

# Health and Social Care Bill 2011

*Impact Assessments*

# Impact Assessments for the Health and Social Care Bill

This document is the Impact Assessments (IAs) for the Health and Social Care Bill, 2011. It provides the six IAs that accompany the Bill, which cover:

Annex A	Commissioning for patients
Annex B	Regulating providers
Annex C	Local democratic legitimacy
Annex D	HealthWatch
Annex E	Public bodies
Annex F	Public health

This should be read alongside the “Coordinating document”. They also link across to the Equality Analysis, which correspond to the Annexes listed above and have been published as a separate document.

<b>Title:</b> <b>Commissioning for patients (clinical commissioning and the NHS Commissioning Board)</b> <b>Lead department or agency:</b> <b>Department of Health</b> <b>Other departments or agencies:</b>	<b>Impact Assessment (IA)</b>
	IA No: 6030
	Date: 25/08/2011
	Stage: Final
	Source of intervention: Domestic
	Type of measure: Primary legislation

## Summary: Intervention and Options

### What is the problem under consideration? Why is government intervention necessary?

The White Paper proposed ways of addressing the problem that decision making is too far removed from patients. The Department considers that GPs, working with other local clinicians, are best placed to make decisions with patients about the pathway of care they should follow but do not currently have responsibility for decisions about service design. GPs decisions determine large proportions of NHS expenditure, but they do not currently have responsibility for these budgets.

### What are the policy objectives and the intended effects?

The objectives are:

- to enable service design to be sensitive to patient needs and preferences
- to align clinical and financial responsibility in decision making

The intended effects are:

- to improve patient experience and quality of care
- to secure efficient prescribing and referral patterns, improving value for money

### What policy options have been considered? Please justify preferred option (further details in Evidence Base)

1. Clinical commissioning and the NHS Commissioning Board. Clinical commissioning will give local clinical commissioning groups (CCGs) greater freedom to design services around patients to improve patient experience and quality of care. Aligning clinical and financial responsibility creates incentives to ensure commissioning decisions provide value for money through efficient prescribing and referral patterns.

An independent NHS Commissioning Board will be set up to support CCGs and provide national leadership on commissioning for quality improvement. It will allocate and account for NHS resources, and hold CCGs to account.

When will the policy be reviewed to establish its impact and the extent to which the policy objectives have been achieved?	It will be reviewed
Are there arrangements in place that will allow a systematic collection of monitoring information for future policy review?	Yes

**SELECT SIGNATORY Sign-off** For consultation stage Impact Assessments:

*I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.*

Signed by the responsible Minister: ..... *Howz* ..... Date: ..... *1.9.11* .....

# Summary: Analysis and Evidence

# Policy Option 1

## Description:

Transfer responsibility for commissioning from PCTs and SHAs to clinical commissioning groups and the NHS Commissioning Board.

Price Base Year 2010	PV Base Year 2010	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: £5,909m	High: £6,352m	Best Estimate: £6,074m - £6187m

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	£882m	0	£838m
High	£1,360m	0	£1,281m
Best Estimate	£1,061m - £1,181m	0	£1,002m - £1,116m

### Description and scale of key monetised costs by 'main affected groups'

The costs above are the redundancy and non-redundancy costs associated with the abolition of PCTs and SHAs. The costs vary according to the number of staff that transfer from PCTs and SHAs to CCGs and the NHS Commissioning Board, as set out in the coordinating document.

### Other key non-monetised costs by 'main affected groups'

There are no hypothesised non-monetised costs. Some of the risks are identified below which, if they are not mitigated, would become non-monetised costs.

BENEFITS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	0	£861m	£7,189m
High	0	£861m	£7,189m
Best Estimate	0	£861m	£7,189m

### Description and scale of key monetised benefits by 'main affected groups'

The monetised benefit above is from the reduction in the costs of commissioning, as outlined in the coordinating document for the impact assessments.

### Other key non-monetised benefits by 'main affected groups'

There are non-monetised benefits from improved clinical engagement, improved outcomes and more responsive and co-ordinated care. There are additional financial benefits from clinical commissioning that arise from the alignment of clinical and financial incentives arise from savings in terms of reduced variation / level of outpatient referrals and elective activity, improved care of patients with long term conditions, reductions in growth/ level of urgent and emergency admissions, and improved prescribing.

### Key assumptions/sensitivities/risks

Discount rate (%)

3.5

The key risks are:

- CCGs not having the capacity and capability to engage with and deliver clinical commissioning;
- Potential conflicts of interest between CCG members as providers and commissioners of patient care;
- Potential higher transaction costs as we change the number of organisations commissioning services
- The ability of CCGs to manage risk;
- The ability of GP to deliver the potential financial savings outlined above.

Direct impact on business (Equivalent Annual) £m):			In scope of OIOO?	Measure classified as
Costs: 0	Benefits: 0	Net: 0	No	NA

## Enforcement, Implementation and Wider Impacts

What is the geographic coverage of the policy/option?	England				
From what date will the policy be implemented?	01/04/2011				
Which organisation(s) will enforce the policy?	DH				
What is the annual change in enforcement cost (£m)?	0				
Does enforcement comply with Hampton principles?	Yes				
Does implementation go beyond minimum EU requirements?	No				
What is the CO <sub>2</sub> equivalent change in greenhouse gas emissions? (Million tonnes CO <sub>2</sub> equivalent)	<b>Traded:</b> 0		<b>Non-traded:</b> 0		
Does the proposal have an impact on competition?	No				
What proportion (%) of Total PV costs/benefits is directly attributable to primary legislation, if applicable?	<b>Costs:</b> 0		<b>Benefits:</b> 0		
Annual cost (£m) per organisation (excl. Transition) (Constant Price)	<b>Micro</b>	<b>&lt; 20</b>	<b>Small</b>	<b>Medium</b>	<b>Large</b>
Are any of these organisations exempt?	No	No	No	No	No

## Specific Impact Tests: Checklist

Set out in the table below where information on any SITs undertaken as part of the analysis of the policy options can be found in the evidence base. For guidance on how to complete each test, double-click on the link for the guidance provided by the relevant department.

Please note this checklist is not intended to list each and every statutory consideration that departments should take into account when deciding which policy option to follow. It is the responsibility of departments to make sure that their duties are complied with.

Does your policy option/proposal have an impact on...?	Impact	Page ref within IA
<b>Statutory equality duties</b> <sup>1</sup> <a href="#">Statutory Equality Duties Impact Test guidance</a>	Yes	EA Annex A
<b>Economic impacts</b>		
Competition <a href="#">Competition Assessment Impact Test guidance</a>	No	29
Small firms <a href="#">Small Firms Impact Test guidance</a>	No	29
<b>Environmental impacts</b>		
Greenhouse gas assessment <a href="#">Greenhouse Gas Assessment Impact Test guidance</a>	No	29
Wider environmental issues <a href="#">Wider Environmental Issues Impact Test guidance</a>	No	29
<b>Social impacts</b>		
Health and well-being <a href="#">Health and Well-being Impact Test guidance</a>	Yes	7-27
Human rights <a href="#">Human Rights Impact Test guidance</a>	No	29
Justice system <a href="#">Justice Impact Test guidance</a>	No	29
Rural proofing <a href="#">Rural Proofing Impact Test guidance</a>	No	29
<b>Sustainable development</b> <a href="#">Sustainable Development Impact Test guidance</a>	No	29

<sup>1</sup> Race, disability and gender Impact assessments are statutory requirements for relevant policies. Equality statutory requirements will be expanded 2011, once the Equality Bill comes into force. Statutory equality duties part of the Equality Bill apply to GB only. The Toolkit provides advice on statutory equality duties for public authorities with a remit in Northern Ireland.

## Evidence Base (for summary sheets) – Notes

Use this space to set out the relevant references, evidence, analysis and detailed narrative from which you have generated your policy options or proposal. Please fill in **References** section.

### References

Include the links to relevant legislation and publications, such as public impact assessment of earlier stages (e.g. Consultation, Final, Enactment).

No.	Legislation or publication
1	DH (2010): “Equity and Excellence: Liberating the NHS”
2	DH (2010): “Liberating the NHS: Legislative framework and next steps”
3	DH (2011): “NHS Future Forum recommendations to Government”
4	DH (2011): “Government response to the NHS Future Forum report”

+ Add another row

### Annual profile of monetised costs and benefits\* - (£m) constant prices

This table is for the lowest possible estates costs, of £80m.

	Y <sub>0</sub>	Y <sub>1</sub>	Y <sub>2</sub>	Y <sub>3</sub>	Y <sub>4</sub>	Y <sub>5</sub>	Y <sub>6</sub>	Y <sub>7</sub>	Y <sub>8</sub>	Y <sub>9</sub>
<b>Costs – low estate costs estimates</b>										
Transition costs	215	376	116	239	115	0	0	0	0	0
Annual recurring cost	0	0	0	0	0	0	0	0	0	0
<b>Total annual costs</b>	215	376	116	239	115	0	0	0	0	0
<b>Costs – high estate costs estimates</b>										
Transition costs	239	419	129	266	128	0	0	0	0	0
Annual recurring cost	0	0	0	0	0	0	0	0	0	0
<b>Total annual costs</b>	239	419	129	266	128	0	0	0	0	0
<b>Benefits</b>										
Transition benefits	0	0	0	0	0	0	0	0	0	0
Annual recurring benefits	240	458	631	869	1,068	1,068	1,068	1,068	1,068	1,068
<b>Total annual benefits</b>	240	458	631	869	1,068	1,068	1,068	1,068	1,068	1,068

\* For non-monetised benefits please see summary pages and main evidence base section

## Evidence Base (for summary sheets)

### What is the problem we are trying to address? Why is Government Intervention necessary?

- A1. The White Paper proposed ways of addressing the problem that decision making is too far removed from patients. The Department considers that GPs and other local clinicians are best placed to make decisions with patients about the pathway of care they should follow, but do not currently have responsibility for decisions about service design. GPs decisions determine large proportions of NHS expenditure, but they do not currently have responsibility for these budgets.
- A2. Indeed GPs play a critical role in influencing NHS expenditure, both through their referral and prescribing decisions and (less directly) through the quality and accessibility of the services they provide for patients and the impact that these have on emergency and urgent care provided elsewhere in the system. Clinical commissioning in this sense gives groups of practices financial accountability for the consequences of their decisions.
- A3. Respondents to the White Paper consultation gave considerable support for the principle that key decisions affecting patient care should be made by healthcare professionals in partnership with patients and the wider public, rather than by managerial organisations. Overall, there was much support for the objectives behind clinical commissioning.

### Objective of the Policy

- A4. Clinical commissioning will give local groups of GP Practices, called clinical commissioning groups (CCGs), greater freedom to design services around patients to improve patient experience and quality of care. Aligning clinical and financial responsibility creates incentives to ensure commissioning decisions provide value for money and improved quality of care through efficient prescribing and referral patterns.
- A5. To support CCGs, an independent NHS Commissioning Board will also be set up. It will be responsible for allocating and accounting for NHS resources, including holding CCGs to account. In the past, politicians have been able to influence decisions being made at a local level, when the Strategic Health Authority (SHA) or the Primary Care Trust (PCT) was best placed to judge what was necessary for their local population. Now, we will move to a system of strong and independent bodies at national and local level. It will remain the Secretary of State's function to ensure that the system architecture works and adapts so that multiple national players are able to come together to provide a clear and coherent context within which local organisations are empowered to act.
- A6. The NHS Commissioning Board will be held to account for delivering improved patient outcomes instead of top-down process targets and will focus on achieving equal access to health services designed around the needs of the patient, for which it will be rigorously held to account by Ministers. The NHS Commissioning Board will have responsibility for ensuring the development of individual CCGs, providing tools and incentives to enable them to commission effectively, holding them to account for outcomes and financial performance, and intervening where appropriate. Ministers will not have powers to intervene in relation to individual commissioning decisions other than in instances where contested service changes are referred to them.

### *Timeline*

- A7. Prospective CCGs will begin to come together (building on practice based commissioning) in 2010/11. It is expected that CCGs will be able to be authorised as statutory bodies from July 2012, prior to taking on full statutory responsibilities from April 2013. The intention is that all

clinical commissioning groups are in place by April 2013, however, the NHS Commissioning Board will be able to undertake functions of CCGs which are not fully operational, or ask that other CCGs take on specific functions. This amendment has been made since the original impact assessment to reflect the “NHS Future Forum recommendations to Government” report.

## Background

A8. The White Paper, *Equity and excellence: Liberating the NHS*, outlined the Government's vision for clinical commissioning. CCGs of GP practices, working with other health and social care professionals, and in partnership with local communities and local authorities, will commission the majority of NHS services. CCGs will not be directly responsible for the commissioning services that GPs themselves provide, but they will become increasingly influential in driving up the quality of general practice.

## *Experience from previous clinical commissioning schemes*

A9. Following the purchaser provider split introduced as part of the internal market reforms, GP fundholding was introduced in 1991 and ran until 1997, by which time over half of all GPs were fundholders. Under this scheme, volunteer general practices (this may mean a degree of self-selection bias) were allocated budgets to purchase a restricted range of services for their patients, predominantly elective hospital procedures, community health services and prescribing.

A10. GP fund holders exercised the purchaser function for their registered patients for these services in place of the Health Authority, who continued to be responsible for working with GPs to ensure the needs of the whole community were met. Health Authorities also continued to have a direct purchasing role (e.g. on behalf of non-fund holding GPs, for services excluded from the fundholding scheme, or for specialist services which cover more than a single district). GPs were allowed to use any savings to reinvest in other services for their patients.

A11. The Health Authority calculated the fund holding budget primarily based on historic activity costs, although some consideration was given to how this related to fair funding/weighted capitation formulae. The budget was made up of three elements – practice staff budget, prescribing and elective secondary care budget. Fundholders could, with the agreement of the Health Authority, move money between these three budgets.

A12. From 1994, several variations were developed placing more responsibility with GPs, based on the experience of the preceding years, which had shown that purchasing delivers more appropriate services for patients when GPs are involved, and particularly where they are involved by taking on the direct control of resources used by their patients:

- a new **community fundholding** option covering staff, drugs and community health services (excluding all hospital treatments including outpatients) was introduced for smaller practices (or groups of practices) of 3,000 patients or for those who were not ready to take on standard fundholding;
- the standard fundholding scheme was expanded and the minimum list size for practices wanting to enter the scheme lowered from 7,000 to 5,000 patients;
- **53 total purchasing pilots** (TPPs) ran from 1995 – 97 where GPs purchased all hospital and community health services for their patients, including A&E services (building on an initial set of four successful pioneer schemes in Bromsgrove, Runcorn, Berkshire, and Worth Valley in West Yorkshire). The fundholders normally formed a purchasing consortium to spread financial risk and developed a purchasing plan in collaboration with the health authority. There was no legislation establishing the scheme, so the budgets for the projects had to remain the ultimate responsibility of the local health authority, whereas fundholders held budgets in their own right.



- A13. Those areas that participated in TPPs were fundholders that also took on a wider role. However, the budget for this wider role was not the same as fundholding. This additional budget was managed by a committee of the Health Authority, which was made up of Health Authority staff as well as the lead GPs.
- A14. Both fundholding budgets as well as TPP budgets were kept separate from the contract that the GPs held for the provision of primary medical care. Fundholders joined the scheme on an ongoing basis. There was no time limit, and the Health Authority could only remove a GP from the scheme because of a serious issue. Even then, the GP had a right of appeal directly to the Secretary of State. An overspend, for example, was not reason enough to remove fundholding status from a GP. The Health Authority was obligated to meet the overspend of any fundholding practice – although this was not common with the majority of practices making annual savings. GP fund holding was abolished by the 1999 health act with the system reverting to commissioning being led by Health Authorities.
- A15. The results of GP fundholding were mixed. The principal effects were presented in terms of GP fundholders compared to non-GP fundholders<sup>2</sup>:
- achieved shorter waits for their patients – primarily as a result of having fewer long (3 -12 month) waits;
  - reduced their referral rates to hospitals;
  - had smaller rises in prescribing costs;
  - received more than an equitable share of resources;
  - they were seen to have high transaction costs.
- A16. The overall evidence of the cost effectiveness evidence of GP fundholding is mixed. Whilst GP fundholders reported underspends in the order of £206 million in 2004/5, the Audit Commission estimated the transaction costs in the order of £230 million.<sup>3 4</sup>
- A17. TPPs were relatively short-lived and focussed on specific areas of care and successfully reduced bed days and admissions, though in the time available, few successfully reconfigured patterns of care. TPP pilots did control expenditure and have an impact.<sup>2 5</sup> However, it remained difficult to extract and transfer resources from secondary to primary care.<sup>6</sup>
- A18. The evidence base suggested that in many instances, smaller and single practices performed better financially than larger practices.<sup>2 5</sup> This suggests that inter-GP relationships were strong enough to balance the extra financial risk due to their small size.
- A19. Following the abolition of fundholding, responsibility for commissioning has in turn passed from Health Authorities, in partnership with their Primary Care Groups, to 303 and in turn 151 PCTs to whom financial allocations are currently made. PCTs have been held to account via assurance processes, the most recent being World Class Commissioning, for their commissioning competencies, behaviours and outcomes.

### *Practice based commissioning*

- A20. Within the PCT framework, practice based commissioning (PBC) was introduced in 2004 to enable GP practices, together with other healthcare professionals, to play a stronger role in

<sup>2</sup> Lewis R (2004) Practice-Led Commissioning: Harnessing the power of the frontline Kings' Fund.

<sup>3</sup> Le Grand J, Mays N, Mulligan J-A (1998) *Learning from the NHS Internal Market*, p52-54, King's Fund

<sup>4</sup> Audit Commission (1996) *What the Doctor Ordered: a study of GP Fundholding in England and Wales*, London:HSMO.

<sup>5</sup> Wyke S, Mays N, Street A, Bevan G, McLoed H, Goodwin N (2003) Should general practitioners purchase health care for their patients? The total purchasing experiment in Britain.

<sup>6</sup> Wyke S, Mays N, Abbott S, Bevan G, Goodwin N, Killoran A, Malbon G, McLoed H, Posnett J, Rafaty J, Robinson R (1999) *National Evaluation of Total Purchasing Pilot Projects*, p49, King's Fund.

designing and commissioning wider healthcare services for local practice populations, either on an individual practice basis or (more commonly) across wider groupings of GP practices in a locality.

- A21. GP practices, by way of the Person Based Resource Allocation formula, received an indicative share of their PCTs budget representing the wider healthcare costs (e.g. hospital services, diagnostic services, prescribing costs) for the patients on their list and are encouraged to help design services that make more effective use of these resources.
- A22. Where there are savings on the indicative budget through better use of resources, the GP practices involved could use some of these savings to invest in new services. Practices could also develop business cases to get PCT approval for providing a wider range of services within primary care.
- A23. The PBC survey<sup>7</sup> suggests that in terms of financial savings, there was some limited success. While 70% of PBC clusters or consortia and independent practices leads reported they had achieved no savings within their indicative PBC budget, 30% did report savings, though data on the actual level of these savings was not collected. However, as the Nuffield Trust note, '*research evidence points to the significant potential of GP Commissioning consortia holding real as opposed to indicative budgets*'<sup>8</sup>. While most leads (86%) have a good relationship with their PCT in terms of PBC, there were more mixed views of the support provided. Quality of management support and information and data were reported as good by 63% and 51% of leads respectively, the speed of PCT decision making on business cases is 29% and the quality of PCT feedback on business cases is 33%<sup>7</sup>.
- A24. There was also a mixed response in terms of the influence of and involvement of PBC clusters or consortia. Leads had great or fair influence over clinicians in their PBC cluster or consortium (85%) and with the PCT (56%), but less so with secondary care clinicians (24%) and secondary care managers (15%). Similarly, while the PCT involved 62% of leads to a great or fair extent in addressing variation in primary care use of resources or referrals, only 20% did so for working with the local authority<sup>7</sup>.
- A25. Some respondents to the *Equity and Excellence: Liberating the NHS* consultation were clear that PBC in their area was working well and that it was unnecessary to make further changes. Conversely, others reported that even where PBC was working well, it could be further improved if the groups had more autonomy and accountability.

### *Analysis of practice based Commissioning*

- A26. To determine whether the success of PBC in terms of demand management, analysis at PBC level was undertaken for referral and activity growth for the years 07/08 to 09/10. No significant trends over time or across PBC cluster or consortium size were found for annual activity growth rates. However, when analysing activity growth rates over two years (07/08 – 09/10 growth rate), the results showed that PBC clusters or consortia within PCTs which are considered to be 'strong' at engaging in commissioning have lower activity growth rates than those PBC clusters or consortia within PCTs which are considered to be 'weak' at engaging in commissioning. While there was significant variation within the averages for the results of 'weak' and 'strong commissioners', a scenario analysis showed no change in the trend.<sup>9</sup>

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<sup>7</sup> Department of Health (2010) Practice Based Commissioning Group and Independent Leads Survey: Wave 3.

<sup>8</sup> Nuffield Trust (2010) Consultation Response 'Liberating the NHS: Commissioning for patients.

<sup>9</sup> GP referral rates from 2007/8 to 2009/10 increased by 10.9% in 'Strong' practices (8 practices) and increased by 15.1% in 'Weak' practices (7 practices). Elective inpatient admissions increased by 8.9% in 'Strong' practices and increased by 15.6% in 'Weak' practices. Total inpatient admissions increased by 6.2% in 'Strong' practices and

A27. We were unable to identify significant trends with respect to PBC cluster or consortium sizes. However, membership data on PBC clusters or consortia is a snapshot as at September 2010 and covers only around 90% of practice. Any trend may therefore have been hidden by noise in the data.

### *Changes to the system architecture.*

A28. Since previous iterations of clinical commissioning, outlined above, there have been significant changes to the NHS system architecture including the following reforms:

- The payment by results policy has introduced a comprehensive fixed price system for an increasing array of NHS activities. This means that for tariff activities, CCGs will not need to engage in contract price negotiations thereby reducing potential transaction costs. Going forward, it is proposed that Monitor take on the role of the provider regulator, and will both set prices and promote competition, where appropriate, on the provider side;
- Given the fixed price tariff, providers can maintain quality as it avoids the risk of reduced prices being delivered by lowering quality. In addition, the Care Quality Commission operates the quality regulator function;
- The development of the Person Based Allocation Formula (PBRA) means that it is possible to set more accurate 'hard' budgets for CCGs by estimating needs at the individual level rather than using averages for geographical areas (such as Wards). This makes resource allocation more sensitive to the specific registered population of each practice which comprises a CCG<sup>10</sup>; and
- Significant improvements in access / waiting times, for example, due to the 18 week target, which limits a CCG's ability to differentiate themselves from competing / neighbouring CCGs.

## **Options**

A29. This impact assessment presents the preferred option of a move to commissioning by CCGs and the creation of the NHS Commissioning Board. Within this preferred option, there are a number of factors to consider in the implementation of this system – for instance, whether some services are commissioned by CCGs and others by the Board. The following sections include an examination of the overall costs and benefits and how the preferred option can be implemented such that net benefits are maximised.

## **Benefits**

### *Benefits of clinical commissioning through clinical commissioning groups*

A30. By giving GPs freedom to design services around patients, clinical commissioning is expected to deliver benefits in terms of improved services that deliver better outcomes, improved patient experience, and more efficient management of NHS resources that will facilitate the delivery of the efficiency savings identified through the QIPP programme.

A31. The primary benefits of clinical commissioning are likely to be:

- Clinical engagement;
- Improved outcomes;
- Improved quality of healthcare;

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increased by 11.5% in 'Weak' practices. Caution is required in interpreting these results due to the small number of practices covered by the analysis.

<sup>10</sup> Developing a person-based resource allocation formula for allocations to general practices in England", The Nuffield Trust, London. (<http://www.nuffieldtrust.org.uk/projects/index.aspx?id=338>)

- Alignment of financial and clinical incentives and accountability, with expenditure decisions more closely aligned to budget holders;
- More effective use of peer review, for example, in terms of referral management;
- More responsive care / co-ordination and care planning, delivering clinically appropriate care closer to home;
- Enhanced access to community services; and
- Decision-making closer to the patient, which will also support choice policy and the intention to have the patient at the heart of decisions about their care.

A32. The interaction of the above benefits are expected to lead to the delivery of financial benefits in terms of savings from:

- Better management of patients with Long Term Conditions,
- Reductions in the growth / level of emergency admissions through improved management of care and improved decisions about the care an individual receives;
- Slower growth in referrals to and activity within secondary care alongside reduced variation in service utilisation, thereby improving allocative efficiency; and
- Improved prescribing.

