise commercial discipline across the sector.

Implications of the review

2.14 **A streamlined sector:** Fewer arm's-length bodies will mean fewer central organisations for frontline staff to have to deal with, and less resource tied up in administrative overheads associated with individual bodies, for example, boards and governance and business support functions such as finance, HR, and IT. Clarity of the scope of organisations will reduce mission creep.

2.15 **Less bureaucracy**: Key to the effective and efficient delivery of arm's-length bodies' functions will be their practical demonstration of the principles of good regulation (proportionate, accountable, consistent, transparent and targeted) throughout the range of their work. This will deliver an interaction with

providers that collectively impacts in a way which is far more positive than the sum of their individual activities.

2.16 **Reduced intervention:** Where appropriate, the level of intervention by arm's-length bodies will be rolled back, for example, integrated licensing and proportionate regulation using a risk-based approach to the frequency of inspections.

2.17 **Greater efficiency through contestability:** For large scale central functions, alternative organisational and delivery models may exist which will deliver services in a more cost effective way.

3 THE NEW CONFIGURATION OF ARM'S-LENGTH BODIES

3.1 Our White Paper *Equity and excellence: Liberating the NHS* sets out our intention to:

- establish an independent NHS Board;
- expand Monitor's role so that it becomes an economic regulator;
- strengthen and streamline the Care Quality Commission as a quality inspectorate;
- expand the role of the National Institute for Health and Clinical Excellence to develop quality standards for social care and put it on firmer statutory footing;
- put the Health and Social Care Information Centre on a firmer statutory footing; and
- create a new Public Health Service within the Department of Health.

3.2 The proposals set out in this document take account of these system changes and, where appropriate, essential functions will be transferred from our arm's-length bodies sector to other parts of the wider system.

3.3 The assessment of our arm's-length bodies means that, subject to Parliamentary approval:

- six of our arm's-length bodies have a clear future as arm's-length bodies, albeit operating in the most cost effective and efficient way: Monitor, the Care Quality Commission, the National Institute for Health and Clinical Excellence, the Medicines & Healthcare products Regulatory Agency, the Health and Social Care Information Centre and NHS Blood & Transplant;
- the functions of two of our arm's-length bodies will be transferred to other organisations to achieve greater synergies where appropriate: the Human Fertilisation and Embryology Authority and the Human Tissue Authority. Further work is required to examine in greater detail the practicalities involved and we propose that they remain as independent arm's-length bodies in the short term, with the aim that their functions will be transferred by the end of the current Parliament;

- two of our arm's-length bodies will be abolished as statutory organisations and their functions will be transferred to the Secretary of State as part of the new Public Health Service: the Health Protection Agency and the National Treatment Agency;

- there are four of our arm's-length bodies which we propose to abolish from the sector; the Alcohol Education Research Council, the Appointments Commission, the National Patient Safety Agency and NHS Institute for Innovation and Improvement.

- one of our arm's-length bodies will be moved out of the sector to operate on a full-cost recovery basis: the Council for Healthcare Regulatory Excellence;

- one of our arm's-length bodies will have its function transferred to an existing professional regulator: the General Social Care Council;

- two of our arm's-length bodies will be subject to a commercial review by industry experts to identify potential opportunities for greater efficiency through outsourcing, divestment and contestability and/or employee ownership: NHS Litigation Authority and NHS Business Services Authority.

3.4 Overall, these proposals will simplify the national landscape, reduce duplication and bureaucracy and better align the arm's-length bodies sector with the rest of the health and social care system by:

- ensuring that functions related to quality and safety improvement are devolved closer to the frontline;

- integrating and streamlining existing national health improvement and protection bodies and functions within a new Public Health Service;

- creating a more coherent and resilient regulatory system with clarity of responsibilities and reduced bureaucracy around licensing and inspection;

- centralising data returns in the Health and Social Care Information Centre;

- maximising opportunities for outsourcing of functions and shared business support functions across the sector to reduce overall costs and seeking to realise assets through the commercialisation of activities.

3.5 We propose the following for each of our arm's-length bodies:

Raising Standards

National Institute for Health and Clinical Excellence (NICE)

3.6 The National Institute for Health and Clinical Excellence is a Special Health Authority, which was established to improve the quality of care that patients receive and to reduce the variation in the quality of care. The National Institute for Health and Clinical Excellence provides national guidance on public health, health technologies, clinical practice and interventional procedures. Its authoritative advice will be essential in future to support the work of the NHS Commissioning Board in developing quality standards along each part of the patient pathway, and outcome indicators for each step. The National Institute for Health and Clinical Excellence will rapidly expand its existing work programme to create a broad library of standards for all the main pathways of care. The standards will extend beyond NHS care, informing the work of local authorities and the Public Health Service. We intend that the forthcoming Health Bill will contain provisions to put the National Institute for Health and Clinical Excellence on a firmer statutory footing securing its independence and core functions and extending its remit to social care.

3.7 We intend to expand the role of the National Institute for Health and Clinical Excellence to develop quality standards for adult social care. In addition, proposals for the creation of a Public Health Service are likely to impact on the National Institute for Health and Clinical Excellence's public health functions. It is envisaged that the National Institute for Health and Clinical Excellence will retain a public health function, and that it will provide advice to Secretary of State on specific topics he refers to them.

Rationalising the regulatory landscape

3.8 Best practice suggests that regulation should be relevant, effective and proportionate. This has implications for the way we organise the regulators in health and social care. Each should have a clear remit, with clear authority and minimal overlap between one regulator and another. But from the perspective of those who are regulated, it is also important to minimise the bureaucratic overhead due to multiple lines of accountability, licences, inspections, data collections, and so on.

3.9 Where we see an essential and continuing role for regulation, we have assessed whether the regulator's functions really do need to be delivered by an arm's-length body. If they do not, we have considered the alternatives. And, in all instances we have considered the cost effectiveness of the arrangements, for the benefit of the taxpayer and for those who are regulated.

3.10 So in future, we propose to have:

- one quality regulator;
- one economic regulator;
- one medicines and devices regulator; and
- one research regulator.

3.11 The quality and economic regulators will work closely together to deliver a joint licensing regime.

3.12 Over time we propose that these bodies will largely assume the responsibilities of the regulators currently responsible for human fertilisation and embryology, and for human tissue. We intend to transfer responsibility for the regulation of social workers out of the arm's-length bodies sector to an existing professional regulator and to remove from the arm's-length bodies sector the body responsible for oversight of the nine professional regulators.

Care Quality Commission (CQC) – a single quality inspectorate

3.13 The Care Quality Commission is an executive non-departmental body (NDPB) which registers health and social care providers against essential levels of safety and quality, and has significant powers of enforcement. The Care Quality Commission undertakes inspections and special reviews, and currently undertakes periodic reviews of health and social care, including commissioners. The Care Quality Commission is also responsible for protecting the rights of people detained under the Mental Health Act.

3.14 We consider that overall the Care Quality Commission's functions satisfy the criteria for arm's-length body status. There are significant benefits in retaining an integrated health and social care quality regulator. The Care Quality Commission has demonstrated cost effectiveness, delivering the registration of NHS organisations whilst making significant progress in realising economies of scope and scale from the bringing together of three predecessor bodies (the Mental Health Act Commission, the Health Care Commission, and the Commission for Social Care Inspection) into one organisation.

3.15 We therefore propose only limited changes to the Care Quality Commission's existing functions. The Care Quality Commission will continue to act as the quality inspectorate across health and social care for both publicly and privately funded care. To avoid double jeopardy and duplication, the NHS Commissioning Board will take over the current Care Quality Commission responsibility of assessing NHS commissioners, although the Care Quality Commission will continue to conduct periodic reviews of adult social care and retain its responsibilities under the Mental Health Act.

3.16 In relation to the NHS the Care Quality Commission will, together with Monitor, operate a joint licensing regime. The Care Quality Commission and Monitor already have a duty of co-operation in primary legislation to work closely together to ensure that the regulatory burden of multiple licences is reduced, whilst ensuring robust and proportionate regulation. In due course, subject to changes described elsewhere in this section, it is possible that the Care Quality Commission could take on responsibility for a broader range of licensing functions, including some of the functions of the Human Embryology and Fertilisation Authority and the Human Tissue Authority. Once again, we would expect to see a more integrated and coherent approach to licensing so that the outcome is effective and proportionate regulation, minimising the regulatory burden and maximising cost effectiveness.

3.17 The Care Quality Commission will continue to inspect providers against essential levels of safety and quality in a targeted and risk-based way, taking into account information it receives about a provider. We intend that this information will come through a range of sources including patient feedback and complaints, Healthwatch England, GP consortia and the NHS Commissioning Board. Where inspection reveals that a provider is not meeting essential levels of safety and quality, the Care Quality Commission will take enforcement action to bring about improvement.

3.18 Finally, we propose that Healthwatch England, a new independent consumer champion, which will be an advocate for patients' rights and concerns, will be located with a distinct identity within the Care Quality Commission and will enjoy the benefits of the Care Quality Commission's independence and scale of operations, including avoiding duplicating work on the assessment of public opinions on health and care issues.

Monitor – a single economic regulator

3.19 Monitor – currently responsible for authorising and regulating NHS Foundation Trusts – will, subject to legislation, be transformed into a new economic regulator. Economic regulation, and the future role of Monitor, is the subject of a separate document in this series and is therefore not discussed further here.

Medicines and Healthcare products Regulatory Agency (MHRA) – a single medicines and devices regulator

3.20 The Medicines and Healthcare products Regulatory Agency is an Executive Agency of the Department of Health, which regulates production of medicines and other healthcare products. It is responsible for ensuring that medicines and medical devices work and are acceptably safe. The Medicines and Healthcare products Regulatory Agency provides advice to the Secretary of State on medicines and devices, and leads the negotiation and implementation of the Medicines Act and European legislation. Its functions are essential, and it satisfies the Government's test for arm's-length bodies to remain in the sector. The Medicines and Healthcare products Regulatory Agency is largely self-funding through the fees it charges. Therefore, we do not propose to change the status of the Medicines and Healthcare products Regulatory Agency, nor do we intend to transfer its functions to another body. There is a question as to whether it would be most appropriate to transfer to the Medicines and Healthcare products Regulatory Agency some of the Human Tissue Authority's functions in respect of licensing establishments working with tissues and cells for human application. This would be subject to further work around how the transfer of the Human Tissue Authority's functions will be effected and would not be taken forward in the Health Bill.

A new research regulator

3.21 We have asked the Academy of Medical Sciences to conduct an independent review of the regulation and governance of medical research which is expected to report in autumn 2010. Currently a number of different arm's-length bodies have responsibility for different aspects of research regulation, including giving permissions. There is a strong argument for rationalising this and creating greater strategic coherence around research by placing responsibility for these different aspects of medical research regulation within one arm's-length body that would perform a stand-alone technical function as a research regulator. This would streamline the process of gaining permission to undertake medical research, making it more attractive to universities and health institutions. Moreover, there is potential for a single research regulator to have wider cross-government reach.

3.22 In the light of the Academy of Medical Sciences review, we will consider legislation affecting medical research, and the bureaucracy that flows from it, and bring forward plans for radical simplification.

Human Tissue Authority (HTA)

3.23 The Human Tissue Authority was established in 2005 in response to inquiries into the taking and retention of body parts without consent at Alder Hey, Bristol

and elsewhere. It oversees the removal, storage and use of organs and tissue from deceased people, and the storage and use of organs and tissue taken from living people, for certain activities specified in the Human Tissue Act 2004. It also acts as the Competent Authority for the EU Directive on Tissues and Cells, overseeing the donation, procurement, testing, processing, preservation, storage and distribution of human tissues and cells for human application.

3.24 Many of the functions performed by the Human Tissue Authority remain essential and satisfy the tests for arm's-length bodies, but we do not consider that there is a compelling case for the Human Tissue Authority to remain a separate entity. On the contrary, we believe that there is significant potential to achieve greater synergy and cost effectiveness through transferring the functions of the Human Tissue Authority to other organisations as follows.

3.25 First, we propose that the Human Tissue Authority's licensing activities, in respect of the removal, storage and use of tissue, should be transferred to the Care Quality Commission. These activities could potentially benefit from alignment with the Care Quality Commission's wider inspection and licensing teams to provide a single licensing framework for activities involving human tissue. This will be considered alongside exploring a possible role for the Medicines and Healthcare products Regulatory Agency in relation to tissues and cells for human application.

3.26 And second, we propose that the Human Tissue Authority's regulatory function relating to research could be transferred to a new research regulator, as described above. The research regulatory activities of the Human Tissue Authority are within the scope of the Academy of Medical Sciences review of medical and science research regulation, and subject to the outcome of that review we consider that there could be significant advantage in consolidating the Human Tissue Authority's research regulation with similar functions from the Human Fertilisation and Embryology Authority and the National Patient Safety Agency (i.e. the National Research Ethics Service).

3.27 The timing and detail of these changes will be dependent on the outcome of the Academy of Medical Sciences review and on a further detailed examination of the legislative implications, including the impact on devolved administrations. The legal framework within which the Human Tissue Authority operates is complex, and we recognise the extraordinary sensitivity of this subject area. Given the complexity of the legislative framework, and the amount of work needed to ensure that the functions which are transferred to other organisations (e.g. the Care Quality Commission and a research regulator) are fully integrated into their new organisation, we do not intend to legislate for this in the Health Bill in the autumn.

3.28 We will engage with the Human Tissue Authority and other key stakeholders to develop detailed proposals, including options for handling those functions currently carried out by the Human Tissue Authority that may not sit well with the Care Quality Commission or the proposed new research regulator (for example the regulation of the public display of human material and the approval of live donations of organs, bone marrow and peripheral blood stem cells for transplantation).

Human Fertilisation and Embryology Authority (HFEA)

3.29 The Human Fertilisation and Embryology Authority is responsible for licensing fertility treatments and research conducted using human embryos. As such, it deals with issues that are judicially and ethically complex and contentious. By being at arm's-length, the Human Fertilisation and Embryology Authority separates sensitive issues from government and its independence is trusted. The Human Fertilisation and Embryology Authority's functions satisfy the criteria for being undertaken by an arm's-length body.

3.30 Notwithstanding this, there are clear synergies between some of the functions performed by the Human Fertilisation and Embryology Authority, the Human Tissue Authority and the Care Quality Commission, and there is significant read across to the potential scope of a new research regulator. There are therefore opportunities to rationalise some of the Human Fertilisation and Embryology Authority's functions that would lead to a different organisational solution for the future. As with the Human Tissue Authority, the Human Fertilisation and Embryology Authority research licensing function is subject to the wider review by the Academy of Medical Science on research and governance regulation, due to report in the autumn. Moving this function to a new research regulator, to achieve the benefits described above, reduces the justification for the Human Embryology and Fertilisation Authority to continue as a separate regulator, and opens the way for its remaining functions relating to the regulation of fertility clinics to be transferred to the Care Quality Commission.

3.31 This would help ensure that maintenance of the register of treatment, the provision of information for donor-conceived people and researchers, the provision of a Code of Practice for centres, and information for patients and licensing are kept whole. There may be potential for the Human Fertilisation and Embryology Authority's information collection and retention functions to pass to the Health and Social Care Information Centre, in line with the general approach to other arm's-length bodies' information needs, but the particular confidentiality issues need further consideration.

3.32 As with the Human Tissue Authority, the legal framework within which the Human Fertilisation and Embryology Authority operates is complex, and we

recognise the extraordinary sensitivity of this subject area. Given the complexity of the legislative framework, and the amount of work needed to ensure that the functions which are transferred to other organisations (e.g. the Care Quality Commission and the research regulator) are fully integrated into their new organisation, we do not intend to legislate for this in the Health Bill in the autumn, but aim to introduce the necessary legislation within the Parliament. We intend to engage fully with the Human Fertilisation and Embryology Authority, the Human Tissue Authority and other key stakeholders to develop detailed proposals with a view to bringing forward legislation to achieve these changes in due course.

3.33 Therefore, we propose that the Human Fertilisation and Embryology Authority should remain as a separate arm's-length body in the short term with the aim that its functions will be transferred by the end of the current Parliament. In the meantime, we will examine in greater detail the practicalities (and legal implications) of how to divide the Human Fertilisation and Embryology Authority functions between a new research regulator and the Care Quality Commission.

Council for Healthcare Regulatory Excellence (CHRE)

3.34 The Council for Healthcare Regulatory Excellence is an Executive Non-Departmental Public Body responsible for scrutiny and quality assurance of the nine health care professions regulators in the UK. We have considered whether it is essential that there continues to be a regulator of the professional regulators. We concluded that the Council for Healthcare Regulatory Excellence does currently fulfill an ongoing need to quality assure professional regulation, but we will keep this under review.

3.35 Going forward, we see no compelling reason why the Council for Healthcare Regulatory Excellence should remain as an Executive Non-Departmental Public Body in the arm's-length bodies sector. Therefore, we propose to make it self-funding through a levy on those it regulates. We also propose to extend the Council for Healthcare Regulatory Excellence's remit to set standards for and to quality assure, voluntary registers held by existing statutory health and care professions regulators, and others such as professional bodies. We intend to include provisions in the Health Bill to make these and associated changes.

General Social Care Council (GSCC)

3.36 The General Social Care Council is an Exective Non-Departmental Public Body responsible for the regulation of social workers and social work students in England. It is anomalous as the only professional regulator answerable directly to the Secretary of State for Health.

3.37 We see no compelling reason why the General Social Care Council should remain as an Executive Non-Departmental Public Body in the arm's-length bodies sector, and we see potentially significant benefits from putting the regulation of social workers on a similar footing to the regulation of health professions. This involves the regulator being funded through registration fees charged to those registered, set at a level to cover the regulatory functions. In this way members of a regulated profession buy into their professional standards, which are set independently of government, and have an incentive to ensure these are upheld throughout the profession.

3.38 Therefore, we intend to abolish the General Social Care Council and move the regulation of social workers out of the arm's-length bodies sector to make it financially independent of government. We believe that in future, the most appropriate model for the ongoing regulation of the social care workforce is to transfer responsibility for these functions to the Health Professions Council, a well established and efficient regulatory body currently regulating over 200,000 registrants from fifteen professions. The Health Professions Council - which will be renamed to reflect its new remit - operates a full cost recovery scheme and currently charges an annual fee of £76 per year, which is considerably less than the likely registration fee if the General Social Care Council were to operate alone on a full-cost recovery basis.

3.39 The Health Professions Council has an existing comprehensive and cohesive system of professional regulation which would apply to social care workers. This differs from the General Social Care Council model in several ways:

- the Health Professions Council is solely responsible for setting standards of education and training for its registrants, whereas it is the Secretary of State's function to ascertain what training is required to become a social worker;

- unlike the General Social Care Council, the Health Professions Council do not register students, though as part of the approval process the Health Professions Council requires all Higher Education Institutes delivering pre-registration courses to operate a fitness for practice system for students;

- unlike the General Social Care Council, the Health Profession Council does not in practice approve post-registration courses apart from those related to prescribing drugs, although it has the power to do so.

3.40 We anticipate that the differences would be explored through a review of social care regulation. The abolition of the General Social Care Council, the transfer of functions in relation to the regulation of the social worker workforce and related changes will require primary legislation. The timing of these changes is

dependent on discussion with the Health Professions Council and the General Social Care Council to ensure an orderly transition.

3.41 Finally, the General Social Care Council is also responsible for the payment of Education Support Grants, and we propose that if this function is to continue it should transfer to another body.

A Public Health Service

3.42 We propose to support the cross-government public health strategy through the creation of a new Public Health Service directly accountable to the Secretary of State, to integrate and streamline existing health improvement and protection bodies and functions, with an increased emphasis on research, analysis and evaluation. As a part of that development we intend to abolish the Health Protection Agency and the National Treatment Agency for Substance Misuse as statutory organisations and transfer their functions to the Secretary of State as part of the Public Health Service.

3.43 The critical functions of the National Treatment Agency for Substance Misuse which support the local delivery of drug treatment services would be integrated into the Public Health Service. We believe that this move would tackle the dependency problems of individuals, and address the entire range of issues which users face. The full recovery of drug users back into society, housing and employment will provide significant benefits to all.

