NHS

Equity and excellence:

Liberating the NHS

Analytical strategy for the White Paper and associated documents

DH Department of Health

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Overview

1. The White Paper 'Equity and Excellence: Liberating the NHS' was published on 12 July 2010, setting out the Government's strategy for the NHS. This document forms part of a suite of supporting publications, which expand on and seek views on the detail behind key elements of the planned reforms. The White Paper seeks views on the policies included, in particular on:

   - Commissioning for Patients
   - Freeing Providers and Economic Regulation
   - Local Democratic Legitimacy in Health
   - The Review of Arm's-Length Bodies
   - The NHS Outcomes Framework

2. There will be further documents forthcoming on the information strategy; workforce planning, education and training; accessing cancer drugs through a new fund; and how to extend and expand choice policy.

3. The White Paper set out the Government's plans to create a more responsive, patient-centred NHS, which achieves outcomes that are among the best in the world. It provides a policy framework to support that ambition, with increased autonomy and clear accountability at every level in the NHS, including strengthened democratic legitimacy for local areas.

4. This document outlines the strategy for Impact Assessments for the policies announced within the White Paper. Those for the NHS Outcomes Framework and the arm's-length body review will be published within the next two weeks; for those that will be published when the Health Bill is introduced, this paper will discuss the purpose of the policy, and the anticipated benefits, costs and risks that will be analysed within the Impact Assessments.

5. This document therefore forms part of the overall public consultation on the White Paper and its constituent parts, on which the Department is currently seeking views. We are taking forward this work in partnership with external organisations, seeking their help and expertise in developing and assessing proposals that work in practice.

Overall purpose of the White Paper

6. The main aims of the White Paper are:

    i. Putting patients and the public first;

    ii. Focusing on improvement in quality and healthcare outcomes;

    iii. Autonomy, accountability and democratic legitimacy; and

    iv. Cutting bureaucracy and increasing efficiency.

7. The White Paper will simplify the existing structure of the NHS. Duplication of functions will be reduced, and there will be greater clarity about the role of different organisations within the system. It will help to ensure that the NHS is both sustainable and self-improving in the longer term, through rewarding providers of high-quality services. Control in the system will be provided by quality and economic regulation, in conjunction with clinically led commissioning.

8. Patients and the public often want more involvement in decisions about their care, and there is evidence to suggest that giving patients more control over decisions about their care can both improve health outcomes and reduce costs. For this to work effectively, the patient must be able to make an informed choice, making use of relevant information, and the patient and the health system must work together to make the best possible decision. Therefore, shared decision-making, the information strategy, and extending choice come together to give the patient more input in decisions about their care. HealthWatch supports this, by giving patients more voice within local commissioning decisions, thereby supporting patient choice.

9. Introducing an NHS Outcomes Framework will help to drive improved outcomes. It will also increase transparency within the NHS, and enable the Secretary of State to hold the NHS Commissioning Board to account. This will mean that the NHS Commissioning Board, GP consortia, patients and the public will all have better information about the quality of services delivered by individual providers.

10. The White Paper will increase autonomy within the NHS, and enable decisions to be made at the most appropriate level. Providers and clinicians within them will be empowered. Providers will have the freedom to respond to patient needs and preferences. Moving commissioning functions to GP consortia will mean that there is greater alignment between clinical decision-making and the financial consequences of these decisions. Increased autonomy will be accompanied by greater accountability, to patients, the public and

others within the health system. Increased local democratic legitimacy is a benefit in itself, but is also a means to ensure that the voice of the public is taken seriously.

11. While the first three headings of the White Paper deal predominantly with increasing quality, the last – cutting bureaucracy and increasing efficiency – is predominantly about making better use of available resources. Within the arm's-length body sector, there are currently 18 organisations, whose functions often overlap. To both simplify the system and to save money, this needs to be rationalised. The same also applies to other areas, such as central programmes. Unnecessary bureaucracy associated with medical research and data returns will also be removed.

12. This gives a very broad overview of the aims of the White Paper - more detail is provided in the White Paper itself. The next section begins to look at the impact of the proposed changes, and how it will be analysed.

Assessing the impact of the White Paper

13. The White Paper contains a number of policies that are interlinked and mutually reinforcing. Because of this, the impact of the policies needs to be considered together. For example, the impact of extending choice policy to also cover greater choice of clinician and choice of treatment will be linked to the impact of the introduction of the information strategy, and it will be challenging to disentangle the impacts of these policies separately within the Impact Assessment process.

