NHS Reforms – update

Summary of the Operating Framework 2011-12 and White Paper response

On Wednesday 15th December 2010 the Department of Health published two key documents that pave the way for reforms outlined in the White Paper for Health, Equity and Excellence: Liberating the NHS. While major changes are planned, the government says the NHS Constitution will remain at the heart of the health service.

This document gives a summary of the main actions, changes and challenges.

White paper consultation response

Around 6,000 responses were received by the DH as part of the consultation, leading the government to refine its proposals to:

- significantly strengthen the role of Health and Wellbeing Boards, and enhance joint working arrangements through a new responsibility to develop a joint health and wellbeing strategy spanning the NHS, social care, public health and potentially other local services.
- create a more distinct identity for HealthWatch England, led by a statutory committee within the Care Quality Commission
- increase transparency in commissioning by requiring all GP consortia to have a published constitution
- change in proposal that maternity services should be commissioned by the NHS Commissioning Board – to be carried out now by GPs
- extend councils' formal scrutiny powers to cover all NHS funded services, and give local authorities greater freedom in how these are exercised
- phase the timetable for giving local authorities responsibility for commissioning NHS complaints advocacy services, and allow flexibility to commission from other organisations as well as from local HealthWatch
- give GP consortia a stronger role in supporting the NHS Commissioning Board to drive up quality in primary care
- create an explicit duty for all arm's-length bodies to cooperate in carrying out their functions, backed by a new mechanism for resolving disputes
- allow a longer and more phased transition period for completing reforms to providers
- create a clearer, more phased approach to the introduction of GP commissioning, by setting up a programme of GP consortia pathfinders
- accelerate the introduction of Health and Wellbeing Boards through a new programme of early implementers

Operating Framework 2011-2012

The Framework gives details about the transition process to new structures, setting a timetable for change, financial implications and working arrangements for the year ahead. Key milestones are detailed in Appendix 1 (p9).

New key commitments

As well as maintaining existing quality improvements, new key commitments will be:

- Increasing overall numbers of health visitors by 4,200 by April 2015
- Family Nurse Partnership programme – to improve outcomes for most vulnerable first time teenage mothers and their children
- Establishment of Cancer Drugs Fund - operational from April 2011
- Military and veterans health
- Guidance shortly published on services for people with autism
- Progress against dementia services
- Progress against carers strategy

Areas identified for improvement

- Healthcare for people with learning disabilities
- Children and young people's physical and mental health
- Diabetes
- Sharing non confidential information to tackle violence
- Regional trauma networks
- Respiratory disease

Transition to new NHS commissioning structures

The NHS faces the significant challenge in 2011-2012 of maintaining current performance and QIPP delivery, whilst simultaneously preparing and beginning to put in place the future system. The Operating Framework and Health and Social Care Bill, expected in January 2011, will be the key drivers in achieving this.

National Commissioning Board (NCB)

- National Commissioning Board in shadow form during 2011-12, accountable from April 2012 when SHAs abolished
- Drawing on NICE quality standards, the NCB will develop high-level commissioning guidance for GP consortia

- From 2013-14, price setting will be the joint responsibility of the NCB and Monitor (NCB designing the pricing structure, Monitor setting levels)
- Main office in Leeds. Will decide on location of other staff once set up
- NCB will have payment incentives:
  - Quality and Outcomes Framework: developed by the NCB and NICE, this will be used to pay GPs as providers
  - Commissioning for Quality and Innovation (CQUIN) payment framework, to be developed by NCB and consortia with providers

Securing capacity:

- Sustaining capacity in the 'old' system while ensuring emerging organisations get early support
- Clustering of PCTs to also help meet efficiencies
- Provider Development Authority created to support trusts to foundation status
- A specially agreed pre-authorised Mutually Agreed Resignation Scheme

Commissioning

- PCTs to play critical role till 2013 but not all 151 will be maintained in transition
- Clustering will consolidate PCT capacity to:
  - oversee delivery during transition and close down of old system
  - Support emerging consortia, developing commissioning support providers
- Single executive team by June 2011 and governance arrangements published in January 2011 - Design of executive teams locally determined
- No statutory mergers, so PCTs retain their existing allocations
- Accountable for: key performance indicators to support QIPP efficiencies, indicators relating to new commitments and reform, and clinically relevant indicators from existing measures
- Identify staff whose future role lies in commissioning – some will work directly with consortia, other from within the cluster in 'commissioning support units'
- Units supported to create social enterprises or joint ventures with private sector or civil society organisation by April 2013 – consortia as 'customers'
- Operating Framework states clusters to provide the following support to GP Commissioning Consortium:
  - An organisational development expert / facilitator
  - A qualified or accredited senior finance manager (this may be shared across consortia)
  - An individual with expertise of appropriate governance arrangements / corporate affairs

  - A commissioning expert to support the consortium in their assessment of how they will deliver their future commissioning responsibilities.