A33. GPs see 800,000 people a day / 300 million people a year and play a pivotal role in helping to coordinate NHS care. The GPs' role is particularly prominent for people with long-term conditions, and in helping patients to access wider or more specialised NHS services through the thousands of referral decisions they make on a daily basis. The quality and availability of primary care services also has a wider impact on A&E attendances and emergency admissions.

A34. GPs, in partnership with other local healthcare professionals such as community nurses and pharmacists, are best placed to understand the health needs of local populations and how to design services that provide more effective, joined-up and preventive care. Clinical commissioning should also provide CCGs with incentives to invest in 'upstream' interventions in community based services that keep people healthier for longer and prevent or delay more expensive 'downstream' treatment. There will of course be a balance between the upstream investments made directly by GPs and CCGs and those undertaken by local authority based directors of public health.

A35. Patients can have increased confidence that GPs will be acting as knowledgeable agents focusing on maximising the care they provide for their given allocation. Clinicians are better placed than managers to assess patients' needs, and the changes will incentivise GPs to maintain and justify clinical thresholds. Therefore, demand management will be seen more favourably by patients and will be more effective.

A36. Clinical commissioning, in conjunction with the national Payment by Results (PbR) tariffs, means GPs, once they have selected to commission a particular service or activity, can concentrate their efforts on choosing providers that deliver the highest quality outcomes for a pre-determined price.

A37. Compared to earlier versions of GP led commissioning, commissioning by CCGs is more likely to deliver benefits due to:

- The fact that each CCGs will hold hard budgets;
- The fundamental changes to the system architecture outlined above. In particular, with PbR meaning that money follows the patient, the system now ensures that CCGs that make savings (for example, by successfully reducing admission rates) accrue the savings rather than them remaining with the provider;
- The universal implementation of clinical commissioning as all practices will be part of CCGs; and

- Transaction costs will be limited via the introduction of a management cost allowance, meaning that CCGs will not be able to go above this amount<sup>11</sup>.

### *Estimating potential benefits from improved commissioning*

- A38. While there are clear potential benefits as a result of the changes to commissioning, as set out in paragraphs A30 and A31, it is difficult to quantify the savings associated with an improvement in commissioning. The text above talks about why CCGs are expected to be an improvement over current commissioning arrangements, but a robust figure around the cost savings or the health gains associated with the changes in commissioning is highly problematic to estimate.
- A39. Based on the qualitative improvements outlined above, the Department believes that the new structure of the system, especially within commissioning, offers additional opportunities to improve productivity on top of the QIPP programme,<sup>12</sup> through improvements in demand management, long-term conditions and primary care prescribing. However, it is not possible to state monetised figures about the contribution that the changes in commissioning would make to this, as it is very difficult to estimate what would happen without the reforms.
- A40. There is a further link to the benefits cited within both the coordinating document and Annex B (which covers the changes to provision). The £13bn - £20bn figure quoted is unlikely to be achievable through provider reform only, but again it is difficult, if not impossible, to state with any certainty what contribution the changes to commissioning would make to this.
- A41. The main benefit of the changes to commissioning, other than the cost-savings outlined below, is around improved commissioning. For the reasons given above, CCGs, supported by the NHS Commissioning Board, are likely to be better at commissioning healthcare than PCTs and SHAs are at present. This would lead directly to an increase in health outcomes. As with the potential cost-savings, it is very difficult to state with any certainty the improvement in health outcomes that will be achieved.

### Benefits from reducing the cost of commissioning

- A42. New information was available in the 2010/11 accounts that enables the cost of commissioning to be estimated. This is estimated at £2,749m for PCTs for 2010/11, as set out in the coordinating document and the Appendix to it. This includes £240m that is included within the baseline because PCTs and SHAs reduced the overall spending, by reducing the workforce, in 2010/11 which was not originally anticipated. As explained in the coordinating document and the Appendix, this is ascribable to the modernisation. It also includes £100m contingency funding, to allow for error in how money has been split between PCT commissioner and provider functions, as this is the first time that this data has been collected.
- A43. There will be some additional costs associated with current SHA level commissioning (for specialised services, for example). As outlined in the coordinating document, the baseline spend for SHAs for 2010/11 was £456m.
- A44. This impact assessment follows the assumptions of the coordinating document. The move from PCTs and SHAs to CCGs and the NHS Commissioning Board will reduce the running costs of the system by approximately one-third, in real terms. For the reasons discussed above (and below), this is assumed to have no negative impact on the quality of patient care, it is outlined above how this change is likely to have positive effects on health. The budgets for CCGs will also be limited, and CCGs will not be able to exceed them. This means that the risk is not around the

<sup>11</sup> This represents a risk if CCGs cannot operate effectively within this budget. This is discussed further below.

<sup>12</sup> A full list of the QIPP workstreams is available at <http://www.dh.gov.uk/en/Healthcare/Qualityandproductivity/QIPPworkstreams/index.htm>.

money-saving that is discussed below, but is around the additional benefits associated with professionally-led commissioning. This is discussed in more detail within the risks section.

A45. Table A1 below summarises the baseline spending for PCTs and SHAs, and what the running cost reduction would mean in terms of cost-savings.

**Table A1: Cost-savings per annum, 2010/11 to 2019/20**

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	Total
PCT budgets at 2010/11 level (£m)	2,749	2,749	2,749	2,749	2,749	2,749	2,749	2,749	2,749	2,749	
SHA budgets at 2010/11 level (£m)	456	456	456	456	456	456	456	456	456	456	
Total commissioning budget (£m)	3,205	3,205	3,205	3,205	3,205	3,205	3,205	3,205	3,205	3,205	
Real commissioning budget running costs (£m)	2,965	2,747	2,574	2,336	2,137	2,137	2,137	2,137	2,137	2,137	
<b>Saving per annum (£m)</b>	<b>240</b>	<b>458</b>	<b>631</b>	<b>869</b>	<b>1,068</b>	<b>1,068</b>	<b>1,068</b>	<b>1,068</b>	<b>1,068</b>	<b>1,068</b>	<b>8,608</b>

A46. Therefore, the future costs of commissioning will be £1,068m less than existing costs, per annum. It is assumed here that the one-third reduction in administrative spending applies equally to PCTs, SHAs and other organisations within the administrative spending baseline. This may not be the case in practice, but the one-third reduction across the totality will be. This is a subset of the £12bn total saving set out in the coordinating document.

## Costs

### *Cost of clinical commissioning*

#### Transition costs – redundancy

A47. As outlined within Tables 3a, 3b, 4a and 4b of the coordinating document, redundancy costs across PCTs and SHAs are estimated to be £810m, with a range from £632m to £989m depending on the proportion of SHA and PCT staff that were in post in April 2011 that transfer to the new organisations. Table 4b of the coordinating document gives sensitivity around this.

#### Transition costs – non-redundancy

A48. There will be transition costs associated with reducing the cost of commissioning as outlined above.

A49. Table 2 shows non-staff transition costs (excluding Estates costs) are estimated to be approximately £257m. This is based on informatics and other start-up costs of £1.7m per PCT associated with transferring functions to CCGs and LAs

**Table A2: Estimated transition costs per PCT**

	Period of double running (months)	Cost of double running per PCT (£000s)
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Informatics	6	950
Payroll	3	44
HR Policy and Procedure	6	57
Primary Care admin	3	34
Management	6	518
Transfer of functions to Local Authorities	-	100
Total	-	1,703

- A50. The co-ordinating document (paragraph 73) sets out estimates of estates transition costs across the whole system. It is not possible to produce estimates for PCTs and SHAs, however as the majority of the Estates transition costs are likely to be due to PCTs and SHAs, the whole costs are attributed to this section of the impact assessment.
- A51. The NHS Commissioning Board is expected to be formed from a combination of staff and functions from PCTs, SHAs and DH. Transition costs are expected to be relatively low – based on the NAO report referenced in the coordinating document, this is assumed at £6.3m excluding estates.
- A52. The NHS Future Forum report, and the Government response to it, stated that SHAs will continue for a year longer than was initially announced, and that CCGs will only take up commissioning responsibilities when they are ready to do so, from April 2013 onwards. This has slightly altered the transition costs, as set out in the coordinating document, as some existing organisations will be in place for slightly longer.
- A53. There will also be interim arrangements in place beyond April 2013. The intention is that all clinical commissioning groups are in place by April 2013. To mitigate the risk, and following the report of the NHS Future Forum, this will only happen when the NHS Commissioning Board is satisfied that the clinical commissioning group is ready and willing to do so.
- A54. Therefore, the total PCT and SHA non-staff transition costs are estimated to be approximately £257m + £6.3m + £80m to £200m. This gives a range from £343m to £463m for non-redundancy costs associated with the proposed changes to the commissioning system.
- A55. To break these figures down, an estimate has been made based on the maximum number of staff that are affordable given the trajectory of administrative spending reduction set out in table A1 above, and is also drawn from the overall redundancy figures shown in tables 4a and 4b of the coordinating document. This is displayed in the “annual profile of monetised costs and benefits”, set out on page 6 of this document.

### Running costs

- A56. The commissioning functions currently undertaken by PCTs, and which will be retained, will transfer to CCGs, the NHS Commissioning Board or local authorities. Paragraphs A42-A46 set out the expected reduced administration budgets and future costs of commissioning. This section addresses the risk that CCGs may not be able to perform their commissioning duties effectively within these lower running costs. This is discussed further within the risks section below.
- A57. At this time, precise predictions of future running costs of clinical commissioning are difficult until there is greater clarity of the number, size and form that CCGs will take - factors which will be determined locally. However, this impact assessment considers costs of four main types of commissioning functions, i) functions directly supporting commissioning healthcare services (excluding primary care), ii) functions relating to primary care, iii) other statutory functions, iv) overhead functions.

### Running costs: functions directly supporting commissioning healthcare services (excluding primary care)

- A58. There are a range of functions that directly support commissioning healthcare services, including:
- population health needs assessment;
  - strategy development;
  - patient and public engagement;
  - procurement and contracting; and
  - validation and reimbursement.
- A59. CCGs will generally be responsible for these functions. This will also require working closely with local authorities, particularly with respect to needs assessment, strategy development and patient and public engagement. Public health staff currently employed by PCTs, but due to transfer to local authorities, play a key role in needs assessment and strategy development.
- A60. If all CCGs, assuming their populations are smaller than PCTs, were to independently undertake these functions, there may be lost economies of scale. However, there are a number of options for CCGs to mitigate the potential lost economies of scale, such as choosing to act collectively, for instance by adopting a lead commissioner model to negotiate and monitor contracts 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.

### Running costs: functions relating to primary care

- A61. The main function is managing contracts with Primary care practitioners. This function will transfer to the NHS Commissioning Board, which is likely to generate some economies of scale, and is discussed in more detail later in this document.

### Running costs: other statutory functions

- A62. There are a range of statutory functions, such as assurance and risk management, complaints handling and medical records management.
- A63. Further work will be undertaken to determine where each of these functions remain or transfer to successor organisations. It is not possible to estimate the future costs until this work has been completed.

### Running costs: overhead functions

- A64. These functions include general administration functions, such as Human Resources (HR), Finance, Estates, IT and informatics that provide support to the commissioning organisation.
- A65. It is likely that economies of scale will apply to these functions, which will mean that additional costs may be incurred if a large number of smaller CCGs perform each of these functions independently. However, CCGs would be able to mitigate this by utilising shared resources. Those functions that move to the NHS Commissioning Board are likely to benefit from economies of scale, and for the functions that transfer to local authorities, opportunities may exist for them to be undertaken at little or no extra cost.
- A66. Overall, the future costs are dependent on a number of factors, particularly the number and size of CCGs, on which the Department is not being prescriptive. Ultimately, the extent to which CCGs can and will join together to perform functions will be the determinant of future costs. Preliminary analysis suggests that if CCGs are established with an average size of 100,000 population, in a similar form to PCTs and without any sharing of resources to deliver some functions, then some functions may incur additional costs. It is estimated that this would increase



the costs of commissioning by up to £410 million if it were to happen, from the baseline described above (with a one-third reduction).<sup>13</sup>

- A67. So far, there are 257 pathfinder CCGs, covering approximately 97% of the population of England. Assuming an equivalent size of CCGs for the remainder of the country, this would give a total number of CCGs of approximately 250. While the configurations of the pathfinder CCGs are preliminary, and may not be the same when commissioning functions are formally devolved to CCGs, beginning in April 2013, this does indicate a potential scale of the overall number. The upper end of the £0 - £410m range, displayed above, is based on a worst-case scenario (of 500 CCGs who do not work together).
- A68. However, the running costs allowance of CCGs will be fixed and monitored so CCGs will not be able to incur higher running costs. Therefore, the Department's best estimate is that there will be £0 additional costs associated with CCGs undertaking commissioning functions<sup>14</sup>. This means that if CCGs cannot commission within the administrative budget set, then the risk is to the quality of commissioning rather than to the financial saving (see A79 for how this is mitigated).
- A69. Analysis of the cost of commissioning based on organisational running costs of a sample of 11 PCTs showed that there was more than a two-fold variation in the running costs per head of the commissioning functions of these PCTs. While caution is required in the interpretation of these figures due to the difficulty of consistently allocating the costs of functions in different organisations and the low numbers of organisations involved, the analysis showed that the PCT with the lowest running costs per head was 3.1% of healthcare spend. This is 30% less than the average costs of 4.5% of total healthcare spend. This indicates that CCGs have the potential to deliver clinical commissioning with significantly lower running costs.
- A70. Additionally, given the restriction that will be place on CCGs administration costs in the future, there will be strong incentives for CCGs to undertake their commissioning role in an efficient manner. As stated in paragraph A65, CCGs can mitigate the risk of lost economies of scale by working together to perform some functions. They will also have the flexibility to commission collaboratively and use external commissioning support,
- A71. The Department is therefore confident that sufficient processes are being put in place to enable CCGs to be able to commission services effectively within the future running costs allowance.
- A72. Additional risks associated with CCGs carrying out functions with this level of running costs are addressed below.

### **Implications on running costs from amendments following NHS Future Forum report**

- A73. Clinical commissioning groups will be required to have a governing body including lay, nursing, and secondary care doctor representation. The governing body must have public meetings CCGs will also need to demonstrate that they secured advice from a broad range of health professionals, and that commissioning plans have been produced with the involvement of health and wellbeing boards and that they explain in particular how the CCG will discharge its duties in

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<sup>13</sup> Based on a sample off 11 PCTs, there is a relationship between running costs per head and size of population covered (with an R-squared in the range of 0.30 to 0.35). Using the co-efficient of the relationship between size of population and costs provides an estimate that moving from PCTs to CCGs with an assumed average population size of 100,000 would increase costs by 17%.

<sup>14</sup> A best estimate is used here rather than an expected value as it is not anticipated that there will a fall in the quality or an increase in the cost of commissioning. Should such risks arise, it will be necessary to take steps to mitigate their effects.

relation to public and patient involvement. CCGs must also consult the individuals they have responsibility for commissioning services for when they prepare their commissioning plans.

- A74. It is expected that the NHS Commissioning Board will host arrangements for professional advice, through Clinical Networks and Clinical Senates. This will be based on existing arrangements and will provide a mechanism for strengthening multi-professional involvement in commissioning plans. The Board will have a strong authorisation and assurance process, including a requirement to consult the relevant health and wellbeing boards for the annual assessment of clinical commissioning groups and a role to provide assurance on appointments of accountable officers to CCGs.
- A75. Linked to this, there are additional requirements for health and wellbeing boards regarding patient and public involvement and involvement in developing commissioning plans.
- A76. CCGs, the NHS Commissioning Board and health and wellbeing boards must deliver all functions within their running costs. Statutory requirements such as those described in paragraphs A73 to A75 must be delivered and this reduces the resources available for other commissioning functions. This is discussed further within the risks section below.
- A77. However, the arrangements described in this section provide a solid framework for ensuring that the process for making commissioning decisions is robust and transparent. Ensuring involvement from patients and the public and a range of professionals in primary and community care, secondary care and local authorities will help to ensure that commissioning plans will deliver the best services for patients and provide value for money from the healthcare budget.

## Issues and risks

### *Risks of clinical commissioning*

- A78. **Capacity and Capability.** The greatest risk in terms of policy delivery is the capacity and capability of CCGs to deliver effective clinical commissioning, given the reduction in the resources available. This is increased by the fact that the scale of the policy change is both large, i.e. all GP practices must conform, and it is mandatory. Linked to this are the risks associated with the loss of corporate memory as the transition from the current 151 commissioning organisations to a larger number of CCGs.
- A79. It will be for the NHS Commissioning Board to both provide support to and monitor whether CCGs can both manage with a set level of administration costs and deliver effective commissioning. The Department will monitor whether this is an issue or not, and take actions accordingly to mitigate the risk. The NHS Commissioning Board will provide support to CCGs to help deliver effective commissioning, for example by developing model contracts.
- A80. **Engagement of GPs** To provide appropriate incentives for CCGs to deliver improved outcomes, it is proposed that the NHS Commissioning Board may make a payment to a CCG in respect of quality. The Government will discuss further with the NHS and the professions how to ensure that these arrangements create the right incentives to improve quality and outcomes.
- A81. The quality premium creates a strong incentive for GPs to work to ensure effective management of referrals and prescribing, however a risk remains that not all GPs will engage.
- A82. The NHS Commissioning Board will be able to intervene in the event that a CCG is unable to fulfil its duties effectively, for example in the event of financial failure or where there is a risk of failure. This could include the Board taking over the CCG's commissioning responsibilities or assigning them to a third party (for example a neighbouring CCGs).

- A83. In terms of within-CCG sanctions, whilst professional peer review play an important role, ultimately CCGs will be able to apply to the NHS Commissioning Board to be dissolved should members be unable to agree whether all members of the CCGs are performing to the required standards.
- A84. **Shorter term risks** of joined-up working (i.e. with local authorities, other practices, other health and social care professionals) include inefficiencies and lack of communication resulting from organisational and working practice differences, and the potential reduced emphasis on the QIPP by GPs as they realign themselves. Additionally, there may be a risk related to allocating budgets to CCGs in the transition period given until membership and functions have settled down.
- A85. **Fragmentation.** LAs and CCGs working together are unlikely to fall into the same exact geographical area. In addition, some of the services commissioned by the NHS Commissioning Board and CCGs will overlap.
- A86. **Cream Skimming** Should patients choose to switch to a GP in an alternative CCG, GP practices are prevented by the terms of their contract to refuse the registration of a patient with their practice on the grounds of medical condition(s) suffered. This mitigates the risk of cream skimming as GPs will have to take on new patients regardless of the costs associated with any condition with which they present.
- A87. **Conflicts of Interest** Whilst a CCG may commission a service from a provider in which a GP has an interest, where this would provide best value in terms of quality and cost, this can only be done following an open and fair procurement, and with the CCG ensuring it manages conflicts of interest. A framework will be developed that allows such commissioning of new services whilst guarding against real or perceived conflicts of interest. This will require transparency over how commissioning decisions are made, and the value of services commissioned from GP practices. The legislation imposes various safeguards against anti-competitive behaviour. The strengthened governance arrangements described in paragraph A73 will help to manage the risk around conflicts of interest. Monitor will have powers to intervene when there has been a breach of regulations (made under clause 70) that require commissioners to adhere to good practice in relation to procurement, protect and promote the right of patients to make choices with respect to treatment and other health care services and not act in an anti-competitive manner.
- A88. **High Transaction Costs** The transaction costs of GP fundholding were very high and were a significant practical objection to the schemes.<sup>23</sup> There is a view that excessive bureaucracy was created to ensure that there was no fraud with GPs. With the introduction of PbR (set price), electronic systems including choose and book, financial and clinical records should be more closely easily linked in any new system. This should dramatically reduce the burden associated with transaction costs.
- A89. **CCG Size** There is no consensus on a minimum size to handle the financial risk.<sup>25</sup> Inter-GP relations and peer review are strong forces and can counter the effects of higher statistical risk in smaller CCGs for many services. However, while some high risk services are best covered at a more regional level, risks could be shared by CCGs grouping together to form their own risk pools.

## **Rationale, costs and benefits of the NHS Commissioning Board**

- A90. In the past, politicians have been able to influence decisions being made at a local level. The White Paper proposes moving to a system with clear separation of functions and a transparent, rules-based system set out in legislation under which the different organisations are empowered to act. It will remain the Secretary of State's function to ensure that the system architecture works and can adapt as the system develops.

- A91. To support the principle that commissioning decisions are best taken at a local level by clinicians, working in partnership with patients and free from political interference, it is necessary that there is an independent body to provide support and assurance of CCGs. It will also perform functions for which it would be unviable for CCGs to have individual responsibility.
- A92. The NHS Commissioning Board will therefore be established as and an Executive Non-Departmental Public Body with specific statutory responsibility for ensuring the capability of individual CCGs, providing tools and incentive to enable them to commission effectively and intervening where appropriate.
- A93. To fulfil this role effectively the White Paper proposes that the NHS Commissioning Board should perform a number of functions independently of the Department of Health:
- providing national leadership on commissioning for quality improvement;
  - promoting and extending public and patient involvement and choice;
  - ensuring the development of CCGs and holding them to account;
  - commissioning certain services that are not commissioned by CCGs; and
  - allocating and accounting for NHS resources.
- A94. The NHS Commissioning Board's focus will be on achieving equal access to health services designed around the needs of the patient, for which it will be held to account by Ministers through an annual mandate and a performance framework based on population outcomes measures. The NHS Commissioning Board will have a fundamental role in translating the priorities set by the Government through those mechanisms into clinical strategies by performing functions that have previously been the role of the Department of Health, including:
- setting commissioning guidelines on the basis of clinically approved quality standards developed with advice from NICE, that promotes joint working across health, public health and social care;
  - designing model NHS contracts for CCGs to adapt and use with providers and to setting standards for high quality care;
  - 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 CCGs, hosting clinical networks, for example for cancer, diabetes and stroke, and clinical senates to bring together a range of experts from across different health and social care professions to advise on the breadth of services; and
  - Were these functions to continue to be set from the Department of Health there would be a risk that they could be used to impose additional requirements on CCGs, undermining their freedom to commission according to local and individual needs. By vesting these functions in an independent body, which is bound to perform them in such a way as to deliver the overall priorities set annually by the Government, there will be greater transparency and clarity about what the Government wants to achieve. It will also provide stability and reassurance for clinicians to enable them to concentrate on taking clinical decisions in the best interests of patients.
- A95. Clinical autonomy would be similarly undermined if there remained scope for the Department of Health and Ministers to influence commissioning behaviours by having responsibility for the assuring and intervening in relation to individual CCGs or for providing financial assistance to individual CCGs.

- A96. We therefore consider it is essential for the NHS Commissioning Board has independent responsibilities for establishing CCGs in the same way Monitor currently has in relation to foundation trusts. The NHS Commissioning Board will need to satisfy itself through its establishment process that prospective CCGs have sufficient financial arrangements and controls in place to ensure appropriate stewardship of public money and have the capability to commission the required services and fulfil their duties. It will have powers to attach conditions to the establishment of a CCG. This could include special arrangements as to how they exercise certain functions, or it could if necessary enable the Board itself – or another CCG acting on behalf of the Board – to exercise certain functions for a limited period while the CCG develops the necessary capacity.
- A97. Similarly, it is essential that there is independent financial accountability for CCGs. The White Paper proposed that the NHS Commissioning Board's Accounting Officer will be accountable to the Department for the overall commissioning revenue limit. The intention is therefore that the NHS Commissioning Board in turn will hold the individual Accountable Officers of each CCG responsible for their share of the total funding allocation, and this will include the duty to achieve financial balance.
- A98. The NHS Commissioning Board will also have responsibility for:
- assessing the financial preparedness of CCGs before they are established;
  - holding CCGs to account for financial performance including keeping proper accounts in the form set by the NHS Commissioning Board; and
  - in relation to external audit, issuing guidance on financial risk management and to intervene where there is a significant risk of financial failure.
- A99. This will include the option for the NHS Commissioning Board to provide financial assistance, via a transparent mechanism of intervention. We also propose to ensure that the Board can adjust CCGs' allocations in future years to reflect previous overspends or underspends, so that there are further incentives for good financial management.
- A100. As opposed to current arrangements, establishment of the NHS Commissioning Board in place of the existing SHAs has other benefits including:
- principle of subsidiarity – setting policy as well as delivery strategy from DH duplicates functions and creates instability due to shifting political priorities. Greater efficiency can be achieved if DH sets overall strategy and direction and an independent body is free to determine technical aspects of how delivered, based on sources of clinical advice such as NICE, Royal Colleges and other experts; and
  - reducing bureaucracy – less central control means there is less need for intermediate tiers to communicate instructions down through the system and manage delivery.