14. The Health Bill will be introduced in this Parliamentary session. Between now and then, the Department will be developing the analytical framework to give a picture of the likely effects of the White Paper. This paper gives an initial indication of what benefits, costs and risks will be analysed within this.

15. There are already Impact Assessments to accompany the arm's-length body (ALB) review and the Outcomes Framework. For the ALB review, this is because the costs and benefits of the changes proposed are self-contained, and can be considered separately. For the Outcomes Framework, because the Framework will not be going into legislation, there is a need to quantify the potential effects of the policy at this stage. Furthermore, while some parts of the White Paper, such as the NHS Commissioning Board, are dependent upon the NHS Outcomes Framework, the implementation of the framework itself is not dependent on other parts of the White Paper. The primary benefit of the Outcomes Framework is expected to be an increase in the quality of

healthcare, by supporting autonomy and accountability and helping the Secretary of State to hold the NHS Commissioning Board to account.

16. For those policies that do not currently have Impact Assessments alongside them, they will be published alongside or shortly after the response to the consultation, or alongside their publications later in the year. The Department will use the consultation period to inform the development of the Impact Assessments to ensure that a wide ranging and robust analysis is undertaken. The Department will take a view when more work has been done about whether this will be best analysed within one overall Impact Assessment, or as several individual Impact Assessments with an over-arching coordinating document.

17. This analytical strategy document sits alongside an initial Equality Impact Assessment (EqIA) for the White Paper. The programme set out in the White Paper is rooted in the Government's intention to put patients first. A patient-led NHS is one that involves all patients in the development of services that meet their needs and takes account of their lifestyles, backgrounds and characteristics. Fairness is a cornerstone of the White Paper, and services need to address inequalities and insensitivities. This will require an understanding of, and genuine dialogue with, patients so that their needs are properly understood and addressed. Further involvement with stakeholders and partners, including patients, service users, carers and the public will take place over the coming months on the detailed policies in the White Paper. Feedback from this involvement will provide further evidence and will inform a full EqIA, which will be produced in the autumn, alongside the response to the consultation on the White Paper.

18. Any new Impact Assessments will not cover all policies that are discussed within the White Paper. For example, the single telephone number for every kind of urgent care service[1] or the personal health budgets pilots[2], already have published Impact Assessments. Some, such as the new cancer drugs fund, were announced within the Coalition Agreement and an Impact Assessment will be published separately. Others, such as the workforce planning, education and training system, will change, and the associated Impact Assessment will outline the rationale and effects of this in more detail.

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[1] Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_116498

[2] Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/DH_094806

Benefits, costs and risks

19. This section outlines the analytical framework for assessing the impact of the White Paper, and sets out some of the benefits, costs and risks that will be analysed in the Impact Assessments. At present, this is divided into the sections set out in the White Paper (chapters 2-5), with anything specific to a particular policy identified separately.

20. The main benefits of these changes will be realised in the longer term. The changes proposed within the White Paper aim to make the NHS both self-improving and financially sustainable. This is through introducing or bolstering incentives for quality improvement, through the NHS Outcomes Framework and through giving patients more input to decisions made about their care. Staff and providers will be given greater freedoms to respond to patient preferences and to make improvements to service lines and care pathways as they see fit, both to increase quality and to reduce costs. As outlined within the White Paper, the changes in the structure of the NHS will need to be accompanied by a change in the regulatory structure of the system. This is to ensure that services provided are of sufficient quality, and that provision of essential services is maintained. The cost reductions that will accrue through the reduction in management costs will start to be realised in the short term.

21. Alongside this, the costs associated with the White Paper will be front-loaded. There will be significant numbers of redundancies within business support functions. The changes to the structure of the health system – including the introduction of the NHS Commissioning Board and local democratic legitimacy, the abolition of Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) and the arm’s length body review – will incur significant redundancy costs in the short term. There are also costs associated with changing the system around loss of productivity within the transition period, and potentially relocation of staff. These short-term costs will be accompanied by reductions in bureaucracy spend in the longer term, with the aim being an overall cut by at least a third in real terms. It is, however, disingenuous to infer that all of these costs and benefits are solely the product of the White Paper, as management costs must be reduced to ensure the protection of front-line services, irrespective of the policies announced.