3.44 Our programme for public health will be set out later this year and more detail on what it means for these two organisations, and dedicated public health ring-fenced funding to support delivery of local services, will be set out in the context of the new Public Health Service. We will engage with the Health Protection Agency and the National Treatment Agency for Substance Misuse to ensure a smooth and orderly transition.

Alcohol Education and Research Council (AERC)

3.45 The Alcohol Education and Research Council was established as an Executive Non-Departmental Public Body via the Licensing (Alcohol Education and Research) Act 1981. The Alcohol Education and Research Council has charitable status and administers a fund of around £8m to support research into the prevention of alcohol-related harm. The Department does not provide funding for this arm's-length body. Overall, the organisation does not satisfy the criteria for Department of Health arm's-length bodies. We intend to remove this organisation from our arm's-length bodies sector while seeking to maximise opportunities for the organisation to contribute to the development of the evidence base for effective policy across Government to reduce harm from

alcohol misuse. We will engage with the Alcohol Education and Research Council on the options.

NHS Blood and Transplant (NHS BT)

3.46 NHS Blood and Transplant is a Special Health Authority, responsible for securing the safe supply of blood to the NHS in England and Wales, and similarly, solid organs, tissues, and stem cells across the UK. NHS Blood and Transplant works closely with the Devolved Administrations, charities and the NHS to promote altruistic donation for the benefit of patients. Through the Bio Products Laboratory, NHS Blood and Transplant also manufactures therapeutic plasma products which are supplied on a commercial basis to the NHS and world markets.

3.47 There are strong arguments for retaining the majority of these functions within a single national system. These arguments include: economy of scale and supply; public health requirements in relation to quality, safety and consistency across the blood, tissue and transplant service; and critically, public sensitivities regarding the voluntary donation of blood, tissues and organs. We consider that transferring NHS Blood and Transplant out of the arm's-length bodies sector and moving to a different delivery model would risk destabilising the current national donor system.

3.48 However, we do consider that Bio Products Laboratory will benefit from greater commercial freedom and closer integration with its plasma supply chain, and it will therefore be transferred into a Department of Health-owned limited company. There may be opportunities for more cost effective operations and commercial arrangement within the remaining divisions of NHS Blood and Transplant, such as contracting out some discrete functions, provided there is no conflict with the public health considerations. We therefore recommend that, with the exception of Bio Products Laboratory, the organisation remains within the arm's-length body sector and we will commission an in-depth review into opportunities to make it more commercially effective. Subject to the findings of the commercial review, we propose to work with the Devolved Administrations to explore the potential for the UK blood services to enhance opportunities for cost-effective working between them.

Information and Intelligence

Health and Social Care Information Centre (IC)

3.49. Information, combined with the right support, is the key to better care, better outcomes and reduced costs. However, within the arm's-length bodies sector and across the wider infrastructure supporting health and social care, there is a duplication of roles and responsibilities around collection, analysis and

dissemination of information. This is no longer acceptable as it places a significant burden and costs on the frontline. We intend to make aggregate data widely available to patients, the public, researchers and other organisations in a standard format.

3.50 To achieve this we propose that the Health and Social Care Information Centre will become the national repository for data across health care, public health and adult social care with lead responsibility for data collection and assuring the data quality of those returns. It will make data available for use by third parties. It will need to meet the needs of a multiplicity of customers: the DH, the NHS, local authorities, social care, regulators, researchers, the Office for National Statistics, the public and Parliament. This proposal would mean that other arm's-length bodies would relinquish their data collection roles to the Health and Social Care Information Centre. In future, the relationship between the NHS Commissioning Board and the Health and Social Care Information Centre will be critical to ensure that the NHS Commissioning Board can exercise its management functions. The forthcoming Health Bill will contain provisions to put the Health and Social Care Information Centre on a firmer statutory footing, with clearer powers across organisations in the health and care system, with a functional scope focussed on data collection and giving it powers across organisations in the health and social care system.

3.51 All of this is expected to minimise existing duplication and overlap in collections of data from multiple organisations as well as the overall cost of collection to the system.

3.52 The way in which the Health and Social Care Information Centre would perform this role will be covered further in an Information Strategy to be published later this year.

Public Appointments

Appointments Commission (AC)

3.53 The Appointments Commission provides recruitment services and related functions (managing suspensions) at reasonable costs, provides value for money and has built up considerable NHS expertise. The Commission has been a very valuable body for Department of Health and the NHS over the last decade. It has an important role to play to support reorganisation in both the NHS and arm's-length bodies sector over the forthcoming transition period, to ensure we retain effective boards and transitions are well-managed.

3.54 However, in the future, NHS Trusts are expected to become Foundation Trusts and SHAs are to be abolished. The Government's intention for the future of PCTs has been set out in the White Paper and the ending of PCT public

appointments means that in the future the Commission's NHS work would disappear. The emerging future model across government is one where there will also be a sizeable reduction in the number of national public appointments. Accountability for these appointments would rest with Ministers and the process will remain subject to scrutiny by the Commissioner for Public Appointments, to ensure the process remains open, transparent and appointments are made on merit. The Government has also signalled that key appointments may also be subject to Select Committee scrutiny.

3.55 The NHS and public appointments landscape is to change radically and there will be no need for an on-going central public body to carry out the functions the Commission currently provide beyond 2012. We therefore propose to abolish the Appointments Commission during 2012 and we will engage with the Commission on managing a transition period to abolition.

Quality and Safety Improvement

3.56 Patient safety is synonymous with improving overall clinical excellence and sits at the heart of the quality agenda. Currently, functions associated with quality and safety improvement are distributed across a number of arm's-length bodies as well as elsewhere in the health and social care system. This creates complexity and there is still some way to go to embed improvement fully across the NHS.

3.57 In future, the NHS Commissioning Board will provide national leadership on commissioning for quality improvement and we propose that some essential functions supporting this role from the National Patient Safety Agency and the NHS Institute for Innovation and Improvement should be brought together within the mainstream work of the NHS Commissioning Board to exploit the leverage that commissioning would provide in placing quality and safety at the heart of patient care.

National Patient Safety Agency (NPSA)

3.58 The National Patient Safety Agency was established as a Special Health Authority in 2001. Its core function is to improve the safety of NHS care by promoting a culture of reporting and learning from adverse events. It does this primarily through its Patient Safety Division, which runs the National Reporting and Learning Systems.

3.59 Following the last review of arm's-length bodies, a number of other discrete functions related to patient safety were brought together within the National Patient Safety Agency. The functions of the organisation, whilst necessary within a system supporting wider quality and safety improvement, do not of

themselves need to be performed at arm's-length of the Department and could be delivered elsewhere in the system.

3.60 We propose to abolish the National Patient Safety Agency. Some National Patient Safety Agency functions will become part of the remit of the NHS Board, while others will be supported to continue in other ways. The following functions will transfer to elsewhere in the wider health system:

3.61 The work of the Patient Safety Division relating to reporting and learning from serious patient safety incidents should move to the NHS Commissioning Board, as a Patient Safety sub-committee of the Board, covering the whole function from getting evidence to working up evidence-based safe services. This would provide an opportunity to preserve the synergy between learning and operational practice that already exists in the system. We will engage with the National Patient Safety Agency to discuss the transitional arrangements for the Patient Safety Division.

3.62 The National Clinical Assessment Service, which helps healthcare managers and practitioners to understand, manage and prevent concerns with the performance of doctors, dentists and pharmacists, should continue in the short term. It is valued by employers of doctors, dentists and pharmacists whose performance calls for rehabilitation to ensure continued safe practice. However, there is an expectation that revalidation of the medical profession and other incentives in the system will reduce the need for this service in the future. We propose that, over the next few years, the National Clinical Assessment Service will become a self-funded service and the Department intends to agree a date with the service for achieving self-sufficiency.

3.63 The National Research Ethics Service helps protect the interests of patients and research participants in clinical trials and facilitates and promotes ethical research. It includes recognising and authorising Research Ethics Committees, which approve individual research applications. We propose that the future of the National Research Ethics Service is considered as part of the wider Academy of Medical Science's review of research regulation with a view to moving this function into a single research regulatory body.

3.64 The National Patient Safety Agency currently commissions three confidential enquiries to provide learning on what went wrong in adverse healthcare incidents. In future, the enquiries could sit with the National Clinical Audit Patient Outcome Programme (NCAPOP – consists of 30 individual national clinical audits) managed on behalf of the Department by the Healthcare Quality Improvement Partnership (HQIP).

3.65 We will engage with the National Patient Safety Agency about the implementation of the proposals contained in this document.

NHS Institute for Innovation and Improvement (NHS III)

3.66 The NHS Institute for Innovation and Improvement was established as a Special Health Authority under the National Health Service Act 2006 and is an arm's-length body sponsored by the Department of Health to act as the NHS' "in house improvement organisation". Its purpose is to support the NHS to transform healthcare for patients and the public by rapidly developing and spreading new ways of working, new technology and world-class leadership. It supports NHS organisations in analysing their current practices against best practice and implementing changes to achieve better results.

3.67 It is currently funded largely through grant in aid from the Department of Health; in addition it has been developing a commercial model selling additional services to the NHS and international organisations to generate revenue that can be reinvested in further NHS work.

3.68 The NHS Institute for Innovation and Improvement has provided leadership and tools to support quality improvements across the NHS. In future, the NHS Commissioning Board will assume a leadership role in commissioning for quality improvement and the responsibility for improving outcomes will occur at every level of the NHS.

3.69 In assessing the NHS Institute for Innovation and Improvement it does not satisfy the criteria for an arm's-length body and we intend therefore to abolish the NHS Institute for Innovation and Improvement as an arm's-length body, transferring to the NHS Commissioning Board those functions that will support the Board in leading on quality improvement and building capacity within the wider system.

3.70 We will engage with the NHS Institute for Innovation and Improvement on reviewing and evaluating its remaining functions with a view to determining whether opportunities exist for alternative commercial delivery models, for example, creating a social enterprise or independent membership organisation, and whether or not to stop providing certain functions altogether.

3.71 The NHS Institute for Innovation and Improvement also manages the NHS management training schemes along with their associated bursaries. The future of these schemes and their administration will be considered in the wider context of the recent White Paper.

Exploring commercial opportunities

NHS Litigation Authority (NHS LA)

3.72 The NHS Litigation Authority is a Special Health Authority, responsible for the management and settlement of very large current and future liabilities attached to NHS bodies. These liabilities accrue predominantly, but not wholly, as a result of clinical negligence claims.

3.73 There is a strong case for pooling risk between NHS organisations – there are obvious economies of scale and it does not make sense to disaggregate responsibility for managing the risk and processing the claims and payment. But, it is not clear that this function satisfies the criteria for arm's-length bodies status, and there may be potential for greater efficiencies. More importantly, we consider that there may be opportunities to introduce greater commercial management and practice to improve the efficiency of the services provided. We therefore intend to commission an industry review of the NHS Litigation Authority, to identify these potential opportunities for greater commercial involvement, recognising the impact on future organisational form, with a view to its likely removal from the arm's-length bodies sector as soon as is practicably possible.

NHS Business Services Authority (NHS BSA)

3.74 The NHS Business Services Authority processes transactions for the NHS where there are significant economies of scale in undertaking them once at a national level. The organisation provides, for example, pensions administration and dental and prescription payments. In addition, the NHS Business Service Authority has a number of discrete responsibilities (e.g. counter fraud, dental inspections and supply chain contract management) where there is less obvious alignment with the core purpose.

3.75 Although it is not clear that the NHS Business Services Authority functions satisfy the three criteria for arm's-length bodies status, there are economies of scale for some of their activities by performing them nationally. However, there may be potential for alternative delivery models and we consider that there may be significant opportunities to introduce commercial skills and management to improve the efficiency of the services provided. We therefore intend to commission a commercial review of the NHS Business Services Authority, to identify potential opportunities for greater private sector involvement, including the possibility of removing activities from the arm's-length body sector. In addition we will explore opportunities to remove from the NHS Business Services Authority their non-core activities, and where necessary finding an alternative approach to delivering the functions.

3.76 The NHS Business Services Authority was set up through secondary legislation, therefore any changes may not require primary legislation, though this would depend on the precise approach. We do not anticipate any NHS Business Service Authority specific provisions in the forthcoming Health Bill.

4 REDUCING BUREAUCRACY AND INCREASING EFFICIENCIES

4.1 Reconfiguration of organisations or rationalisation of functions will not, of themselves, offer up the scale of savings required, and in any event would largely be achieved towards the end of the savings period. But, together with the measures outlined below, such as tightening governance and aggregating business support functions, these changes will contribute to a comprehensive reduction in the Department's spend across the sector, a reduction in duplication and improved cost effectiveness.

4.2 Even where current arm's-length bodies remain relatively unchanged, there is an expectation that they will all contribute significant efficiency savings.

4.3 We will identify opportunities to raise capital and improve the commercial performance of trading activities within the arm's-length bodies sector and the Department of Health, increasing independent sector ownership and involvement in trading activities, and outsourcing. This builds on an existing commercialisation and divestment programme within the Department.

4.4 We will expect all arm's-length bodies to work towards integrating their business support functions to achieve greater efficiencies and economies of scale across arm's-length bodies and Department of Health business support functions, including finance and payroll. Allied to this, there is work to maximise efficient and effective use of arm's-length bodies and Department of Health estate leading to opportunities to reduce the number of properties across the arm's-length bodies and Department of Health portfolio and wherever possible, co-locate organisations.

4.5 We will also introduce tighter governance and accountability of the management of the arm's-length bodies sector, which could include:

- putting the Department of Health governance arrangements of arm's-length bodies on a professional footing to ensure: that all arm's-length bodies have clarity about the scope of their functions, accountabilities and objectives; stop mission creep; and drive up efficiency, effectiveness and value for money;
- increasing public accountability and transparency by requiring arm's-length bodies to publish more information, including financial and performance information; and

- ensuring that arm's-length bodies boards are streamlined and have the right skills and composition to operate effectively, drive value for money and challenge performance.

4.6 A key part of the future operation of arm's-length bodies will be to ensure that the burden of their activities on providers (and any other organisation) is both understood and justifiable. Cumulatively, across the arm's-length bodies sector, this burden should reduce year-on-year as measured by quantitative and qualitative feedback from providers.

4.7 To achieve this reduction will require individual arm's-length bodies to embed the principles of good regulation (proportionate, accountable, consistent, transparent and targeted) within the culture and practice of their organisations. Paramount within this will be to act on feedback from customers to develop and utilise more innovative methods to deliver their functions effectively.

4.8 To achieve a collective reduction in burden year-on-year, individual arm's-length bodies will work proactively in partnership with others, co-ordinating and scheduling activity, sharing methodologies, findings and views, to achieve a more complementary programme of activities from a provider perspective.

4.9 Centralisation of data collections in the Health and Social Care Information Centre is intended to help drive through a reduction in burden through the removal of duplication, overlap and similar requests in slightly different forms, and ensure that the flow of any future data collections is effectively dealt with.

5 MAKING IT HAPPEN

Engaging external organisations and transition to the new landscape

5.1 This report describes a set of changes across the arm's-length bodies sector within the context of the wider changes envisaged for the NHS in *Equity and excellence: Liberating the NHS.*

5.2 Much work now needs to be undertaken to implement the changes described in the document. We will engage with the arm's-length bodies and key stakeholders, including the Devolved Administrations and other government departments, to flesh out the detail of each recommendation and will draw on the expertise of the arm's-length bodies sector and others to develop detailed implementation plans.

5.3 We expect that implementation of the proposals will be completed by 2014 in line with the wider system changes. To support the changes envisaged across the whole system, the Department will issue a framework for managing the initial transition steps. This will include the principles and the values that the Department will hold itself to, to ensure that the transition is managed fairly and transparently, and in a way that respects staff and the contributions they make. Some organisations will disappear and some functions will shift to other organisations as a result of the changes described in this document. We will work with the individual arm's-length bodies to ensure that these changes are managed smoothly and ensure that business continuity is maintained throughout the transition period. Annex C sets out an indicative implementation timeline.

5.4 We intend as a priority to take forward proposals to reduce the cost of the business support functions of the arm's-length bodies by increasing the level of integration and sharing resources, and making greater use of private sector involvement. We will engage with arm's-length bodies on a programme to make some initial savings within 12-18 months, with a staged implementation to the optimum level of integration, sharing and use of the private sector over the next 2-3 years. The programme includes identifying opportunities for estate rationalisation and co-location of organisations.

5.5 We have already put in place spending controls around pay, expenses, travel, consultancy, communications and IT and we envisage that these controls will continue. Arm's-length bodies will have less freedom to determine how they spend their money in these areas.

5.6 We will introduce tighter governance and sponsorship arrangements from April 2011, and we intend to issue new framework agreements setting out clearly the Department's understanding of the scope of the arm's-length bodies' functions and clear objectives against which they will be held to account.

Legislative changes

5.7 Many of the changes outlined in this document will require primary and secondary legislation. The Queen's speech included a major Health Bill and a Public Bodies Bill for the first legislative programme. The Government will introduce these bills this autumn and the changes, where appropriate, will be enacted through one of these bills: our intention is that the majority of changes will be in place during 2012/13.