### **Scope of clinical commissioning groups and the NHS Commissioning Board**

- A101. The principle behind the changes to commissioning architecture are to enable CCGs of GP practices to take the lead in arranging care for their patients and so that funding decisions are taken closer to the level at which decisions are taken.
- A102. This is less relevant where:
- GPs do not refer patients directly to services or for services where GP do not have a significant role in the prevention of ill health;
  - services are arranged for population sizes which would make them difficult for CCGs to plan for and account for based on their budgets;

- where care is led by other healthcare professionals and the role of the GP is less central – for instance where patients are in a specialised service led by specialist nurses & consultants
- where there is a potential conflict of interest in CCGs commissioning a service.

### *Commissioning and budget holding*

A103. In the following sections, it is important to recognise that responsibility for commissioning a service and budgetary responsibility for a service need not be held by the same organisation. For example, in the section on pharmaceutical services this IA explains the benefits of these services being commissioned by the Board. However, as GPs are responsible for generating the costs of dispensing medicines when they make prescribing decisions, it is entirely reasonable that the costs of dispensing should fall to CCGs. There may be other areas where similar arrangements are appropriate but work on the detailed relative benefits is still ongoing. This is not likely to have a material impact on the overall cost/benefit analysis presented in this IA.

### *Commissioning Primary Medical Services*

A104. PCTs are currently under a duty to exercise their powers so as to provide (or secure the provision of) primary medical services in their area, to the extent that it considers necessary to meet all reasonable requirements.

A105. There are currently four mechanisms by which they can do so,

- general medical services (GMS) contracts
- personal medical services (PMS) agreements
- alternative provider medical services (APMS) contracts
- PCT provided medical services (PCTMS)

A106. There are approximately 8,200 PCT contracts with providers of primary medical services, of which approximately 4,600 are GMS contracts and 3,400 PMS agreements. APMS contracts make up about 2-3% of primary medical services contracts

A107. The Government wishes to devolve power and responsibility for commissioning services to the healthcare professionals closest to patients: GPs and their practice teams working in CCGs. This might suggest that the duty to commission primary medical services should sit with the commissioning CCGs.

A108. However, it is also very important that the new NHS architecture commands public confidence and is shown to be based upon principles of transparency and fairness in spending decisions and the promotion of appropriate competition. The CCGs will be made up of local primary medical service providers (general practices). To allow a group constituted in this way to have the duty to commission essential primary medical care from its own practices to “the extent that it considers necessary to meet all reasonable requirements” would be to give the CCGs control over market entry. There would be a clear ability to prevent or limit market entry by any new service providers who might provide competition to existing CCGs members. Whether this risk is theoretical or real it is an open invitation to accusations of protectionism.

A109. It is also necessary to ensure that decisions about the price and specification for essential primary medical services and about the operation of patient choice of general practice are made independently.

A110. For these reasons, we believe that public confidence in the system is best ensured by re-locating the PCT role of commissioning essential primary medical services with the Board.

A111. This would not preclude CCGs from commissioning other services, including services that go beyond the scope of essential primary medical services, from those primary medical service providers who are contracted by the NHS Commissioning Board provided they act fairly and transparently and promote choice and competition.

A112. The Board will have no provider functions and the current ability for PCTs to provide primary medical services themselves will be discontinued

### *Commissioning Pharmaceutical Services*

A113. PCTs are also currently required to make arrangements for the provision of pharmaceutical services under the NHS Act 2006. There are 10,291 NHS pharmacies in England 61% of which are multiple contractors (6 or more premises).

A114. The White Paper proposes that commissioning of pharmaceutical services be conferred directly on the NHS Commissioning Board and that it will be for the Board to determine how best it carries out its commissioning functions for Pharmaceutical Services under the community pharmacy contractual framework (CPCF).

A115. Pharmaceutical contractors would wish to be assured that commissioning and market entry arrangements are sufficiently robust and objective so that no one profession has control or undue influence over the others.

A116. Commissioning of pharmaceutical services by the Board increases patient choice. Pharmaceutical contractors can and do provide services which could also be commissioned and provided by GPs eg smoking cessation & weight management.

A117. Entry to the pharmaceutical list is controlled through legislation. The Regulations are there not only to ensure access to and choice of NHS pharmaceutical services but to also ensure that entry to the NHS pharmaceutical services market achieves the right balance between a regime which encourages enterprise and innovation with the requirement that the NHS plans service commissioning to meet identified local needs.

A118. The transfer of commissioning to the NHS Commissioning Board would mean that responsibility for maintaining lists of pharmaceutical contractors and recognition of local pharmaceutical contractor representative committees will also lie with the Board.

A119. Although the greatest benefit lies with these services being *commissioned* by the Board, GPs are responsible for generating the costs of dispensing medicines when they make prescribing decisions. Therefore, the *costs of dispensing* should fall to CCGs.

A120. The responsibility for developing and publishing Pharmaceutical Needs Assessments (PNA) will transfer to local authorities. The requirements of the PNA mirror closely and are designed to be an integral element of Joint Strategic Needs Assessments which the White Paper has made clear are to be part of the Public Health Service function in local authorities.

### *Commissioning Dental Services*

A121. The White Paper proposes that the requirement to commission dental services, which currently rests with PCTs, will be conferred directly on the NHS Commissioning Board. It will then be for the Board to determine how best it carries out its commissioning functions.

A122. The transfer of commissioning to the Board means that responsibility for maintaining lists of dental contractors and recognition of local contractor representative committees will also lie with the Board.

- A123. Responsibility for developing and publishing Joint Strategic Needs Assessments are proposed to be part of the Public Health Service function in local authorities. The public health functions related to dentistry, including epidemiology, oral health promotion and water fluoridation schemes, will become part of the proposed Public Health Service.
- A124. The NHS Board is viewed as the most appropriate commissioner for dental services because it could do so with lower costs and patients and dentists would benefit from more consistent and high-quality commissioning with proportionate performance management.
- A125. Dentistry is very largely a "direct entry" service. People tend to go straight to a dentist either for routine check-ups, or when suffering symptoms such as toothache. As such, it falls outside the knowledge and expertise of general medical practitioners and it is therefore not considered to be clinically appropriate for CCGs to commission dental services.
- A126. Dental commissioning is also quite specialist, as dentists have their own contracts, and it is considered it would be more cost-effective to have the Board exercise that function than to seek to delegate it across CCGs. Increasingly we are seeing dentistry provided by so-called "dental corporates" - bodies which run large numbers of practices. The large corporates now have over 10% of the market, and smaller and medium size corporates are also growing. It makes sense for the corporates to have one point of contact for commissioning purposes.
- A127. It should also lead to greater consistency of approach, in line with the policy intention of moving to a more standardised dental contract over time. Dentists have been critical of inconsistency between PCTs who currently commission dentistry. Representatives of the dental profession have said in response to the White Paper that they strongly favour dental commissioning being a function of the NHS Commissioning Board.

### *Commissioning Ophthalmic Services*

- A128. It is proposed that NHS Commissioning Board will commission primary eye health services. This is essentially the administration of the NHS sight test and optical voucher schemes. The costs of administration will be significantly lower if this function is undertaken by the Board nationally and, as these are national entitlements, there are little benefits to local commissioning.
- A129. Most other eye care is likely to be commissioned by CCGs.

### *Commissioning Secure Mental Health Services*

- A130. Mental health secure services provide treatment for people with mental health disorders that mean that they are at significant risk of harming themselves or others. Many of these patients will be detained under the Mental Health Act. Many, but not all of these patients, will be convicted offenders.
- A131. High, medium and low secure services are currently commissioned through specialist commissioning arrangements. There are three high secure hospitals – Ashworth, Broadmoor and Rampton – with about 800 beds in total. There are 66 medium secure units in England with approximately 60% of those provided by the NHS. There are about 3,000 patients nationally. There are around 2000 low security beds.
- A132. It is thought appropriate for secure services to be commissioned through the Commissioning Board because these are low volume/high cost services. Patients have complex needs and often long lengths of stay. Commissioners need specialist expertise to make links across and along the patient pathway (for example with the Ministry of Justice and National Offender Management Service).



## Commissioning Specialised Services

- A133. The current specialised services architecture and arrangements were set up in 2007, following an independent review by Sir David Carter. SHAs have a statutory responsibility for commissioning nationally designated services. This is delegated to NHS London who host the National Specialised Commissioning Team (NSCT). Funds come from PCT allocations transferred annually into a budget held by NHS London (currently around £0.5bn).
- A134. PCTs also delegate responsibility for other services, excluding those services that are commissioned nationally, to 10 Specialised Commissioning Groups (SCGs) which are so-terminus with SHAs. These services (34 in total) are defined in the Specialised Services National Definitions Set (SSNDS). Spending on regional specialised commissioning by SCGs is around £5.8bn per year. However, there is variability around the country as to the number of services on the SSNDS which are actually commissioned through SCGs and the total spend by PCTs on services within the SSNDS is believed to be around £9.3bn. This means that the total cost of commissioning specialised services, nationally and regionally, is £9.8bn, as set out in Table A4.
- A135. Specialised services are characterised by the fact that they are usually high cost, low volume treatments which are provided by a small number of providers. As a minimum, they require a planning population of more than 1m. Commissioning these services at a national and regional level allows needs to be assessed across a broader population base and commissioners to take a more strategic approach to ensure an appropriate level of provision is available across the country. It also allows financial risk to be managed, as individual commissioners do not have to fund expensive cases at random intervals from their budgets. Expert commissioners are also in a better position to challenge providers to secure greater consistency and improved outcomes.
- A136. We are therefore of the view that specialised services would be more appropriate for the NHS Commissioning Board to commission in order to replicate effective aspects of the current arrangements. We also believe there is potential to reduce management costs and deliver improved outcomes through:
- streamlining decision-making, funding, planning and commissioning all of services needing a planning population of over one million;
  - creation of an identifiable pooled budget as recommended by the Health Select Committee, reducing the need for contingencies;
  - more transparent criteria, and decision-making processes for determining what is commissioned nationally based on expert advice;
  - providing greater consistency and reducing unacceptable and inequitable access to specialised services across the country;
  - ensuring quality improvements through nationally agreed clinical standards;
  - pooling existing multi-disciplinary specialised commissioning expertise, reducing administration costs and a tier of bureaucracy; and
  - enabling consistent approach to service specifications to contain costs and get best value for money (e.g. agreeing single tariffs across providers).

**Table A3: Breakdown of current budgets for specialised commissioning**

Service	Planned Funding 2010/11 £m (rounded)	Comment
<b>National Specialised Services</b>	509	Commissioned by the National Specialised Commissioning Team
<b>Regional Specialised</b>	5,025	Commissioned in line with Specialised Services National Definition Set through the

<b>Commissioning</b>		Specialised Commissioning Groups
<b>PCT commissioning</b>	4,247	Commissioned in line with Specialised Services National Definition Set by PCTs

### *Commissioning Prison Health*

- A137. From April 2003, funding responsibility for prison health services transferred from the Home Office to the Department of Health and from 2006, PCTs have received funding to commission health services for people in the prison(s) in their locality to improve levels of access and the quality and range of health services to meet the needs of prisoners. Working in partnership with the NHS has improved health services aimed at diagnosing, treating illness, reducing health inequalities, risky health behaviour, morbidity and mortality of offenders.
- A138. People in prison have significant co-morbidity mental health, alcohol, drug and physical problems and have typically led chaotic lives prior to incarceration, characterised by little formal contact with NHS services. Primary care services are the major health services in prison and provides a prime opportunity to deliver therapeutic and prevention services that act as a hub to treat and then refer patients to appropriate secondary or tertiary services.
- A139. Many services delivered in prison such as primary care, health promotion mental health in reach, sexual health services drug and alcohol services are commissioned using the prison PCT allocation of £248m. The range and type of these services may vary according to the health needs of the individual prison population, gender, age and length of sentence. Between 5%-15% of this may become part of new Public Health ring-fence.
- A140. Additionally some services delivered in prison may be part of the wider NHS specialist services or PCT services, such as Hepatitis C diagnostic and treatment services, smoking cessation; funding for these arising from total PCT allocations.
- A141. We consider that prison healthcare would be more appropriate for the Board to commission due to the importance of consistency around the country, links to Other Government Department agencies at regional level and impact large prison populations would have on the budget and commissioning priorities of CCGs.

### *Commissioning Secondary Care for HM Forces Personnel*

- A142. Defense Medical Services (DMS) health centres, which are not part of the NHS, are currently responsible for commissioning and providing primary healthcare to HM Forces personnel.
- A143. The Ministry of Defence (MoD) currently commissions and funds around 50,000 episodes of care directly from NHS Trusts (MoD Hospital Unit (MSHU) contracts) or independent sector providers. where non-NHS standard pathways are required (e.g. fastrack treatment, pre-emptive surgery). It is intended that MoD will continue to commission and fund this activity directly.
- A144. DMS can refer resident HM forces to NHS secondary care which is currently funded by the responsible PCT. PCT allocations include funding for hospital and community health care for HM Forces within their area on an unregistered patient basis.
- A145. The DMS health centres currently refer a significant number of HM Forces personnel and dependents for NHS treatment and care annually, resulting in approximately 50,000 finished consultant episodes of mostly elective care.
- A146. The frequency of secondary care interventions for HM Forces personnel is understood to be higher than for an equivalent civilian demographic due to the physically demanding nature of their

employment and impact of deployments. Further work is being undertaken to determine the differential.

A147. It is considered that it would be difficult to account for changes in the distribution of HM Forces personnel around the country in allocations to CCGs and that these changes in demographic would be difficult for them to account for in their commissioning plans. We therefore propose that the NHS Commissioning Board will be responsible for commissioning appropriate capacity to provide for secondary care referrals by DMS in areas where there are military bases.

## Annexes

Annex 1 should be used to set out the Post Implementation Review Plan as detailed below. Further annexes may be added where the Specific Impact Tests yield information relevant to an overall understanding of policy options.

### Annex A1: Post Implementation Review (PIR) Plan

A PIR should be undertaken, usually three to five years after implementation of the policy, but exceptionally a longer period may be more appropriate. A PIR should examine the extent to which the implemented regulations have achieved their objectives, assess their costs and benefits and identify whether they are having any unintended consequences. Please set out the PIR Plan as detailed below. If there is no plan to do a PIR please provide reasons below.

<p><b>Basis of the review:</b> [The basis of the review could be statutory (forming part of the legislation), it could be to review existing policy or there could be a political commitment to review]; Exact details of the review have not yet been planned, but will build on planned evaluations of commissioning by external academics from the DH funded Policy Research Programme. This is in addition to the ongoing reviews within the system, set out in the coordinating document.</p>
<p><b>Review objective:</b> [Is it intended as a proportionate check that regulation is operating as expected to tackle the problem of concern?; or as a wider exploration of the policy approach taken?; or as a link from policy objective to outcome?] The review will assess whether clinical commissioning has delivered an effective system for planning and commissioning healthcare designed around patients.</p>
<p><b>Review approach and rationale:</b> [e.g. describe here the review approach (in-depth evaluation, scope review of monitoring data, scan of stakeholder views, etc.) and the rationale that made choosing such an approach] The review will assess processes and outcomes of CCGs.</p>
<p><b>Baseline:</b> [The current (baseline) position against which the change introduced by the legislation can be measured] The evidence from World Class Commissioning and the WCC steering group evaluation programme will help form the baseline.</p>
<p><b>Success criteria:</b> [Criteria showing achievement of the policy objectives as set out in the final impact assessment; criteria for modifying or replacing the policy if it does not achieve its objectives] Clinical commissioning has improved processes and outcomes of commissioning.</p>
<p><b>Monitoring information arrangements:</b> [Provide further details of the planned/existing arrangements in place that will allow a systematic collection systematic collection of monitoring information for future policy review] Regular monitoring of expenditure, activity and outcomes.</p>
<p><b>Reasons for not planning a PIR:</b> [If there is no plan to do a PIR please provide reasons here]</p>

## Annex A2: Specific Impact Tests

### Competition

*Would the proposal directly limit the number or range of suppliers?*

The proposals would have no impact on the number or range of providers of healthcare or related services.

*Would the proposal indirectly limit the number or range of suppliers?*

The proposals would have no impact on the number or range of providers of healthcare or related services.

*Would the proposal limit the ability of suppliers to compete?*

The proposals would have no impact on the ability of potential providers of healthcare or related services to compete.

*Would the proposal reduce the incentives of suppliers to compete vigorously?*

The proposals will have no impact on incentives for providers of healthcare or related services.

### Small Firms

It is not expected that firms will incur any significant additional costs as a result of this measure – and therefore there is no reason to expect any disproportionate cost impact for small firms.

### Environmental and sustainability impacts

The proposals would not have a negative impact on environmental and sustainability issues.

### Human Rights

There is no reason to expect any significant impact on human rights

### Justice system impacts

There is no reason to expect any significant impact on the justice system.

### Rural proofing

The policies on the development of the new NHS Commissioning Board and clinical commissioning are unlikely to have an inequitable impact on rural areas or people. Clinical commissioning will give CCGs of GP practices the same freedom to design services around patients to improve patient experience and quality of care regardless of where those patients reside. The independent NHS Commissioning Board will be set up to support CCGs and provide national leadership on commissioning for quality improvement. It will allocate and account for NHS resources, and hold CCGs to account. The intention is to give GP practices flexibility to decide how they come together to form CCGs, subject to being able to demonstrate to the NHS Commissioning Board, when applying to be established, that they have workable arrangements to enable them to carry out their statutory duties. Clearly, when formulating policy it may be appropriate to consider further the needs of rural communities.

Title: <b>Provider Regulation</b>  Lead department or agency: <b>Department of Health</b>  Other departments or agencies:	<b>Impact Assessment (IA)</b>
	IA No: 6031
	Date: 25/08/2011
	Stage: Final
	Source of intervention: Domestic
	Type of measure: Primary legislation

## Summary: Intervention and Options

### What is the problem under consideration? Why is government intervention necessary?

England's ageing population, the greater prevalence of long-term conditions, and rapid advances in disease treatment options, are putting ever increasing pressure on NHS finances. Efficiency improvements in health service delivery are increasingly required to sustain the NHS funding model. Such improvement is more likely where providers are able to develop services under a stable, consistent, and transparent regulatory regime. Currently, regulation of providers is fragmented and inconsistent, hampering NHS efficiency. Change is necessary to establish a transparent regulatory regime that applies to all providers, overseen by a regulator that is operationally free from government and provider influence, and which has a clear remit and set of objectives on which to base its policy.

### What are the policy objectives and the intended effects?

Establish a transparent and provider neutral regulatory regime for the health sector with a clear incentive structure that drives improvements in provider efficiency and the quality of services received by patients. Under the new regulatory system, efficient providers will have greater opportunities to: expand their services to more patients; adapt their service offering and innovate; develop mechanisms to integrate services around the needs of patients; and to invest to expand their delivery capacity.

Achieving these objectives should result in improved cost efficiency and higher quality services for patients.

### What policy options have been considered? Please justify preferred option (further details in Evidence Base)

Two Options have been assessed:

Option 1 (Do Nothing Option). Institutional responsibility for provider regulation remains unchanged (i.e. largely within DH) and application of the regulatory framework is the responsibility of multiple bodies.

Option 2. Establish Monitor as an independent regulator of providers of NHS services with a remit to revise, develop, and operate the regulatory framework to drive quality and efficiency improvement in the delivery of these services. Some statutory restrictions on Foundation Trusts will be removed so that they can respond innovatively to the new system and governance of FTs will be strengthened.

Preferred Option is Option 2. It supports service reconfiguration, provider innovation, and provider investment, leading to higher quality and more efficient service provision. It will support progress to meeting the QIPP challenge.

Will the policy be reviewed? It will/will not be reviewed	If applicable, set review date	01/2019
What is the basis for this review? basis of review menu	If applicable, set sunset clause date	N/A
Are there arrangements in place that will allow a systematic collection of monitoring information for future policy review?	Yes	

**SELECT SIGNATORY Sign-off** For final proposal stage Impact Assessments:

*I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) the benefits justify the costs.*

Signed by the responsible Minister: ..... *M. H. M.* ..... Date: ..... *1.9.11* .....

# Summary: Analysis and Evidence

# Policy Option 2

## Description:

Establish Monitor as an independent provider regulator for the health sector with a revised regulatory framework.

Price Base Year 2010	PV Base Year 2010	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: <b>Optional</b>	High: <b>Optional</b>	Best Estimate:

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional	Optional	<b>Optional</b>
High	Optional	Optional	<b>Optional</b>
Best Estimate	£12m (note 1 below)	£84m (note 2 below) x2.4 <sup>15</sup> = £202m	

### Description and scale of key monetised costs by 'main affected groups'

The principal direct cost is the annual operating cost of the new Provider regulator. In steady state (from 2015/16), this is estimated at £82m per annum. Estimated transition cost of organisational change to establish the new regulator is £12.5m. Both these estimates may change as further detailed work on the functions of Monitor is progressed.

An estimate of the cost of supporting new FT governance arrangements is a one-off cost of £7m and an annual recurring cost of £2.1m.

### Other key non-monetised costs by 'main affected groups'

BENEFITS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional	Optional	<b>Optional</b>
High	Optional	Optional	<b>Optional</b>
Best Estimate			

### Description and scale of key monetised benefits by 'main affected groups'

It has not been possible to develop a robust monetary estimate of the benefits of changes to the regulatory regime.

### Other key non-monetised benefits by 'main affected groups'

In 2009, Mckinsey estimated that the NHS could achieve recurrent annual efficiency gains of £13-20bn within 3-5 years. A stable and transparent regulatory regime and the consistent application of the rules will support the realisation of efficiency savings and quality gains as providers will face a clear set of incentives to improve. The proposals outlined here have the potential to drive innovation in the system and significant efficiency gains and only a small efficiency improvement is needed to cover the estimated annual cost of the new system (for example, on the current NHS budget of more than £100bn annually, a 1% efficiency gain translates to £1bn in monetary terms).

### Key assumptions/sensitivities/risks

Discount rate (%)

3.5

\*1 Cost to establish new regulator (£5m) plus one-off cost new governance arrangements (£7m)

\*2 Annual running cost of Monitor – (£82m) plus annual cost of new governance arrangements (£2m)

The annual operating cost of Monitor is subject to uncertainty and a work programme is in place to scope the regulator's functions, staff needs and costs per employee.

Direct impact on business (Equivalent Annual) £m):			In scope of	Measure classified as
Costs:	Benefits:	Net:	Yes	OUT

<sup>15</sup> The estimate of the costs has been multiplied by 2.4 in line with DH methodologies.

## Enforcement, Implementation and Wider Impacts

What is the geographic coverage of the policy/option?		Options			
From what date will the policy be implemented?		01/04/2012			
Which organisation(s) will enforce the policy?		Department of Health			
What is the annual change in enforcement cost (£m)?		N/A			
Does enforcement comply with Hampton principles?		Yes			
Does implementation go beyond minimum EU requirements?		N/A			
What is the CO <sub>2</sub> equivalent change in greenhouse gas emissions? (Million tonnes CO <sub>2</sub> equivalent)		Traded:		Non-traded:	
Does the proposal have an impact on competition?		Yes			
What proportion (%) of Total PV costs/benefits is directly attributable to primary legislation, if applicable?		Costs:		Benefits:	
Annual cost (£m) per organisation (excl. Transition) (Constant Price)	Micro	< 20	Small	Medium	Large
Are any of these organisations exempt?	No	No	No	No	No

## Specific Impact Tests: Checklist

Set out in the table below where information on any SITs undertaken as part of the analysis of the policy options can be found in the evidence base. For guidance on how to complete each test, double-click on the link for the guidance provided by the relevant department.

Please note this checklist is not intended to list each and every statutory consideration that departments should take into account when deciding which policy option to follow. It is the responsibility of departments to make sure that their duties are complied with.

Does your policy option/proposal have an impact on...?	Impact	Page ref within IA
<b>Statutory equality duties</b> <a href="#">Statutory Equality Duties Impact Test guidance</a>	Yes	EA Annex B
<b>Economic impacts</b>		
Competition <a href="#">Competition Assessment Impact Test guidance</a>	Yes	67
Small firms <a href="#">Small Firms Impact Test guidance</a>	No	
<b>Environmental impacts</b>		
Greenhouse gas assessment <a href="#">Greenhouse Gas Assessment Impact Test guidance</a>	No	
Wider environmental issues <a href="#">Wider Environmental Issues Impact Test guidance</a>	No	
<b>Social impacts</b>		
Health and well-being <a href="#">Health and Well-being Impact Test guidance</a>	Yes	67
Human rights <a href="#">Human Rights Impact Test guidance</a>	No	
Justice system <a href="#">Justice Impact Test guidance</a>	Yes	68
Rural proofing <a href="#">Rural Proofing Impact Test guidance</a>	No	
<b>Sustainable development</b> <a href="#">Sustainable Development Impact Test guidance</a>	Yes	67



## Evidence Base (for summary sheets) – Notes

Use this space to set out the relevant references, evidence, analysis and detailed narrative from which you have generated your policy options or proposal.