Putting patients and the public first

22. The aim of this section, including the policies around shared decision-making, extending and expanding choice, the information strategy and the introduction of HealthWatch to strengthen patient voice, is to create an NHS that is more responsive to those it serves. This is achieved through giving people the opportunity to make informed decisions about their care. If this cultural change is achieved, this will deliver major benefits to the NHS: this also represents a significant risk, as the NHS is often paternalistic, with empowered patients being the exception rather than the rule. This will take time to change.

23. This group of policies are anticipated to improve both patient experience and This group of policies are anticipated to improve both patient satisfaction and clinical outcomes. They will also encourage providers to be more responsive to patient needs and preferences, by appropriately rewarding those providers that patients choose. Therefore, the Department will be looking for the effects associated with putting the patient at the heart of the decision making process, such as changes in satisfaction levels and clinical outcomes. The effect on health resources used across the NHS will also be analysed, as there is evidence indicating that increasing patient involvement in decisions about their care can both improve outcomes and may bring significant reductions in cost for some clinical areas. This will be supported by the information strategy, which will seek to ensure that a range of information that effectively summarises patient experience, clinical effectiveness and patient safety is available to support patients to make informed choices. The introduction of HealthWatch will help ensure that local commissioning decisions more accurately reflect local preferences, and 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, such as those subject to the Mental Capacity Act. The work around HealthWatch will **also** have links to the transferring commissioning functions to GP consortia and the freeing of providers. Therefore, analytical work for HealthWatch will set out available evidence around the link between good public engagement and outcomes for patients, and the role it will have in supporting better quality care.

24. Future analysis will consider the time taken by health professionals at the outset to support decision-making. Patients should already have input into decisions about their care, so the extra time required may be minimal, and it may be that greater patient involvement at the outset saves professional time

later and increases concordance with treatment. There could be costs associated with generating and providing the necessary information in usable forms within the information strategy, depending on the options ultimately adopted. Additional costs will be mitigated through the broader rationalisation of data returns to the Department – as stated in the White Paper, there are large numbers of separate data returns, and so focusing on relevant and informative returns and discontinuing the rest will reduce or remove the cost implication of the extra information. There will be costs associated with HealthWatch delivering the national and local functions as outlined within the White Paper, in particular staff-related spending to support these functions, but these again will be at least partially offset by removing existing functions that have a similar remit.

25. As with any policies based around patient choice and information, there are risks associated with people from different population groups benefiting disproportionately. Future analysis will consider the likelihood of such effects, their impact, and options for mitigating the risk. There will need to be a particular focus on providing information in a variety of forms that all patients can access – the Impact Assessment, especially the Equality Impact Assessment section, for personal health budgets provides more detail on some of the risks of inadvertently excluding some groups of people. A further consideration will be whether the extension of choice could serve to destabilise providers as patients opt away from them, a risk that will need to be managed though not avoided. The information strategy must provide accurate, timely and relevant information about providers – if it does not accurately reflect provider quality, there is a risk that it will inappropriately distort provider behaviour. These risks will be discussed in more detail within the documents alongside the forthcoming Health Bill.

Focusing on improvement in quality and healthcare outcomes

26. The main benefit of introducing the NHS Outcomes Framework will be to encourage improvements in the health outcomes identified. This is outlined within the accompanying Impact Assessment, to be published shortly. This will be achieved by supporting accountability of the NHS Commissioning Board to the Secretary of State and replacing the burden of existing performance management mechanisms.

27. There are the direct costs associated with introducing new outcome measures into the health system, such as the costs of collecting and disseminating the information itself, though again this may be negated by the rationalisation of existing data collections. There may also be costs – and potentially cost reductions[3] - associated with providers increasing their performance to a level that the NHS Commissioning Board and GP consortia deem acceptable, though this will depend upon how commissioners decide to promote the outcomes set by the Secretary of State.

28. The main risk to consider is that if unrepresentative outcome indicators are selected, NHS behaviour will be distorted through inappropriate focus on these at the expense of all other outcomes. If the underlying information is unreliable or unrepresentative, there may be incentives for the NHS to avoid treating the highest risk patients, or to reduce focus on outcomes that are not closely monitored. This means there is a necessity to ensure that the outcome indicators selected are an accurate reflection of the quality of the provider.