Arm's-Length Bodies reviewed 2010 Annex A

Arm's-length bodies	Type	Role	Proposal
Alcohol Education and Research Council	Executive Non-Departmental Public Body (ENDPB) and registered charity	Administers the Alcohol Education and Research Fund	**Abolish** as an ALB and remove from the sector, while seeking to maximise the opportunities for effective cross-government policy to reduce the harm from alcohol misuse.
Appointments Commission	ENDPB	Makes public appointments	**Abolish** as an ALB during 2012 in view of the very substantial reduction in the number of appointments required. Move remaining appointments to the Department of Health.
Care Quality Commission	ENDPB	Regulates health and adult social care provision	**Retain** as quality inspectorate across health and social care, operating a joint licensing regime with Monitor. Host organisation for Healthwatch England. Current responsibility of assessing NHS commissioning moves to the NHS Commissioning Board. May receive

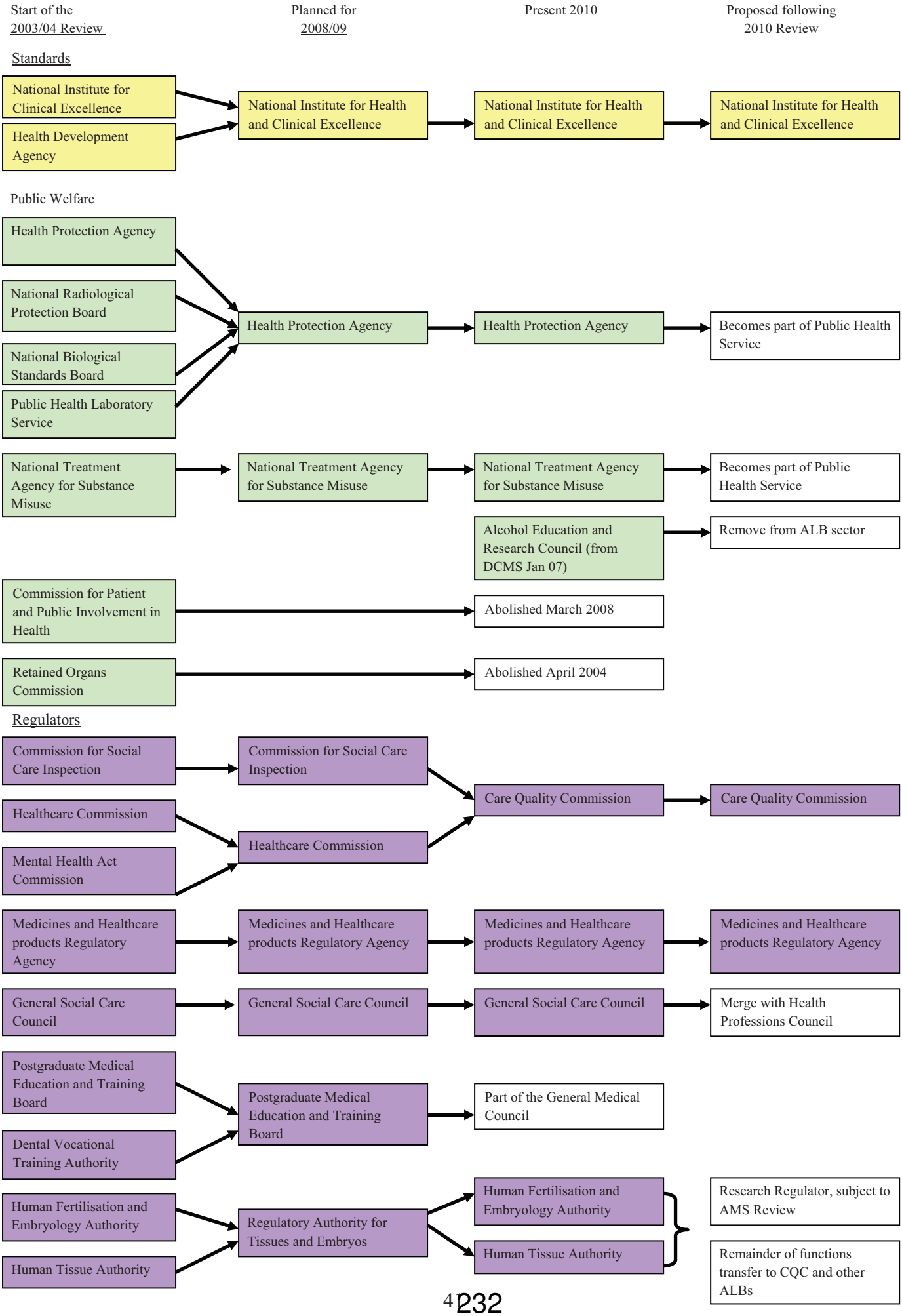
Arm's-length bodies	Type	Role	Proposal
			functions from other organisations, e.g. HTA and HFEA.
Council for Healthcare Regulatory Excellence	ENDPB	Oversees professional regulators	**Remove** from the sector. Make a self-funding body by charging a levy on regulators. Extend role to set standards for and quality assure voluntary registers.
General Social Care Council	ENDPB	Regulates social workers	**Transfer** the regulation of social workers to the Health Professions Council, which will be renamed to reflect its new remit.
Health and Social Care Information Centre	Special Health Authority(SpHA)	Collects and provides health and social care information	**Retain**, and put on a firmer statutory footing by establishing it in primary legislation. National repository for data collection across health care, public health and adult social care. Clearer focus on data collection, with a close working relationship with the NHS Commissioning Board.
Health Protection Agency	ENDPB	Protects the health and wellbeing of	**Abolish** as a statutory

Arm's-length bodies	Type	Role	Proposal
		the population	organisation and transfer functions to the Secretary of State as part of the new Public Health Service.
Human Fertilisation and Embryology Authority	ENDPB	Regulates human embryo storage, research and assisted reproduction treatment	**Retain** as a separate ALB for the time being, with the aim of transferring its functions by the end of the current Parliament. In the meantime, we will examine the practicalities (and legal implications) of how to divide the HFEA's functions between a new research regulator, the Care Quality Commission and the Health and Social Care Information Centre.
Human Tissue Authority	ENDPB	Regulates the removal, storage and use of human tissue and organs	**Retain** as a separate ALB for the time being, with the aim of transferring its functions by the end of the current Parliament. In the meantime, we will examine the practicalities (and legal implications)

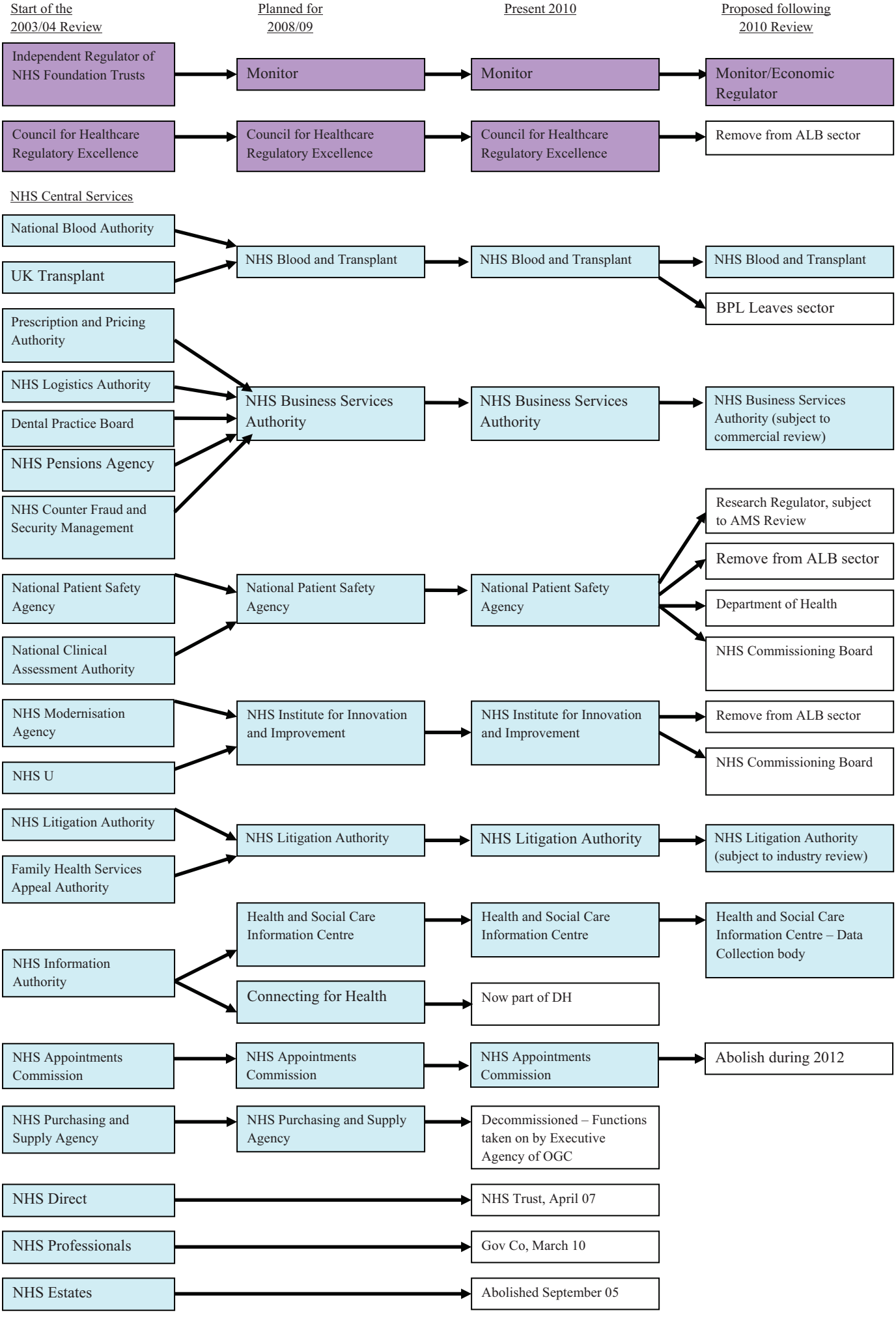
Arm's-length bodies	Type	Role	Proposal
			of how to divide the HTA's functions between a new research regulator, the Care Quality Commission and the Health and Social Care Information Centre.
Medicines and Healthcare products Regulatory Agency	Executive agency	Regulates medical devices and medicines	**Retain**, with the expectation that it will undertake its regulatory duties in the most cost effective way.
Monitor	ENDPB	Assesses, licences and monitors NHS Foundation Trusts	**Retain** and make an economic regulator, operating a joint licensing regime with CQC.
National Institute for Health and Clinical Excellence	SpHA	Provides national guidance on the promotion of good health and the prevention and treatment of ill-health	**Retain**, and put its advisory function on a firmer statutory footing by establishing it in primary legislation. Expand scope to include social care standards.
National Patient Safety Agency	SpHA	Promotes patient safety and manages the National Clinical Assessment Service, the National Research Ethics Service and confidential enquiries.	**Abolish** as an ALB. Safety functions retained and transferred to the National Commissioning Board. Explore transfer of National Research Ethics Service functions to single

Arm's-length bodies	Type	Role	Proposal
			research regulator. National Clinical Assessment Service to become self-funding over the next two to three years.
National Treatment Agency for Substance Misuse	SpHA	Works to increase the availability, capacity and effectiveness of drug treatment in England	**Abolish** as an ALB, and transfer functions to the Secretary of State as part of the new Public Health Service.
NHS Blood and Transplant	SpHA	Responsible for securing the safe supply of blood to the NHS in England and Wales, and similarly, solid organs, tissues, stem cells across the UK.	**Retain**, and commission an in-depth review of opportunities to make more commercially effective. Transfer Bio-Products Laboratory out of NHSBT into a Department of Health owned company.
NHS Business Services Authority	SpHA	Provides central services to the NHS	**Retain** in short term, and commission commercial review to identify potential for increased commercial opportunities, including potential to remove functions from the ALB sector.
NHS Institute for Innovation and	SpHA	Supports the NHS by spreading new	**Remove** from ALB sector. Move

Arm's-length bodies	Type	Role	Proposal
Improvement		ways of working, new technology and leadership	functions which will support the NHS Commissioning Board in leading for quality improvement to the Board. Review the potential for its remaining functions to be delivered through alternative commercial delivery models.
NHS Litigation Authority	SpHA	Handles negligence claims and works to improve risk management practices in the NHS	**Retain**, and commission an industry review to identify potential opportunities for greater commercial involvement.



Note: Proposals to be considered against Academy of Medical Sciences Review and other functions


Start of the 2003/04 Review
Planned for 2008/09
Present 2010
Proposed following 2010 Review
Independent Regulator of NHS Foundation Trusts
Monitor
Monitor
Monitor/Economic Regulator
Council for Healthcare Regulatory Excellence
Council for Healthcare Regulatory Excellence
Council for Healthcare Regulatory Excellence
Remove from ALB sector
NHS Central Services
National Blood Authority
UK Transplant
NHS Blood and Transplant
NHS Blood and Transplant
NHS Blood and Transplant
BPL Leaves sector
Prescription and Pricing Authority
NHS Logistics Authority
Dental Practice Board
NHS Pensions Agency
NHS Counter Fraud and Security Management
NHS Business Services Authority
NHS Business Services Authority
NHS Business Services Authority (subject to commercial review)
National Patient Safety Agency
National Clinical Assessment Authority
National Patient Safety Agency
National Patient Safety Agency
Research Regulator, subject to AMS Review
Remove from ALB sector
Department of Health
NHS Commissioning Board
NHS Modernisation Agency
NHS U
NHS Institute for Innovation and Improvement
NHS Institute for Innovation and Improvement
Remove from ALB sector
NHS Commissioning Board
NHS Litigation Authority
Family Health Services Appeal Authority
NHS Litigation Authority
NHS Litigation Authority
NHS Litigation Authority (subject to industry review)
NHS Information Authority
Health and Social Care Information Centre
Connecting for Health
Health and Social Care Information Centre
Now part of DH
Health and Social Care Information Centre – Data Collection body
NHS Appointments Commission
NHS Appointments Commission
NHS Appointments Commission
Abolish during 2012
NHS Purchasing and Supply Agency
NHS Purchasing and Supply Agency
Decommissioned – Functions taken on by Executive Agency of OGC
NHS Direct
NHS Trust, April 07
NHS Professionals
Gov Co, March 10
NHS Estates
Abolished September 05

Annex C

Implementation indicative timetable for action

Commitment	**Date**
Health Bill introduced in Parliament Public Bodies (Reform) Bill introduced in Parliament	Autumn 2010
NHS Litigation Authority – industry review completed NHS Business Services Authority – commercial review completed NHS Blood and Transplant – review of commercial opportunities complete	December 2010
Engagement on implementation with key stakeholders, including Devolved Administrations	Summer and autumn 2010
Shadow NHS Commissioning Board established as Special Health Authority	April 2011
NHS Commissioning Board fully established Public Health Service in place NICE put on a firmer statutory footing Monitor established as an economic regulator Healthwatch England established within the Care Quality Commission Health and Social Care Information Centre put on a firmer statutory footing Alcohol Education and Research Council removed from arm's-length body sector General Social Care Council functions transferred to Health Professions Council Health Protection Agency and National Treatment Agency for Substance Misuse transfer to Public Health Service	April 2012

National Patient Safety Agency transfer of some functions to NHS Commissioning Board and others transferred elsewhere NHS Institute for Innovation and Improvement complete transfer of functions and removal from arm's-length body sector completed	
Appointments Commission abolished	During 2012
Council for Healthcare Regulatory Excellence removed from sector and becomes self-funding Human Tissue Authority and Human Embryology and Fertilisation Authority abolished and functions transferred elsewhere	April 2013
Integration of business support functions across arm's-length bodies	By 2013/14

Glossary

Arm's-length bodies (ALBs) – ALBs are Government-funded organisations which work closely with local services, and other ALBs. In the Department they regulate the system, improve standards, protect public welfare and support local services. The Department has three main types of ALB: executive agencies, executive non-departmental public bodies, and special health authorities.

Commissioning – the process of assessing the needs of a local population and putting in place services to meet those needs.

Devolved administrations – the governments of Scotland, Wales and Northern Ireland.

Executive Agencies – executive agencies have responsibility for particular business areas. The agencies are still part of, and accountable to, the Department.

Executive non-Departmental public bodies (ENDPBs) – an ENDPB is a body set up by statute which has a role in the processes of national Government, but is not a Government Department or part of one.

Foundation trusts – NHS providers who achieve foundation trust status have greater freedoms and are subject to less central control than others, enabling them to be more responsive to the needs of local populations.

Health Bill – proposals for a Health Bill were included in the Queen's Speech for the first Parliamentary session of the coalition Government. The Health Bill will bring forward the legislative changes required for the implementation of the proposals in this White Paper.

Primary care trusts (PCTs) – the NHS body currently responsible for commissioning healthcare services and, in most cases, providing community-based services such as district nursing, for a local area.

Provider – organisations which provide services direct to patients, including hospitals, mental health services and ambulance services.

Public Bodies (Reform) Bill – proposals for a Public Bodies Bill were included in the Queen's Speech for the first Parliamentary session of the coalition Government. The Bill forms part of the Government's strategy to increase accountability and transparency.

Special health authorities (SpHAs) – SpHAs are independent bodies, but are subject to ministerial direction like other NHS bodies. They provide a service to the public and/or the NHS, and generally provide a service for the whole population of England, rather than for a particular local community.

Strategic health authorities (SHAs) – the 10 public bodies which currently oversee commissioning and provision of NHS services at a regional level.

White Paper, ***Equity and Excellence: Liberating the NHS*** – published on 12 July 2010, the White Paper sets out the Government's long-term vision for the NHS.

NHS

Liberating the NHS:

Transparency in outcomes – a framework for the NHS

A consultation on proposals

238

DH Department of Health

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Document Purpose	Consultation/Discussion
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Circulation List	
Description	This document is a full consultation document on the approach to developing an Outcomes Framework for the NHS. The framework will identify a focused but balanced set of outcome measures that will act as a catalyst for driving quality across all services and will enable the Secretary of State to hold the NHS Commissioning Board to account by providing an indication on the overall progress of the NHS.
Cross Ref	White Paper - Liberating the NHS
Superseded Docs	N/A
Action Required	Chapter 4 of the document and the website will set out
Timing	**11/10/2010 - Consultation closes**
Contact Details	Quality and Outcomes Policy Room 6A Skipton House, 80 London Road London SE1 6LH (020) 7972 2000 nhswhitepaper@dh.gsi.gov.uk
For Recipient's Use	

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Foreword

There can be no doubt that over the last decade the hard work and dedication of staff working throughout the NHS has brought about major improvements in outcomes for patients. However, progress has not been universal and even where improvement has been achieved it has not always been as fast or as deep as it could have been.

All too often, the NHS has been hamstrung by a focus on nationally determined process targets which have had a distorting effect on clinical priorities, disempowered healthcare professionals and stifled innovation. We therefore need to recalibrate the whole of the NHS system so it focuses on what really matters to patients and carers and what we know motivates healthcare professionals - the delivery of better health outcomes.

We should be ambitious in our aspirations. We should aim for the NHS to deliver amongst the best outcomes for patients in the world - not just in a few services but in all service areas.

The Coalition Government's White Paper, "*Equity and Excellence: Liberating the NHS"*, set out how the improvement of healthcare outcomes for all will be the primary purpose of the NHS. This means ensuring that the accountabilities running throughout the system are squarely focussed on the outcomes achieved for patients- not the processes by which they are achieved.

This accountability starts with the Secretary of State and the Government. Liberating the NHS from central control and political interference does not mean abdicating responsibility for whether the NHS succeeds or fails. I, and all future Secretaries of State should be judged on our success in creating a continuously improving NHS as measured by the outcomes that it is achieving for patients.

This consultation document is about establishing that accountability at a national level in an open and transparent way. It is about determining how the success of the NHS should be judged and, therefore, the success of the Government in delivering our vision for healthcare.

But, with the NHS delivering over 1400 hospital-based procedures and interventions for 7 million elective admissions a year, around the same number of non-elective admissions and approximately 300 million general practice consultations a year, this is no easy task. It will take a significant change in the culture and focus of the NHS, driven by staff who are empowered, engaged and well supported to provide better patient care.

We are therefore looking for your help in constructing an NHS Outcomes Framework. A framework that will act as a catalyst for driving up quality and promoting equity and excellence across all services and that will provide an indication of the overall performance of the system in an international context. A transparent framework that will be used to hold the new NHS Commissioning Board to account for progress but equally one that patients, carers and the public can use to hold the Government to account.

The Rt Hon Andrew Lansley CBE MP
Secretary of State for Health

1. The purpose of this consultation

Introduction

1.1. The White Paper *Equity and Excellence: Liberating the NHS* set out the Government's strategy for the NHS[1]. The intention is to create an NHS which is much more responsive to patients, and achieves better outcomes, with increased autonomy and clear accountability at every level.

1.2. *Liberating the NHS* makes clear the Government's policy intentions, and provides a coherent framework. Further work lies ahead to develop and implement detailed proposals. In progressing this work, the Department will be engaging with external organisations, seeking their help and wishing to benefit from their expertise.

1.3. This document, *Transparency in outcomes: a framework for the NHS*, provides further information on proposals for developing an NHS Outcomes Framework. It seeks views on a number of specific consultation questions.

1.4. This is part of a public consultation on specific aspects of the White Paper. The initial suite of supporting papers also includes:

- *Commissioning for patients*
- *Regulating healthcare providers*
- *Local democratic legitimacy in health*
- *The review of arm's-length bodies*

1.5. The Government will publish a response prior to the introduction of a Health Bill later this year.

1.6. Chapter 3 of the White Paper explained how, in future, the Secretary of State would hold the NHS to account for improving healthcare outcomes through a new NHS Outcomes Framework. A framework that would be made up of a focused set of national outcomes set by the Secretary of State and against which a new NHS Commissioning Board would be held to account. There was also a clear commitment to working with clinicians, patients, carers and representative groups to create this framework and identify outcome indicators that are based on the best available evidence.

[1] Available at: http://www.dh.gov.uk/LiberatingtheNHS

What are we consulting on?

1.7. The purpose of this consultation is to seek the help of those working in the NHS and the patients, carers and public it is there to serve in developing the first NHS Outcomes Framework. This consultation asks for views on:

- the principles that should underpin the framework (Chapter 2);
- a proposed structure and approach that could be used to develop the framework (Chapter 2);
- how the proposed framework can support equality across all groups and can help reduce health inequalities (Chapter 2);
- how the proposed framework can support the necessary partnership working between public health and social care services needed to deliver the outcomes that matter most to patients and carers (Chapter 2); and
- potential outcome indicators, including methods for selection, that could be presented in the framework (Chapter 3 and Annex A).

1.8. This consultation therefore forms part of the overall public consultation on the White Paper and its constituent parts, on which the Department is currently actively seeking views. The Coalition Government is taking forward this work in partnership with external organisations, seeking their help and expertise in developing proposals that work in practice. This work will link to the broader cross-government approach to performance, which will be published alongside the Spending Review later this year.