### No. Legislation or publication

- 1 Equity and Excellence: Liberating the NHS (White Paper).  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_117353](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353)
- 2 Liberating the NHS: Greater choice and control. A consultation on proposals.  
[http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH\\_119651](http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_119651)
- 3 Future Forum Report  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_127443](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127443)
- 4 Government Response to Future Forum  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_127444](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127444)
- 5 Other sources are referenced in the main text

## Evidence Base (for summary sheets)

### A. What is the problem under consideration? Summary of analytical narrative.

- B1. The provision of health services in the NHS is based on patients receiving the treatment they need, irrespective of their ability to pay. Health service users do not pay for services directly, with the NHS being funded through general taxation. The NHS faces a high degree of financial pressure in future, as demand for services increases more rapidly as the population ages, long-term conditions become more prevalent, and technological advances mean that ever more sophisticated treatment options become available. The scope for tax rises or public spending cuts elsewhere to fund this increased demand is limited and efficiency improvements in the delivery of health services are needed to ensure that the NHS funding model is sustainable in the long-term. This is often referred to as the Nicholson Challenge or the QIPP Challenge (Quality, Innovation, Productivity and Prevention).
- B2. There is a large and diverse literature on efficiency in the NHS and how it could be improved. Themes include better procurement practices, stronger leadership and management on the provider-side, clinically-led commissioning, changes to the service mix – especially a shift from acute to community services and from cure to prevention, sharper incentives for providers to respond to patient need (more patient choice supported by provider competition), and better integration of care around the needs of the patient.
- B3. The reform package is designed to support the realisation of efficiency gains across these and other themes by giving patients more power and professionals greater freedom. The provider regulation strand of the reforms is designed to ensure that providers face the right incentives and have the required freedom and opportunity to adapt service delivery to better meet commissioner and patient demands in a cost-effective way. Provider responsiveness is more likely where providers have managerial control of their organisations and operate under a transparent and stable regulatory regime that supports the expansion of efficient providers and protects patients in the event that services transfer from one provider to another. Such a regulatory regime would enable cost-efficiencies and improvement in the quality of care through development of a higher quality and more innovative provider base, whilst ensuring that changes to services do not adversely impact on patients.
- B4. Under current arrangements, it is the Department of Health that defines the regulatory regime governing the NHS. The Department is responsible for high-level competition policy (Principles and Rules for Cooperation and Competition), the payment rules for many NHS services (Payment by Results), and rules that apply when an NHS provider fails financially (the failure regime). The Foundation Trust regulator, Monitor, is responsible for the regulation of Foundation Trusts, including the operation of a financial distress regime.
- B5. The implementation of the regulatory regime rests with PCTs, SHAs, DH and Monitor, with the Cooperation and Competition Panel having an important advisory role. This fragmentation of responsibility means that there is not a consistent approach to provider regulation across the country, and there is a significant risk of short-termism and of political lobbying having undue influence on decision-making.
- B6. There is also a potential conflict of interest in that DH is both the custodian of NHS assets (e.g. acute trusts) and is currently responsible for the regulatory framework governing these assets. What is needed is a regulatory system free from conflicts of interest where the interests of patients and taxpayers take priority over the interests of providers.
- B7. The current system of regulation does not do enough to support service reconfiguration, the integration of care around the needs of the patient, and patient choice enabled by effective provider

competition. It is difficult for commissioners to reconfigure services, to shift care out of acute settings, and to focus more on prevention rather than cure. It is difficult for providers to respond to patient choice and for successful and popular providers to expand their services. The result is an NHS that is not as efficient as it could be; in an efficient system, the NHS would be serving more patients at better quality for the same resource input. The evidence relating to this is set out below.

- B8. Some of the ways in which a lack of clarity regarding the regulation of providers and inconsistent application of rules have stifled efforts to improve efficiency are as follows:
- Providers are more risk adverse than they would otherwise be and innovation and investment are below desirable levels;
  - There are barriers to entry for providers who wish to supply services to new groups of patients, meaning that quality and efficiency are lower than they could be. Providers do not face a fair playing field;
  - Acute hospitals have strong incentives to treat patients in their hospitals, rather than in community settings. Shifting money into prevention and community settings is extremely difficult;
  - Integration of care around the needs of the patient is not consistently achieved, sometimes due to a lack of clarity concerning what type of cooperative agreements between providers are allowable under competition rules and design of payment mechanisms.
- B9. In addition, operational constraints on Foundation Trusts have limited their freedom and motivation to invest and innovate to increase the quality and cost effectiveness of the services they provide.
- B10. These are just some examples of how sub-optimal provider regulation has had an adverse impact on efficiency. The challenge for policy makers is to develop a regulatory framework and regulatory institutions that result in strong incentives for providers to respond to commissioner and patient needs. Such a framework needs to be transparent, consistent, flexible, and stable. Experience in other sectors of the economy has shown that such a regulatory framework is far more likely to emerge when a single and independent provider regulator is responsible for its development and application.
- B11. The model of provider regulation set out in the Health Bill is designed to overcome the inadequacies of existing arrangements and support the realisation of efficiency gains. An independent regulator (Monitor) will be charged with developing a more transparent system of regulation that enables potential efficiencies to be captured, especially from the integration of services around the needs of patients and the exercise of patient choice. Monitor will have freedom to design a flexible regulatory regime, implemented through provider licences (to be issued in conjunction with CQC, who remain responsible for ensuring providers meet minimum quality standards). It will control and be able to use several levers (pricing, provider failure arrangements, competition rules) to support the realisation of efficiency gains.
- B12. The regulator will be responsible for mitigating the risks inherent in a more flexible and open health system. For example, by ensuring that:
- Transfer of services from one provider to another does not result in patients losing access to essential services.
  - There are appropriate safeguards against cherry picking by new providers (new providers taking only low cost patients from incumbents, with the risk that the incumbent provider is destabilised financially).

- B13. It is probable that the current regulatory system does hamper efforts to meet the needs of certain patient groups and communities. Given that the current system does not always enable patient and taxpayer interests to take precedence over the interests of incumbent providers, it does not always enable patients to benefit from a wider choice of providers, including niche providers who are often especially adept at tailoring their services to the needs of local groups whose access to health services is restricted – indeed, this is often their primary objective.
- B14. In summary, Government intervention is necessary to establish an independent regulator of NHS providers that is responsible for defining and operating a transparent and provider-neutral regulatory regime. The regulator must be independent of ownership of any part of the system and of political influence. The regulator's primary objective will be to support the realisation of improved efficiency in the NHS, especially from the scope for greater patient choice and better integration of services around the needs of patients. The regulator must have appropriate resources to carry out its functions and duties to a high standard.
- B15. This leads us to define two options:
1. Do Nothing
  2. Establish an independent regulator of NHS providers with a remit to develop and operate a regulatory framework to support the realisation of efficiency gains in the NHS.

## **B. What are the policy objectives and the intended effects?**

- B16. The policy objective is to redesign the current system of regulation of NHS providers to support commissioners and providers to improve efficiency and deliver better value for money for patients and taxpayers.
- B17. The end impact of the changes will be a more efficient NHS, with services that are higher quality, more responsive to patient needs, and delivered efficiently.
- B18. The intended outputs of the new system are:
- A more transparent and stable framework of provider regulation (rules of the game) that gives organisations within the system greater clarity as to their expected conduct and future direction.
  - Clear lines of responsibility for the operation of the framework, to provide consistency across the country and a more strategic and stable approach to provider regulation.
  - A regulator and regulatory framework that are operationally free from political influence.
- B19. It is expected that these outputs will support a number of outcomes:
- Providers will have greater confidence to innovate and invest to support strategic change and service reconfiguration and be more responsive to changing patient and commissioner demands.
  - The incentive structure will be designed so that sharp incentives exist for providers to deliver services efficiently. There will be a more flexible and responsive supply-side, with strong providers increasingly confident in their ability to redesign services for patient benefit.
  - There will be movement towards a fairer playing field, whereby providers are not unfairly disadvantaged as a result of their characteristics (e.g. ownership, size, location and complexity of patient they treat).
- B20. There are a number of risks and constraints in a system that is more flexible:
- Geographical and vertical equity. People in more remote areas or from lower socio-economic backgrounds could find it more difficult to access some services if reconfiguration results in fewer providers (this might be the case for some specialist acute services).
  - Provider abuse of dominant position. Large incumbent providers could face stronger incentives to act anti-competitively to discourage change and to maintain the status quo.
  - Transition risks. Changes in the organisation providing services and/or in the way services are delivered could result in patients losing access to services during the transition period.
- B21. The regulatory system must be designed to mitigate these risks, through careful design of pricing structures, rules, and regulations, and effective monitoring and evaluation.

## C. What are the underlying causes of the problem?

What are the mechanisms through which changes to sector regulation could drive efficiency?

- B22. As set out above, the issue we are addressing is that efficiency in the NHS is below its potential level because of a sub-optimal system of regulation that acts as a constraint on providers responding to patient and commissioner needs. This has arisen as a result of piecemeal change over time, with changes to both the organisations responsible for regulating the system and to the regulatory framework.
- B23. Handing responsibility for provider regulation to an independent organisation that is free of political influence should result in the development of a more coherent and stable framework of provider regulation. This should help to unlock efficiencies from three key sources:
- Directly, through greater regulatory transparency and stability. Providers will have a better understanding of what they can and cannot do and increased certainty that changes to the regulatory framework will be evolutionary (the rules of the game will not change with political fortunes).
  - Directly through the development of sharper incentives to achieve desirable outcomes. For example, the development of rules that support service integration.
  - Indirectly, through the benefits of patient choice, enabled by more effective competition for patients between providers. Providers have to work harder to secure demand from commissioners and patients and be more responsive to their needs. This should result in services that are better tailored to patient needs and could be an important enabler of care that is more centred around the needs of the patient (integrated services).

### Greater Regulatory Transparency and Stability

- B24. The Department for Business, Innovation and Skills recently set out a framework for effective sector regulation<sup>16</sup>. According to this, the Government's role is to establish the policy direction and to make politically sensitive trade-offs between objectives, leaving regulators to carry out their regulatory duties independently. This recognises that if Governments are involved in operational decisions, they may be tempted to base decisions on political motives, rather than what is best for the long term sustainability of the sector in question. So for example, in the health sector, it is possible that a reduction in the number of hospitals offering stroke services is needed to improve the quality of care and ensure financial sustainability. Closure of local services can be politically unpopular and as a result, politicians may be uneasy about driving through the necessary changes.
- B25. Leaving the detailed application of regulation to be carried out independently of government has significant benefits in terms of stability and predictability of regulation and the concentration of regulatory expertise. The Future Forum recommended that transferring competition powers to an expert and independent regulator of NHS providers was the best safeguard against competition being applied disproportionately.
- B26. Whilst regulators should be independent of government departments, they should be accountable to Parliament. Effective accountability for an independent regulator requires transparency, a requirement to explain decision-making, exposure to scrutiny, and the right to challenge

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<sup>16</sup> Principles for Economic Regulation. BIS. April 2011

decisions. Open and committed consultation about proposals plays an important role in strengthening transparency.

- B27. It is essential that the regulator's priorities are clear and the effective design of a regulator's duties is vital to its success. The Government can use periodic guidance to help focus regulator's priorities. Regulator's duties should be outcome focused and avoid detailing the manner in which they are to be met. The regulator should be free to use the levers it has control over to achieve its objectives.

## **Sharper Incentives: Service Integration Example**

- B28. Integrated care refers to the co-ordinated delivery of health and care services to individuals in a way that enables them to maximise their independence, health, and well-being. Integrated care can be provided by a single or multiple organisations; the important thing is that the different parts of the organisation(s) that provide services to an individual work together to combine and co-ordinate all the services needed to meet the assessed needs of each individual. Integrated health and social care services address the changing nature of health service demands, with an ageing population, rising expectations, and advances in medical technologies resulting in many people living with one or more long term conditions for many years.

- B29. The experience of care for too many patients is fragmented, between different parts of the health service and between the NHS and social care or other services. The NHS Future Forum describes the current situation as follows: "What is also clear is that services under the existing system are currently highly fragmented across the NHS, public health and social care; and within the NHS, between primary, secondary and tertiary care."

- B30. There are huge opportunities to make services more integrated, building on the many examples of good practice that already exist. To quote the Future Forum: "There are already examples of successful integration of health and social care at different levels in the NHS. While there are many examples in local communities of multidisciplinary teams working together to meet the needs of individual patients and carers, there are also examples of integrated services at a larger scale for example in stroke care in London, diabetes in Bolton and in the care of older people in Torbay".

- B31. Integrated care can have a positive impact on the quality of services and the cost of services because:

- Individuals do not need to repeat their story to different clinicians and carers and clinicians/carers have all the information they need to treat the individual.
- Individuals can be guided through best practice care pathways and are more likely to receive the appropriate treatment at the appropriate time. This helps to avoid emergency admissions and expensive acute care. Integrated care recognises that health and social care outcomes are interdependent.
- Appropriate and timely social care support can avoid costly hospital admissions.

- B32. In line with the Future Forum's recommendation, the NHS Commissioning Board will promote innovative ways of demonstrating how care can be made more integrated for patients: by developing tariffs for integrated pathways of care, and exploring opportunities to move towards single budgets for health and social care, in line with the Government's wider proposals on Community Budgets. The new independent regulatory regime will support providers to integrate care by setting prices appropriately and giving greater certainty regarding the structure of payment mechanisms going forward.

## **More Effective Patient Choice Enabled by Provider Competition**

### *Overview*

- B33. Over the past twenty years, as in other sectors of the economy where public sector organisations provide services directly, there has been a drive to introduce competitive disciplines into the provision of some NHS services. In recent years, patient choice has been introduced into parts of the health service – particularly elective acute services - so that there is ‘competition in the market’. The rationale for introducing patient choice of provider is that it provides incentives for providers to tailor services more closely to patient needs, as failure to do so results in lost revenue as patients switch provider (funding follows the patient). Through the mechanism of choice, providers have to compete with each other to attract patients and maintain revenues.
- B34. The reform programme signals an acceleration of the extension of patient choice. The Future Form report states: “Patients want to have real choice and control over their care that extends well beyond just choice of provider”. As recommended by the Forum, the Secretary of State’s mandate to the NHS Commissioning Board will set clear expectations about offering patients choice – a ‘choice mandate’. Commissioners will have opportunities to extend choice of provider into areas where this is not currently available, such as community services and mental health services, through the Any Qualified Provider policy. Part of the role of the Regulator will be to support this, whilst making clear that choice is not appropriate for all services (e.g. accident and emergency).
- B35. For choice to be effective, some key enablers must be in place. Patients need to have access to information to help them choose the best provider for them. Also, providers must be able to respond to choice by developing their service offer in innovative ways to meet patient needs. Poor quality and inefficient providers must not be propped up by subsidies, but rather either reformed or allowed to make way for better quality and more efficient providers. Such a system requires highly effective regulation to ensure that these enablers are in place, that incumbent providers do not stifle choice, and that provider failure is carefully managed so that patients do not lose access to key services during transition from one provider to another.
- B36. The new system of regulation should support effective patient choice by establishing a more transparent and stable regulatory regime that encourages the most efficient providers to expand their service offer to an increasing number of patients. The Regulator would also be able to use the levers at its disposal, such as pricing, to support effective choice.
- B37. There has also been an increasing expectation that for some services where patient choice has not been introduced, commissioners should look to contract for services via competitive tenders – so called ‘competition for the market’ - rather than issuing contracts non-competitively to incumbent providers.

#### *Evidence Base: Benefits of Competition*

- B38. Economic theory and quantitative research studies have a clear message that more competitive markets can deliver better results for consumers. Where firms must satisfy the needs of consumers or face business failure, they have a powerful incentive to provide products and services that meet these needs at the lowest possible price, and to innovate to ensure they can continue to meet consumer preferences (and indeed shape these preferences) in future. Some of the most frequently cited studies<sup>17</sup> are:
- Nickell (1996)<sup>18</sup> finds that firms which face more competition have significantly greater productivity growth than those facing more muted competition. The difference between the 80<sup>th</sup> and 20<sup>th</sup> percentile is 4 percentage points.
  - A study of transition economies (Djankov and Murrell, 2002)<sup>19</sup> finds that the degree of competition has a significant impact on economic performance.

<sup>17</sup> These studies base their conclusions on findings from a diverse set of business sectors.

<sup>18</sup> Nickell, S. Competition and Corporate Performance. *Journal of Political Economy*, 1996. Volume 104



- Ahn (2002)<sup>20</sup> reviews a large number of studies on the link between competition and innovation and concludes that competition encourages innovative activities and has a significant impact on long-term productivity growth: “Competition has pervasive and long lasting effects on economic performance by affecting economic actors’ incentive structure, by encouraging their innovative activities, and by selecting more efficient ones from less efficient ones over time”.

B39. Whilst in theory, the potential for competition can have a powerful effect on how incumbent firms behave – if the threat is real enough, they may well behave as if they are in a competitive market – in most sectors of the economy, competition requires a degree of firm entry and exit (or, at least, expansion and contraction). For example:

- Nickell (1996) estimates that up to 40% of productivity differences between Organisation for Economic Cooperation and Development (OECD) countries is accounted for by the level of firm entry and exit;
- A study by Frontier Economics for the Office of Fair Trading (OFT)<sup>21</sup> on choice and competition in public service markets concludes that “Supply-side flexibility around entry, exit and expansion is critical. In public service markets a key issue is around the exit of poor performing providers”; and
- Barnes and Haskell<sup>22</sup> conclude as follows with regard to plant level productivity in the private sector: “The major insight from plant-level evidence is that at least half of productivity growth over a decade is due to changes in the market fortunes of good and bad firms, with entry and exit particularly important in this reallocation process. Thus, policy has to let the market work. Hindrance of free entry, propping up firms who would otherwise exit and stopping firms from competing will all slow the reallocation process down that is crucial for raising productivity”. Data from their analysis of UK manufacturing plant labour productivity between 1994 and 1998 shows significant variation within sectors (best plants are 3.5 – 6 times as productive as the worst).

B40. For competition to be effective, company management must be able to respond to competitive pressures. The Frontier Economics study for OFT concludes that: “Managerial incentives and behaviours can be made more responsive to competitive pressures by granting additional autonomy and changing institutional structures” and that “granting flexibility and managerial autonomy to providers also create incentives to innovate or seek efficiency gains”.

B41. The substantial resource deployed in competition agencies and industry regulators across the developed world (e.g. the Office of Fair Trading, Competition Commission and OFGEM in the UK) is based on a widely held belief that competition is beneficial – these organisations are charged with identifying and correcting anti-competitive practices by firms and more generally, providing a policy framework that enables competition to flourish.

B42. A summary of the estimated benefits of the UK competition agencies is presented in Box 1 below.

### **Box 1: Estimates of the Economic Benefit of Competition Agency Activity**

The Office of Fair Trading is the UK’s consumer and competition authority and its overarching mission is to make markets work well for consumers. It’s most recent impact assessment report sets out the

<sup>19</sup> Djankov S and Murrell P, (2002). Enterprise Restructuring in transition: a quantitative survey. *Journal of Economic Literature*, 40(3), 739-92

<sup>20</sup> Ahn, S. (2002). Competition, innovation and productivity growth: a review of theory and evidence, *Economics Department Working Papers No 37*, OECD

<sup>21</sup> Choice and Competition in Public Services: A Guide for Policy Makers. March 2010

<sup>22</sup> Matthew Barnes and Jonathan Haskell: Productivity, Competition and Downsizing. [www.hm-treasury.gov.uk/d/254.pdf](http://www.hm-treasury.gov.uk/d/254.pdf)

direct benefits to consumers from its work. The report finds that over the period 2006 to 2009 the OFT has delivered annually, on average, financial benefits to consumers of £409m, against its average annual costs of £53m.

The Competition Commission (CC) is one of the independent public bodies, which help ensure healthy competition between companies in the UK for the benefit of companies, customers and the economy. It investigates and addresses issues of concern in three areas: mergers; markets (when it appears that competition may be being prevented, distorted or restricted in a particular market); and in regulated sectors such as utilities.

The CC estimates an economic benefit from the work completed in 2007/08 by itself and OFT in merger and market inquiries of just over £600 million. The CC notes that attribution of the combined benefit to the two authorities is the result of arbitrary assumptions, but that based on their convention for apportioning such combined benefits, the figure attributed to the CC is just over £400 million. This compares well to its costs, which are less than 6 per cent of this figure.

B43. A recent DTi study<sup>23</sup> provides a demonstration of the benefits of increased competition in six markets in the UK. It contains six market case studies drawn from a variety of sectors where competition had previously been absent or muted. The case studies were not selected randomly but on the basis that benefits were likely to be found. It presents evidence of the type and magnitude of the benefits following market interventions to develop competition and improve market dynamics.

B44. Of the six case studies, three relate to removal of anti-competitive practices by firms, and three to deregulation/liberalisation<sup>24</sup>:

- Removal of anti-competitive practices: net book agreement; new cars; and replica kits
- Deregulation: retail opticians; international telephone calls; and passenger flights in Europe

B45. In all cases, it was hoped that the intervention would remove a market imperfection and thereby lead to significant price reductions. With the exception of opticians, very significant price falls were recorded following the interventions. Four out of six case studies found evidence of improved quality and choice. In the telecoms market in particular, a more open market provided the stimulus for investing in new technology. Harmful effects from greater competition were generally absent, although in the case of opticians, there were fewer eye tests post deregulation - although it should be noted that the increase in competition also coincided with the removal of the universal entitlement to free eye tests.

B46. The evidence above does not imply that unfettered competition without regulation is a desirable outcome in the NHS. Rather, it indicates that for some health services, there are likely to be efficiency gains from properly regulated competition. The evidence in the section below relates specifically to the NHS and is supportive of this conclusion.

#### *Evidence on impact of choice and competition NHS reforms to date*

B47. A July 2010 study by health economists Martin Gaynor, Rodrigo Moreno-Serra, and Carol Propper<sup>25</sup> investigated outcomes in the NHS following the introduction of choice in 2006. They conclude as follows: "We find that the effect of competition is to save lives without raising costs. Patients discharged from hospitals located in markets where competition was more feasible were

<sup>23</sup> DTI Economics Paper Number 9, The Benefits From Competition: Some Illustrative UK Cases

<sup>24</sup> Removal of government imposed restrictions that limited the scope for free competition.

<sup>25</sup> Death by Market Power: Reform, Competition and Patient Outcomes in the National Health Service. NBER Working Paper No. 16164, July 2010.

less likely to die, had shorter length of stay and were treated at the same cost". The study found that there was a larger inflow of patients to better quality hospitals after the 2006 NHS reforms, suggesting that popular providers in health care are able to expand supply.

- B48. A January 2010 study by the London School of Economics<sup>26</sup> also looked at NHS data post-introduction of choice in 2006. The key conclusion is as follows: "Using AMI mortality as a quality indicator, we find that mortality fell more quickly (i.e. quality improved) for patients living in more competitive markets after the introduction of hospital competition in January 2006. Our results suggest that hospital competition in markets with fixed prices can lead to improvements in clinical quality".
- B49. Evidence from the LSE shows that management quality - measured using a new survey tool - is strongly correlated with financial and clinical outcomes such as survival rates from emergency heart attack admissions (AMI). Moreover, the study finds that higher competition (as indicated by a greater number of neighbouring hospitals) is positively correlated with increased management quality<sup>27</sup>.
- B50. These findings largely mirror those from US evidence on Medicare, which, like the NHS acute sector, is a fixed-price payment regime. The majority of these studies indicate that under fixed-priced competition, higher levels of competition lead to improvements in clinical performance, so long as price covers marginal cost.
- B51. The above quantitative studies report some positive impact from the NHS market-based health reforms. A recent report by Civitas<sup>28</sup> presents the findings of a year-long qualitative study of the impact of the NHS market reforms on efficiency. The report finds some incidences of market based reform delivering efficiencies but concludes that the reforms have "failed thus far to deliver such benefits on any meaningful or systematic scale".
- B52. The report highlights some of the risks inherent in greater use of competition as a lever in delivering NHS services. For example, some participants in the research reported that collaboration is suffering and that high quality care is being undermined by organisational self-interest.
- B53. It also raises the issue of the complexity of the policy framework governing the NHS and the risk that "market incentives will forever be quashed by the centralised and political nature of the NHS".
- B54. The report includes much evidence to suggest that a market could improve outcomes in the NHS and that the lack of results to date is a result of weaknesses in the current market structure and regulatory framework. Some direct quotes from the report of particular relevance are as follows:
- "There is a strong case to be made that such policies [*i.e. market based reforms*] have been ineffective because to date there has not been a functioning 'market' in the NHS. Currently, so many barriers exist to the operation of a market that it seems wrong to draw any concrete conclusions on its effectiveness. Barriers, for example, have meant that providers are able to operate as monopolies dictating terms to PCTs, rather than competing for PCT business."
  - "Examples provided by both commissioners and providers suggest that, although benefits are not currently widespread, more profound effects would be possible if a market were bedded in."
  - "There is an uneven playing field between NHS and private/voluntary sector providers."