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[3] There is more detail provided about this in chapter 5 of the White Paper.

Autonomy, accountability and democratic legitimacy

Commissioning

29. At present, commissioning functions are split between PCTs and Practice-Based Commissioning (PBC). Devolving commissioning responsibility to GP consortia will build directly on the current function of PBC, and will remove the duplication between PBC and PCTs. Shifting the commissioning function to GP consortia will ensure that clinical decisions are aligned with the financial consequences of those decisions. GPs are well placed to design care packages for patients, which should lead to improved health outcomes and tighter financial control. There will be clearer incentives for more integrated and preventative care where those closest to the decision – the GP and the patient – think this is appropriate. Therefore, within this section, the main benefits that will be analysed are around improving outcomes and containing or reducing costs.

30. GP commissioning will need assuring at a higher level. Alongside this, some commissioning decisions, for example those around specialised commissioning, will not be appropriate to be performed at GP consortia level, as the numbers of cases commissioned from any one consortia will be low. These functions will be undertaken by the NHS Commissioning Board. The Board will also have functions around providing national leadership on commissioning for quality improvement, promoting public involvement, and allocating NHS resources to GP consortia. The Board will then be accountable to the Secretary of State for meeting the outcomes set out in the NHS Outcomes Framework and ensuring financial stability. However, as the ability of the Secretary of State to intervene in particular decisions will be diminished, there will therefore be less political distortion within the system.

31. The benefits identified within this section of the White Paper will overlap with those from increasing patient and public involvement, as the change in the commissioning function moves commissioning closer to the patient. There will also be reduced costs, as management and business support functions are reduced, for example through rationalisation of the relevant SHA functions into the NHS Commissioning Board. There will be a link between the benefits of devolving commissioning functions to GP consortia and the benefits of freeing providers, as when the policies are joined together they will help to create a social market within health where good providers thrive and poor providers can fail.

32. Making the NHS Commissioning Board an independent organisation will mean that it is free to set guidelines on best practice for local commissioners to use, and to use outcome measures for monitoring performance that are clinically based. The Board should therefore support provision of more effective and efficient care, and avoid creating perverse incentives by over-focusing on certain processes. Therefore, future analysis will be based on health outcomes, both those the Secretary of State sets for the Board and other outcome measures, and around costs.

33. There will be some costs associated with this. As discussed above, there are the short-term redundancy costs, alongside which running costs will fall. The new commissioning system may be cheaper, and the Department will undertake further work to quantify the change in costs. There are likely to be some costs associated with the set-up of the NHS Commissioning Board. The risks here are more significant, as consortia may not have the capability or capacity to commission effectively, and it may take time for all consortia to develop this capability and capacity. This will mean that the Board has an important support and assurance role to play. The Board will also be responsible for allocating NHS resources to GP consortia, which will be a change from the present allocation system. As most GP consortia will be smaller organisations than PCTs are at present, there may need to be some sort of pooling of risk.

Providers

34. Increasing provider freedom will mean that they can respond to patient needs and preferences, so that there is competition or contestability[4] within local health economies. Increasing provider freedom also enables greater responsiveness of services according to what clinicians think is most beneficial and according to patient preferences. This works in conjunction with the shared decision making process, increasing choice and the information strategy outlined above, as patients will choose providers who offer higher quality and more responsive services. The funding associated with that person will follow them, and so rewards for excellent and innovative providers will increase. Equally, if providers offer poor quality services or are financially unsustainable, a robust framework for dealing with failure will be required. Therefore, the main benefits that will be analysed in this section are around improved outcomes and reduced costs, which arise from moving away from hierarchical management control.

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[4] Contestability means that there is the threat of competition, rather than there actually being competition. If the threat of competition exists, then providers in the market will respond as if they are in competition and act accordingly. This means that the benefits of competition can be achieved even in the absence of competition.

35. Alongside the freeing of providers, the licensing of providers can be simplified. Monitor will help to ensure that providers act in the best interests of patients, and that in the event of provider failure they will ensure service continuity. This safeguards patients and the public in the event of provider organisations becoming unsustainable. The Care Quality Commission (CQC) will retain responsibility for regulation of essential quality standards. Therefore, all providers will need to be licensed by CQC, and some providers will have special licensing conditions that are dependent on the structure of local healthcare supply. The main benefits of freeing providers and the revised regulatory structure are therefore around regulated competition, and there are further benefits associated with simplifying the current system.