Why focus on outcomes? A question of accountability

1.9. In a system as vast and diverse as the NHS, responsible for spending some £80bn of taxpayers' money, and delivering critical services to so many, it is essential to get the accountabilities right at every level of the system. These accountabilities must be focussed on delivering high quality outcomes for patients.

1.10. However, unless we are clear about what we mean by quality and are able to measure it, there can be no meaningful accountability. The NHS Next Stage Review[2] led by Lord Darzi helped the NHS define quality as:

- the **effectiveness** of the treatment and care provided to patients;

[2] *High Quality Care for All: NHS Next Stage Review Final Report*, Department of Health, 30 June 2008

- the **safety** of the treatment and care provided to patients; and
- the broader **experience** patients and their carers have of the treatment and care they receive.

1.11. In terms of measuring these three areas, it is legitimate to look at:

- **the structures of care** – based on robust evidence, how should treatment and care be structured in order to maximise the chance of a good outcome for the patient?
- **the processes of care** – based on robust evidence, what are the things that should be done to maximise the chance of a good outcome for the patient? and
- **the outcomes of care** – what actually happens to the health of the patient - the outcome - as a result of the treatment and care they receive?[3]

1.12. However, at a national level the focus and accountability should, as far as possible, be centred around the outcomes of care. Locally, the structures and processes of care will need to be monitored but focusing on these too heavily at a national level can lead to a distortion of clinical priorities and risks creating a whole system of accountability that it is more concerned with the means than the result - an accountability system that has lost sight of the purpose of the NHS.

What do we mean by an "NHS Outcomes Framework"?

1.13. The NHS Outcomes Framework will be made up of a focussed set of national outcome goals that will provide an indication of the overall performance of the NHS.

1.14. These outcome goals will provide a means by which patients, the public and Parliament can hold the Secretary of State for Health to account for the overall performance of the NHS. They will also provide a mechanism by which the Secretary of State can hold the new NHS Commissioning Board to account for securing improved health outcomes for patients through the commissioning process.

1.15. Beyond accountability, it is intended that the NHS Outcomes Framework will act as a catalyst for driving up quality across all NHS services. It will not,

[3] The structure-process-outcome formulation was included in *Evaluating the Quality of Medical Care,* Donabedian, A; Milbank Memorial Fund Quarterly: Health and Society 44 (3; pt. 2):166–203; 1966.

however, be used as a tool to performance manage providers of NHS care. The framework and the national outcome indicators it will include will also bring about greater transparency about the quality of healthcare services by guiding the publication of broader and more locally relevant information for use by patients, their carers and the public.

1.16. Once set, it will be for the NHS Commissioning Board to determine how best to deliver improvements against the selected outcomes by working with GP consortia and making use of the various tools and levers it will have at its disposal. For example, the Board will be able to commission Quality Standards from NICE, which it will then use to provide more detailed commissioning guidance on how best to meet the national outcome goals included in the framework. The Board will also be able to draw on these Quality Standards to support it in designing payment mechanisms and incentive schemes such as the Commissioning for Quality and Innovation (CQUIN) Payment Framework.

1.17. In addition, the NHS Commissioning Board will work with clinicians, patients and the public to develop the set of indicators it will use to operationalise the national outcome goals sets by the Secretary of State. For example, this might draw upon existing measures such as the Vital Signs indicators[4] where they are clinically relevant or reflect other improvements that are important to patients, as well as those indicators included on the menu of *Indicators for Quality Improvement*[5].

1.18. The design and development of a commissioning framework for GP consortia, as discussed in detail in an accompanying consultation document, *Liberating the NHS: commissioning for patients,*[6] will also be the responsibility of the NHS Commissioning Board. This commissioning framework will need to flow from and support the delivery of the national outcome goals set by the Secretary of State in the NHS Outcomes Framework.

1.19. This consultation document begins to describe what the NHS Outcomes Framework will look like. Taking into account your responses and the business plan the Department of Health will agree as part of the Spending Review, the first NHS Outcomes Framework 2011/12 will be developed. This will set out what the Secretary of State will expect of the NHS Commissioning Board (which will be in existence in its shadow form from 1 April 2011).

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[4] Vital Signs and Existing Commitments can be found in the NHS Operating Framework for 2010/11 at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110107

[5] The menu of Indicators for Quality Improvement is available at http://www.ic.nhs.uk/services/measuring-for-quality-improvement

[6] Available at: http://dh.gov.uk/liberatingtheNHS

2. Scope, principles and structure of an NHS Outcomes Framework

2.1. The previous chapter set out the Government's vision for improvement in quality and healthcare outcomes as being the primary purpose of all NHS funded-care, what is meant by an outcome and the purpose of an NHS Outcomes Framework. This chapter provides more detail on the scope of the framework and proposes a set of principles which the Government will use to develop the NHS Outcomes Frameworks as it evolves over the coming years. It also puts forward a structure for the framework and seeks views on this.

Scope

2.2. The White Paper set out how the current performance regime will be replaced with separate frameworks for outcomes that set direction for the NHS, public health and social care, which provide for clear and unambiguous accountability, and enable better joint working. The primary purpose of the NHS Outcomes Framework will, therefore, be to focus on the outcomes that the NHS can deliver through the provision of treatment and healthcare.

2.3. However, there will of course be some outcomes which the NHS cannot deliver alone, but where it will need to work in partnership with public health and prevention services. Similarly, if we are to really focus on what matters most to patients, many of the outcomes that are likely to feature in the final NHS Outcomes Framework will require the NHS to work with adult social care services, children's services and other local services. The approach to outcomes in adult social care will be developed using the same principles and designed to align outcomes across the NHS and its local partners as far as possible.

2.4. Local authorities will promote integration and partnership working between the NHS, adult social care, public health and other local services. They will bring together partners to agree local priorities for the benefit of patients and taxpayers, informed by community and neighbourhood needs. A crucial element in designing the NHS Outcomes Framework will be considering how it will incentivise more integrated care.

2.5. The NHS Outcomes Framework will include the national outcomes goals which will be used by the Secretary of State to monitor the progress of the NHS Commissioning Board. The NHS Commissioning Board will be free to determine how these outcomes will be translated into a broader framework

covering all NHS funded care which it will use to hold GP consortia to account and which will provide the public with meaningful information on which to base choices about their healthcare.

Principles

2.6. The proposed principles that will guide the development of the NHS Outcomes Framework are set out below.

Key principles
• Accountability and transparency • Balanced • Focused on what matters to patients and healthcare professionals • Promoting excellence and equality • Focused on outcomes that the NHS can influence but working in partnership with other public services where required • Internationally comparable • Evolving over time

Accountability and transparency

2.7. The NHS Outcomes Framework is intended to sharpen the accountabilities in the system for delivering better and more equitable outcomes – it is not about setting priorities for the service. The Secretary of State for Health will use the NHS Outcomes Framework as a balanced scorecard or dashboard to monitor the progress of the NHS in delivering care to patients.

2.8. Accountability can only be effective if it is matched by transparency. The data against each of the outcomes that are presented in the NHS Outcomes Framework will be made publicly available, so that the NHS and public can see the progress of the NHS for themselves. More detail on this will be set out in the Department of Health's information strategy in the autumn.

Balanced

2.9. To make sure that the NHS Outcomes Framework provides an accurate reflection of the overall progress of the NHS, a balanced set of outcomes will be chosen. They will be used to hold the NHS Commissioning Board to account for overseeing the commissioning of a comprehensive healthcare service.

2.10. This will span the definition of quality which Lord Darzi set out in 2008[7] and which the NHS has embraced:

- Effectiveness
- Patient experience
- Safety

2.11. The following chapter describes proposals for developing the NHS Outcomes Framework, ordered around these aspects of quality.

Focused on what matters to patients and healthcare professionals

2.12. The White Paper articulated a vision that would make the NHS more accountable to patients and that would free staff from excessive bureaucracy and top-down control.

2.13. This means including indicators that record the effectiveness of treatment from the clinical perspective but also from the perspective of patients. The indicators included in the framework therefore need to cover both clinical outcome measures as well as patient reported outcome measures (PROMs). It also means recognising the importance of measuring the experience of patients when judging the progress of the NHS and the safety of care that is being delivered.

2.14. Freeing professionals from excessive bureaucracy means measuring the progress of the NHS against outcomes that are clinically relevant and that professionals themselves recognise as accurately tracking the delivery of improved quality and outcomes for patients.

2.15. As set out in *Equity and Excellence: Liberating the NHS*, staff who are empowered, engaged and well supported provide better patient care. The White Paper committed the Government to promote staff engagement and partnership working. This will be a key part of the development of the aims of the White Paper and the proposals set out in this document, and why the Government is publishing this full and open consultation document, and seeking your views.

Promoting excellence and equality

2.16. The purpose of the NHS Outcomes Framework will be to drive the NHS towards achieving excellence rather than minimum standards. Ensuring that

[7] *High Quality Care for All: NHS Next Stage Review Final Report*, Department of Health, 30 June 2008

providers of NHS care meet minimum standards or the essential levels of quality and safety is the responsibility of the Care Quality Commission.[8]

2.17. The NHS Outcomes Framework should recognise the importance of reducing inequalities and promoting equality. For example, because of the social gradient in most health outcomes, the most potential health gain will often be available from the lower reaches of the gradient, from disadvantaged groups and areas.

2.18. Therefore, as far as possible, outcomes will also be chosen so that they can be measured by different equalities characteristics and by local area. The delivery of outcomes is likely to vary according to geographic area and across different population groups. By collecting data that makes the outcomes understandable according to equalities characteristics and by area the Government and NHS Commissioning Board will be in a position to promote equality and tackle inequalities in outcomes.

Focused on outcomes that the NHS can influence but working in partnership with other public services where required

2.19. As far as possible, the NHS (and its constituent parts) will be held to account for outcomes that it alone can influence. For all outcome indicators, where relevant, the NHS Outcomes Framework should identify the extent to which the NHS will be held accountable, as distinct from the contribution of public health interventions and social care services.

2.20. There will, of course, be outcomes that can only be delivered for patients and carers if the NHS works in partnership with the new public health service that will be created and with social care services. The Department of Health will be constructing and consulting on outcomes frameworks for these sectors in coming months as part of an integrated cross-service approach in the Spending Review. These will be developed so that strategies can be developed to ensure that organisations provide complementary and integrated services.

Internationally comparable

2.21. The Government's vision for the NHS is for it to be a world leader in healthcare provision. At its best, the NHS is world class. But, the NHS today still achieves relatively poor outcomes in some major areas when compared to its peer countries.

2.22. However, outcomes included in the framework should not be selected solely in areas where the NHS is performing less well than other international

[8] Details on registration can be found on the CQC's website at http://www.cqc.org.uk/

healthcare systems, as this perspective may not identify what matters most to patients. International comparisons can only be based on what comparable data is available and this may not always reflect the most important quality improvement challenges facing individual healthcare systems. Nevertheless, wherever possible and appropriate, the NHS Outcomes Framework will include outcome indicators which are internationally comparable, for example amongst OECD nations[9], or the EU 15, or 27[10].

2.23. Interpreting international comparisons is complex and making comparisons for new indicators is costly and takes time. So, the importance of making intra-UK comparisons should not be underestimated and can be a relatively simpler approach. This has been used by organisations such as the Nuffield Trust[11] and The Health Foundation[12]and as a first step, the Department of Health will support the development of metrics that allow intra-UK comparisons to be made.

Evolving over time

2.24. The first publication of the NHS Outcomes Framework will, as a starting point, use existing outcome indicators for which data can be collected. This will mean that the NHS Outcomes Framework for 2011/12 may not necessarily meet all of the principles set out in this chapter. However, the nature of the changes to the NHS landscape that were announced in the White Paper and the time lag to develop new indicators means that the NHS Outcomes Framework will evolve over time. It will be reviewed annually to ensure that it focuses on the most important issues and so that it can accommodate new and better outcome indicators as they become available.

Questions

1. ***Do you agree with the key principles which will underpin the development of the NHS Outcomes Framework?***

2. ***Are there any other principles which should be considered?***

3. ***How can we ensure that the NHS Outcomes Framework will deliver more equitable outcomes and contribute to a reduction in health inequalities?***

[9] Organisation for Economic Co-operation and Development. Details of member countries are available at http://www.oecd.org/document/58/0,3343,en_2649_201185_1889402_1_1_1_1,00.html

[10] As defined in the *Glossary of Statistical Terms*, OECD, available at http://stats.oecd.org/glossary/

[11] Most recently in Funding and Performance of Healthcare Systems in the Four Countries of the UK Before and After Devolution, *Nuffield Trust, January 2010*

[12] See Quality in Healthcare in England, Wales, Scotland, Northern Ireland: an intra-UK chartbook at http://www.health.org.uk/document.rm?id=1022

4. ***How can we ensure that where outcomes require integrated care across the NHS, public health and/or social care services, this happens?***

Structure of the NHS Outcomes Framework

2.25. The NHS Outcomes Framework will include a balanced set of outcome goals spanning effectiveness, patient experience, and safety. To achieve this, it is proposed that the NHS Outcomes Framework should be developed around a set of five outcome domains that attempt to capture what the NHS should be delivering for patients. The five domains are set out in Figure 1 below.

Figure 1 – Five domains of the NHS Outcomes Framework

Questions

5. ***Do you agree with the five outcome domains that are proposed in Figure 1 as making up the NHS Outcomes Framework?***

6. ***Do they appropriately cover the range of healthcare outcomes that the NHS is responsible for delivering to patients?***[13]

Structure of each domain

2.26. Figure 2 explains how the framework will be structured for each of the five outcome domains.

[13] **Please note** that public health and prevention will be covered in a separate consultation, linking to this framework where appropriate

Figure 2 – Structure of each domain in the NHS Outcomes Framework

Overarching outcomes indicator

2.1 For each domain, the NHS Outcomes Framework will identify an **overarching outcome indicator or set of indicators**, allowing progress of the NHS to be tracked across the breadth of NHS activity covered by the domain. It will provide a mechanism for ensuring that the NHS Commissioning Board does not lose sight of its role in overseeing the commissioning of a comprehensive healthcare service.

Improvement Areas

2.27. For each domain there will then be a small set of specific areas identified in which the NHS Commissioning Board will be tasked with securing improved outcomes through its role in overseeing the commissioning process to be led by GP consortia. These **improvement areas** will be chosen, as far as possible, according to an evidence-based method or approach.

2.28. For each of the specific improvement areas, a corresponding **outcome indicator** will be identified in order to hold the NHS Commissioning Board to account for the progress being made. As already explained, the new system of accountability that the NHS Outcomes Framework will introduce will evolve over time. The first NHS Outcomes Framework will be populated in the short term by outcome indicators that are already available for measurement.

NICE Quality Standards

2.29. Finally, the delivery of the outcomes in the NHS Outcomes Framework will be supported by a suite of **NICE Quality Standards**[14]**.** The White Paper set out the crucial role NICE Quality Standards will play in supporting the delivering of improved outcomes by informing the commissioning process. The Department of Health currently commissions NICE to produce these standards but this function will transfer to the NHS Commissioning Board once it is established and GP consortia will refer to them when commissioning services locally.

[14] More information on NICE Quality Standards is available on the NICE website at: http://www.nice.org.uk/aboutnice/qualitystandards

2.30. Quality Standards provide an authoritative definition of what high quality care looks like for a particular care pathway or service. They are developed by NICE, working in partnership with clinicians, leading experts and healthcare specialists in that particular field, drawing on available evidence of best practice.

2.31. Over the next 5 years, NICE will produce a library of approximately 150 Quality Standards covering the majority of NHS activity to support the NHS in delivering the outcomes in the NHS Outcomes Framework. Given that these standards will tend to focus on a pathway of care, any one Quality Standard is likely to span two or more domains of the NHS Outcomes Framework The first three Quality Standards were published on 30 June, on stroke treatment and rehabilitation, dementia care, and the prevention of venous thromboembolism.[15]

Question

7. Does the proposed structure of the NHS Outcomes Framework under each domain seem sensible?

Risks and Limitations

2.32. Even with indicators which focus on outcomes, there is still a risk of distorting behaviour in a way that is not best for patients. It is possible that, in order to deliver an outcome in one area, local NHS organisations will end up neglecting other areas. To avoid this, it is important that the NHS Outcomes Framework strives to be as comprehensive as possible, covering most of what the NHS should be delivering for all patients.

2.33. In practice, comprehensive outcome indicators are not always available or feasible, and it may even be necessary, at least in the short term, to use some carefully chosen proxy outcome measures. It will therefore be important to take a view of the NHS Outcomes Framework as a whole, including the links between the various indicators, and to design it to avoid undesirable distortions of behaviour.

2.34. Developing indicators which measure outcomes accurately, representatively and in a timely fashion is complicated and takes time. Over time new indicators will become available which will improve the NHS Outcomes Framework's ability to accurately judge the outcomes being delivered for

[15] The first three Quality Standards can be downloaded at: http://www.nice.org.uk/aboutnice/qualitystandards/qualitystandards.jsp

patients. Each of the domains face different challenges in respect of the indicators available, which are explained later in this document.

2.35. The following chapter takes you through how the NHS Outcomes Framework might be constructed. Annex A sets out example outcome indicators. These may not be the best or the most suitable indicators, so your views on these are very welcome as part of this consultation.

3. What would an NHS Outcomes Framework look like?

Annex A provides additional information about the indicators referred to in this chapter, as well as possible alternative indicators and other relevant technical points. Interested readers should refer to Annex A at the points indicated in this chapter.

3.1. The previous chapter proposed a structure for the NHS Outcomes Framework based around five outcome domains:

- **Domain 1:** Preventing people from dying prematurely
- **Domain 2:** Enhancing the quality of life for people with long-term conditions
- **Domain 3:** Helping people to recover from episodes of ill health or following injury
- **Domain 4:** Ensuring people have a positive experience of care
- **Domain 5:** Treating and caring for people in a safe environment and protecting them from avoidable harm

3.2. Each of the above domains would then be covered by:

- **An overarching outcome indicator** or indicators to measure progress across the breadth of NHS activity covered by the domain
- Approximately **five, more specific, improvement areas** with supporting outcome indicators to measure progress of the NHS against each improvement area
- **A suite of supporting Quality Standards** developed by NICE setting out the structures and processes of care that the evidence suggests would be most likely to deliver improved outcomes for the overall domain as well as the specific improvement areas within the domain

3.3. Taking this structure as a starting point for consultation, the rest of this chapter puts forward proposals for what the overarching outcome indicators for each domain could be; a method for selecting the specific improvement areas within each domain; and, based on that method, what some of the potential improvement areas and their supporting outcome indicators might be.

Annex A 1
Design principles for outcome indicators

3.4. Developing a framework like this will never be straightforward or neat. The categorisation of the outcomes proposed may not be perfect, and there will almost certainly be debate as to which category certain conditions fall into.

DOMAIN 1: PREVENTING PEOPLE FROM DYING PREMATURELY

3.5. In thinking through what outcome indicators might be presented in this domain, two underlying principles have been used.

- **People should not die early where medical intervention could make a difference.** A key function of the NHS is to stop people from dying at a point where medical intervention could prevent that death. Many such deaths occur before old age. However, the definition of 'premature' death, while often referring to deaths under age 75, is not hard and fast, and many people live healthy lives at much older ages.
- **Focus on what the NHS can do.** Not all deaths can be avoided by the provision of healthcare alone, so the NHS needs to be clear about where it can and should improve outcomes, and what level of contribution it can make, acknowledging areas where it will need to work with partners to deliver the outcomes that matter most to patients.

Overarching Indicator

3.6. Following the principles set out above, the overarching indicator for this domain should tell us whether the NHS is reducing mortality in areas where it can make a difference. **Mortality amenable to healthcare** measures the number of deaths that occur from a pre-defined set of conditions that have been judged to be amenable to healthcare interventions, and so should not lead to deaths at specified ages. More detail on this outcome indicator can be found in Annex A.

Annex A 2
Technical details of indicators

Question

8. Is 'mortality amenable to healthcare' an appropriate overarching outcome indicator to use for this domain? Are there any others that should be considered?