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<sup>26</sup> Cooper, Gibbons, Jones and McGuire. Does Hospital Competition Save Lives? Evidence from the NHS Patient Choice Reforms. Working Paper 16/2010. LSE Health. January 2010

<sup>27</sup> Bloom, Propper, Seiler and Van Reenen (2010), The Impact of Competition on Management Quality: Evidence from Public Hospitals, Centre for Economic Performance

<sup>28</sup> Refusing Treatment: The NHS and Market Based Reform

- “A PCTs ability to tender a service, open the market to new entrants, and/or shift services is restricted by: existing NHS providers operating at full capacity; significant barriers to entry for private and voluntary sector organisations; bullying and predatory pricing by acute trusts; poor data quality; and the bureaucratic and time-consuming nature of the procurement process.”

B55. Overall, the report concludes that on the balance of evidence, “the NHS market is largely failing to deliver because it is being stifled and distorted”.

B56. This idea that the market could work if only it was better regulated and structured is supported by DH led consultations with commissioners and providers during the last two years during projects on ‘health market analysis’ and ‘fair playing field’. For example, during the fair playing field consultations, the most frequent problem identified by voluntary providers was the scarcity of competitive tenders and the lack of opportunities to present their service offer to commissioners.

B57. A report by the Audit Commission in 2008 (“Is the Treatment Working?”) also found that the market reform programme was having a positive impact on the NHS, despite limited implementation. With regards to choice and competition it concluded that:

- NHS patients are beginning to benefit from the existence of a diverse range of providers and there is anecdotal evidence that competition is improving services for patients in some areas;
- The fear of the impact of patient choice, rather than actual choice, appears to be driving a positive change in attitude among providers. Some PCTs can also point successfully to improving services through tendering.

B58. It also concluded that there is no evidence of Foundation Trust status being a catalyst for innovation: “.... despite the improved quality of service, FT status does not yet seem to be empowering organisations to deliver innovative models of patient care”.

B59. These evidence sources suggest that recent NHS reforms have had a positive impact on patient outcomes, but could have a greater impact if supported by an independent, transparent and stable regulatory regime.

#### *Fair Playing Field*

B60. Providers of NHS services currently face different cost conditions as a result of their organisational type. Such distortions go both ways: some, such as access to NHS Pensions, favour NHS providers; others, such as the ability to choose which patients to accept, favour the independent sector. This section summarises the available evidence on the impact of different distortions. **It must be stressed that this evidence base is incomplete and only a subset of distortions are reliably quantified at the present time. Some of the distortions that stakeholders believed to be amongst the most significant could not be quantified.**

B61. NHS services are provided by a range of provider types, including statutory NHS organisations, private sector providers, social enterprises, and charities. Providers currently face different cost conditions purely because of their organisational type. These arbitrary cost advantages for particular provider types are referred to as ‘fair playing field distortions’.

B62. The existence of fair playing field distortions results in inefficiency if one type of provider is significantly advantaged or disadvantaged relative to another. Distortions can result in contracts not being awarded to the best provider following a competitive tendering process. Moreover, an otherwise efficient provider might be unable to compete under patient choice because distortions are enshrined in national tariffs. Tariffs are set on the basis of cost data provided by NHS organisations; if the costs of NHS organisations are significantly different from those of private and voluntary providers (e.g. they might be lower due to hidden subsidies, or higher due to a more complex case mix), then distortions to the fair playing field will result.

- B63. A recent study of fair playing field distortions<sup>29</sup> was able to quantify the impact of **some** of the distortions identified. Our conclusion from the report is that it cannot necessarily be the case that costs incurred by private acute providers are higher than their NHS equivalent- even though this independent report found that some quantifiable distortions<sup>30</sup> result in £14 per £100 higher costs- as some significant unquantifiable distortions not included are likely to act against NHS providers. The pensions and cost of capital distortions are the most significant. It should be noted that the extent of the distortion will vary by service depending on the input mix and capital employed. For example, the pensions distortion will be greater for higher paid staff, so a service that requires significant consultant input will have a higher pensions distortion than one which does not.
- B64. A list of important fair playing field distortions identified by recent studies and stakeholder consultations, including those not quantified, is below. There are some distortions that are likely to significantly penalise NHS organisations relative to other provider types, but are very difficult to quantify as they work via tariff – the two issues under the ‘cross subsidy in tariff’ heading in the table are the principal examples.
- B65. Many of the distortions viewed as significant by the voluntary and charitable sectors relate to a lack of transparency around tendering of services and also, when services are put out to tender, an overly bureaucratic and high cost process.
- B66. **As noted earlier, it is important to stress that the evidence currently available is incomplete as some of the distortions that are likely to be significant have not been quantified. Some of these are expected to work in favour of independent sector providers, and so it is not possible to state with any certainty whether the current distortions systematically favour any particular groups of providers.**

**Table B1: Fair Playing Field Distortions**

Distortion	Quantified (yes or no); If quantified, impact on cost base (£ per £100 of cost) of private acute provider relative to NHS acute provider; Impact (high, medium or low).
<p><b>Pensions</b></p> <p>The NHS employee pension creates a disadvantage for providers whose staff are unable to access it, requiring them to incur significant cost in matching the NHS pension benefits or offering alternative benefits to attract staff. If the employee and employer contributions payable under the NHS pension were used to buy a pension in the financial markets, the benefits would be significantly less than those offered by the NHS pension – there is effectively government subsidy of NHS pensions.</p>	<p>YES £7 High</p>
<p><b>Labour Terms and Conditions</b></p> <p>Non-statutory providers can offer greater flexibility in their terms and conditions than the NHS, which can be a benefit in attracting staff from the NHS statutory sector. As the NHS is the largest employer of health professionals in the UK, it effectively sets the benchmark for staff remuneration and all NHS trusts use the same agreement. NHS Foundation Trusts are entitled to leave the national pay and conditions agreement (known as ‘Agenda for Change’); however very few have chosen to do so. Non-statutory NHS providers, however, have greater flexibility in their staff terms and conditions which may allow them to recruit staff in preference to the NHS. The statutory protections offered to NHS staff tend to restrict workplace mobility and can make it very expensive to make staff redundant, which impacts the costs of NHS providers and their ability to adapt to changing market requirements</p>	<p>NO  High</p>

<sup>29</sup> KPMG Fair Playing Field Report, 2009, economic analysis commissioned by Department of Health.

<sup>30</sup> Tax, capital and pension distortions are those quantified in the report.

<p><b>Cost of Capital</b></p> <p>There are a number of distortions here:</p> <p>a) Public dividend capital rate paid on public investment is much cheaper than private cost of capital, giving NHS providers an advantage over non-NHS providers.</p> <p>b) PFI. NHS providers with PFI schemes are disadvantaged relative to NHS providers who do not have such schemes, due to the higher cost of capital.</p> <p>c) PFI guarantee. State under-writing of PFI schemes means long-term private capital projects are cheaper than on fully commercial terms.</p>	<p>YES</p> <p>£4 (refers to distortion a)</p> <p>High</p>
<p><b>Clinical negligence cover</b></p> <p>Statutory NHS providers have access to the Clinical Negligence Scheme for Trusts (CNST), which handles all claims for clinical negligence arising from the care they provide. Due to the nature of the scheme and its coverage of the overwhelming majority of clinical activity, CNST cover is significantly less expensive for statutory NHS providers than equivalent cover available to private providers from commercial insurers (although CNST is available to private providers in a limited range of circumstances)</p>	<p>No</p> <p>Medium</p>
<p><b>Cultural behaviours</b></p> <p>Cultural behaviours tend to be more advantageous to NHS incumbent providers and make it more difficult for new providers to enter the market, as they tend to reinforce the position of the incumbent. This includes a perceived bias of commissioners preferring NHS providers, a failure to tender for services, and an overly bureaucratic tendering process when services are tendered. Voluntary and charitable providers view these distortions as particularly significant.</p>	<p>No</p> <p>High</p>
<p><b>Tariff Bundling and 'Missing' Tariffs</b></p> <p>The bundling of tariffs makes it difficult for providers to compete for services within the bundle (e.g. diagnostics). The lack of a tariff for many types of services makes contracting more difficult and less consistent, reducing the likelihood that these services will be tendered.</p>	<p>No</p> <p>Medium</p>
<p><b>Tariffs</b></p> <p>Large multi-product hospitals must take emergency admissions 24/7, which are perceived to be underfunded due to the way that costs are reported by NHS Trusts - this leads to the use of elective activity to systematically underfund, so they use tariff for elective admissions to cross-subsidise the large overheads (eg access to critical care, trauma surgery, consultant on-call, ward staff).</p> <p>NHS hospitals treat more complex patients than private hospitals within any Healthcare Resource Group, as they have to generally accept all elective referrals regardless of cost/complexity- whereas due to the nature of the care they provide private providers accept a narrower cohort of patients can have referral criteria, choosing who they treat.</p> <p>For both these distortions, non-NHS providers benefit because they do not offer emergency admittance or take especially complex patients – but tariffs are relatively broad categories based on NHS average costs, which include these higher cost cases.</p>	<p>No</p> <p>High</p>
<p><b>Corporation Tax</b></p> <p>Private sector providers and social enterprises are disadvantaged by being subject to corporation tax, reducing their returns. NHS providers and charities are exempt.</p>	<p>Yes</p> <p>£2</p> <p>Medium</p>
<p><b>VAT</b></p> <p>Private sector providers benefit from the VAT exemption for healthcare in that they do not have to charge VAT on many of the services they provide. The other side of this is that they consequently cannot recover a significant portion of the VAT costs they incur. Likewise, VCS providers do not have to charge VAT but cannot recover their VAT costs. However they do benefit from certain other relief applying to the wider charity sector. NHS providers are advantaged in as much as their overall funding takes account of VAT costs in the same way as any other cost.</p>	<p>Yes</p> <p>£1</p> <p>Low</p>

## Conclusions

- B67. A single, independent and well-resourced regulator of providers of NHS services will be in a strong position to develop a regulatory framework that is more transparent and stable than that which currently exists. In itself, this should support efficiency gains in the NHS, as providers will be more confident of making decisions in the certainty that the rules of the game will not change as political fortunes ebb and flow.
- B68. An expert and independent regulator will be better equipped to develop sharper incentives that lead to better outcomes for patients. For example, changes to prices, the failure regime, rules on cooperation and competition that facilitate patient choice and the integration of services around the needs of patients.
- B69. Moreover, a strong regulator should be able to bolster efficiency by:
- Increasing autonomy for NHS providers so that they can respond more flexibly to patient needs.
  - Strong policing of anti-competitive practices to restrain the market power of large incumbent providers and giving efficient and innovative providers more opportunities to expand provision and enter new markets
  - Developing a better understanding of how costs vary as a result of the distortions in the market, and action to make the playing field fairer
  - Developing and operating a failure regime that allows organisations to fail, whilst ensuring that valuable assets continue to be available and patients continue to have access to essential services during the transition to a new provider.

## **D. What policy options have been considered? (*Possible treatments.*) The Do Nothing Option (Option 1) and Derivation of Other Options**

### **Do Nothing Option (Institutional responsibility as now; scope of regulation unchanged)**

- B70. The functions of provider regulation reside within several organisations. The Department of Health sets the overarching framework of provider regulation – the rules and processes governing organisational behaviour. It sets national tariffs for many health services (Payment by Results), specifies standard contract forms, and issues guidance on procurement and business conduct more generally (e.g. the Promotion Code). The Department also determines the high-level cooperation and competition policy for the NHS, as set out in the Principles and Rules for Cooperation and Competition (PRCC). All providers of NHS services, including private providers, are subject to PRCC. Monitor has wide ranging powers to regulate Foundation Trusts.
- B71. The implementation of the regulatory framework is split between several organisations. Primary Care Trusts are responsible for commissioning and managing providers in distinct geographical areas and have an important practical role in ensuring service continuity when providers fail and in determining prices not subject to Payment by Results. Strategic Health Authorities oversee Primary Care Trusts at a regional level and have broad system management responsibilities.
- B72. Primary Care Trusts and Strategic Health Authorities are responsible for ensuring local compliance with PRCC. Should local resolution prove impossible, the Cooperation and Competition Panel (CCP) is responsible for advising the Secretary of State on matters of compliance with PRCC. SofS may then take action as he or she deems appropriate; CCP does not have statutory powers.
- B73. NHS providers in financial difficulty are subject to two distress regimes, depending on their status. For NHS Trusts and PCT-providers, the regime is described in “Developing the NHS Performance Regime” (June 2008). A Trust can be designated as “underperforming”, “seriously underperforming”, or “challenged”. These organisations are subject to interventions proportionate to the severity of the underperformance, with PCTs and SHAs leading the process. Since 2004, Monitor has applied its regulatory powers to resolving underperformance in Foundation Trusts, as outlined in its “Compliance Framework”.
- B74. DH is also responsible for the Regime for Unsustainable NHS Providers. This regime governs what happens in the event of clinical and/or financial failure of an NHS provider. Providers with different organisational forms (private sector, charity, social enterprise) are currently subject to standard insolvency rules.
- B75. The Do Nothing Option involves maintaining regulatory responsibilities where they currently lie without any change to the regulatory framework. This is the benchmark against which Option 2 is assessed.

### **Option 2: Independent Regulator of Providers of NHS Services and Revised Regulatory Framework**

#### **Independent Regulator of Providers of NHS Services**

##### *Overview: Monitor’s Powers and Duties*

- B76. For Option 2, Monitor is expanded to take on new duties as an independent regulator of providers of NHS services. Monitor will be responsible for establishing a transparent and clear framework of provider regulation that protects and promotes patient interest by facilitating the economic, efficient, and effective provision of high quality healthcare services to meet patient needs. It will have powers to develop a pricing system and an approach to provider co-operation, competition, and financial distress/failure to achieve its overarching objectives.



- B77. Monitor will be free to develop its approach to regulation using the powers at its disposal and in line with its duties. The Bill makes clear that Ministers are responsible for holding Monitor to account, but not for the direct operational management of the organisation.
- B78. It will be the responsibility of commissioners – rather than Monitor – to decide how patient choice is applied to particular services. It is for commissioners to determine the shape of services, according to patients' preferences and needs. This will include considering how services should be bundled or integrated for competition purposes. The NHS Commissioning Board, in consultation with Monitor, will set out guidance on how choice and competition should be applied to particular services and this will include guidance on how services should be bundled or integrated.
- B79. Supporting the implementation of this guidance will be an important strategic driver for Monitor, whose core duty will be to protect and promote patients' interests. Monitor's role will be to develop a system of regulation that supports the key enablers of NHS efficiency, especially patient choice and service integration (across primary care and secondary care, and between NHS and social care). This will include action to tackle anti-competitive behaviour that is working to the detriment of patient interests, the use of prices and rules of conduct as an incentive to drive desirable behaviour by providers, a revised failure regime and service continuity arrangements that support effective service reconfiguration and provider restructuring, and action to move towards a fair playing field.
- B80. These functions are not new – they are all currently part of the existing regulatory framework established by DH and Monitor, as described above. The Principles and Rules for Co-Operation and Competition will be maintained and given a clearer statutory underpinning. The body that applies them, the Co-operation and Competition Panel, will transfer to Monitor and retain its distinct identity.
- B81. To implement the regulatory framework, the regulator will have powers to issue a provider licence to providers. To minimise bureaucracy, a joint licensing arrangement with CQC (who regulate minimum quality standards) will be introduced.
- B82. As now, competition between providers of NHS services will be on the basis of quality, not price. There will be additional safeguards against price competition and cherry picking (where a provider accepts only the easier lower cost cases).

#### *Power to Set Prices*

- B83. Under Payment by Results (PbR), DH is currently responsible for setting prices for a subset of NHS-funded services. These centrally imposed prices are a vital enabler of patient choice in the acute sector, since providers know that they will be reimbursed for the activity they undertake. They also help to drive efficiency as prices are based on average costs and efficiency requirements are built in to annual uplifts.
- B84. At a high level, the price setting process requires:
- Development of currencies (these are standardised units of service, e.g. HRGs)
  - Pricing structure and rules – e.g. average prices or best practice tariffs
  - Setting the price level to apply for currencies in each year
- B85. For health services not covered by national tariff, prices are negotiated locally between commissioners and providers.
- B86. Price-setting is enormously important for system efficiency. The currencies that payment is based on can have a big impact on provider behaviour. The actual prices in place for currencies have an important influence on hospital finances and incentives to undertake different activities.
- B87. DH currently develops currencies and sets prices. It has a strong incentive to drive efficiency, since it is the funding body and wants the best outcomes possible from the NHS budget. Moving

price-setting responsibility to Monitor is expected to support enhanced efficiency gains in the NHS because:

- The price-setting regime will be independent of changing political fortunes and there will be long-term transparency in the aims of price-setting. This will support new entry and expansion by providers as well as establishing a fairer playing field. Monitor and the NHS Commissioning Board will have a duty to ensure fair reimbursement for efficient service delivery. To aid this, Monitor will have the power to set differential prices for providers based on their unavoidable cost differences (such as location and the complexity of case they treat). The Bill now makes clear that Monitor would also have to have regard for the impact on provider costs of the use of patient selection criteria and the range of services delivered and adjust prices accordingly. However, these differential prices may not be framed on the basis of ownership.
- An independent regulator will be better placed to recruit pricing experts from other industries.
- Combining price-setting and competition expertise and responsibilities in a single organisation will lead to more joined-up thinking about pricing to support patient choice and service integration.

B88. The decision as to which services are to be opened to choice will in future rest with the NHS Commissioning Board, although Monitor will need to influence this decision as it will be well placed to advise on the impact of change on providers and patients. It would then be Monitor's responsibility to set national prices for these services, based on currencies that have been pre-agreed with the NHS Commissioning Board. Close working between the two organisations will be required and a process is being designed to enable this, including arbitration arrangements for dispute resolution.

B89. The close working between the NHS Commissioning Board and Monitor in price-setting is a reflection of the importance of the other organisation's decisions on the ability of each to deliver their objectives. As the purchasers of healthcare, the NHS Commissioning Board will lead on what it will pay for (in terms of bundles of services etc). This, however, has an implication for competition and service integration, so Monitor needs to be able to influence that process. Monitor will set prices to drive efficiency improvement, but the prices set will have a significant impact on the NHS Commissioning Board's role of overseeing NHS finances.

B90. As well as setting prices for services under the national tariff, Monitor will have powers to issue guidance on rules governing local price-setting.

## Expected Benefits

B91. The table below summarises the measures, intermediate outcomes and expected benefits

Measures	Intermediate Outcomes	Expected Benefits
Responsibility for price setting is transferred from DH to Monitor	<p>There is increased certainty around the structure and level of prices.</p> <p>The regulator develops into a centre of expertise on price-setting, attracting pricing professionals from other industries and developing a strong technical capability and capacity.</p> <p>Prices are increasingly reflective of clinical best practice and efficient costs with currencies (developed jointly with the NHS Commissioning Board) designed to</p>	<p>Providers have a better understanding of their cost structures and therefore the services they are best placed to provide – they vary their service offering on this basis.</p> <p>Providers are more able to define and implement solutions to developing better integration of services around the needs of the patient.</p> <p>Economic efficiency is improved: technical efficiency (quality provision at reduced cost); allocative efficiency (the service mix is</p>

	sharpen incentives for high quality and efficient provision of services.	optimised – e.g. shift to prevention); and dynamic efficiency (innovation is encouraged by the more stable and transparent regime)
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### Competition Policy and Enforcement

B92. As described above, this function is currently carried out across a number of organisations. The Department of Health determines the overarching competition policy for the NHS (the PRCC – effectively the rules governing provider behaviour). As a result, there is a significant degree of uncertainty as to the stability of these rules, as they are dependent on the political cycle. This uncertainty acts as a barrier to innovation and investment by providers. To address this, under Option 2, Monitor would become the sole body responsible for regulating competition and enforcing procurement regulations set by the Secretary of State in the health sector (including tertiary, secondary and primary care services). Monitor would maintain, interpret and develop the PRCC, and have powers to impose remedies and sanctions to address restrictions on cooperation and competition that act against patient interests.

B93. It is also proposed that Monitor will be able to:

- Impose general licence conditions to prevent anti-competitive behaviour. For example, rules to prevent misleading advertising.
- Investigate anti-competitive conduct and impose remedies under concurrent powers with the Office of Fair Trading with regards to the Competition Act 1998 and Articles 101 and 102 of the Treaty of the Functioning of the European Union.
- Carry out market studies to investigate markets where competition is not functioning properly. It will have power to refer malfunctioning markets to the Competition Commission for investigation (for all publicly and privately funded healthcare and adult social care)
- Investigate complaints about commissioners – for example, where a commissioner has been accused of unfairly favouring a specific provider.

B94. For the regulator to exercise these functions requires a complement of staff with competition expertise and a consultancy budget (as the workload is unlikely to be constant and it would be inefficient to have an in-house team that can meet peak demand). It is proposed that the CCP will be integrated into Monitor to provide part of the required resource.

Measures	Intermediate Outcomes	Expected Benefits
Develops a cooperation and competition policy, through the PRCC and licence conditions  Investigates anti-competitive conduct  Undertakes market studies  Investigates complaints regarding commissioners	Increasingly transparent and stable cooperation and competition policy  Move towards fair playing field  Increasing clarity over time on acceptability of different types of mergers, joint ventures, and other co-operative arrangements	Optimal organisation of providers, with providers more able to restructure and collaborate to focus on areas of comparative strength  More efficient provision of services  Innovation to improve the integration of services

### *Power to Define and Operate Continuity of Service Arrangements*

- B95. For the quality of health services to improve over the long-term, more effective providers must be enabled to innovate, invest, and expand, whilst poorer providers may need to contract or exit completely. Historically, local and political objections have constrained the contraction of poorer performing providers. International experience<sup>31</sup> confirms that the state finds it politically hard to step away from underwriting deficits and to allow hospitals to exit or significantly contract their service offering.
- B96. The overarching policy objectives of the service continuity regime are to protect patients' access to essential services and drive out inefficiency, whilst maintaining democratic legitimacy and supporting a fair playing field. Under Option 2, responsibility for the service continuity arrangements will pass from DH to Monitor, who will be responsible for the design and implementation of a revised continuity of service regime. This is an important step to ensure that patients' and taxpayers' interests are put first and that where existing provider arrangements are not sustainable, changes are introduced to drive long-term efficiency improvement – for example, by shifting more resources out of hospital care and into prevention and community services. The new regime is designed to strengthen incentives for providers to manage risk effectively and to solve problems locally, rather than rewarding failure through 'bail-outs' or other short-term fixes that will result in poorer value for money over the longer term. The new regime will be designed to protect patient access to essential services in the event of changes to services.
- B97. The new regime would only apply to NHS Foundation Trusts (from April 2013) and for private providers of NHS services (from 2014 at the earliest). While there are still NHS Trusts that have not yet been able to achieve Foundation Trust status (i.e. at least until 2016), these will continue to be governed by the Health Act 2009 (i.e. the previous Government's) regime. That regime operates under Secretary of State's direction, who would take final decisions on proposed solutions in individual cases, with no role for Monitor.
- B98. The new failure regime is likely to have a number of features to support the long-term reconfiguration of health services and sector efficiency, whilst ensuring continuity of essential services for patients:
- Commissioners will remain responsible (as now) for securing services to meet the healthcare needs of their populations, including in the event of a provider of those services being at risk or becoming unsustainable in its current form.
  - Monitor's role would be to support commissioners in this, through: (i) proactive regulation of providers through additional licence conditions to assess and mitigate risk; (ii) intervention to support recovery where a provider is in 'distress' and; (iii) as a last resort, through intervention to secure continuity of services in the event of a provider becoming unsustainable. In this way, the regulatory regime would operate in cycles:
    - **Normal operations** – proactive regulation to monitor and mitigate risk
    - **Distress** – regulatory intervention in response to risk and to support recovery. This recognises that it is likely to be more cost-effective to restructure operations to ensure long-term sustainability prior to provider failure
    - **Return to normalcy** – rolling back of interventions as risk reduces
- B99. As a last resort, where intervention to support recovery has been unsuccessful or where an organisation is fundamentally unviable, the regime must provide a mechanism to secure patients have continued access to essential services, whilst removing stranded costs to ensure value for taxpayers' money. Solutions in such cases are likely to require more than just management change because of structural problems that mean that the status quo is unsustainable. For example, organisational change (for example, through a merger) may be needed to achieve economies of scale and/or service reconfiguration may be required to improve quality and productivity.