36. The direct costs of freeing providers and of simplifying the regulatory regime are likely to be relatively low. Expanding the role of Monitor will incur some direct costs, as will requiring all NHS Trusts to achieve Foundation Trust (FT) status. All providers will be competing on a fair playing field. The risks are more significant than the direct costs. Freeing providers to create a thriving social market carries major potential benefits through increased quality and reduced costs, but regulation of the social market will need to be effective so the benefits of competition can be realised. For example, many aspects of healthcare have significant barriers to entry, so competition will always have limits – this can be overcome by ensuring the market is contestable, if not competitive. There are numerous information asymmetries[5] within the system, which the information strategy and the advocacy role of HealthWatch will help to overcome. There are also externalities[6] within healthcare, which will mean that it is important to get the pricing and regulation systems right. There are further risks around how failure is dealt with – it must be robust and transparent, with those responsible being held to account for it. Otherwise, the risk of failure will not be credible and so providers will not have the incentives to avoid it by being continuously improving organisations. This puts a major emphasis on the framework for dealing with failure, including the special administration and insolvency regime. Part of the insolvency regime will be to develop risk pooling arrangements, which are likely to carry significant costs.

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[5] Information asymmetry means that different people or groups involved in making a decision, for example the patient and their GP, have different information about what the situation is. The GP will have the healthcare expertise, whereas the patient will know more about themselves and what they benefit from.

[6] Externalities occur when the benefit or cost to the person and the benefit or cost to society are not the same. For example, if someone is vaccinated against a disease, they do not get infected, but they also do not infect others. This means the benefit to society will be greater than to the individual.

Local democratic legitimacy

37. This is a benefit in itself. Further potential benefits include the increased integration resulting from: moving some PCT functions into Local Authorities; improving partnership working across the NHS; public health and social care; and through bolstering the incentives set out in the section about involving patients and the public in the decision-making process. There are further benefits and costs around abolishing PCTs, as discussed above.

Strengthening incentives

38. For the incentives talked about in the White Paper to deliver the intended effects outlined above, more transparency of funding is required in the system. For example, even if patients can choose providers that have had the freedom to respond to patient preferences, informed by relevant information, if the funding is not transparent and does not follow the patient the incentives will be blunted. This means that as much health funding as is possible must be transparent, and notionally attached to the person. This means that if a person opts for a particular provider, that provider is rewarded financially. While this is the case in the majority of acute care at present, this is not the case within community services or mental health, and so pricing will need to become more transparent to facilitate this. It will also be important for overall funding of providers and commissioners to become more transparent, with any essential subsidies being made explicit.

39. The strengthening of incentives and increased transparency will be supported through a strengthened commissioning function. Alongside this, increasing incentives for quality improvement through further bolstering pay-for-performance and expanding best practice tariffs will mean that there is the incentive for high quality patient centred care everywhere within the system.

Cutting bureaucracy and increasing efficiency

40. The policies identified in this area have the aim of making better use of available resources within the current system. In addition to the costs and ongoing cost reductions associated with reducing the number of staff identified above, there are further benefits around simplification of the existing system and reducing duplication. These mirror the likely benefits and costs associated with all of the policies identified within this section of the White Paper, and are about increasing efficiency of necessary functions.

Transition

41. There are clear risks associated with the transition period. For example, SHAs and PCTs will cease to exist, but there will be a reliance on them in the short-term around both managing the transition period and delivering ongoing efficiency savings, such as those associated with the QIPP programme. Further, as outlined both within the White Paper and above, the policies outlined within the White Paper aim to re-design the structure of the health system so that it becomes more transparent, and transfers more control over decisions to clinicians and to patients. If some of these reforms are not fully implemented, then there is a risk that the system does not ensure that this is the case. The framework for managing the transition is published alongside the White Paper, and it sets out the risks in more detail as well as identifying strategies for mitigating them.

Responders are invited to comment on the analytical framework set out above. In particular, this includes considerations of whether the identified benefits, costs and risks are suitable, and whether there are any omissions. Responses to the questions in the White Paper and its supporting documents should be sent to NHSwhitepaper@dh.gsi.gov.uk by 5th October.