Improvement Areas

Annex A 3

Selecting improvement areas based on mortality data

3.7. It is reasonable to assume that lower mortality rates from a particular condition in other countries indicate that mortality rates here could be improved, although different recording and coding practices can skew these comparisons. Internationally comparable mortality statistics, such as those collated by the World Health Organisation[16], can therefore be used to identify the component conditions of mortality amenable to healthcare on which England performs worse than comparable countries (see Annex A for UK comparisons)[17]. The proposal is that these causes should be considered as possible improvement areas in this domain, and following this logic the two causes with the most scope for improvement (excluding those with known coding issues) are **heart disease** and **stroke**.

3.8. Some of the causes set out in the table in Annex A can logically be grouped into broader topic areas. For example, while breast cancer is one of the areas on which the UK appears to perform worst, there are a number of other cancers on which the UK also performs at or worse than the level of comparable countries, so a broader outcome on **cancer** mortality would cover a number of relevant areas.

Annex A 4

Technical details of indicators

3.9. However, international comparisons on cancer more commonly use survival rates than mortality (because mortality is affected by incidence as well as survival once diagnosed), so if cancer is selected as an improvement area then survival measures may be more appropriate outcome indicators. International comparisons on cancer survival show that England performs worse than comparable countries. Poorer survival rates as well as mortality rates add weight to the argument for cancer's inclusion. See Annex A for more details on survival and other specific indicators.

Question

9. Do you think this is an appropriate way to select improvement areas in this domain?

[16] http://www.euro.who.int/en/what-we-do/data-and-evidence/databases

[17] UK data is more readily available and is a reasonable approximation for England, which makes up 84% of the UK's population. It will be possible to make the same comparisons for England in the future.

Other Considerations

Older people

3.10. This domain necessarily looks at premature deaths (rather than all deaths), as healthcare cannot hope to keep people alive indefinitely. The definition of mortality amenable to healthcare used here defines 'premature' as under the age of 75. This is a widely used definition, but whether a death at any age is premature depends on the specific circumstances. Considering all deaths above a particular age as 'not premature' discriminates against older people who still lead healthy and fulfilling lives.

3.11. The proposed NHS Outcomes Framework currently accounts for mortality in older people in two ways:

- many avoidable deaths for older people occur in hospital and are covered by the fifth domain, *treating and caring for people in a safe environment and protecting them from avoidable harm*; and
- some outcome indicators relating to the specific improvement areas that could be used in this domain, such as one-year and five-year cancer survival or healthy life expectancy at 65 (see Annex A), are applicable to all age groups.

Annex A 5
Technical details of indicators

3.12. However, it may still be necessary to consider including an outcomes indicator that specifically addresses mortality in older people, such as healthy life expectancy at 65 (see Annex A).

Questions

10. Does the NHS Outcomes Framework take sufficient account of avoidable mortality in older people as proposed?

11. If not, what would be a suitable outcome indicator to address this issue?

Children

3.13. Sheer weight of numbers means that mortality amenable to healthcare is dominated by deaths in older adults, and there is a risk that children will be neglected when selecting improvement areas. There is therefore an argument for including an outcome specifically relating to children. There are two items in the table in Annex A (section 5) that relate specifically to children and that the UK appears to perform badly on: perinatal deaths (although this may be

Annex A 5
Technical details of indicators

the result of a coding issue) – for which an appropriate indicator would be **infant mortality**; and **respiratory diseases** in children aged 0-14.

Question
12. Are either of these appropriate areas of focus for mortality in children? Should anything else be considered?

Inequalities

3.14. Some groups of people, for example those with serious mental illnesses, have significantly worse mortality outcomes than the population as a whole. While the NHS will aim to narrow inequalities in all the outcome indicators in this framework, it may be desirable to select some improvement areas in where there are significant inequalities in outcomes.

Cost effectiveness

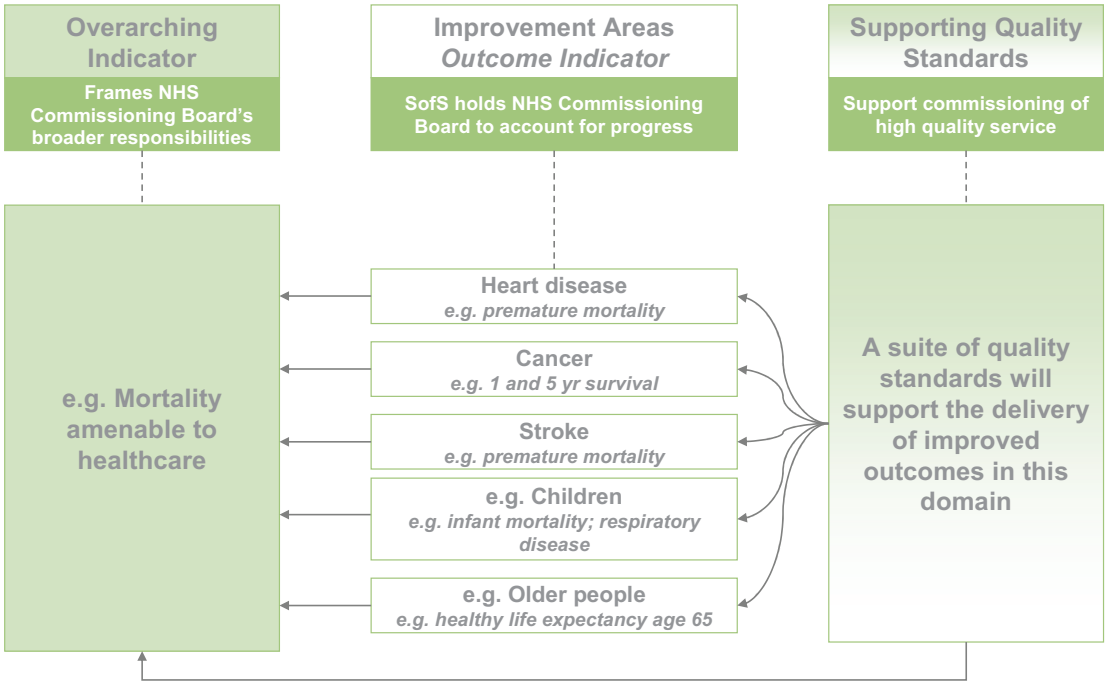
3.15. It will be essential to ensure that improvements in mortality amenable to healthcare represent a cost-effective use of resources and do not inadvertently divert resources from areas where a greater scope for improved health gain may exist. This will be assessed explicitly in the Impact Assessment that will accompany the final NHS Outcomes Framework for 2011/12.

Quality Standards

3.16. To support commissioning for excellent outcomes in all domains of this framework, there will be a suite of quality standards setting out what high quality care looks like across all major pathways of care. Some topics for Quality Standard development will be selected to reflect areas that are most important to improving outcomes in this domain.

3.17. Based on the above method and analysis, Figure 3 illustrates what this domain might look like.

Figure 3 - Preventing people from dying prematurely



DOMAIN 2: ENHANCING QUALITY OF LIFE FOR PEOPLE WITH LONG-TERM CONDITIONS

3.18. This domain is concerned with the treatment and care the NHS provides to people living with long-term conditions, including those with mental health related long-term conditions. In thinking through what outcome indicators might be presented in this domain, three underlying principles have been used.

- **Treating the individual.** Patients do not see themselves as a condition; they see themselves as people who have one or more long-term conditions. 29% of people with long-term conditions now live with more than one condition,[18] and it is expected that in the future this proportion will rise further. Looking at conditions individually risks ignoring the needs of this increasingly significant group, so it is proposed to take a general view of the needs of and desired outcomes for those with long-term conditions, both mental and physical.
- **Functional and episodic outcomes.** The framework should focus on the outcomes that are important to those living with long-term conditions. These relate to the debilitating effect that the conditions can have on their lives, such as preventing them from being physically active, working or living independently. The importance of acute episodes that can develop into long-term conditions is also

[18] General Lifestyle Survey 2008-09

recognised, and that good management of the condition can reduce their frequency and severity.

- **Meeting the needs of all age groups.** People with long-term conditions of different ages have different needs, particularly in relation to the functional outcomes that they want to achieve. As such it is proposed to separately identify appropriate functional outcomes for children, adults, and older people.

Overarching Indicator

Overarching indicators currently available

3.19. While an overarching measure of quality of life for those with long-term conditions is not currently available, there are existing surveys that collect information that is relevant to this domain: the Labour Force Survey[19] measures the "percentage of people with long-term conditions where day to day activity is affected"; and the GP patient survey currently measures the "percentage of people feeling supported to manage their condition".

Annex A 6
Technical details of indicators

Question

13. Are either of these appropriate overarching outcome indicators for this domain? Are there any other outcome indicators that should be considered?

Overarching indicators that could be developed

3.20. More detailed information on quality of life for those with long-term conditions could be obtained through a Patient Reported Outcome Measure (PROM), or similar, for long-term conditions in general. There are standard questionnaire-based tools for measuring quality of life, such as EQ-5D[20], which is currently included in the Health Survey for England and could potentially be included in other national surveys.

Annex A 6
Technical details of indicators

Question

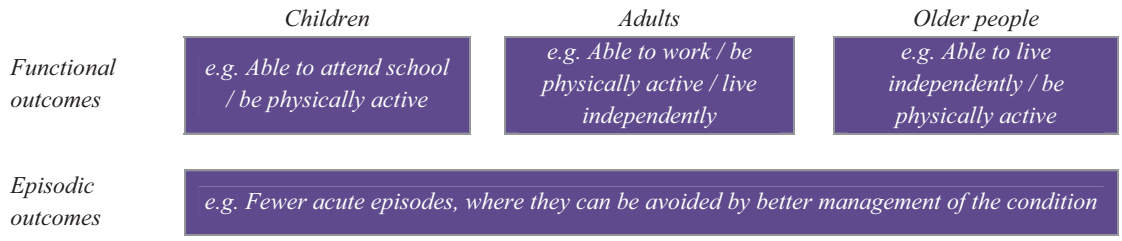
14. Would indicators such as these be good measures of NHS progress in this domain? Is it feasible to develop and implement them? Are there any other indicators that should be considered for the future?

[19] http://www.statistics.gov.uk/CCI/SearchRes.asp?term=labour+force+survey&x=31&y=12
[20] http://www.euroqol.org/

Improvement Areas

3.21. International comparisons are not available for some of the outcomes that are important for people with long-term conditions, so it is not possible to infer a level of performance that the NHS should be able to achieve. As such, it is not possible to select areas based on improvement potential, so it is proposed to select a set of outcomes that address the things that are most important to those with long-term conditions. Following the logic, set out above, of identifying functional and episodic outcomes for different age groups, figure 4 shows how the improvement areas might look.

Figure 4 – functional and episodic outcomes that are important to different age groups



3.22. The interaction between healthcare and other services will be particularly important in this domain. Many of the outcomes set out in figure 4, such as whether older people are able to live independently, can only be achieved through effective partnership working between the health and social care systems.

3.23. Data on some of the outcomes set out in figure 4 are not routinely collected, so relevant outcome indicators may not currently exist in all cases. Annex A contains a list of the relevant outcome indicators that do currently exist, as well as others that could be developed.

Annex A 7
Technical details of indicators

Quality Standards

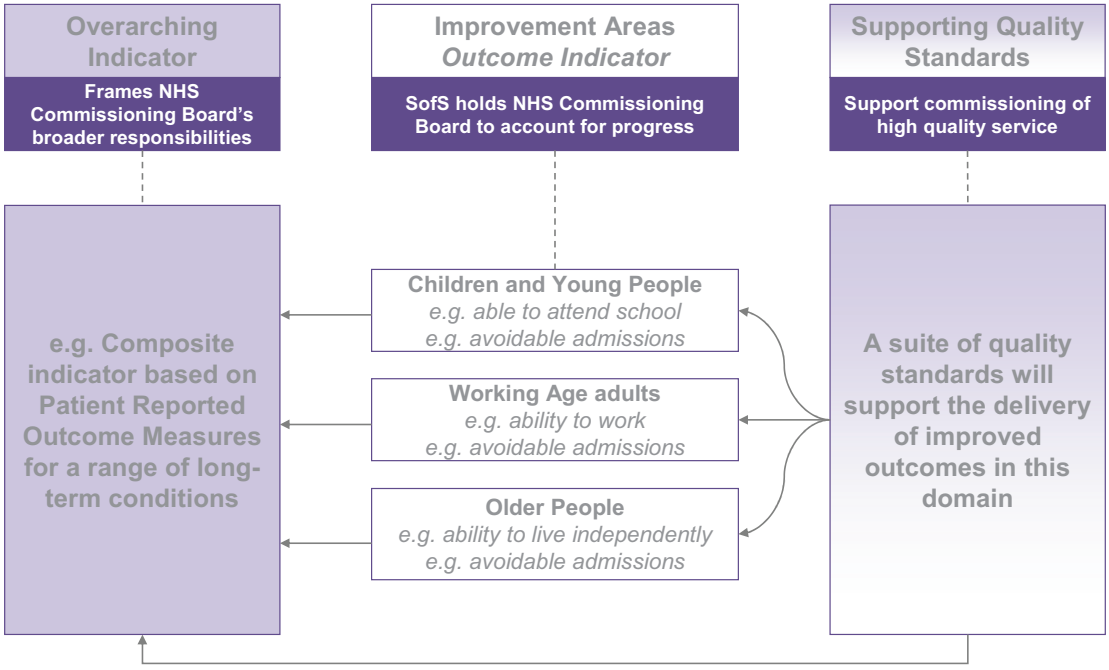
3.24. To support commissioning of excellent outcomes in all domains of this framework, there will be a suite of quality standards setting out what high quality care looks like across all major pathways of care. Some topics for Quality Standards will be selected to reflect areas that are most important to improving outcomes in this domain.

Question

15. As well as developing Quality Standards for specific long-term conditions, are there any cross-cutting topics relevant to long-term conditions that should be considered?

3.25. Based on the above method and analysis, Figure 5 below illustrates what this domain might look like.

Figure 5: enhancing quality of life for people with long-term conditions



DOMAIN 3: HELPING PEOPLE TO RECOVER FROM EPISODES OF ILLNESS OR FOLLOWING INJURY

3.26. This domain is about achieving the best possible outcomes for people who develop treatable conditions or who suffer injuries. The aims of this domain can be expressed as two broad outcomes.

- **Preventing conditions from becoming more serious**. Some conditions should not, in the presence of timely and effective healthcare, become serious. For these conditions, the NHS should aim to minimise the impact on people's lives.
- **Helping people recover from serious illness or injury**. As well as preventing deaths, the NHS should aim to ensure that, as far as possible, those who suffer a serious illness or other debilitating event

recover quickly and painlessly to their original health status, or close to it.

3.27. In thinking through what outcome indicators might populate this domain, **meeting the needs of all age groups** has again been taken as a guiding principle. Although older people are the biggest users of NHS services, it is important that the needs of other age groups are not ignored. People of different ages have different healthcare needs and this is reflected in the approach to this domain.

Overarching Indicator

Overarching indicators currently available

3.28. Due to the diversity of this domain, it has not been possible to identify a single indicator that covers its entirety. Instead, it is more easily dealt with as the two related outcomes set out above: preventing conditions from becoming more serious; and, helping people to recover from serious illness or injury. The indicators set out below are an attempt to cover these two aspects using what is currently available. These indicators are not pure outcomes but proxies for outcomes:

Annex A 8
Technical details of indicators

- **Emergency hospital admissions for acute conditions usually managed in primary care**
  This indicator shows how well the NHS is doing at preventing curable conditions from becoming more serious, and largely reflects the outcomes achieved in primary care.
- **Emergency bed days associated with repeat acute admissions**
  Most conditions, if treated effectively, should not require repeat admissions to hospital. Where patients are readmitted for emergency care, it is an indication that the outcome of their original treatment was not as good as it should have been.[21]

Question

16. Are these appropriate overarching outcome indicators for this domain? Are there any other indicators that should be considered?

[21] Two definitions of each of these indicators are set out in Annex A, section 8

Overarching indicators that could be developed

3.29. In the future it may be possible to develop indicators for this domain that focus more explicitly on outcomes and so reduce the risk of perverse incentives. These may be based on patient reported measures, although current methodologies are not general enough to cover the whole domain.

Annex A 8
Technical details of indicators

Question

17. What overarching outcome indicators could be developed for this domain in the longer term?

Improvement Areas

3.30. Patient Reported Outcome Measures (PROMs) are a powerful way of measuring health outcomes as perceived by patients, and are applicable to this domain. However, current methodologies for acute care require questions to be asked of the patient before and after treatment, and so can only be applied routinely to planned episodes of care. While in future it may be possible to develop similar measures for unplanned care, this is not a realistic proposition in the short term.

3.31. It is therefore proposed that PROMs be used in this domain to monitor outcomes in planned care. PROMs are currently collected for some specific elective procedures, and could be applied to a broader array of other procedures, or more generally, in the future.

3.32. For unplanned care the proposal is to look at which causes are the most important for each age group, and to select outcome indicators to cover these areas. One way of identifying suitable areas of focus is to look at emergency bed days, which is a measure of the likelihood of someone needing emergency care for a given cause, and how long they are likely to be in hospital. Figure 6 shows the causes that lead to the most emergency bed days for children, adults and older people.

Annex A 9
Methodology for identifying common causes of emergency care

Figure 6 – causes leading to most emergency bed days and the proportion of all emergency bed days attributable to each (excluding long-term conditions)

Children	
Fractures (excluding head injuries)	6%
Bronchiolitis	6%
Upper respiratory tract infection	5%
Pneumonia*	3%
Head injury	2%

Adults	
Fractures (excluding head injuries)	4%
Stroke	3%
Pneumonia*	3%
Depression	2%
Heart attack	1%

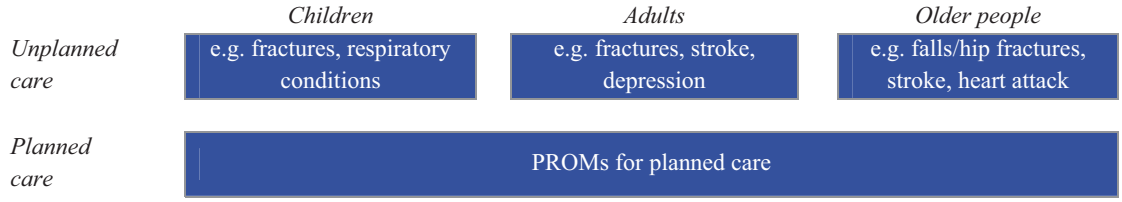
Older people	
Fractures (excluding head injuries)	11%
of which hip fractures	*8%*
Stroke	7%
Pneumonia*	7%
Heart attack	2%
Head injury	1%

* there are known coding issues with pneumonia, so it may be over-represented here

3.33. Figure 7 gives an overview of the improvement areas for this domain, following the logic set out in the previous paragraphs. Annex A contains a list of outcome indicators that are relevant to this domain, some of which might be suitable for inclusion in the framework.

Annex A 10
Technical details of indicators

Figure 7 – improvement areas for planned and unplanned care



Questions

18. Is this a suitable approach for selecting some improvement areas for this domain? Would another method be more appropriate?