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<sup>31</sup> The Dutch Health Ministry 2008 rescue of the IJsselmeerziekenhuizen hospital. Dutch policy at the time was to have no failure regime and allow the market to replace failing services. However, the Minister of Health came to the conclusion that a bankruptcy would cause a break in the continuity of care, as there were no regional alternative to provide the care to replace the hospital's services.

- B100. In such cases, Monitor would trigger further intervention by appointing a third party (i.e. ‘administrator’ or ‘intervention team’) to take control of a provider’s affairs and secure continuity of services. In individual cases, it would be for commissioners to determine which services must be secured in pursuance of their overarching duties to secure that patients have access to the services they need. Therefore, the ‘administrator’ would need to agree proposed solutions with commissioners, prior to consultation with the local community, and to agree any changes to those plans following consultation. Once agreed, the administrator would implement the solutions and the services would continue to be regulated under ‘normal operations’.
- B101. In the event that a provider does become clinically and/or financially unsustainable, Monitor will be responsible for supporting commissioners to secure access to essential services during transition of services to new providers and/or the restructuring of existing providers. Should a provider encounter risk, local commissioners will be responsible for developing a plan of which services should be protected in the event of provider failure, following statutory guidance and with support from a Monitor appointed team.
- B102. This is important for the longer-term efficiency and sustainability of the NHS. The QIPP savings represent a significant challenge to the NHS over the next few years. The proposed changes to the regulatory regime for providers mean that where services are low quality or where a provider, or parts of it, may be financially or clinically unsustainable, there are mechanisms to deal with it, that strikes the right balance between maintaining democratic legitimacy and avoiding political interference, which may not be in the long-term interests of patients or the population. In fact, there may be significant adverse impact on patients over the longer term in *preventing* reconfigurations, for example, where this is necessary to fund investment in improving community care for the ageing population and supporting people with long-term conditions- even though this is politically expedient.
- B103. However, the provisions set out in the Bill emphasise Monitor’s role in intervening proactively to mitigate risk, support recovery and prevent failure wherever possible. In addition, the Bill will require Monitor to set up effective mechanisms for providing financial assistance to FTs in trust special administration and companies in health special administration. Funding could be issued to an administrator to ensure the continuity of essential NHS services. The intention is that providers and commissioners of essential services would fund this financial assistance directly. Risk-based levies on providers would place incentives on providers to reduce their risk of failure. Commissioner charges could place incentives on commissioners to manage the market to reduce the impact of any failure.

## Expected benefits

Measures	Intermediate Outcomes	Expected Benefits
<p>Independent, rules-based distress regime</p> <p>Independent and rules based failure regimes</p> <p>Statutory criteria to guide commissioners in identifying services to be protected in the event of provider failure (to ensure service continuity for patients during the transition to new provider arrangements)</p>	<p>Better management of providers and improved dialogue with commissioners around service reconfiguration, as it is clear to provider managers that provider failure will result in restructuring or closure, rather than support to maintain the status quo through allocation of additional public funds.</p> <p>Providers more likely to take action early to remedy structural weaknesses (e.g. restructure operations)</p> <p>Possibility of more failure cases, but greater failure rate not necessary to produce benefits – exit and entry into service lines, with the threat of overall failure will produce benefits without providers necessarily failing.</p>	<p>More timely and more efficient service reconfiguration and provider restructuring</p> <p>New entry and expansion by more efficient, high quality providers</p> <p>Improved efficiency in the provision of NHS services</p>

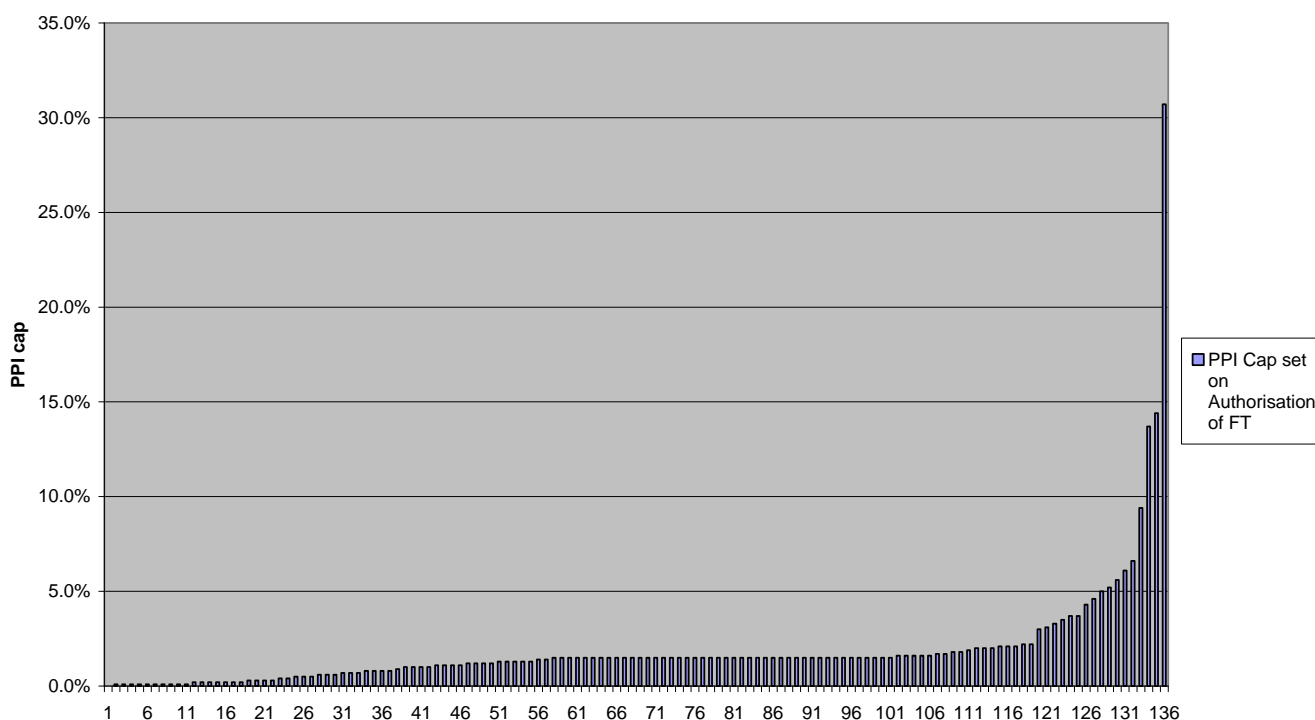
## Changes to Foundation Trusts - enhanced autonomy

- B104. The Foundation Trust model devolves decision making from Whitehall to local organisations and their communities and staff. These reforms strengthen existing arrangements to ensure that public NHS providers are accountable, transparent and autonomous in the way they operate, so they can better support innovation and the provision of high quality, locally responsive care to patients.
- B105. All NHS providers will become, or become part of, a Foundation Trusts, which are not subject to direction from the Secretary of State. This will ensure that all NHS providers are autonomous and subject to the same transparent and stable regulatory regime.
- B106. In order to enable FTs to better respond to patient and commissioners' preferences, several changes to the FT corporate form are also proposed. The intention is to ensure that all providers of healthcare to the NHS are subject to the same freedoms and constraints in a regulated market.
- B107. In most cases, the proposed changes call for a transfer of powers, responsibilities and/or constraints. For example, removing the power of Monitor to approve changes to an FT's constitution is replaced by the need for any such changes to be approved by the FT's Board of Directors and Council of Governors. Similarly, there will continue to be constraints on lending and on assets used for delivering key services, even though these will no longer be exercised through the legislation on Monitor's FT-specific role.
- B108. For these reasons, most of the proposed changes to Foundation Trusts freedoms will not affect the net costs within the overall system; they merely transfer accountability (and potentially some costs) within the system (whether that be to different organisations or from a national to a local level). The Government's aim is to deliver a fair playing field where all providers have access to the same opportunities and operate under a regulatory framework that is proportional and non-discriminatory.
- B109. The main proposed changes are as follows:

### *Removal of the Private Patient Income (PPI) cap for FTs*

- B110. FTs are currently subject to a cap on income derived from private charges. Acute FT income from non-NHS activity is capped at the 2002/03 level as a percentage of total income, and mental health FT income is capped at 1.5%, resulting in arbitrary and variable levels of PPI caps across FTs, as demonstrated in the graph below.

Variation in PPI Caps across Foundation Trusts (data from Monitor's 2010/11 accounts)



B111. This proposal would remove the arbitrary and variable PPI caps across FTs (whilst retaining their principal purpose to provide goods and services for the purposes of the health service in England) resulting in all FTs being treated equally. The proposal to remove the cap would also remove some of the perverse consequences arising from the PPI cap, such as:

1. Preventing an internationally respected organisation such as Great Ormond Street Hospital from continuing to generate significant revenue through provision of private services if it were to become an FT;
2. limiting the ability of leading NHS hospitals to exploit the power of their brand abroad; and
3. resistance to decommissioning unnecessary/inefficient NHS services simply to avoid breaching the cap.

B112. Removing the cap would help to release the creativity and innovation of FTs to meet the challenges ahead and to generate funds for investment in new facilities. Removal of the cap would help FTs to realise their potential so that additional income from non-NHS sources (including from joint ventures and partnerships, as well as direct work with private patients) can be reinvested to improve services for all patients.

B113. To provide assurance and transparency, FTs will be required to produce separate accounts for NHS and private-funded services.

*Removal of the Prudential Borrowing Code (PBC) and limiting future financial assistance*

B114. FTs are already free to borrow in the commercial debt market but unlike voluntary and private sector providers, they are currently subject to direct statutory limits on the level of borrowing. The rationale for this is to protect the Department of Health's (and ultimately the taxpayer's) investment in FTs against the risk that FTs take on too great a debt burden and become financially unsustainable. If FTs are to be free to respond to patient needs and to innovate, they will need access to funding to take advantage of opportunities. It is proposed that the existing PBC will be removed and that the risk of FTs overstretching themselves financially will instead be

managed through creditors and sector regulation, as it will be for other types of organisations, with the new regulatory system containing strong incentives for financial discipline.

- B115. Removing the statutory control does not mean that borrowing will be uncontrolled. FTs will have their business plans appraised by the FT board with due diligence undertaken by lenders and conditions on all debt (whether DH or commercial) will constrain borrowing beyond levels that would present an unacceptable risk to the lenders – including the taxpayer. The Department is committed to ensuring transparency in the management of the taxpayer investment with any conditions applied to debt or financing by the DH being consistent with those applied by any commercial lender. Some financial stability measures are also likely to form part of standard licence conditions or criteria once Monitor's licensing regime comes into force. For example, licensing criteria or licence conditions might require providers to provide assurance of financial stability through holding credit ratings. In both cases, these will only be triggered where there is material financial risk would not interfere with the operational freedom of FTs. This should free FTs to invest in innovation and develop services more flexibly whilst being exposed to commercial rigour on lending.
- B116. These proposed changes are therefore designed to avoid a conflict of interest and start moving towards a fairer playing field in the provision of capital finance to FTs.
- B117. It is likely that it will take a few years for a commercial market to develop for lending to FTs; for this initial period, the Department will need to continue to provide loans and other financing to meet ongoing capital requirements. Any new DH financing will be made in line with guidance that the Secretary of State will be required to produce under primary legislation. This guidance will set out the criteria for issuing finance, its terms and conditions and actions on default. This will ensure that all financing to FTs provided on behalf of the taxpayer will be on made within a transparent rules based regime, and which, for loans, has regard to commercial principles.

#### *A Change in the Process for Mergers of, and Organisational Changes to, Foundation Trusts*

- B118. The current legislative framework for FTs can make mergers burdensome, with both organisations required to dissolve. Additionally, the current legislation only facilitates mergers and the acquisition by an FT of an NHS trust: there is no legislative provision for an FT to acquire another FT and separations and voluntary dissolutions of FTs are not currently possible. Monitor is currently responsible for authorising mergers of FTs. This combination of controls makes it difficult for FTs to respond to changing demands of patients and commissioners by restructuring their organisations efficiently (e.g. via joint ventures, mergers and separations etc). In addition to the current merger provisions, the Bill will enable FTs to acquire another FT as well as allowing FTs to separate into two or more FTs. The Bill will allow FTs to take their own decisions regarding restructuring, with the consent of their governors, subject to the constraints that apply to all organisations going through such changes.
- B119. Like other organisations, Foundation Trusts' will be subject to merger controls to protect competition. The Office of Fair Trading (OFT) will act on mergers using the current general merger controls under the Enterprise Act 2002. To aid this, the Bill explicitly provides for mergers involving FTs to be subject to the merger regime. While they get up to speed with this regime, Foundation Trusts and NHS Trusts will be required to pre-notify the OFT of any proposed mergers or acquisitions. This will provide cost-savings and continuity compared to not pre-notifying, as it will mitigate the risk of a merger taking place and then having to be undone as it impedes competition. The changes will bring merger policy for FTs more into line with other types of healthcare provider and should allow provider restructuring in future to be conducted along the most efficient lines.

#### *Strengthening the governance of FTs.*



- B120. This proposal is aimed at counterbalancing the increased autonomy and independence being given to FTs. As FTs move further from central and political interference, the existing local governance and accountability framework needs to be made more robust. This means that certain powers currently conferred on Monitor – such as approving changes to an FT’s constitution and the removal of an FT’s directors – will be replaced by stronger corporate governance. This includes increased clarity about duties on directors (including for promoting the success of the FT for the benefit of members and public) and governors (for holding the non-executive directors to account for the performance of the board of directors and representing the interests of the FT membership and wider public) and arrangements to help governors do this.
- B121. Under Bill proposals, governors would be able to require directors to attend a special meeting to obtain information and they would be able to vote on motions at such a meeting, similar to a special general meeting for another organisation. The Bill also provides powers for Monitor to set up an independent advice panel to consider concerns from governors, if they are not able to address these locally and think that an FT is not complying with its own constitution or the underlying legislation. The panel’s decisions would not be binding, but it would be an authoritative source of advice. This will back up the change to make governors’ role in holding the board to account more explicit. Ultimately, though, the responsibility for ensuring that their governance systems are fit for purpose will lie with Foundation Trusts themselves.
- B122. To ensure that the public can be fully confident in the openness, transparency and accountability of foundation trusts and can better challenge and scrutinise the delivery of local healthcare provision, Foundation Trusts will be required to hold their board meetings in public.

### Expected Benefits

B123. The table below summarises the major measures, intermediate outcomes and expected benefits:

Measures	Intermediate Outcomes	Expected Benefits
<p>Removal of PPI caps</p> <p>FTs have new powers similar to those other providers have, with Monitor no longer operating existing constraints (eg constitution changes &amp; mergers, removal of PBC)</p>	<p>More flexibility to develop services, including marketing overseas, and generate revenues that bolster future investment in patient needs</p> <p>More autonomous and innovative providers</p>	<p>Better and more efficient organisations and services for patients</p> <p>FTs can grow income through developing private patient revenue streams</p>

### Implementation: Joint Licensing Regime

- B124. Provider regulation incorporates rules and regulations relating to competition and co-operation, pricing, and service continuity and organisational failure. Monitor will implement this new system of regulating providers via the PRCC and through a new licensing regime (provider licence).
- B125. To minimise regulatory burden and to achieve desired outcomes, a two-tier approach to the new provider licence is envisaged. All providers will be subject to general licence conditions covering standard regulatory requirements (e.g. provision of data). Some providers will be subject to additional licence conditions covering provider specific requirements (e.g. maintaining a specialist service that is available at very few providers nationally). The Bill provides for a licence modifications appeal process, whereby appeals will be referred to the Competition Commission for independent scrutiny if necessary.

- B126. Licensing is used in many other industries such as energy and water to implement a framework of economic regulation and is a well-established tool for minimising regulatory burden and maximising transparency.
- B127. At present, the CQC licenses providers of healthcare to assure that they comply with minimum quality and safety standards. This will continue to be the case under the new system and the regulatory framework for quality and safety standards is unchanged.
- B128. The provider licence will be issued by Monitor and CQC will continue to issue licences for quality/safety assurance purposes. A joint licensing process will be implemented to minimise bureaucracy and duplication of effort.

#### One In One Out

- B129. Unlike the current system, the new system will also include checks and balances to ensure that the regulation is appropriate. Therefore, DH is both confident that the proposed changes do not represent an increase in regulation for providers, be they public or private, and that there will be future further reductions in regulation if the proposed regime is felt to be more onerous than is necessary. The potential reduction is, however, unquantifiable.
- B130. Therefore, within the One In One Out framework, this is classified as an “out”. It is not, however, possible to quantify the size of this effect.

## E. Impacts, Costs and Benefits of Option 2

### Set out the mechanism by which Option 2 is intended to work, its expected scale of impact, and the evidence supporting these expectations:

B131. The mechanism by which efficiency of delivery of NHS health services will be improved is via greater transparency, certainty, and stability in the regulatory framework governing providers of NHS services. It is expected that providers will be more proactive in restructuring their operations, expanding into new service areas, and redesigning their service offers to meet patient needs. Foundation Trusts will have greater freedoms to develop their service offering to better respond to patient needs.

B132. Under the revised regulatory regime, all providers will be:

- Operating on an increasingly fair playing field.
- Subject to a transparent and stable pricing regime, with prices covering an increasing range of services.
- Subject to a consistent and stable regulatory regime which deals quickly and effectively with anti-competitive behaviour and provider distress and failure.

B133. This should ensure a much more vibrant and confident supply side, with providers more able to develop their service offering to respond to patient choice and to meet patient needs – for example, by integrating services around the needs of patients.

### ii Set out the costs and benefits of the option arising from the impacts listed in section Ei.

#### Costs

B134. A bottom-up estimate of Monitor's annual operating costs has been developed by the Economic Regulation Unit. This is built up from a cost analysis of the work-streams for which Monitor will become responsible. This estimate is not definitive – work is ongoing to develop the functions of Monitor and other organisations (e.g. the NHS Commissioning Board).

B135. Staffing structures are based on comparison with other regulators and analysis of need for the health sector. The steady state (from 2015/16) full time equivalent (FTE) staff numbers by function are shown in the table below.

**Table B2: estimated staff numbers for the Provider regulator**

Function	Steady State FTE Estimate (from 2015/16)
Board	6
Provider Regulation	385
Regulatory Strategy	36
Legal	25
FT Regulation	99
Corporate	44
<b>Total</b>	<b>595</b>

B136. The estimated number of FTE staff is 595. Application of pay rate assumptions (average pay rate of £84k, including on-costs) results in a staff cost estimate of £50m.

B137. The total estimated operating cost of the provider regulator in 2015/16 (steady state) is £82m per annum. The major single cost item is £50m for permanent staff. Other significant cost categories are as follows:

- Spend on consultancy services of £14m per annum
- Non-pay costs relating to permanent staff of £7m per annum
- Legal fees of £4m per annum
- Premia for recruiting outsourced staff of £4m per annum
- Premises cost of £3m per annum

### Cost of new FT Governance Regime

- B138. FTs will have to consider how to ensure that their governors have the skills and knowledge they require to meet the needs of the new strengthened governance regime. It is likely that there will be some costs associated with this but the extent of these costs is currently unclear.
- B139. In estimating a cost for the strengthened governance regime, we could assume that a one-off cost of £1,000 could represent the cost of strengthening the skills of a governor to meet the needs of the new regime. Applying this cost to the approximate number of existing governors (4,000<sup>32</sup>) and to an estimate of the number of new governor roles that will be required as NHS trusts become FTs over the next few years (could be estimated as approximately 3,000<sup>33</sup>) there could be a one-off cost of approximately £7m ( (4,000 + 3,000) \* £1,000 ).
- B140. However, if we assume that the average length of service of a governor is around 5 years, there could be additional costs of strengthening the skills of replacement governors. This could be approximated by assuming that each year a fifth of all governors (1/5<sup>th</sup> \* 7,000 = 1,400) are replaced resulting in a yearly cost of approximately £1.4m<sup>34</sup>. Governors may require some refreshing of skills associated with the new strengthened governance regime. It is unclear what the rate of this requirement may be but it could be assumed at half the yearly cost of that associated with training of replacement governors (£0.7m per year).
- B141. Therefore, an approximate estimate, given the uncertainties, of the cost of the new strengthened governance regime could be around £28m over 10 years (£7m + (£2.1m \* 10 years)).

### Benefits

- B142. The reform package as a whole is designed to improve health outcomes and patient experience and DH will monitor available metrics to understand the impact of the reform package as a whole. The reforms stand together and it is not proposed to attempt to quantify the benefits from the revised regulatory regime alone.
- B143. What is clear from the evidence is that in health and other sectors of the economy, there is much to be gained from a move from a regulatory regime that is defined by government and which is implemented by numerous organisations, to one which is defined and developed by a single independent regulator. The benefits arise from two principal sources:
- The expertise and skill that is developed within a strong and independent regulator, which leads to a better understanding of how efficiency in a sector is best delivered and the incentives that need to be put in place to support this. A more transparent and responsive regulatory regime has the potential to drive innovation in the system and release significant efficiency savings.
  - Suppliers and commissioners of services are able to plan on the basis of a transparent and stable regulatory framework, which is free from political control.

<sup>32</sup> This has been estimated using the latest number of FTs (131) multiplied by an estimate of average number of occupied governor seats per FT as at July 2010 (30)

<sup>33</sup> This has been estimated using the latest number of non-FT NHS trusts (110) multiplied by an estimate of average number of occupied governor seats per FT as at July 2010 (30)

<sup>34</sup> This would be an over estimate in early years before all NHS trusts become FTs.

B144. In 2009, a report by McKinsey, estimated that the NHS in England could achieve recurrent annual efficiency gains of £13-20bn within 3-5 years<sup>35</sup>. Given the potential savings available, it is plausible that improvements to the regulatory regime could have a major impact on NHS efficiency.

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<sup>35</sup> The report is accessible on the DH website at [http://www.dh.gov.uk/en/FreedomOfInformation/Freedomofinformationpublicationschemefeedback/FOIreleases/DH\\_116520](http://www.dh.gov.uk/en/FreedomOfInformation/Freedomofinformationpublicationschemefeedback/FOIreleases/DH_116520)

## H. SUMMARY AND WEIGHING OF OPTIONS

B145. The Do Nothing option leaves NHS providers constrained in their ability to respond to patient wishes and does not ensure that the interests of patients and taxpayers take precedence over the interests of providers. Potential efficiencies from an increasing focus on the needs of patients and more innovative and responsive providers would be lost. Whilst it is not possible to quantify the benefits that will accrue from independent and transparent regulation, what is clear, is that if these changes make just a very small contribution to realising the potential efficiency gains in the system, the cost of the new regulatory system will be justified. The evidence base strongly supports the view that a more dynamic supply-side, enabled by increased freedom and independent and transparent regulation, can have a significant impact on system efficiency. Option 2 is therefore preferred to the Do Nothing Option.

# Risks and assumptions

## **Monitor is under resourced and as a result unable to deliver its potential benefits**

- B146. There is a risk that an under resourced Monitor will be unable to effectively regulate the system and deliver the potential benefits possible. As Monitor will be regulating a sector with a budget of over £100bn a year, the opportunities for it to deliver large cash savings and efficiencies are significant. The argument for ensuring Monitor is appropriately resourced is strengthened by the fact that any cost savings they produce will be returned to the NHS budget, rather than in other sectors, where the benefits accrue to consumers. Therefore, if Monitor can save more than £1 for every £1 that they spend, it is mutually beneficial to Monitor and the taxpayer for them to receive that funding.
- B147. As an example, if Monitor's pricing function was understaffed it may employ average cost pricing rather than finding efficient costs for delivery. This could result in large efficiency savings being foregone. Every 1% efficiency saving not realised within the services covered by the NHS tariff currently will cost the NHS budget £260m in forgone efficiencies.

## **Setting Tariffs at the correct level**

- B148. There is a significant risk if administered tariffs are set either too high or too low. If tariffs are too high, in the sense that providers could have delivered services of the same quality but for a lower price, then there is an efficiency loss. If tariffs are too low, then there is a risk that quality is compromised and/or that efficient providers fail. To mitigate this risk, Monitor will be required to develop a transparent pricing methodology that will be subject to consultation and agreement with the NHS Commissioning Board. Monitor must be allocated appropriate resources to be able to carry out its pricing role to the required standard.

## **Appropriate Competitive Mechanisms**

- B149. Monitor's duties will be set out clearly in the Bill to ensure that competition is not an end in itself and that the risks inherent in a system where competition is increasingly a reality are mitigated. Monitor's core duty will be to protect and promote the interests of patients – not to promote competition as if it were an end in itself. Moreover, The Bill will be clear that: competition is on the basis of quality, not price, and that the regulatory regime will be designed to ensure that cherry picking is avoided. It will outlaw any policy to increase or maintain the market share of any particular sector or provider.