GP consortia

- All prospective consortia in place by end 2011-2012, authorised by National Commissioning Board by end 2012-2013 – full budgets in April 2013
- Not every practice in a consortium need be physically located in an area, nor adjacent to other practices
- Potential for small consortia to collaborate on larger scale matters, or for large consortium to break into smaller localities where this makes more sense
- Boundaries can flex. Members can leave and join another consortium, consortia can merge or dissolve. Approval criteria relates to whether prospective consortia can discharge functions and have an appropriate area
- Consortia able to secure support from range of sources: employing staff, buying in from external organisations, or collaborating with local authorities
- Consortia will need to ensure patient engagement in their commissioning decisions, working with relevant partners
- Consortia must have an Accountable Officer (who needn't be a clinician, but must be approved by the NHS Commissioning Board) will have responsibilities for:
  - Ensuring compliance with financial duties
  - Continuous improvements in quality in commissioned services
  - Providing good value for money

Providers

- 2012-2014 – new Provider Development Authority created – oversee drive for FT status completed by April 2014
  - Bulk of Monitors controls over existing FTs removed – new economic regulation system gradually introduced
- Licensing regime from April 2012, price setting 2013-2014 onwards
- Any willing provider extended to community services during 2011-2012
- Community services to publish Quality Accounts for first time
- CQUIN scheme will continue with reduction of venous thromboembolism as the national priority area
- New contracts will be introduced for community providers which have integrated with acute or mental health providers

Outcomes and quality

During transition period Care Quality Commission and National Quality Board ensure stability and standards during transition.

The first Outcomes Framework sets out the outcomes and corresponding indicators that will be used to hold the NHS Commissioning Board to account for the outcomes it delivers through commissioning health services from 2012-13.

It will contain around 50 indicators in five domains:

- Preventing people from dying prematurely
- Enhancing the quality of life for people with long term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm

Continued development of the Quality Framework - NICE will begin work on 31 new Quality Standards next year to add to the 15 already completed or in development.

Consultation launched proposing an outcomes framework for pubic health 'Healthy Lives, Healthy People: transparency in outcomes, proposals for a public health outcomes framework' - deadline **31st March 2011**

Local government, integration and public health

- Shadow Health and Wellbeing Boards (H&WB) in place by end 2011-2012, early implementers encouraged during remainder of this financial year – full powers April 2013 and new scrutiny powers
- Required members: GP consortia, director of adult social services, director of children's services, director of public health, and local HealthWatch, with at least one local elected representative - flexibility allowed over additional members
- H&WB carry out Joint Strategic Needs Assessment (JSNA) to agree a Joint Health and Wellbeing Strategy across NHS, public health, social care and children's services
- LAs will support individual organisations, including GP consortia in linking their commissioning strategies to the Joint Health & Wellbeing Strategy
- LAs directly responsible for overview and scrutiny functions to be locally determined - whether through the continuation of OSCs or alternative
- April 2013 – LAs receive ring fenced public health budget
- Public Health England in shadow form during 2011-2012, full form in 2012-2013 (including Health Protection Agency + National Treatment Agency)

During transition period PCTs will:

- Receive specific allocations to support social care
- Transfer this funding to LAs for spending on social care services to benefit health and to improve overall health and social care outcomes
- Agree appropriate areas for social care with LAs taking into account: *Vision for adult social care: Capable communities and active citizens* and *Recognised, valued and supported: next steps for the Carers Strategy*
- Be responsible for securing post-discharge support, hospitals responsible for any readmissions within 30 days of discharge, PCT recurrent allocations now include funding of £150m for re-ablement and PCTs given separate allocations totalling £648m in 2011-12 to support health and social care integration
- Continue to ensure their statutory duty to consult Overview and Scrutiny Committees

HealthWatch

- Local Involvement Networks (LINks) will evolve into local HealthWatch (LH), supported and led by HealthWatch England as an independent consumer champion within the Care Quality Commission (CQC)
- LH will ensure that the views of patients, carers and the public are represented to commissioners and provide local intelligence for HealthWatch England
- LAs will be able to commission HealthWatch to provide advocacy, advice and information to support people if they have a complaint and to help people make choices about services
- When scrutinising local care services, HealthWatch could decide to take into account patients' views, including whether they feel their rights have been met under the NHS Constitution
- The Health Bill will give local HealthWatch the power to make recommendations to the HealthWatch England committee of CQC for CQC to carry out investigations into health and care services
- Funding for LINks will continue through the transition into local HealthWatch, and will be enhanced to reflect HealthWatch's responsibilities
- LAs will have funding for HealthWatch built into their existing allocations, including additional funding for NHS complaints advocacy and providing advice and information for people making choices
- HealthWatch will have anticipated funding of £53.9 million for 2012-2013 plus £3.2 million for start-up costs
- In 2013-2014, when LAs take on responsibility for commissioning NHS complaints advocacy, the combined funding available for local HealthWatch and NHS complaints advocacy services will rise to £66.1m

- An early priority will be to set out how relationships and accountabilities will work, especially the relationship between local authorities, local HealthWatch and HealthWatch England – early implementers encouraged

Complaints

Health Bill will change the Ombudsman's legislation, strengthening the arrangements for it to share more widely with the NHS and others investigation reports and the statement of reasons in those cases where it decides not to investigate a complaint.