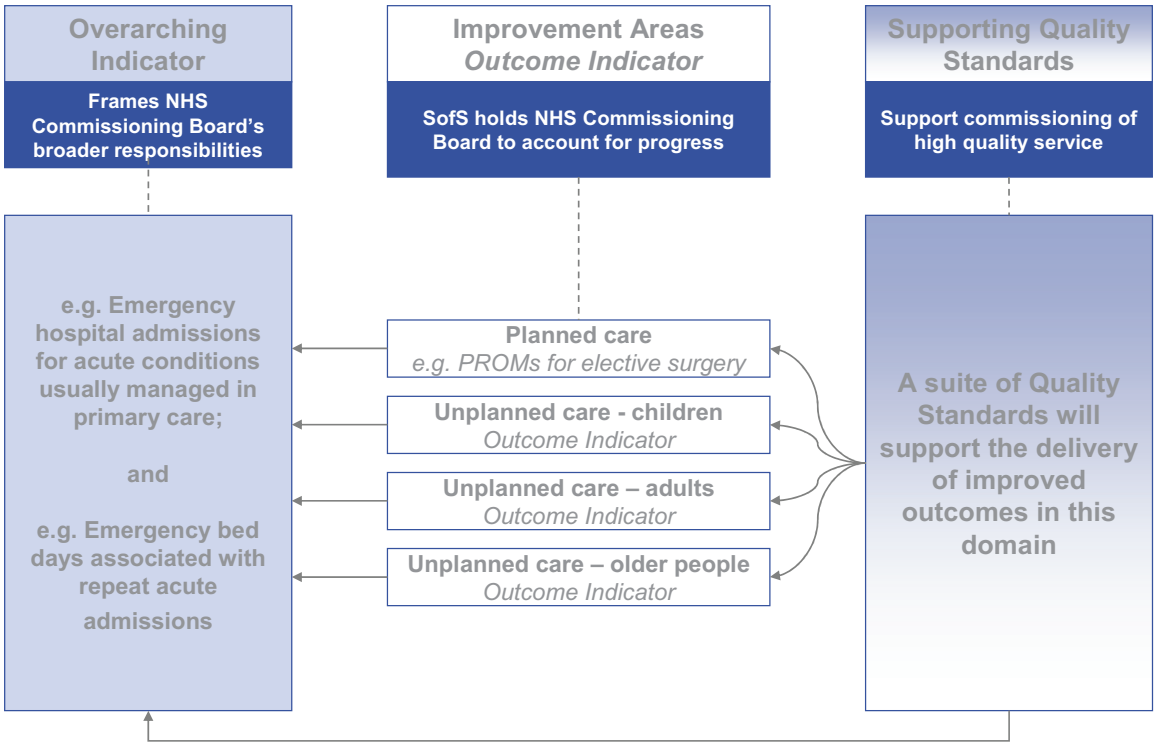
19. What might suitable outcome indicators be in these areas?

Quality Standards

3.34. To support commissioning for excellent outcomes in all domains of this framework, there will be a suite of quality standards setting out what high quality care looks like across all major pathways of care. Some topics for Quality Standards will be selected to reflect areas that are most important to improving outcomes in this domain.

3.35. Based on the above method and analysis, Figure 8 illustrates what this domain might look like

Figure 8: helping people to recover from episodes of illness or following injury



DOMAIN 4: ENSURING PEOPLE HAVE A POSITIVE EXPERIENCE OF CARE

3.36. Quality of care includes the quality of caring. This means how personal care is - the compassion, dignity and respect with which patients are treated, and the extent to which they are given the level of comfort, information and support they require.

3.37. The principle of asking patients and carers to provide direct feedback on the quality of their experience, treatment and care is now standard among health care systems worldwide, and a number of initiatives are in place which seek to make international comparisons.

3.38. This domain has been developed on the basis of four underlying principles or assumptions:

- **Patient experience must be a vital element of the NHS Outcomes Framework** - a health service that delivers the outcomes that matter most cannot only look at how well it is treating people in clinical or medical terms;
- **The existing arrangements for collecting patient experience information do not lend themselves well to the requirements of the NHS Outcomes Framework.** This is a relatively new area of

focus for the NHS and the national and local infrastructure for measuring and monitoring quality *from the patients' point of view* is at a relatively early stage of development There is a degree of challenge and development required nationally and locally over the coming years to create appropriate patient feedback systems to assist the NHS to understand and improve the experience of patients. This consultation seeks your views on proposals for developing a new generation of outcome indicators for patient experience; and

- **It is necessary to measure patient experience now, to drive a step change in improvement** – the evolutionary approach to developing the NHS Outcomes Framework will ensure that new and improved patient feedback mechanisms will be able to inform future iterations of the framework. This consultation sets out some interim options based on what is possible now within the existing national survey infrastructure; and
- **Ensuring that a balanced approach is achieved - so that this work fully supports and complements locally-led innovation and focused improvement activity.** These proposals are based on the key principle that the real benefits of looking at patient experience lie in local clinical teams developing a culture and process for routinely asking their own patients and service users for structured feedback and then acting on what this feedback is telling them about the services they provide.

3.39. With this in mind, this domain of the NHS Outcomes Framework will be constructed in broadly the same way as for the effectiveness elements of the framework.

Overarching Outcome Indicator

3.40. A **short term interim approach** for immediate use as an overarching indicator, **and a longer term approach** for future development is proposed.

3.41. The reason for this two stage approach is that the initial options available for developing an overarching indicator are currently constrained by the existing national survey arrangements, and the limited availability of standardised national data. Most centrally coordinated surveys are conducted at organisation-level, and focus on different NHS services and settings[22] – such

Annex A 11
An overview of patient experience indicators

[22] This includes the GP Patient Survey, the NHS National Patient Survey Programme, and the National Cancer Survey. Further information on each respectively are available via the following web links:

- http://www.gp-patient.co.uk/

as GP practices, inpatients, outpatients, A&E, mental health services, maternity and cancer services. The frequency with which these surveys are conducted varies, so not all take place on an annual basis. The relatively small sample size of most surveys also means that results cannot be reliably analysed below the overall organisation level. More information on the current survey infrastructure is included in Annex A.

3.42. Whilst the interim option is not considered ideal, it is widely recognised by the NHS and so will provide short-term continuity while future indicators (and related survey options) are being developed.

3.43. The short term approach involves:

- tracking performance on a predefined subset of survey questions across available and relevant surveys. This is in line with the approach used in recent years by the independent healthcare regulator and the Department of Health to monitor performance in reported patient experience.[23,24] The chosen questions are categorised under five separate patient experience themes, which can be aggregated to form an overall score for each separate survey that is conducted in any one year.
- The five themes are: access and waiting; safe, high quality coordinated care; better information, more choice; building closer relationships; and clean, friendly comfortable place to be.
- This approach can be applied to surveys that are due to be conducted and published in the next year or so, potentially covering primary care, adult in-patients, maternity services, and community mental health services.

Question

20. Do you agree with the proposed interim option for an overarching outcome indicator?

3.44. The proposed **long-term approach** is to develop an overarching outcome indicator that is based on a limited set of core questions that can be included

- http://www.cqc.org.uk/usingcareservices/healthcare/patientsurveys.cfm
- http://www.quality-health.co.uk/2010cancersurvey.html

[23] Further information is available on the CQC and DH websites: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098525

[24] Further information on the results to date are available on the DH website: http://www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/NationalsurveyofNHSpatients/DH_087516

within all surveys, so covering all relevant care settings and focusing directly on the outcomes that matter most to patients. These questions would ask patients whether they received the care and services they need, and its overall quality (for example, whether it met their requirements, enabled them to maintain their health, or enhanced their quality of life). Appropriate questions are not included within the existing survey programmes, so development work on the precise indicator is required.

Question
21. Do you agree with the proposed long term approach for the development of an overarching outcome indicator?

Improvement Areas

3.45. The available evidence base for identifying robust **improvement areas** is extremely limited - especially in terms of the coverage of current surveys across different conditions, pathways and services. On this basis, it is not possible to set out precise patient experience indicators at this stage – although we can identify broad areas where more focused work is required. It is therefore proposed that the following improvement areas be included in the NHS Outcomes Framework:

- **Primary and community services** – people rely on primary care services for their day-to-day health and well-being, and to access hospital care. During the course of their lives, most people will also come into contact with NHS community services, which provide essential advice, care and support. Both are important areas that warrant closer monitoring of the experience of patients and service users;
- **Acute care –** recent high profile failures in NHS hospitals, such as Mid Staffordshire NHS Foundation Trust, reinforce the importance of continuing to measure the experience of patients in acute care settings (such as accident and emergency, in-patient and out-patient services);
- **Mental health services** – patients with mental health conditions are among the more vulnerable groups receiving NHS care and so specific emphasis should be placed on measuring their experiences. This improvement area could look at the different settings in which care is provided, for example, community mental health services and in-patient mental health services;

- **Children and young people** – children account for up to 40% of GP visits and are frequent users of A&E. However, the NHS has found it more difficult to collect and understand the experience of children and their parents or carers than that of adult patients. There are particular issues and difficulties, both practical and ethical, about surveying children, but these are not insurmountable. Work will be carried out to investigate the possibilities for measuring children's (and their parents' or carers') experiences of their care in a sensitive and appropriate way;
- **Maternity services** – maternity services provide the first significant personal experience of healthcare and for many people, is considered the 'touchstone' of an organisation's quality of care. Adverse events in maternity services make sensational news whereas excellent care is rarely acknowledged or publicly praised. While reducing perinatal mortality is an outcome that needs to be achieved, it does not reflect the circumstances of the overwhelming majority of parents. Positive outcomes need to be measured not only in terms of a healthy baby, but in ways that take into account the new family's experience of using maternity and newborn services;
- **End of life care** – approximately 500,000 people die each year, yet it is very difficult to assess the quality of the care that they receive at the end of life, as the only outcome is death. Society places a very high value on making sure that people have the best possible experience of care at the end of life, and so it is important to assess this experience. This will be measured by recording the views of those closest to the bereaved.

Question

22. Do you agree with the proposed improvement areas and the reasons for choosing those areas?

3.46. For each of these areas, outcome indicators will be identified based on what is available in the **short term**. For in-patient services, the measure developed as a national goal for inclusion within the Commissioning for Quality and Innovation (CQUIN) payment framework for acute care services[25] could be

[25] Further information is available from the DH and NHS Institute for Innovation and Improvement websites:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091443
http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html

used. This is based on producing an overall composite measure score for "responsiveness to the personal needs of patients"[26].

3.47. This composite approach provides a picture of performance for each separate survey, but also over time – with national results being disaggregated down to a local and organisation level. This enables a comparative and time series view of performance on patient experience to be constructed across each of the pre-defined set of questions. The information collected and resulting insight would not only measure progress but also identify where improvements could be made.

3.48. Over **the medium to long term**, new outcomes indicators for improvement areas should be based on the same principles as the national CQUIN goal for acute services (set out above). We envisage these indicators extending across the full range of services and settings covered by national surveys. The initial focus will be on surveys that have already been developed (such as community mental health, maternity, A&E and outpatients services), and extending to other newly developed surveys once they are available.

Quality Standards

3.49. To support commissioning excellent outcomes in all domains of this framework, there will be a suite of Quality Standards setting out what high quality care looks like across all major pathways of care. Some topics for Quality Standards will be selected to reflect areas that are most important to improving outcomes in this area.

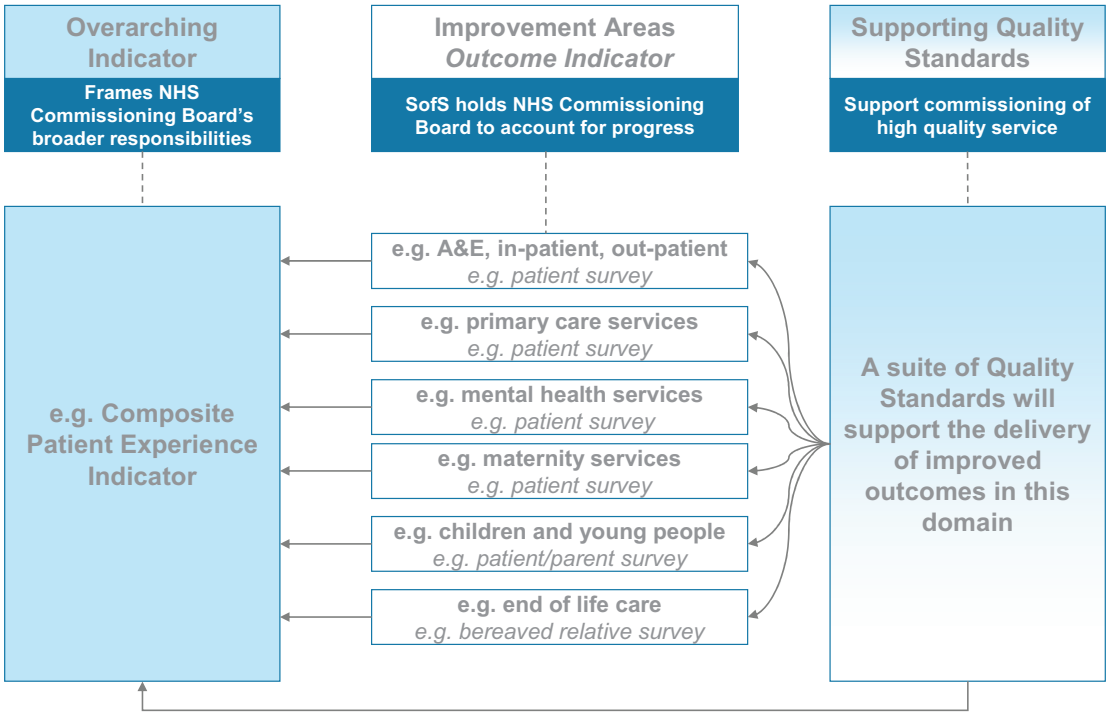
3.50. Although Quality Standards will generally encompass all three domains of quality - effectiveness, patient experience and safety – your views are welcomed on whether the development of dedicated patient experience Quality Standards should be considered for certain services or client groups.

Question
23. Would there be benefit in developing dedicated patient experience Quality Standards for certain services or client groups? If yes, which areas should be considered?

[26] This composite measure is based on five survey questions, covering a range of issues – such as patients being involved in decisions about their care, being able to talk to hospital staff about their worries and fears, having enough privacy, being given information about medication side effects, and being informed who to contact if worried about after leaving hospital. This survey is scheduled to be conducted annually, so providing a regular measure of patient experience.

3.51. Based on the above method and analysis, Figure 9 below illustrates what this domain might look like.

Figure 9: ensuring people have a positive experience of care



Future development of this domain

3.52. Over time, the ambition is for the approach to patient experience to be as robust and comprehensive as that for clinical effectiveness and patient safety. This will involve assessing how best to extend and improve national survey arrangements, with the aim of putting in place a more balanced set of surveys covering a range of settings, services, pathways and patient groups.

3.53. A standardised approach to this work will provide quality assurance and value for money, and it will also facilitate comparisons and benchmarking. A balanced approach to the frequency of national surveys will also be required, which supports and complements locally-led innovation and focused improvement activity.

3.54. To achieve this ambition, it is proposed that this work should involve:

- developing a better understanding of patient experience along specific service lines – for example, within acute care settings (for example, covering inpatient, outpatient and A&E services);

- expanding this focus to take better account of other areas of service provision – such as those covering primary and community care services, maternity services, end of life care, and cancer services;
- identifying services or areas where little work has been conducted to date, but which will provide an insight into how best to approach the work more generically. For example:
    - long term conditions which cut across conventional organisational boundaries (for example chronic obstructive pulmonary disease, diabetes, community rehabilitation services);
    - specific medical procedures or treatments, perhaps allied to available Patient Reported Outcome Measures (PROMS) (see Domain 2 for further details);
    - complex and multiple service use (for example, mental health, frail and older people with complex co-morbidities); or
    - the experiences of particular groups of people who may not have been fully incorporated within the range of surveys conducted to date (such as such as children, young people, and carers).

Question
24. Do you agree with the proposed future approach for this domain?

DOMAIN 5: TREATING AND CARING FOR PEOPLE IN A SAFE ENVIRONMENT AND PROTECTING THEM FROM AVOIDABLE HARM

3.55. As far back as 1863, Florence Nightingale said that *" the very first requirement in a hospital [is] that it should do the sick no harm"*[27]. Keeping patients safe means ensuring that the care environment is safe and clean, reducing avoidable harm such as medication errors and reducing rates of healthcare associated infection.

3.56. In developing this domain of the NHS Outcomes Framework, three underlying principles have been used:

[27] *Notes on Hospitals*, Florence Nightingale, 1863

- **Protecting people from further harm** – patients understand the risk of their condition as well as the risks associated with particular treatments and procedures. But, they rightly expect the NHS to provide them with care when they need it, without causing or contributing additional unacceptable harm or injury in the process;
- **An open and honest culture** – NHS staff should be empowered to expose failings in care. A culture that promotes reporting of safety incidents will allow an organisation to increase the likelihood of reducing the number of harmful incidents by giving it a richer understanding of how to deliver safe care; and
- **Learning from mistakes** – Reporting harmful incidents will not, by themselves, prevent further similar incidents happening. Organisations must be able to learn from incident reports and make tangible changes that improve safety and the public's confidence in the organisation.

Overarching Indicator

3.57. Patient safety is a challenging area in which to identify and deliver good outcomes, as the desired outcome is often the absence rather than presence of an event – i.e. preventing a harmful incident. Therefore, as well as reducing harmful incidents it is vital that the NHS is effective at recognising and reporting safety issues to foster greater understanding of how to deliver safe care.

3.58. For patient safety, an **overarching outcome indicator** should ensure that the NHS has an active patient safety culture, in which organisations are keeping individual patients safe. The proposal is to construct an overarching outcome **indicator**, including three measures:

Annex A 12
Technical details of indicators

i. the number of incidents reported (this should be rising in the short term and comparable with other services in the long term);
ii. the severity of harm (this should be decreasing); and
iii. the number of similar incidents (this should be decreasing).

3.59. An effective patient safety culture is one where an organisation is reporting incidents on an **increasing** basis in the short term and on a comparable basis with other high performing services in the longer term, demonstrating a good reporting culture (i). But this has to be balanced by a **decrease** in the levels of severity, particularly incidents resulting in severe harm and death, demonstrating a good learning culture (ii). There should also be a **reduction**

in the number of the same types of event as this is a good indication that the organisation is implementing and complying with guidance, best practice, and with safety alerts (iii).

3.60. This indicator would provide an indication of whether a just and open safety culture is developing in an organisation, as well as indicating whether more or fewer patients are experiencing unacceptable harm. It would also indicate how well an organisation is learning.

Question
25. Do you agree with the proposed overarching outcome indicator?

Improvement Areas

3.61. Safer care not only leads to a better life for patients and their families – safer care is generally less expensive. Patient safety affects all aspects of health care activity, including:

- the actual treatment provided to people;
- the system in which that care and treatment is provided; and
- the physical building and surroundings in which the treatment is provided and the systems of care operate (patient environment).

3.62. There are also certain vulnerable groups who require a particular focus when it comes to safety: those about to give birth, children, older people, people requiring mental health services and people with learning disabilities. The principles underpinning the proposed overarching outcome indicator – reducing harm and learning from mistakes – can be applied to these groups as well as safe care generally, using the same data source. In addition to this, consideration will be given to whether additional safety outcome measures in these areas could be developed.

3.63. Therefore, the proposed improvement areas have been defined so that they are relevant across the whole of health care. Five specific areas for improvement have been identified, and relevant indicators are included in Annex A. These areas are:

Annex A 13
Technical details of indicators

- **Safe treatment** – e.g. Never Events, reduced venous thromboembolism (VTE), Falls, Medication Errors
- **Safe discharge/transition** – e.g. Emergency re-admissions

- **Patient Environment** – e.g. minimising avoidable infections, cleanliness
- **Safety culture** – e.g. openness about mistakes (reporting)
- **Vulnerable groups** – e.g. maternity, older people

Question
26. Do you agree with the proposed improvement areas and the reasons for choosing those areas?

3.64. The identified improvement areas are provisional. The evidence and methods for choosing certain indicators will be refined in advance of finalising the NHS Outcomes Framework, informed by responses to this consultation.