## **Establishment of Monitor leads to disproportionate regulatory burdens**

- B150. As in other regulated industries, there is a risk that the creation of an independent regulator will lead to the creation of disproportionate regulatory burdens, which impose unnecessary costs on providers or prevent new models of provision from developing. There is evidence that regulators may become captured by industry interests or overly attached to the models of regulation they have developed and retain burdensome regulation longer than necessary.
- B151. For this reason, Monitor will be required to carry out annual reviews of regulatory burdens and impact assessments for new regulation, demonstrating the need for the regulation and why it could not protect the public using lighter touch approaches. In addition, the Competition Commission will carry out seven yearly reviews of the development of competition and regulation in healthcare. It will provide an objective and impartial assessment of how competition and regulation are developing and make recommendations for improvements. There is a concern that there are costs associated with complying with the new regulatory regime. However, much of what is proposed is already applied through law or principles for the commissioning and delivery

of NHS funded care. We would also expect the costs involved with obtaining licence to be small for all providers.

### **Private patients prioritised ahead of NHS patients**

B152. In removing the PPI cap, it is assumed that FTs wishing to generate additional private sector income can do so from three different sources:

- existing independent sector private patients (privately insured or pay-as-you-go)
- additional non-EEA overseas private patients (whom otherwise would not have been able to be treated in England due to the caps); and
- patients who would have otherwise been treated on the NHS but for whom reduced private prices (due to increased competition) now makes private treatment just affordable.

B153. The impact of any such increase in private activity on NHS patients will depend upon how near to capacity an FT is operating and whether:

- NHS FTs respond to the additional private patient income by creating additional capacity to treat private patients; or
- NHS FTs simply allocate more of their existing capacity to treat private patients.

B154. If the former, then NHS patients may derive benefit if the new or enhanced facilities are shared between private and NHS patients.

B155. If the latter, there is a risk that private patients may be prioritised above NHS patients resulting in a growth in waiting lists and waiting times for NHS patients. This is the eventuality that the PPI cap was originally introduced to prevent. However, there are a number of safeguarding factors that act on mitigating this risk some of which were not in place at the inception of FTs in 2004/05. Most pertinently:

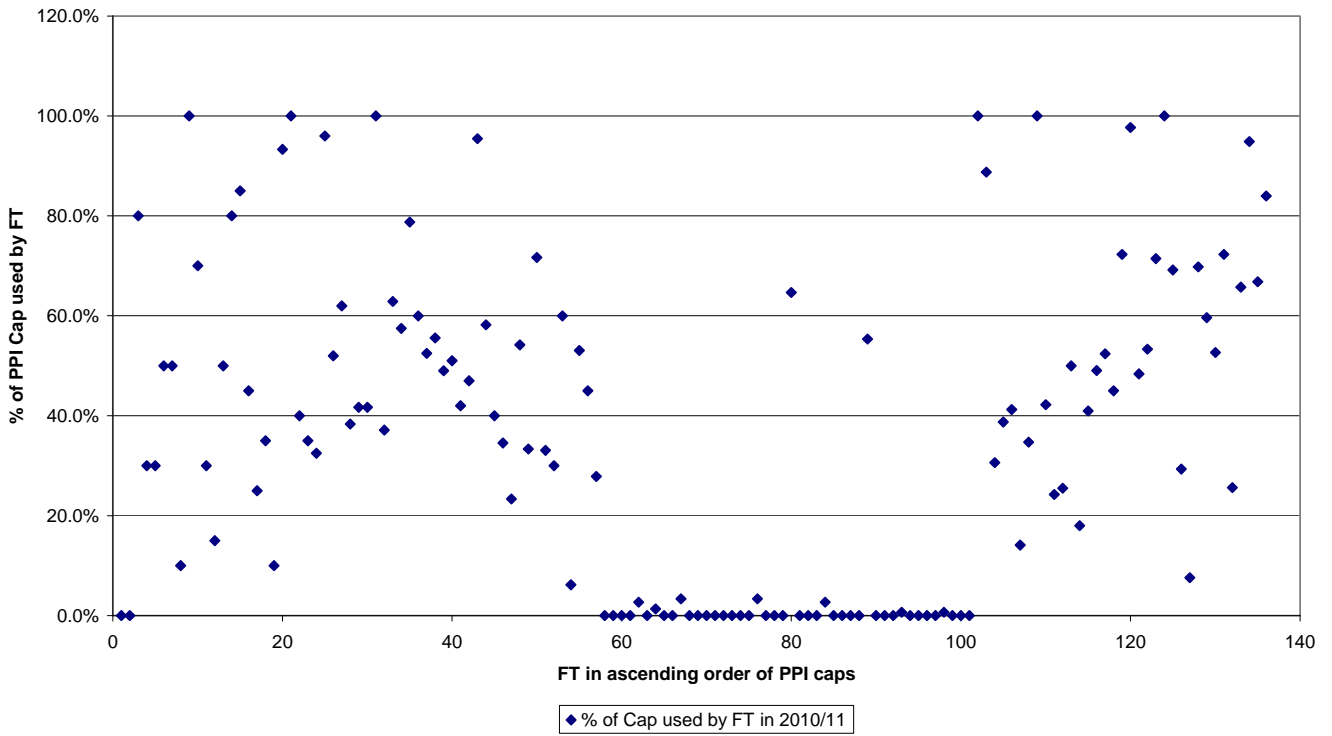
- FTs will retain their principal purpose to provide goods and services for the purposes of the health service in England and cannot distribute profits;
- the NHS Constitution has enshrined an 18 week waiting time from referral to treatment as a patient right. NHS commissioners will therefore need to give due regard to whether they are commissioning care from providers that can honour this commitment;
- the extension of patient choice to Any Qualified Provider, will increase the range of providers on offer, so that organisations with long NHS waiting times will risk losing NHS patients; such choices will be informed by the proposed Information Strategy;
- The Quality, Innovation, Productivity and Prevention (QIPP) plans being prepared by the NHS imply that acute capacity will be substituted for community-delivered care. If realised in practice, these plans suggest that capacity in NHS providers could be diverted to private patients without any diminution in the service offered to NHS patients;
- Data from Monitor's 2010/11 accounts indicates that during that year most FTs operated at a level significantly below their PPI cap<sup>36</sup> – see the chart below. The chart also demonstrates that there is not a strong relationship between the level of the cap and the FT's usage of their entitlement to earn non-NHS income (the trusts are in the same order as that shown in Paragraph B110, i.e. ascending order of their PPI cap). Whilst it is not possible to predict how FTs will behave with the lifting of the caps, the evidence indicates that many FTs will not automatically make use of any ability to earn private income offered to them.

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<sup>36</sup> This is based upon the definition of non-NHS income believed to apply before the High Court ruling in December 2009, this being the definition that would have governed FTs' decisions regarding non-NHS income generation during that period.



Proportion of PPI Cap used by FT (Monitor Accounts 2010/11)



- The FT governors act as community guardians and have a role in relation to the FT's significant investment and policy decision-making. Currently, in law, governors provide views to the FT when it is preparing the FT's forward plans and directors must take account of governors' views. In addition, option 2 involves plans to strengthen the role of governors and separate accounts will be required for NHS and private work, which will help them in scrutinising this.

# Annexes

Annex 1 should be used to set out the Post Implementation Review Plan as detailed below. Further annexes may be added where the Specific Impact Tests yield information relevant to an overall understanding of policy options.

## Annex B1: Post Implementation Review (PIR) Plan

A PIR should be undertaken, usually three to five years after implementation of the policy, but exceptionally a longer period may be more appropriate. A PIR should examine the extent to which the implemented regulations have achieved their objectives, assess their costs and benefits and identify whether they are having any unintended consequences. Please set out the PIR Plan as detailed below. If there is no plan to do a PIR please provide reasons below.

<p><b>Basis of the review:</b> [The basis of the review could be statutory (forming part of the legislation), it could be to review existing policy or there could be a political commitment to review]; Please see coordinating document Post-Implementation Review section.</p>
<p><b>Review objective:</b> [Is it intended as a proportionate check that regulation is operating as expected to tackle the problem of concern?; or as a wider exploration of the policy approach taken?; or as a link from policy objective to outcome?]</p>
<p><b>Review approach and rationale:</b> [e.g. describe here the review approach (in-depth evaluation, scope review of monitoring data, scan of stakeholder views, etc.) and the rationale that made choosing such an approach]</p>
<p><b>Baseline:</b> [The current (baseline) position against which the change introduced by the legislation can be measured]</p>
<p><b>Success criteria:</b> [Criteria showing achievement of the policy objectives as set out in the final impact assessment; criteria for modifying or replacing the policy if it does not achieve its objectives]</p>
<p><b>Monitoring information arrangements:</b> [Provide further details of the planned/existing arrangements in place that will allow a systematic collection systematic collection of monitoring information for future policy review]</p>
<p><b>Reasons for not planning a PIR:</b> [If there is no plan to do a PIR please provide reasons here]</p>

## **Annex B2: Specific Impact Tests**

The main body of the IA includes evidence and explanation of policy development in relation to competition, health and well being, and sustainability. Some of the principal issues and arguments relating to these three specific evaluation criteria are summarised below.

### **Competition**

The overarching rationale for establishing the Provider Regulator is that it will enable fair competition between providers of health services. An independent regulator and a transparent regulatory regime are expected to enable smaller providers (be they privately owned, social enterprises or charities) to flourish and to compete on equal terms with larger NHS Trusts.

### **Health and Well Being**

More intense competition and provider diversity is expected to enable services to be better tailored to the needs of individual patients and patient groups. This should result in improvements to patient experience and patient outcomes, and is expected to support a shift from acute care to community provision and prevention

### **Sustainability**

One of the expected impacts of provider plurality (enabled by independent and transparent provider regulation and a more competitive environment) is shifting care from an acute setting to a community one. This should support care closer to home and reduce the use of private and public transport for attendance at medical appointments.

## Annex B3- The Justice Impact

### Impact of Reform Proposals on the Justice System

A new policy, particularly those involving a change in legislation, can have an impact on the justice system. These impacts need to be considered, anticipated, and planned for at an early stage to make the best use of public funds. The Justice Impact Test<sup>37</sup> is a tool for assessing the impact of policy across the justice system – civil and criminal – and covers legal aid, courts and tribunals, prisons and probation services, prosecuting bodies, and the judiciary. A Justice Impact Test has been undertaken for the sector regulation policy, and a summary of the impact is given below.

The Sector Regulator (Monitor) in exercising its functions as set out in the Health and Social Care Bill, will operate a licensing regime, have concurrent powers with the Office of Fair Trading to apply competition law, and implement a failure regime for providers of NHS services. The enforcement of these functions include the extension of existing criminal offences and civil sanctions/penalties. This is designed to give Monitor a reasonable deterrent to ensure that providers and commissioners comply with the new regulatory regime.

Civil penalties and sanctions and criminal offences will apply in several instances. This would include civil sanctions where providers breach licence conditions or infringe competition law and criminal offences to prevent individuals supplying false or misleading information to Monitor, as part of a Market Investigation, or destroys or falsifies documents or provides false and misleading information as part of a Monitor-led Competition Investigation. Criminal offences could also arise in relation to the provision of information to the Competition Commission following a reference from Monitor.

We do not expect the application of these offences to the health sector to cause significant additional workload for the justice system. Experience in other sectors has shown that the penalties attached to these offences is a sufficiently effective deterrent to ensure compliance and that unlawful activity in relation to market or competition investigations is atypical.

The Bill proposals are expected to increase the workload of the HM Courts and Tribunal Service to a limited degree through a number of appeal rights to the First Tier Tribunal. In particular:

- Refusal to issue a license or revocation of a license for the provision of NHS services. In the event of a refusal or revocation, providers will be able to appeal to the First-Tier Tribunal, and if necessary an onward appeal to the Upper Tribunal.
- Refusal to issue a certificate of compliance in relation to undertakings from commissioners for breaching regulations on anti-competitive conduct, commissioners will be able to appeal to the First Tier Tribunal and if necessary onward appeal to the Upper Tribunal.
- In relation to a decision from Monitor to impose a discretionary requirement for a breach of a licence condition.

The licensing regime is new and as such, it is difficult to quantify impact, however, we expect that there may be more appeals in the first year petering out in the subsequent years as the regime becomes more embedded. The number of possible appeals is not considered to be significant. We are also looking to draw from information from other regulators in respect to this appeal right and that of the refusal to grant a certificate of compliance to assess impact.

We are working with the Ministry of Justice to assess and monitor the impact and agree how these impacts will be managed.

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<sup>37</sup> <http://www.justice.gov.uk/guidance/docs/justice-impact-assessment-guidance-doc.pdf>

<b>Title:</b> <b>Increasing Local Democratic Legitimacy in Health</b>  <b>Lead department or agency:</b> <b>Department of Health</b> <b>Other departments or agencies:</b>	<b>Impact Assessment (IA)</b>
	IA No: 6032
	Date: 25/08/2011
	Stage: Final
	Source of intervention: Domestic
	Type of measure: Primary legislation

## Summary: Intervention and Options

### What is the problem under consideration? Why is government intervention necessary?

Currently, organisations within the health system do not have strong incentives to respond to patients' wishes. The incentives for coordination between different health services are also insufficient. In particular, the links between health and social care are often poor. This often leads to fragmented care, poorer outcomes and lower levels of patient satisfaction. Currently, democratic legitimacy is provided by the Secretary of State for Health, held accountable by Parliament. Democratic decisions taken centrally are less likely to be fully representative of local needs, and there is a significant organisational distance between local NHS decision makers and publicly accountable ministers. More local democratic legitimacy is required.

### What are the policy objectives and the intended effects?

- Increasing local democratic legitimacy in health aims to: strengthen the role of local authorities in relation health and social care by involving councillors and local HealthWatch in identifying local needs and developing an overarching strategy for commissioning to meet those needs; to help ensure that local services can meet local needs.
- Through giving new powers and duties on local authorities and their partner commissioners, we intend to provide stronger incentives and more opportunities to improve coordination and integrated working in a way that better meets local need. This should also create new opportunities for cost efficient commissioning of services and higher quality services provided to patients. The end objectives are to improve outcomes for patients and deliver higher levels of patient satisfaction.

### What policy options have been considered, including any "alternatives to regulation". Please justify the preferred option below.

- The policies outlined in *Liberating the NHS* that do not require legislation are implemented. This is the 'do nothing' option and the costs and benefits of the following options are considered against this baseline;
- The policies outlined in *Liberating the NHS* that require legislation are also implemented. This will give greater powers and responsibility to local authorities, including placing a duty on them to establish a health and wellbeing board within their area, strengthening the joint strategic needs assessment, and introducing the requirement to develop a Joint health and wellbeing strategy. This is the Government's preferred option as it ensures a common, flexible statutory framework across all local authorities. This would also place duties on relevant NHS and local authority commissioners to participate fully in the work of the health and wellbeing board, and would clarify the expectation of partnership working.

Will the policy be reviewed? It will be reviewed	If applicable, set review date 04/2015
What is the basis for this review? PIR	If applicable, set sunset clause date N/A
Are there arrangements in place that will allow a systematic collection of monitoring information for future policy review?	Yes

**SELECT SIGNATORY Sign-off** For consultation stage impact assessments:

***I have read the impact assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) the benefits justify the costs.***

Signed by the responsible Minister: ..... *Mano* ..... Date: ..... 1.9.11 .....

# Summary: Analysis and Evidence

# Policy Option 2

## Description:

Implement proposals around increasing local democratic legitimacy in health, giving greater responsibility to local authorities and establishing a statutory health and wellbeing board within each.

Price Base Year 2010	PV Base Year 2010	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: Non-monetised	High: Non-monetised	Best Estimate: Non-monetised

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Non-monetised	Non-monetised	Non-monetised
High	Non-monetised	Non-monetised	Non-monetised
Best Estimate			

### Description and scale of key monetised costs by 'main affected groups'

No monetised cost

### Other key non-monetised costs by 'main affected groups'

The potential transition costs and increased running costs are considered. The health and wellbeing boards are established through a statutory framework. It is assumed that no staff will transfer to the health and wellbeing board as it will be a committee of the local authority. Transition costs are therefore low. It is also assumed that, given that the framework formalises current roles and functions rather than creating significant new ones, running costs of health and wellbeing boards will be minimal compared to current running costs.

BENEFITS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Non-monetised	Non-monetised	Non-monetised
High	Non-monetised	Non-monetised	Non-monetised
Best Estimate			

### Description and scale of key monetised benefits by 'main affected groups'

No monetised benefit

### Other key non-monetised benefits by 'main affected groups'

Greater democratic involvement, and requiring the attendance of key commissioning partners, elected representatives and local HealthWatch, should ensure stronger joint working and services being tailored more towards local needs and priorities. This should be supported by the enhanced joint strategic needs assessment and joint health and wellbeing strategy, which should serve to identify and address needs across an area. Ultimately this should lead to higher levels of patient satisfaction, improved quality of services and more cost effective commissioning.

### Key assumptions/sensitivities/risks

Discount rate (%)

N/A

The boards' operation may suffer from:

- discontinuities of political leadership;
- political turbulence between local and national bodies; and/or
- low voter turn-out impacting on the 'reach' of the boards into the community.

There is also the risk of greater transition or future running costs than expected, for example, if the health and wellbeing boards were to take on additional functions.

However, this impact assessment outlines proposals and actions taken to mitigate these risks that these risks will not be significantly detrimental to the opportunities for benefits outcomes proposed.

Direct impact on business (Equivalent Annual) £m):			In scope of OIOO?	Measure classified as
Costs: 0	Benefits: 0	Net: 0	No	NA

## Enforcement, Implementation and Wider Impacts

What is the geographic coverage of the policy/option?		England			
From what date will the policy be implemented?		01/04/2013			
Which organisation(s) will enforce the policy?		N/A			
What is the annual change in enforcement cost (£m)?		£0			
Does enforcement comply with Hampton principles?		Yes			
Does implementation go beyond minimum EU requirements?		N/A			
What is the CO <sub>2</sub> equivalent change in greenhouse gas emissions? (Million tonnes CO <sub>2</sub> equivalent)		Traded: 0		Non-traded: 0	
Does the proposal have an impact on competition?		No			
What proportion (%) of Total PV costs/benefits is directly attributable to primary legislation, if applicable?		Costs: 100		Benefits: 100	
Annual cost (£m) per organisation (excl. Transition) (Constant Price)	Micro 0	< 20 0	Small 0	Medium 0	Large 0
Are any of these organisations exempt?	No	No	No	No	No

## Specific Impact Tests: Checklist

Does your policy option/proposal have an impact on...?	Impact	Page ref within IA
<b>Statutory equality duties</b> <sup>38</sup> <a href="#">Statutory Equality Duties Impact Test guidance</a>	Yes	EA Annex C
<b>Economic impacts</b>		
Competition <a href="#">Competition Assessment Impact Test guidance</a>	No	
Small firms <a href="#">Small Firms Impact Test guidance</a>	No	
<b>Environmental impacts</b>		
Greenhouse gas assessment <a href="#">Greenhouse Gas Assessment Impact Test guidance</a>	No	
Wider environmental issues <a href="#">Wider Environmental Issues Impact Test guidance</a>	No	
<b>Social impacts</b>		
Health and well-being <a href="#">Health and Well-being Impact Test guidance</a>	Yes	73-90
Human rights <a href="#">Human Rights Impact Test guidance</a>	No	
Justice system <a href="#">Justice Impact Test guidance</a>	No	
Rural proofing <a href="#">Rural Proofing Impact Test guidance</a>	No	
<b>Sustainable development</b> <a href="#">Sustainable Development Impact Test guidance</a>	No	

<sup>38</sup> Race, disability and gender Impact assessments are statutory requirements for relevant policies. Equality statutory requirements will be expanded 2011, once the Equality Bill comes into force. Statutory equality duties part of the Equality Bill apply to GB only. The Toolkit provides advice on statutory equality duties for public authorities with a remit in Northern Ireland.

## Evidence Base (for summary sheets) – Notes

### References

No.	Legislation or publication
3	<a href="#">Health and Social Care Bill 2010</a>
4	“The White Paper” – <i>Equity &amp; Excellence: Liberating the NHS</i> <a href="http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353">http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353</a>
5	‘Liberating the NHS: Increasing democratic legitimacy in health’, 2010, <a href="http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_117586">http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_117586</a>
6	<i>Liberating the NHS: Legislative framework and next steps</i>
7	‘An information revolution: A consultation on proposals’, 2010, <a href="http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_120080">http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_120080</a>
8	‘Liberating the NHS: Greater choice and control. A consultation on proposals,’ 2010, <a href="http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_119651">http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_119651</a>
9	Government responses to the NHS Future Forum, June 2011-07-21 <a href="http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127443">http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127443</a>

### One in one out

From 1<sup>st</sup> September 2010 all INs (new regulation) that impacts the private sector and civil society organisations (formerly known as the 3<sup>rd</sup> sector) must have balancing OUTs (removal of old regulation; recast regulation to reduce burdens; and simplifications). The proposals around Local Democratic Legitimacy are out of scope of this.



## Evidence Base (for summary sheets)

This section includes:

- i. Problem under consideration
- ii. Rationale for intervention
- iii. Description of proposal and implementation options considered
- iv. Assessment of benefits
- v. Assessment of costs
- vi. Risks

### i. Problem under consideration

- C1. As the White Paper *Equity & Excellence: Liberating the NHS* said, at its best, the NHS is world class<sup>39</sup>. However, compared to other countries, the NHS still achieves relatively poor outcomes. This is in part due to differences in underlying risk factors. Within this context, the NHS could be perceived as lacking the local democratic input to support strong local engagement and leadership required to meet these challenges.
- C2. Given these weaknesses, *Equality and Excellence*, proposed structural reforms to increase local democratic legitimacy, encourage the development of patient centred services, and to strengthen the incentives for commissioners to better meet patient needs. To increase local democratic legitimacy, the proposed reforms intend to establish health and wellbeing boards in every upper-tier authority, involving locally elected councillors and patient and public representatives.

#### ***Problem 1: The current systems are do not encourage high quality, efficient services***

- C3. The NHS scores relatively poorly on being responsive to the patients it serves<sup>40</sup>. It lacks a genuinely patient-centred approach in which services are designed around individual needs, lifestyles and aspirations. Rather than basing NHS services around the patient, the patient often has to fit around the services the NHS delivers.
- C4. Organisations within the current health system do not always have strong incentives to respond to patient needs and preferences. This is especially true of commissioners, who are often seen as remote, only weakly accountable to patients, and with limited means to hear and respond to the needs of patients and the public. As a result, patients and the public have a limited impact on decisions made by Primary Care Trusts (PCTs), undermining the key principle of “no decision about me without me”, which in turn misses the potential benefits associated with giving people more choice and control over decisions about their care.
- C5. In order to break down these barriers, in future, clinical commissioning groups will have far stronger incentives to respond to patients, as a result of both patient choice, and stronger democratic legitimacy.
- C6. For example, in future, patients will have choice at several levels. They will have a choice of GP (and GP practice choice of clinical commissioning group) and, as mentioned in the White Paper, the Government intends to extend the current offer of patient choice to a wider range of

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<sup>39</sup> See [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_117353](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353)

<sup>40</sup> *Equity & Excellence: Liberating the NHS*, page 8. See:

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_117353](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353)

services<sup>41</sup>. This expansion of patient choice will be supported by the NHS information revolution<sup>42</sup>, enabling patients to share in decisions made about their care and find out much more easily about services that are available. These policies will reinforce the incentives placed on both providers and commissioners, but they can only go so far. Where there are local geographically defined health needs that need to be met, encouraging competition between providers via commissioning may be less effective, or not possible.

- C7. Where there is less available choice for commissioners and patients, providers have less incentive to ensure they are offering beneficial services that meet the preferences of patients. Increasing local democratic legitimacy, by establishing health and wellbeing boards, aims to counter this by providing strong input from locally elected councillors the public and patients to encourage commissioners and providers to develop the services that best meet their needs and preferences. This will help to achieve the potential benefits of competition, which are set out in Annex B.
- C8. Stronger local democratic involvement can also encourage better coordination between health and social care. At present, different health services is often less developed or insufficient, and, in particular, the links between health and social care are often poor<sup>43</sup>. This often leads to fragmented care, poorer outcomes and lower levels of patient satisfaction. Democratic involvement should act as a further incentive on providers to create more joined up services.
- C9. The problems above refer to challenges associated with improving the quality of the current system, including that care is not as good as it could be. Currently, there are examples of health and wellbeing boards (or similar structures) already operating successfully in local authorities; however, coverage across the country is variable. For example, in Sheffield, the health and wellbeing partnership is chaired jointly by the council chief executive and the PCT chief executive, in Cambridgeshire the Joint Strategic Needs Assessment (JSNA) has been used to prioritise action across health, social care and district councils and Hammersmith and Fulham have close strategic integrated working between the council and PCT. To ensure a coherent structure and to reduce variation, legislation is needed to ensure a common, yet flexible, approach across England.