Choice, informatics, communications, engagement, patient experience

- Choice extended to new areas of health system – considering maternity, cancer and supported decision making in elective care as potential early objectives
- Patients given access and control to significant part of their health records
- Informatics services to work together to provide shared service for consortia
- Remaining nationally - Choose and Book, Summary Care Record, and services such as GP payments and cancer screening – more information at the end of January
- SHA Directors of Communications to develop shared services arrangements for communication and engagement for PCTs and SHAs – to be put in place over the coming months, taking account of the development of PCT clusters
- Better collection of and timely action on patient experience and feedback – including real time service user feedback to improve quality of care
- Health and Social Care Information Centre developed for centrally collected data

HR strategy

- Estimated staff whose current employment is affected by these reforms = 90,000
- Strategy will support retention of business critical staff through a separate pre-authorised MAR scheme and by using existing contractual flexibilities
- Those wanting to be part of the future system - roles in the new PCT clusters, roles in emerging consortia and by creating opportunities to develop new commissioning support organisations
- Public health staff in PCTs and SHAs may also transfer to local authorities subject to the passage of the Bill
- New regulations in place allowing Chairs and Non Executive Directors to hold multiple appointments on Boards - support business continuity and governance for PCTs moving to clusters

- Opportunities for SHA staff will include being part of the NHS Commissioning Board, the Provider Development Authority, the economic regulator and the new structures for education and training
- Staff in PCTs and SHAs may also of course wish to seek opportunities in the provider sector
- Seek to avoid compulsory redundancies, maximise redeployment and avoid unnecessary redundancy costs
- Further HR guidance produced in early 2011
- Consultation launched around workforce planning, training and education that includes proposals for managing the transition to a new system, and the wind down of the current SHA role – Liberating the NHS: developing the healthcare workforce - **deadline for responses 31st March 2011**.

Financial implications

- NHS to make up to £20bn of efficiency savings by 2014-2015 (previously £15-£20bn by 2013-2014)
- **Allocations -** Revised weighted capitation formula impacted by mental health and health inequalities. Still over target (4%)
- £4.173m out of £648m nationally for social care
- 2% uplift with an additional amount for social care to be transferred to local authorities.
- Allocation include £150m for re-ablement = just under £1m for the PCT (approx)
- Capital accessed by PCTs on a case by case basis
- **Spend Assumptions -** Continue to invest 2%of allocation non recurrently, via business case to SHA who hold PCTs 2%.
- 1.5% tariff reduction
- CQUIN 1.5%
- **Contracting Issues -** Marginal Rates for emergency admissions to continue
- Further development of the payment and contracting systems - best practice tariffs will be expanded in 2011-12, while new currencies will be introduced including adult and neonatal intensive care, smoking cessation and podiatry
- **Management / Running Costs -** 2011-12 Management Fund to develop consortia of £2 per head = £600k
- GP running costs forecast by 2013-14 to be in the region of £25 to £35 per head
- Management Costs changing to running costs - information will not be collected from 2011-12

Appendix 1: Key milestones for transition:

Financial year	Specific time (if available)	Milestone
2011-2012	Early 2011	Health and Social Care Bill
	Early 2011	Further HR guidance published + consultation including proposals for managing transition and wind down of SHAs
	January 2011	Governance arrangements published for PCT clusters
	April 2011	Cancer Drugs Fund established
"	By June 2010	SHAs to establish PCT clusters
"	-	National shadow arrangements for – NCB, new Monitor, Public Health England
"	-	Local shadow arrangements for H&WB
"	-	Further pathfinders / early implementers – HealthWatch, more GP pathfinders
"	-	First year of QIPP delivery
"	-	NHS Trusts begin application process for FT status
2012-2013		Second year QIPP delivery
"	April 2012	NCB + Monitor operational –licensing regime begins (SHAs abolished)
"		PCTs accountable to NCB
"		More learning from GP pathfinders and H&WB early implementers
"		Authorisation of GP consortia begins, all practices members, acting with delegated powers from PCT
"		H&WB in place
"	April 2012	Local HealthWatch arrangements in place – LAs funding
"		Consortia notified of 2013-2014 allocations
"	By end of year	Significant number of Trusts with FT status
2013-2014		Third year QIPP delivery
"	April 2013	PCTs abolished

“	“	Consortia assume fully statutory responsibilities
	“	Commissioning Support Units in place (social enterprises, joint ventures etc)
“	“	H&WB assume fully statutory responsibilities
“	“	Monitoring licensing regime fully operational
“	“	LAs have responsibility for commissioning NHS complaints advocacy
“	March 2014	All trusts have FT status, Provider Development Agency abolished