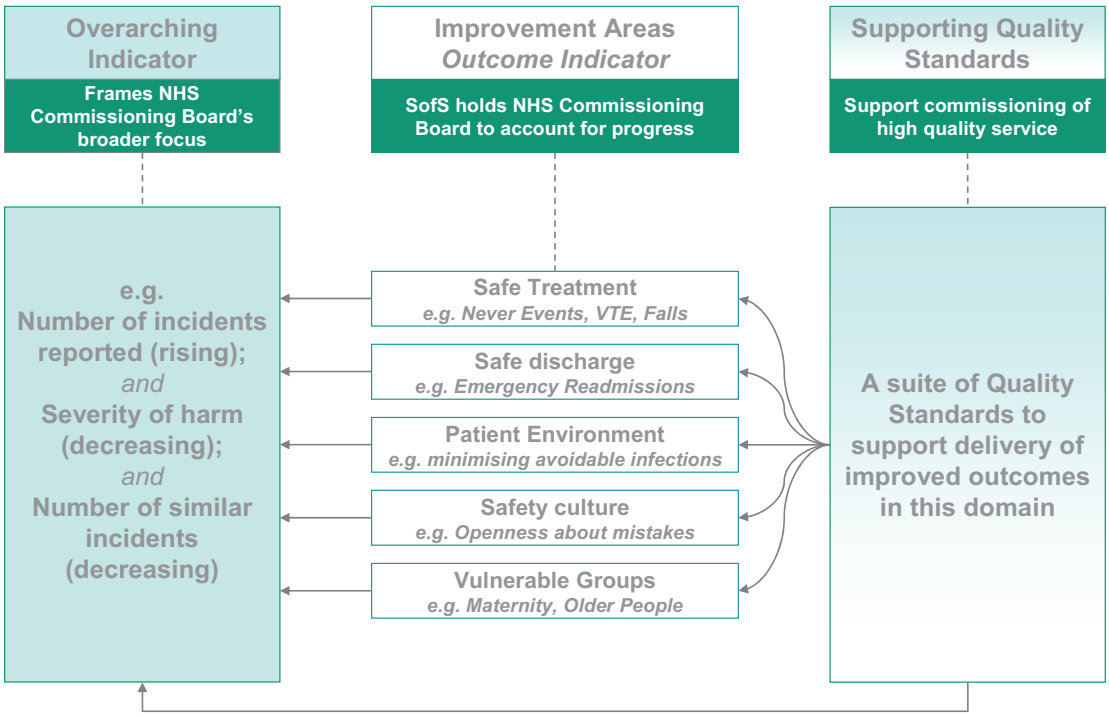
Quality Standards

3.65. To support commissioning excellent outcomes in all domains of this framework, there will be a suite of Quality Standards setting out what high quality care looks like across all major pathways of care. Some topics for Quality Standards will be selected to reflect areas that are most important to improving outcomes in this area. For example, one of the first three quality standards published by NICE was on the prevention of venous thromboembolism[28].

3.66. Based on the above method and analysis, Figure 10 sets out what this domain might look like.

[28] The VTE prevention NICE quality standard was published on 30 June 2010 and is available at http://www.nice.org.uk/aboutnice/qualitystandards/vteprevention/VTEqualitystandard.jsp

Figure 10 - Treating and caring for people in a safe environment and protecting them from avoidable harm



4. Next steps: How can you be involved?

Consultation Questions

4.1. Throughout this document, you are asked questions on the proposals for developing the NHS Outcomes Framework. Your views by way of responses to this consultation are essential to constructing an NHS Outcomes Framework that reflects what matters most to patients, and that is clinically relevant.

4.2. If your views do not fit under any of the specific questions included in Chapters 2 and 3, the following questions are more general, asking you about the proposals for the NHS Outcomes Framework overall, and the Impact Assessment which has been published alongside this consultation document.

Questions

27. What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they can promote equality of opportunity and outcomes for all patients and, where appropriate, NHS staff?

28. Is there any way in which the proposed approach to the NHS Outcomes Framework might impact upon sustainable development?

29. Is the approach to assessing and analysing the likely impacts of potential outcomes and indicators set out in the Impact Assessment appropriate?

30. How can the NHS Outcomes Framework best support the NHS to deliver best value for money?

31. Is there any other issues you feel have been missed on which you would like to express a view?

4.3. These questions, and all the specific questions from Chapters 2 and 3 are set out in **Annex B**.

Next Steps

4.4. This consultation document is the first step in getting active involvement from those who work in the NHS, those who use its services and those who are

clinical and healthcare experts. A full engagement process will be running over a 12 week period from publication of this document.

Timeline to the NHS Outcomes Framework

- **19 July 2010** – publication of consultation document and consultation opens
- **July – October 2010** – engagement process as part of full public consultation
- **11 October 2010** – consultation closes
- **End October / early November 2010** – Government response to the consultation
- **End 2010 / early 2011** - publication of the first NHS Outcomes Framework alongside the NHS Operating Framework for 2011/12

Engagement Process – how to get involved

4.5. This consultation is a formal public consultation in line with the Government Code of Practice on consultations. It will run for the full 12 week period. More details on what a formal consultation means is set out at **Annex C**, along with contact details for comments on the consultation process itself.

4.6. There are a number of questions in this document, both on specific areas of the NHS Outcomes Framework and more generally on which your views are being sought. You can respond to this consultation by:

- coming along to one of our regional events for NHS staff and patients which will be held across the country, details of which will be posted on the DH website shortly; or
- responding to the questions in this document by completing a template which can be downloaded from our website at www.dh.gov.uk/liberatingtheNHS and returning it to us by 11 October 2010 via
  - *email:* nhswhitepaper@dh.gsi.gov.uk
  - *post:* Consultation Responses
    Quality and Outcomes Policy Team
    Room 602A, Skipton House
    80 London Road
    London
    SE1 6LH

Beyond the Engagement Process

4.7. On 1 April 2011, the NHS Commissioning Board will be established in shadow form. It will be held to account by the Secretary of State through the new NHS Outcomes Framework 2011/12.

4.8. The NHS Outcomes Framework will be reviewed and re-issued in Autumn 2011, ahead of the NHS Commissioning Board being formally established (subject to parliamentary approval) on 1 April 2012.

ANNEX A – Possible outcome indicators

Introduction

Selecting outcome indicators to populate the framework

The structure of the Outcomes Framework proposed in Chapter 3 will require the selection of two levels of outcome measure:

- an overarching indicator(s) for each of the five domains; and
- outcome indicators to measure progress in each of the improvement areas in all five domains.

The eventual set of outcome indicators to underpin the NHS Outcomes Framework will be arrived at by a careful process of analysis of the relevance of indicators to the proposed improvement areas; their technical validity; their practical feasibility; and the potential costs and benefits flowing from their use in the NHS Outcomes Framework.

The purpose of this annex – a starting point

To start this selection process, an initial list of potentially relevant outcome indicators has been assembled in this annex. The list includes both indicators that currently exist and those that have been proposed for development. Indicators have been selected for initial consideration on the basis of two essential criteria:

- they are, at least in part, a health outcome measure; and
- they are, at least in part, directly influenced by healthcare actions.

Clearly, many other legitimate measures of quality of care are available. The focus here, however, has been to identify – as far as possible – *outcome* measures, as opposed to indicators of the quality of clinical processes.

An assessment has also been made for each indicator against three other desirable criteria:

- whether it can be disaggregated to sub-national geographical areas and/or equalities dimensions[29];

[29] The six key equality dimensions of race, disability, gender, age, sexual orientation and religion or belief

- whether international comparative data are currently available; and
- whether it is currently collected.

How to respond to this annex

This initial list will undergo more detailed assessment and analysis while this consultation is running. Suggestions for other, more relevant outcome indicators will be very welcome, and will be put through the same assessment and analysis process. Specific feedback on the strengths and weaknesses of any of the potential indicators set out in this annex would also be very helpful.

It is recognised that many of the outcome indicators proposed below may be impacted upon not only by NHS healthcare actions, but also by public health and / or social care interventions. Suggestions are welcomed on how shared responsibility for such outcomes indicators might be attributed to the NHS, public health or social care, and how their relative contributions might be estimated.

Questions

32. What are the strengths and weaknesses of any of the potential outcome indicators listed below with which you are familiar?

33. Are other practical and valid outcome indicators available which would better support the five domains?

34. How might we estimate and attribute the relative contributions of the NHS, public health and social care to these potential outcome indicators?

Using this annex

The structure of this annex

This annex follows the structure of chapter 3 of the main consultation document, taking each of the five proposed domains in turn and listing relevant outcome indicators for each, as well as covering any other technical issues. It should be read alongside chapter 3, which highlights the points at which interested readers should refer to the annex.

Key to indicator information

This annex rates the outcome indicators identified on five criteria that will be considerations when deciding whether the indicators are appropriate for use in the outcomes framework. Each indicator is scored on the following scale:

Y Criteria fully or largely met

P Criteria partly met

N Criteria not met

? Information not available

Links to further information

The websites listed below are rich sources of currently available indicators, and information about those indicators. Most include many process as well as outcomes measures.

- The Information Centre for Health and Social Care (IC)
  http://www.ic.nhs.uk/
- Office of National Statistics (ONS)
  http://www.statistics.gov.uk
- Patient Reported Outcomes Measures (PROMS)
  http://www.ic.nhs.uk/services/patient-reported-outcomes-measures-proms
- Hospital Episodes Statistics (HES)
  http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937
- Quality and Outcomes Framework (QOF)
  http://www.ic.nhs.uk/statistics-and-data-collections/audits-and-performance/the-quality-and-outcomes-framework
- Commissioning for Quality and Innovation (CQUIN) payment framework
  http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html
- Labour Force Survey
  http://www.statistics.gov.uk/CCI/SearchRes.asp?term=labour+force+survey&x=31&y=12
- National Hip Fracture Database (NHFD)
  http://www.nhfd.co.uk/
- NHS Comparators
  https://www.nhscomparators.nhs.uk/NHSComparators/Login.aspx
- Clinical and Health Outcomes Knowledge Base (NCHOD)
  http://www.nchod.nhs.uk/
- Indicators for Quality Improvement (IQI)
  http://www.ic.nhs.uk/services/measuring-for-quality-improvement
- National Indicator Set:
  http://www.communities.gov.uk/publications/localgovernment/updatednidefinitions

- OECD Health Data
  http://www.ecosante.org/index2.php?base=OCDE&langs=ENG&langh=ENG&ref=YES&sessionid=0b674c314b12274cceca8210648564df
- WHO
  http://www.euro.who.int/en/what-we-do/data-and-evidence/databases
- EUROCARE
  http://www.eurocare.it/
- Amenable Mortality: discussion of technical issues (2004)
  http://www.nuffieldtrust.org.uk/ecomm/files/21404avoidablemortality2.pdf
- Amenable Mortality: International Comparisons (Nolte & McKee 2003 paper)
  http://www.bmj.com/cgi/content/full/327/7424/1129?ijkey=c9397b45fe1c75f152868f2fd1417b8de6a19851
- Amenable Mortality: International Comparisons (Nolte & McKee 2008 paper)
  http://www.commonwealthfund.org/Content/Publications/In-the-Literature/2008/Jan/Measuring-the-Health-of-Nations--Updating-an-Earlier-Analysis.aspx
- Amenable Mortality: NCHOD definition
  http://www.nchod.nhs.uk/NCHOD/compendium.nsf/361d5bea85d84b7c802573a30020fcd5/0369316d2ebea946652570d1001cb76c!OpenDocument

Specific outcome indicators and technical issues

The main body of the annex follows.

GENERAL ISSUES

1. Design principles for outcome indicators (paragraph 3.3)

This consultation has focused on indicators that:

- measure health outcomes rather than NHS processes;
- are broad indicators - capturing as much NHS business and as many patients and conditions as possible ;
- can be significantly influenced by healthcare (where possible any public health and social care contribution is excluded from the indicators);
- focus on areas where there is evidence that performance can be improved;
- can be disaggregated by age, sex, geography, other equalities strands and other variables such as condition ;
- are meaningful to the public;

- are statistically sound; and
- can be measured from April 2011 (for the initial set).

Questions

35. Are these appropriate principles on which to select outcome indicators? Should any other principles be considered?

DOMAIN 1: PREVENTING PEOPLE FROM DYING PREMATURELY

2. Overarching indicators (paragraph 3.6)

	Measure of Health Outcome	*Significantly influenced by healthcare*	*Disaggregation by Equalities & Geography*	*International comparisons available*	*Currently collected*
Mortality amenable to healthcare	Y	Y	P	P	Y
All age all cause mortality	Y	P	Y	Y	Y

Technical considerations around amenable mortality

- There is no one agreed definition of amenable mortality; we have used the Nolte & McKee 2008[30] definition for the illustration in Figure 2.
- The indicator is not regularly calculated for international comparison, but can be calculated using existing international comparative data, subject to agreeing a definition.
- Most definitions of amenable mortality only include deaths under 75. Some causes are only considered amenable in younger age groups, e.g. diabetes under 50.
- In practice, some of the mortality included may not be amenable to healthcare, and some will be preventable by public health measures and the wider environment.
- There will be a time-lag in measurement of the indicator – the latest internationally comparative data is at least two years old.

[30] E. Nolte and C. M. McKee (2008). Measuring The Health Of Nations: Updating An Earlier Analysis. *Health Affairs*

- There can be a significant time lag between diagnosis and outcomes – outcomes seen may be a result of interventions several years previously, especially with cancer.
- The National Centre for Health Outcomes Development (NCHOD) currently collects this indicator nationally, but uses a slightly different definition.

3. Selecting improvement areas based on mortality data (paragraphs 3.7 and 3.8)

The table below presents age-standardised death rates per 100,000 from causes amenable to healthcare (ages 0-74; definition from Nolte & McKee 2008; data from World Health Organisation online mortality database). UK[31] rates are compared with the median rate of a comparable set of European countries (the EU-15; Greece is excluded as it does not submit data). All international comparisons should be interpreted with caution, due to differences in registration systems and coding conventions.

Cause	*UK*	*EU-15 median*	*Difference*
Ischaemic heart disease: 50% of deaths	22.26	16.31	+5.95
Pneumonia[32]	6.56	3.44	+3.12
Perinatal deaths, all causes (excl. stillbirths)[33]	4.42	3.35	+1.07
Stroke	14.40	13.64	+0.76
Peptic ulcer	1.47	0.79	+0.68
Breast cancer	10.70	10.20	+0.50
Epilepsy	1.50	1.07	+0.42
Congenital cardiovascular anomalies	1.32	1.05	+0.28
All respiratory diseases ages 0-14 (excl. pneumonia, influenza)	0.28	0.10	+0.18
Abdominal hernia	0.35	0.17	+0.17
Chronic rheumatic heart disease	0.62	0.45	+0.16
Cholelithiasis and cholecystitis (gallstones)	0.35	0.25	+0.10
Tuberculosis	0.28	0.22	+0.06
Appendicitis	0.11	0.05	+0.05
Maternal death	0.12	0.07	+0.05
Hodgkin's disease	0.35	0.30	+0.04
Skin cancer	0.26	0.22	+0.04
Cervical cancer	1.08	1.05	+0.03

[31] UK data is more readily available and is a reasonable approximation for England, which makes up 84% of the UK's population. It is possible to make the same comparisons for England in the future.
[32] There are known coding issues here; deaths assigned to pneumonia may have a different underlying cause
[33] There are differences in the way in which countries record neonatal deaths, so rates may not be comparable

Cause	*UK*	*EU-15 median*	*Difference*
Misadventures to patients during surgical and medical care	0.29	0.27	+0.02
Diabetes	0.52	0.50	+0.02
Whooping cough	0.01	0.00	+0.01
Benign prostatic hyperplasia	0.02	0.02	+0.00
Measles	0.00	0.00	+0.00
Diseases of the thyroid	0.07	0.08	-0.00
Leukaemia	0.60	0.61	-0.00
Cancer of the uterus	0.03	0.04	-0.01
Testicular cancer	0.09	0.11	-0.01
Intestinal infections	0.01	0.02	-0.02
Influenza	0.03	0.05	-0.02
Hypertensive disease	1.89	1.92	-0.03
Colorectal cancer	10.92	11.08	-0.16
Other infections (diphtheria, tetanus, septicaemia, poliomyelitis)	1.43	1.90	-0.47
Nephritis and nephrosis	1.09	1.65	-0.56

4. Improvement areas (paragraph 3.9)

Mortality itself is measurable and internationally comparable, and so is an appropriate outcome indicator to use for many of these improvement areas. There are some exceptions where there are known issues, for example differences in coding and recording practices both between and within countries (e.g. pneumonia). There are also other ways of addressing this issue, such as using survival rather than mortality data. Some specific indicators are set out below.

	Essential		*Desirable*		
	Measure of Health Outcome	*Significantly influenced by healthcare*	*Disaggregation by Equalities & Geography*	*International comparisons available*	*Currently collected*
Premature mortality from ischaemic heart disease, 0-74 years (ONS)	Y	P	P	Y	Y
Premature mortality from all cardiovascular disease, 0-74 years (ONS)	Y	P	P	Y	Y
30-day mortality after first time Coronary Artery Bypass Graft (incomplete national coverage) (CCAD)	Y	P	P	N	Y
30-day mortality after first time aortic valve replacement (incomplete national coverage) (CCAD)	Y	P	P	N	Y
30 day mortality following congenital heart disease surgery (national coverage incomplete for age 16+) (CCAD)	Y	P	P	N	Y
Premature mortality from stroke, 0-74 years (ONS)	Y	Y	P	Y	Y
Premature mortality from cancer, 0-74 (ONS)	Y	P	P	Y	Y
One- and five-year cancer survival (ONS, EUROCARE, OECD; note time lag)	P	Y	P	Y	Y

5. Other considerations (paragraphs 3.11 and 3.13)

The following indicators could potentially be used to take account of mortality in children and older people.

	Essential		Desirable		
	Measure of Health Outcome	*Significantly influenced by healthcare*	*Disaggregation by Equalities & Geography*	*International comparisons available*	*Currently collected*
Healthy life expectancy at age 65 (ONS)	Y	P	P	Y	Y
Excess winter deaths (ONS)	Y	P	P	N	Y
Infant mortality (ONS)	Y	Y	Y	Y	Y
Premature mortality from respiratory disease, 0-14 (ONS)	Y	P	P	Y	Y
Amenable mortality for people with serious mental illness (ONS / MHMDS, Information Centre)	Y	Y	Y	N	N

DOMAIN 2: ENHANCING QUALITY OF LIFE FOR PEOPLE WITH LONG-TERM CONDITIONS

6. Overarching indicators (paragraphs 3.19 and 3.20)

	Essential		Desirable		
	Measure of Health Outcome	*Significantly influenced by healthcare*	*Disaggregation by Equalities & Geography*	*International comparisons available*	*Currently collected*
Percentage of people with long-term conditions where day to day activity affected (Labour Force Survey)	Y	P	Y	N	Y
Percentage of people with long-term conditions feeling supported to manage condition (currently in the GP Patient Survey)	Y	Y	Y	N	Y
Percentage of people with a long-term condition who say they are confident are that they can manage their own health	Y	Y	N	N	P
Generic PROM for all patients with long-term conditions	Y	Y	P	N	N

7. Improvement areas (paragraph 3.23)

The indicators set out in the table below resulted from an initial review of outcome indicators in this area. In the main body of this document the preferred option of using functional and episodic outcomes that apply to all conditions has been set out, but the list below also includes condition-specific outcome indicators that currently exist.

	Essential		Desirable		
	Measure of Health Outcome	*Significantly influenced by healthcare*	*Disaggregation by Equalities & Geography*	*International comparisons available*	*Currently collected*
PROMs for specific long-term conditions	Y	Y	P	N	P
Percentage of people with long-term conditions who report that their health affects the amount or type of work they can undertake (Labour Force Survey)	Y	P	Y	N	Y
Emergency hospital admissions for ambulatory care sensitive conditions – chronic (NHS Comparators)	P	Y	P	P	Y
Emergency hospital admissions for specific chronic conditions usually managed in primary care (NCHOD)	P	Y	P	P	Y
Emergency hospital admissions: for children with asthma (NCHOD)	P	Y	P	N	Y
Emergency hospital admissions: for fractured proximal femur (NCHOD)	P	P	P	N	Y
Emergency hospital admissions: for diabetic ketoacedosis and coma (NCHOD)	P	Y	P	N	Y
Emergency hospital admissions: for schizophrenia (NCHOD)	P	P	P	N	Y
Emergency admissions related to: alcohol dependence; drug dependence (HES)	P	P	Y	N	P
Proportion of adults with learning disabilities in employment (Information Centre)	P	P	P	N	Y
Unplanned hospital re-admissions for schizophrenia and bipolar disorder (OECD Health at a Glance)	P	Y	P	Y	Y
Proportion of adults in contact with secondary mental health services in employment (Information Centre)	P	P	P	N	Y
Percentage of patients aged 18 years and over on drug treatment for epilepsy who have been seizure free for the last 12 months recorded in the previous 15 months (Information Centre: QOF)	Y	Y	P	N	Y
Range of outcome measures for Coronary Heart Disease (cholesterol, blood pressure) (Information Centre: QOF)	Y	Y	P	N	Y
Range of outcome measures for Stroke (cholesterol, blood pressure) (Information Centre: QOF)	Y	Y	P	N	Y
Percentage of patients with hypertension in whom the last blood pressure is 150/90 or less (Information Centre: QOF)	Y	Y	P	N	Y
Range of outcome measures for diabetes, 17 years and over (cholesterol, blood pressure, HbA1c) (Information Centre: QOF)	Y	Y	P	N	Y
Range of outcome measures for diabetes in children (cholesterol, blood pressure, HbA1c) (Information Centre: QOF)	Y	Y	?	N	N
The percentage of patients on the chronic kidney disease register in whom the last blood pressure reading is 140/85 or less, 18 years and over (Information Centre: QOF)	Y	Y	P	N	Y
Diabetes acute complication rate (OECD Health at a Glance)	Y	Y	Y	Y	Y
Health of the Nation Outcome Scale (HoNOS), for people with mental illness (MHMDS, Information Centre)	Y	P	P	P	P
Proportion of people with dementia who do not stay in hospital longer than people without dementia do for similar conditions (HES)	P	Y	Y	N	P

	Essential		Desirable		
	Measure of Health Outcome	*Significantly influenced by healthcare*	*Disaggregation by Equalities & Geography*	*International comparisons available*	*Currently collected*
Mortality from suicide and injury of undetermined intent	Y	P	Y	Y	Y
Indicators for sickle cell in children: pain management; or avoidance of serious complications such as stroke	Y	Y	?	N	N

It may also be possible to develop other outcome indicators in the future.

- Specific questions relating to the functional outcomes that are relevant for each age group could be included in national surveys.
- It may be possible to use data collected by other Government departments, such as workforce data from DWP, to infer functional outcomes. Work would be needed to ensure that any such inferences are valid.

DOMAIN 3: HELPING PEOPLE TO RECOVER FROM EPISODES OF ILLNESS OR FOLLOWING INJURY

8. Overarching indicators (paragraphs 3.28 and 3.29)

	Essential		Desirable		
	Measure of Health Outcome	*Significantly influenced by healthcare*	*Disaggregation by Equalities & Geography*	*International comparisons available*	*Currently collected*
Emergency hospital admissions for acute conditions usually managed in primary care (NCHOD)	P	Y	P	P	Y
Emergency hospital admissions for Ambulatory Care Sensitive Conditions – acute (NHS Comparators)	P	Y	P	P	Y
Emergency bed days associated with repeat acute admissions (2+ pa) (HES)	P	Y	Y	N	P
Percentage of emergency admissions to any hospital in England occurring within 28 days of the last, previous discharge from hospital after admission (NCHOD)	P	Y	P	N	Y

9. Methodology for selecting the most common causes of emergency care (paragraph 3.32)

Hospital Episode Statistics (HES) provide information about the number of bed days that result from emergency admissions. These bed days can be linked to the primary diagnosis of the patient, indicated by an ICD-10 code, and so it is possible to estimate

the number of bed days that relate to a given cause, as long as the ICD-10 codes for that cause are known. For the purpose of this consultation, a list of causes and corresponding ICD-10 codes was taken from work previously carried out by the National Quality Board (NQB) to identify areas that should be prioritised for quality improvement activities.

10. Improvement areas (paragraph 3.33)

	Essential		*Desirable*		
	Measure of Health Outcome	*Significantly influenced by healthcare*	*Disaggregation by Equalities & Geography*	*International comparisons available*	*Currently collected*
PROMS for specific surgical procedures (hip replacement, knee replacement, hernia, varicose veins)	Y	Y	Y	P	Y
Emergency hospital admissions for children with gastroenteritis (NCHOD)	P	P	P	N	Y
Emergency hospital admissions for children with lower respiratory tract infections (NCHOD)	P	P	P	N	Y
Fragility fractures: The proportion of patients recovering to their previous levels of mobility - walking ability at 30 and 120 days (National Hip Fracture Database)	Y	Y	P	N	P
Health status 6 months after stroke	Y	P	?	N	N
Identification and successful treatment of HepC patients	Y	P	?	N	N
Emergency re-admissions to hospital within 28 days of discharge: for fractured proximal femur (NCHOD)	P	Y	P	N	Y
Emergency re-admissions to hospital within 28 days of discharge: for stroke (NCHOD)	P	Y	P	N	Y
Emergency re-admissions to hospital within 28 days of discharge: for hysterectomy (NCHOD)	P	Y	P	N	Y
Emergency re-admissions to hospital within 28 days of discharge: for primary hip replacement surgery (NCHOD)	P	Y	P	N	Y
Proportion of patients of all ages (or over 75) discharged back to usual place of residence within 28 days of emergency admission with various conditions (HES/NCHOD)	P	P	P	N	P
Proportion of Older People (65 and over) who were still at home after 91 days following discharge from hospital into rehabilitation services (Information Centre)	P	P	P	N	Y
Acute admissions as a result of falls or falls injuries for over 75s (HES)	P	P	Y	N	Y
The proportion of all falls and hip fractures which are repeat incidents (National Hip Fracture Database)	P	P	P	N	Y

DOMAIN 4: ENSURING PEOPLE HAVE A POSITIVE EXPERIENCE OF CARE

There are currently very few outcome indicators collected nationally in relation to this domain, so rather than providing a list of indicators, this section of the annex gives an overview of the current state of play and direction of travel with respect to measuring patient experience.

11. An overview of patient experience indicators (paragraph 3.41)

The self-reported experience of patients and service users is an important indicator of the quality of service delivery, and it can turn the spotlight on the issues which patients themselves identify as in need of improvement – many of which would otherwise go unmonitored and unmeasured. The use of nationally coordinated surveys is a cost effective way to collect structured and standardised patient feedback, and it is a relatively new development within the NHS. By asking patients questions about specific aspects of their recent treatment and care episode, the overall aim is to produce directly actionable and benchmarkable data[34].

A number of national-level patient experience surveys have been conducted[35], but the focus in recent years has been on developing a range of organisation-level surveys across a broad range of services and settings. Each survey typically covers a wide range of topics covering all phases of the treatment/care episode – including, for example, access and waiting, admission and discharge arrangements, clinician communications, information provision, and facilities and the wider physical environment.

The table below sets out the main organisation-level nationally coordinated patient surveys that have been conducted over the last ten years. These are mainly derived from the **NHS National Patient Survey Programme**[36, 37] and the **GP Patient**

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[34] This focus on direct experience makes this a different approach to that used in many other surveys that are conducted among the general public, and/or ask them to rate or evaluate services overall (such as is the case with the British Social Attitudes Survey – see link below):
http://www.natcen.ac.uk/study/british-social-attitudes-25th-report/findings

[35] For example, covering General Practice (1998, 2002), and patients who have experienced a stroke (2005, 2006), coronary heart disease (1999, 2004), and cancer (2000, 2004). Building on these national-level surveys, the Department has also recently established the National Cancer Patient Experience Survey. This is now underway, and it covers all NHS adult acute trusts in England who provide cancer care, so providing a national and organisation level measure of patient experience. (Further information is available via the following weblink).
http://www.quality-health.co.uk/2010cancersurvey.html

[36] Further information, including results from all surveys, are available on the website of the Care Quality Commission:
http://www.cqc.org.uk/usingcareservices/healthcare/patientsurveys.cfm

[37] In recent years, the Department of Health has also established a survey covering NHS patients who are have been treated by an Independent Sector Treatment Centre (ISTC). This is modelled on the adult

Survey[38]**,** which are thought to be among the most comprehensive and largest survey programmes in existence.

The existing arrangements for collecting patient experience information do not currently fit with the requirements of the NHS Outcomes Framework. Our aim is for patient experience to be as robust and comprehensive as that for clinical effectiveness and patient safety. On this basis, we have set out a series of proposals for developing and extending the infrastructure for measuring and monitoring quality *from the patients' point of view*. Given the purpose of the Outcome Framework, the focus in here is on developing a series of survey options and arrangements that produce robust national outcome goals, but which will also crucially meet local information requirements and assist local benchmark comparisons. A key consideration in taking these proposals is to ensure a balanced approach is achieved, so that this work fully supports and complements locally-led innovation and focused improvement activity.

Year	Survey
2001/02	Adult inpatients*
2002/03	Outpatient services*
	A&E/Emergency services*
	PCT residents registered with a GP*
2003/04	Adult inpatients*
	PCT residents registered with a GP*
	Young patients (day case and inpatient)*
	Users of community mental health services (CPA)*
	Users of ambulance (urgent/emergency – Category a & b) services*
2004/05	Outpatient services*
	A&E/Emergency services*
	PCT residents registered with a GP*
	Users of community mental health services (CPA)*
2005/06	Adult inpatients*
	Users of community mental health services (CPA)*

inpatient survey programme which forms part of the NHS national patient survey programme, and further details are available from the Department of Health website http://www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/NationalsurveyofNHSpatients/DH_083011

[38] Further information is available via the following weblink: http://www.gp-patient.co.uk/

Year	Survey
	PCT residents registered with a GP*
2006/07	Adult inpatients*
	Users of community mental health services (CPA)*
2007/08	GP Patient Survey
	Users of maternity services*
	Adult inpatients*
	PCT residents registered with a GP*
	Users of community mental health services (CPA)*
	A&E/Emergency services*
2008/09	GP Patient Survey
	ISTC survey
	Adult inpatients*
	Ambulance (category C)*
	Mental health inpatients*
2009/10	GP Patient Survey
	ISTC survey
	Outpatient services*
	Adult inpatients*
	Users of community mental health services (CPA)*
2010/11	ISTC survey
	Adult inpatients*
	Users of maternity services*
	Users of community mental health services (CPA)*

* This survey forms part of the NHS National Patient Survey programme

DOMAIN 5: TREATING AND CARING FOR PEOPLE IN A SAFE ENVIRONMENT AND PROTECTING THEM FROM AVOIDABLE HARM

12. Overarching indicators (paragraph 3.58)

	Essential		*Desirable*		
	Measure of Health Outcome	*Significantly influenced by healthcare*	*Disaggregation by Equalities & Geography*	*International comparisons available*	*Currently collected*
Number of incidents reported (NPSA)	P	Y	Y	Y	Y
Severity of harm of incidents reported (NPSA)	Y	Y	P	P	Y
Number of similar incidents (NPSA)	P	Y	P	P	Y

13. Improvement areas (paragraph 3.63)

Safe treatment

	Essential		*Desirable*		
	Measure of Health Outcome	*Significantly influenced by healthcare*	*Disaggregation by Equalities & Geography*	*International comparisons available*	*Currently collected*
Number of never events reported in period (NPSA)	P	Y	P	P	Y
Number of other critical adverse events reported in period (NPSA)	P	Y	P	P	Y
Incidence of pressure ulcers (HES/NPSA)	Y	Y	Y	P	Y
Incidence of VTE (HES)	Y	Y	Y	P	Y
Incidence of in-patient falls (NPSA)	P	Y	Y	P	Y
Incidence of medication errors (NPSA)	P	Y	P	P	Y
Number of readmission episodes due to safety/error (HES)	P	Y	Y	?	Y
Number of controlled drugs incidents (NPSA/CQC)	P	Y	P	P	Y

Safe discharge/transition

	Essential		Desirable		
	Measure of Health Outcome	*Significantly influenced by healthcare*	*Disaggregation by Equalities & Geography*	*International comparisons available*	*Currently collected*
Number of emergency readmissions (HES)	P	P	Y	Y	Y
Medicines reconciliation compliance (NPSA)	P	Y	P	?	Y
Patient reported experience of medicines management (CQC patient survey)	Y	Y	P	N	Y

Patient environment

	Essential		Desirable		
	Measure of Health Outcome	*Significantly influenced by healthcare*	*Disaggregation by Equalities & Geography*	*International comparisons available*	*Currently collected*
Patient survey reported cleanliness (CQC patient survey)	P	Y	P	?	Y
MRSA incidence (HPA)	Y	Y	Y	Y	Y
C.Diff incidence (HPA)	Y	Y	Y	Y	Y
Incidence of surgical site infections (orthopaedics) (HPA)	Y	Y	P	P	Y
Number of central line infections in Intensive Care Units (HPA and NPSA via Matching Michigan)	Y	Y	P	Y	Y
Incidence of ventilator associated pneumonia (HES)	Y	Y	P	P	Y
Incidence of urinary catheter related infections (HES)	Y	Y	P	P	Y

Safety culture

	Essential		Desirable		
	Measure of Health Outcome	*Significantly influenced by healthcare*	*Disaggregation by Equalities & Geography*	*International comparisons available*	*Currently collected*
Errors reported as discussed with patients/relatives/carers	P	Y	N	?	N
Number of safety-related complaints from patients in period	P	Y	N	?	N

Vulnerable groups

	Essential		Desirable		
	Measure of Health Outcome	*Significantly influenced by healthcare*	*Disaggregation by Equalities & Geography*	*International comparisons available*	*Currently collected*
Children - medication errors due to weight calculation errors (NPSA)	Y	Y	P	?	Y
Children - preventable deterioration (NPSA)	Y	Y	P	?	Y
Older people - pressure ulcers (NPSA/HES)	Y	Y	P	P	Y
Older people - medication errors (NPSA)	P	Y	P	P	Y
Older people - preventable delirium	Y	Y	?	?	?
Learning disabilities - medication errors (communication and comprehension) (NPSA)	Y	Y	P	?	Y
Learning disabilities - preventable deterioration (NPSA)	Y	Y	P	?	Y
Learning disabilties - misdiagnosis (communication and comprehension) (NPSA/HES)	P	Y	P	?	Y
Mental Health – inpatient suicides (NPSA/NCEPOD)	Y	Y	Y	N	Y
Maternity – haemorrhage (NPSA)	Y	Y	P	P	Y
Maternity - unexpected or unplanned admission of term baby (>37 weeks) to neonatal care (NNAP database)	P	P	Y	P	Y
Maternity - medication errors (epidural) (NPSA)	P	Y	P	P	Y

ANNEX B – Consultation questions

CHAPTER 2: Scope, purpose and principles of an NHS Outcomes Framework

Principles

1. Do you agree with the key principles which will underpin the development of the NHS Outcomes Framework (page 10)?

2. Are there any other principles which should be considered?

3. How can we ensure that the NHS Outcomes Framework will deliver more equitable outcomes and contribute to a reduction in health inequalities?

4. How can we ensure that where outcomes require integrated care across the NHS, public health and/or social care services, this happens?

Five domains

5. Do you agree with the five domains that are proposed in Figure 1 (page 14) as making up the NHS Outcomes Framework?

6. Do they appropriately cover the range of healthcare outcomes that the NHS is responsible for delivering to patients?[39]

Structure

7. Does the proposed structure of the NHS Outcomes Framework under each domain seem sensible?

[39] **Please note** that public health and prevention will be covered in a separate consultation, linking to this framework where appropriate

CHAPTER 3: What would an NHS Outcomes Framework look like?

Domain 1 - Preventing people from dying prematurely

8. Is 'mortality amenable to healthcare' an appropriate overarching outcome indicator to use for this domain? Are there any others that should be considered?

9. Do you think the method proposed at paras 3.7-3.9 (page 20) is an appropriate way to select improvement areas in this domain?

10. Does the NHS Outcomes Framework take sufficient account of avoidable mortality in older people as proposed in para 3.11 (page 21)?

11. If not, what would be a suitable outcome indicator to address this issue?

12. Are either of the suggestions at para 3.13 (pages 21) appropriate areas of focus for mortality in children? Should anything else be considered?

Domain 2 - Enhancing the quality of life for people with long-term conditions

13. Are either of the suggestions at para 3.19 (page 24) appropriate overarching outcome indicators for this domain? Are there any other outcome indicators that should be considered?

14. Would indicators such as those suggested at para 3.20 (page 24) be good measures of NHS progress in this domain? Is it feasible to develop and implement them? Are there any other indicators that should be considered for the future?

15. As well as developing Quality Standards for specific long-term conditions, are there any cross-cutting topics relevant to long-term conditions that should be considered?

Domain 3 - Helping people to recover from episodes of ill health or following injury

16. Are the suggestions at para 3.28 (page 27) appropriate overarching outcome indicators for this domain? Are there any other indicators that should be considered?

17. What overarching outcome indicators could be developed for this domain in the longer term?

18. Is the proposal at paras 3.30-3.33 (page 28-29) a suitable approach for selecting some improvement areas for this domain? Would another method be appropriate?

19. What might suitable outcome indicators be in these areas?

Domain 4 - Ensuring people have a positive experience of care

20. Do you agree with the proposed interim option for an overarching outcome indicator set out at para 3.43 (page 32)?

21. Do you agree with the proposed long term approach for the development of an overarching outcome indicator set out at para 3.44 (page 32-33)?

22. Do you agree with the proposed improvement areas and the reasons for choosing those areas set out at para 3.45 (pages 33-34)?

23. Would there be benefit in developing dedicated patient experience Quality Standards for certain services or client groups? If yes, which areas should be considered?

24. Do you agree with the proposed future approach for this domain, set out at paras 3.52-3.54 (pages 36-37)?

Domain 5 - Treating and caring for people in a safe environment and protecting them from avoidable harm

25. Do you agree with the proposed overarching outcome indicator set out at para 3.58 (page 38)?

26. Do you agree with the proposed improvement areas proposed at para 3.63 (page 39-40) and the reasons for choosing those areas?

General Consultation Questions

27. What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they can promote equality of opportunity and outcomes for all patients and, where appropriate, NHS staff?

28. Is there any way in which the proposed approach to the NHS Outcomes Framework might impact upon sustainable development?

29. Is the approach to assessing and analysing the likely impacts of potential outcomes and indicators set out in the Impact Assessment appropriate?

30. How can the NHS Outcomes Framework best support the NHS to deliver best value for money?

31. Is there any other issue you feel has been missed on which you would like to express a view?

ANNEX A: Identifying Potential Outcome Indicators

Potential indicators

32. What are the strengths and weaknesses of any of the potential outcome indicators listed in Annex A with which you are familiar?

33. Are other practical and valid outcome indicators available which would better support the five domains?

34. How might we estimate and attribute the relative contributions of the NHS, Public Health and Social Care to these potential outcome indicators?

Principles for selecting indicators

35. Are the principles set out on pages 48 and 49 on which to select outcome indicators appropriate? Should any other principles be considered?

ANNEX C – The Consultation Process

Criteria for consultation

This consultation follows the 'Government Code of Practice'. In particular, we aim to:

- formally consult at a stage where there is scope to influence the policy outcome;
- consult for at least 12 weeks - the policies in this document were included in the NHS White Paper, *Liberating the NHS*, which was launched on 12 July for a 12 week consultation period closing on 11 October;
- be clear about the consultations process in the consultation documents, what is being proposed, the scope to influence and the expected costs and benefits of the proposals;
- ensure the consultation exercise is designed to be accessible to, and clearly targeted at, those people it is intended to reach;
- keep the burden of consultation to a minimum to ensure consultations are effective and to obtain consultees' 'buy-in' to the process;
- analyse responses carefully and give clear feedback to participants following the consultation;
- ensure officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

The full text of the Code of Practice and related guidance is on the Better Regulation website at: www.bis.gov.uk/policies/better-regulation/consultation-guidance

Comments on the consultation process itself

If you have concerns or comments which you would like to make relating specifically to the consultation process itself please contact:

Consultations Coordinator
Department of Health
3E48, Quarry House
Leeds
LS2 7UE
e-mail: consultations.co-ordinator@dh.gsi.gov.uk

Please do not send consultation responses to this address.

Confidentiality of information

We manage the information you provide in response to this consultation in accordance with the Department of Health's Information Charter (available at www.dh.gov.uk).

Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

Summary of the consultation

A response to this consultation will be made available at www.dh.gsi.gov by the end of this year.

Transparency in outcomes – a framework for the NHS
Department of Health

July 2010