### **Problem 2: Lack of local Democratic Legitimacy**

- C10. The current line of democratic accountability for health services across England is through Parliament, and this will continue. However, in the current system some decisions taken centrally, whilst legitimised through democratic representation nationally, may not sufficiently reflect local needs. There is little democratic involvement at PCT level, with the King's Fund (2008)<sup>44</sup> noting that current PCT accountability is "highly centralised: with prime accountability being to the Department of Health and national regulators and auditors, rather than to local people." The report goes on to highlight the "evidence of poor public and patient involvement in

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<sup>41</sup> *Equity & Excellence: Liberating the NHS*, page 17. See: [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_117353](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353) and '*Greater choice and control: A consultation on proposals*', [http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH\\_119651](http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_119651)

<sup>42</sup> See: *Equity & Excellence: Liberating the NHS*, page 13, and '*An information revolution: A consultation on proposals*' [http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH\\_120080](http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_120080)

<sup>43</sup> For both statements there is wide discussion of the problems in the literature. See the following for an overview: Chapman et al – Systematic review of recent innovations in service provision to improve access to primary care – British Journal of General Practice [2004], Hofmarcher et al – Improved Health System Performance Through Better Care Coordination – OECD [2007], Ham et al (2008) '*Altogether now? Policy options for integrating care.*' and McDonald et al (2006) '*Systematic review of system-wide models of comprehensive primary health care*', Audit Commission (2009i), '*Working better together: managing local strategic partnerships*', Audit Commission (2009ii), '*Means to and end: joint financing across health and social care*', Glasby, J. and Peck, E. (eds) (2003) *Care Trusts: partnership working in action*.

<sup>44</sup> 'King's Fund report: Should PCTs be made more locally accountable?', [2008].

the past, an indication of the effort that might be required to engage [and become more accountable to] the public in any comprehensive way in the future.”

- C11. This lack of democratic legitimacy creates a problem in the healthcare system. There are currently few incentives for local health bodies to take account of the needs of local people and communities when designing the care they receive. Although there have been other policies in the past to create an element of local democratic involvement for providers (in particular, foundation trusts have boards of governors that are majority elected by their local membership), there has been an ongoing deficit of democratic legitimacy in NHS commissioning. There is an especially limited role for local democratic involvement in commissioning discussions before decisions are taken. Currently, democratic input is largely restricted to providing scrutiny of decisions after they have been made (such as in the case of service reconfigurations).

## ii. Rationale for intervention

- C12. The White Paper set out our vision for a better NHS. The proposals for increasing local democratic legitimacy in health specifically aim to meet the goals set in the White Paper of foreseeing an NHS that:

- is genuinely centred around the needs of patients and carers;
- gives citizens a greater say in how the NHS is run; and
- is less insular and fragmented, and works much better across boundaries, including with local authorities and between hospitals and practices.

- C13. To achieve these goals, the structural weakness and lack of democratic legitimacy in the NHS must be addressed. This will significantly strengthen the existing, limited, incentives for health professionals to provide coordinated services focused around the needs of communities and individual patients, rather than the needs of the NHS. As patient choice provides incentives to professionals only at an individual level rather than for a geographical area, representatives with a democratic mandate to represent an area must also be involved to speak on behalf of their community and to incentivise professionals to act in their interests.

- C14. The White Paper and the *Health and Social Care Bill* therefore proposed to strengthen partnership working across health and local authorities, supported by local democratic involvement and the involvement of local patients and the public. To do this local authorities will have greater responsibility in four areas:

- leading on preparing, in collaboration with clinical commissioning groups, the revised JSNA and developing the new joint health and wellbeing strategy, to ensure coherent and co-ordinated commissioning strategies across health and social care;
- supporting local patient and public involvement in the development of the JSNA and the JHWS, and the exercise of patient choice (both via HealthWatch, and via other means);
- promoting and encouraging joined up commissioning of local NHS services, social care and health improvement; and
- leading on local health improvement and prevention activity.

- C15. There is the potential to align the incentives of the healthcare system to better meet the needs of local patients and the public. This could be done through the proposals outlined above, underpinning current systems with stronger local democratic involvement. Doing this would create the opportunity for more responsive services that better meet the needs of patients and the public, creating the increased opportunity for improved patient outcomes, and strengthening the democratic legitimacy of local commissioning decisions.

### iii. Description of proposal and implementation options considered

- C16. To enhance their role in health, the Government proposes that local authorities be given the following functions:
- To lead, alongside clinical commissioning groups, the assessment of local population needs and the development of the statutory joint strategic needs assessment;
  - To develop, alongside clinical commissioning groups, the joint health and wellbeing strategy, to address the needs identified in the joint strategic needs assessment;
  - To promote integrated working 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
  - Separately from the health and wellbeing board, to undertake a scrutiny role in relation to major service redesign.
- C17. Through elected councillors, local authorities will bring greater local democratic legitimacy to these roles. They will bring the local perspective into commissioning plans and promote integrated working of local services across the boundaries between the NHS, social care and public health. They will also be able to provide strategic leadership, and to provide oversight of and challenge commissioning decisions in their area.
- C18. The initial consultation<sup>45</sup> *Increasing local democratic legitimacy in health* asked for views on whether this role should be given directly to local authorities, who would then create the necessary structures to deliver them, or to a form prescribed in legislation called the health and wellbeing board. Respondents were strongly supportive of the proposal to have statutory health and wellbeing boards with a clearly established set of high level functions in each local authority, with requirements around minimum membership and duties of participation. This view was also supported by the NHS Future Forum, and the government has welcomed its recommendations<sup>46</sup>.
- C19. Following this consultation, the Government proposes to establish a statutory duty requiring local authorities to establish a health and wellbeing board in their area, which, which would bring together elected members, NHS, public health and social care commissioners and local HealthWatch (representing patients and the public). The government proposals also allow further flexibility.
- C20. The intention is to provide a framework to promote integrated and partnership working between the NHS, social care, public health and other health and wellbeing related local services and improve democratic accountability. The local authority will bring partners together to agree a joint health and wellbeing strategy for the benefit of patients and taxpayers, informed by local people and neighbourhood needs. Commissioners will be under a duty to have regard to the joint health and wellbeing strategy in exercising their commissioning functions and will be required to involve them early in the preparation of their plans. Increased incentives have also been developed via the NHS Commissioning Board's annual assessment of clinical commissioning groups to ensure that clinical commissioning groups commission in a way that contributes to the shared priorities identified in the joint health and wellbeing strategies.
- C21. However, as a result of the consultation, we recognise that giving health and wellbeing boards scrutiny powers would be a potential conflict of interest. We are, therefore, now proposing to

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<sup>45</sup> See [http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH\\_117586](http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_117586)

<sup>46</sup> [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_127443](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127443)

align the current health scrutiny powers with other local authority scrutiny functions and give local authorities the flexibility to decide how best to discharge the scrutiny powers.

- C22. The proposals, including proposed amendments to the scrutiny regulations, which we will consult on fully, are discussed in more detail in the Government's response to the White Paper consultations, *Liberating the NHS: Legislative framework and next steps*.<sup>47</sup>

### **Implementation options considered**

#### Option 1:

- C23. The policies outlined in *Liberating the NHS* that do not require legislation are implemented. This is the 'do nothing' option and the costs and benefits of the following options are considered against this baseline.

#### Option 2:

- C24. The legislative option of the proposals around increasing local democratic legitimacy in health is implemented<sup>48</sup>. This involves giving greater responsibility to local authorities establishing a statutory health and wellbeing board within each local authority. This option entails setting and legislating for a statutory framework within which each health and wellbeing board will operate.
- C25. In contrast to other individual policies whose impacts are assessed in this document, the statutory framework for increasing local democratic legitimacy is intended to be implemented as a single set of structural duties and powers. The consultation proposed either prescribing the manner in which duties were to be discharged (via health and well-being boards) or leaving it to local authorities to decide locally how to discharge their obligations. Following the overwhelming support in the consultation for statutory health and wellbeing boards, we have chosen this option- we do not believe there will be any difference in costs between the two options.
- C26. At their core, the proposals for health and wellbeing boards establish in legislation the board's functions and the minimum membership of the boards. However, it is a minimum set of requirements - there is scope within the framework for individual local authorities to go further, delegating other local authority functions (with the exception of their health scrutiny function) and adding members to meet and respond to local needs. This will create the opportunity for health and wellbeing boards to provide significant strategic leadership for the local health and social care system and provide effective incentives to do so, whilst not placing significant and unnecessary burdens on local authorities. It is the view therefore that the statutory framework should be considered as a whole, rather than as individual constituent parts.
- C27. The proposals for increasing local democratic legitimacy are part of a wider series of reforms as outlined in the White Paper and legislated for in the Health and Social Care Bill. As mentioned in the covering document, there are significant links between the individual policies. These links in the details of the policies reinforce the benefits proposed from implementing the policies. In particular, the proposals for statutory requirements on local authorities to perform certain roles and functions through a health and wellbeing board link to the proposals for changing the commissioning landscape in healthcare, and to encouraging providers, through increased freedoms, to respond to patient preferences.

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<sup>47</sup> [http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/DH\\_122624](http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/DH_122624)

<sup>48</sup> As detailed in the content on the face of the Health and Social Care Bill 2010 and the response to the White Paper consultation

#### iv. Assessment of benefits

C28. This impact assessment examines the characteristics of the health and wellbeing board proposals, explaining why they will improve the performance of the system. The model below captures the possible effects of creating health and wellbeing boards.

### Cost and benefit model for Health & Wellbeing Boards

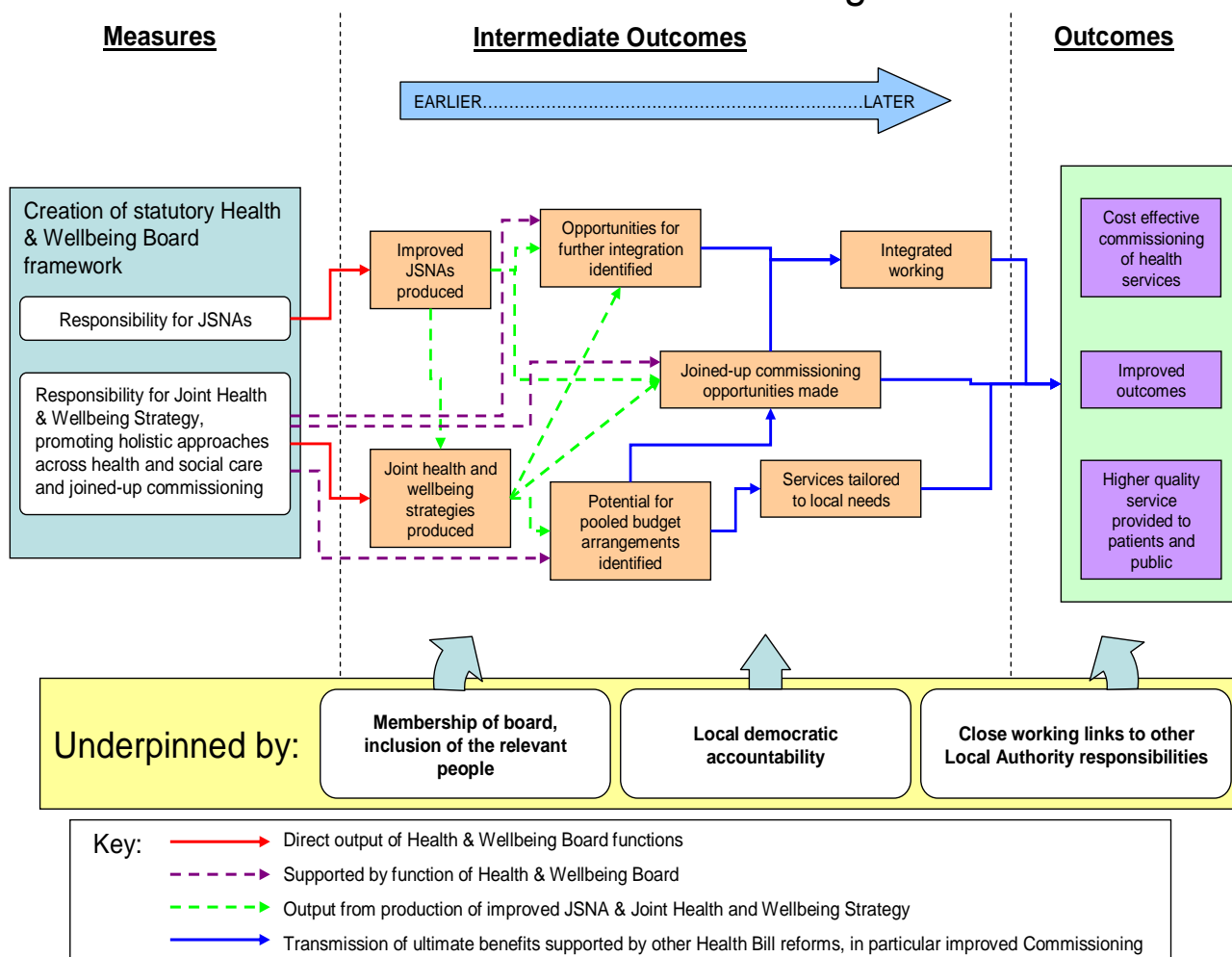


Figure 1: Cost and benefit model for health and wellbeing boards

C29. The proposals for increasing local democratic legitimacy in health give the following responsibilities (as detailed under “Measures” in figure 1) to health and wellbeing boards:

- responsibility for joint strategic needs assessments; and
- responsibility for joint health and wellbeing strategies.

C30. These provide the basis for the health and wellbeing board to perform its main function of joining up and integrating commissioning across the NHS, social care, public health and the engagement of other local partners. This is in order to deliver better health and wellbeing outcomes, better quality of care, and better value.

C31. As mentioned above, the policy of increasing local democratic legitimacy is closely linked to the other policies proposed in the White Paper and covered in the overall impact assessment for the Bill. This impact assessment annex takes the view that the immediate output from the roles and functions of health and wellbeing boards will lead to improved opportunities for integrated working and improved commissioning for patients, that better reflects and meets the needs of local people. The operation of health and wellbeing boards therefore will reinforce the benefit opportunities outlined in the ‘Commissioning For Patients’, ‘Provision’ and ‘Public Health Service’

impact assessments (see Annexes A, B and F to the coordinating document). It is therefore necessary to consider the opportunities for benefits from improved commissioning when examining the benefits of health and wellbeing boards.

C32. As a result, this impact assessment does not provide monetised figures for its benefits. However, paragraphs C46 and C47 show that the value of a minimal improvement in health status (0.2% increase) is greater than £50 million for an average PCT. The direct benefits of the health and wellbeing board are the result of the improved JSNA and joint health and wellbeing strategy process. There is limited evidence on which to base a quantified assessment of the benefits, as it is difficult to disentangle the effects of individual policy interventions. For Local Democratic Legitimacy, this is because it is intimately linked to improved commissioning decisions by the health and wellbeing board. By strengthening the duties in relation to the JSNA and ensuring that the needs it identifies are addressed in a coherent way across health and social care via the joint health and wellbeing strategy, with local authority leadership and clinical expertise, commissioning plans will more closely represent local needs. This will create the opportunity for improved commissioning for patients, integrated working and pooled budget arrangements (in figure 1 this is represented by the green dashed lines). The final transmission of benefits (under “Outcomes” in figure 1) is supported by and reinforces the policies around commissioning for patients; the creation of the NHS Commissioning Board and clinical commissioning groups and the establishment of Public Health England.

#### *Membership of the boards*

C33. The proposals for health and wellbeing boards set out a minimum membership for the boards<sup>49</sup>. This is beneficial as it ensures that the key relevant people from local areas are involved in the board, whilst providing sufficient freedom and flexibility for local areas to invite any other relevant people or organisations onto the board. This could include more elected representatives, third sector organisations, or providers. This reflects the position that Ham (2009i)<sup>50</sup> takes on integrated working, suggesting that it “needs to start from a focus on service users and from different agencies agreeing what they are trying to achieve together”. In a recent review of the JSNA process in the North West SHA region, the North West Public Health Observatory recommended that better coordination of local and regional planning between relevant partners would contribute to the JSNA having a greater impact<sup>51</sup>.

C34. Ensuring the relevant people are involved in the health and wellbeing board is central to the framework proposed for legislation. The fact that it is a minimum membership, including elected representatives and all of the key local commissioners, provides local areas with the opportunity to expand upon it if they desire to ensure that as local areas often differ, their needs are catered for. It will be for local authorities to determine the precise number of elected members on a health and wellbeing board, and they will be free to insist upon having a majority of elected councillors.

#### *Local democratic legitimacy*

C35. The second underpinning aspect of the proposals for health and wellbeing boards is ensuring strong democratic legitimacy for commissioning decisions, through local democratic input, involvement and challenge. This will be delivered by ensuring that democratically elected local councillors sit on the health and wellbeing board and it means that the views of local people are represented. This mixed membership ensures the health and wellbeing board is the key forum in which the health and wellbeing needs of people for whom it is responsible for can be raised and

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<sup>49</sup> ‘*Liberating the NHS: Legislative Framework and Next Steps*’, pg 99, December 2010.

<sup>50</sup> Ham, C, 2009i; ‘*Only connect: policy options for integrating health and social care*’, The Nuffield Trust.

<sup>51</sup> ‘*Joint Strategic Needs Assessment North West Regional Review*’, *North West Public Health Observatory*, June 2009.

addressed at a strategic level, as it brings together clinical and commissioning expertise, alongside elected and patient representatives. The incentives for elected members, through the ballot box, to represent the interests of their constituents, supplement the incentives that are currently in the system (such as patient choice, which only provides incentives on an individual basis, rather than for a geographically defined population) for local people to influence commissioners and providers.

- C36. The 'median voter theorem'<sup>52</sup> posits that democratically elected representatives commit to the policy position of the median (or middle or average) voter. This theorem provides the conjectural argument for increasing democratic legitimacy at a local level. It implies that in a system that is primarily accountable at national level, as in the NHS now, health services will reflect the median English voter. However, the needs and requirements of the median voter across England will differ by constituency and socio-economic group<sup>53</sup>, and so the decision made by central government may not be representative of the different median voters in different local areas. Local councillors are likely to be better placed to represent the median voter in their ward, and in their local authority area more widely. Therefore, strengthening the influence of local government brings the opportunity for increased performance. Establishing statutory health and wellbeing boards will enable locally elected councillors to take account of the needs of the local median voter, creating the opportunity for commissioning decisions to be more representative of local needs.
- C37. Providing local democratic legitimacy also creates a clear line of accountability from the health and wellbeing board to the local people of the local authority area. This creates stronger incentives than those that currently exist in local areas, and in particular the JSNA process, to take account of local needs. The new incentives provided supplement the current incentives that are already present in the system, but which do not necessarily cover all health and social care services. For example, the incentives provided through increased local democratic legitimacy would allow patients and the public to influence services and service provision that is not currently covered by patient choice.
- C38. The King's Fund report, 'Should Primary Care Trusts be made more locally accountable?'<sup>54</sup> outlined some of the impacts of transferring health responsibilities to local authorities, a suggestion with similar details to the proposals for health and wellbeing boards. The report argued that it could lead to perceptions of high legitimacy among citizens and it would build upon current democratic structures, whilst bringing stronger lines of accountability and responsiveness to local people.
- C39. However, local democratic involvement needs to be balanced with clarity around the lines of accountability between clinical commissioning groups, local authorities, health and wellbeing boards and the NHS Commissioning Board. Giving health and wellbeing boards the power to veto or make commissioning decisions for the NHS could confuse these clear relationships, and could potentially result in a situation where health and wellbeing boards were making or vetoing commissioning decisions without being financially accountable for their outcome. The NHS Future Forum considered whether health and wellbeing boards should have a veto. In their report, they said that "many people have called for them to have sign-off powers over the annual commissioning plans which will be developed by commissioning consortia; others reason that this model of dual accountability will be confusing and unworkable." Their view was that rather

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<sup>52</sup> Black, Duncan (1948). "On the rationale of group decision-making". *Journal of Political Economy* 56: 23–34 and Downs, Anthony (1957). *An Economic Theory of Democracy*: Harper Collins.

<sup>53</sup> This is shown through health inequalities between areas across England. See *Independent Inquiry into Inequalities in Health* – the Acheson report (1998) – and the HM Treasury-led cross-cutting review on health inequalities (2002).

<sup>54</sup> Thorlby R, Lewis R and Dixon, J; 2008, 'Should Primary Care Trusts be made more locally accountable?', King's Fund



than seeking a veto, health and wellbeing boards should be stronger and there should be aligned incentives.

#### *Links with other local authority responsibilities*

C40. As health and wellbeing boards will be a committee of the local authority, they are well placed to encourage joint working across different areas. For example, local authorities currently have responsibilities regarding “general health determinants”, such as:

- standards of housing, transport services or public safety,
- employment prospects, earning capacity and any other matters that affect levels of prosperity,
- the degree of ease or difficulty with which persons have access to public services,
- the use, or level of use, of tobacco, alcohol or other substances, and any other matters of personal behaviour or lifestyle, that are or may be harmful to health; and
- any other matters that are determinants of life expectancy or the state of health of persons generally.

C41. Proposals in this Bill will also place further public health duties on local authorities. This is addressed in more detail in the public health impact assessment.

C42. There will be significantly greater opportunities for the health and wellbeing boards to work closely with colleagues in local authorities who work on the areas listed above and take a holistic view of both local needs and local services. This increases the possibility of integrated decisions that join up commissioning, leading to a seamless service and improved outcomes for local people across the different protected equality characteristics. ‘Tackling Health Inequalities’ (2003)<sup>55</sup> supports this view, outlining various measures that would improve health inequalities. In particular, the report recommended that links between specific health policies and those that are initiated outside of the Department of Health but play a key role in social support (e.g. employment and education policies) are recognised and the links are made best use of.

C43. There are several examples of health and wellbeing boards currently in existence, and with evidence suggesting that they have had a positive impact on local commissioning. For example, Birmingham Health and Wellbeing partnership has increased life expectancy (above the national average), developed a social risk assessment tool which has been piloted across the city and developed maternity service linkages between children’s centres and two local PCTs<sup>56</sup>. The partnership has four main priority themes: tackling health inequalities; personalisation and wellbeing; joint commissioning; and user engagement. The proposals for statutory health and wellbeing boards will build on the successes of examples such as Birmingham, helping to provide consistency across areas and framework for a fundamental level of engagement and decisions that are closer to local needs.

#### *Impact of underpinning characteristics of health and wellbeing boards on JSNA and joint health and wellbeing strategy process*

C44. Health and wellbeing boards will increase local involvement in developing JSNAs and joint health and wellbeing strategies. In particular, there will be a duty on the health and wellbeing board to involve local people in the preparation of the JSNA and joint health and wellbeing strategy. Improved community engagement can make the needs assessment more representative and better reflect local needs.

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<sup>55</sup> Dept. of Health (2003) *Tackling Health Inequalities: A Programme for Action*. Report Cm6374. Dept. of Health, London.

<sup>56</sup> See: <http://www.bhwp.nhs.uk/Apps/Content/HTML/ViewContent.aspx?id=29>

- C45. The proposed joint health and wellbeing strategy<sup>57</sup> will enable health and wellbeing boards to look at the totality of resources in their local area. This will be combined with a duty to consider the use of “Health Act” flexibilities<sup>58</sup>, in developing the strategy, so that where appropriate pooled budgets, or lead commissioning can take place. By strengthening the duties in relation to the JSNA and ensuring there is follow through into a joint health and wellbeing strategy, with local authority leadership and clinical expertise, commissioning plans will more closely represent local needs. This again follows through into the increased opportunity for benefits from improved commissioning for patients. Finally, the impacts of the JSNA and the joint health and wellbeing strategy are being strengthened by placing a duty on commissioning consortia, local authorities and the NHS Commissioning Board to have regard to both the JSNA and joint health and wellbeing strategy in discharging their commissioning functions. The health and wellbeing board will also have a clear right to refer their views on clinical commissioning group plans back to the group or to the NHS Commissioning Board for further consideration.
- C46. JSNAs were initially introduced as part of the *Commissioning framework for health and wellbeing*<sup>59</sup> in 2007. The impact assessment of the framework<sup>60</sup> estimated the potential benefit from performing a JSNA on the impacts it would have on health outcomes for the population it targeted. The total benefits of performing and implementing (that is altering commissioning to cater for the needs assessment) a JSNA (with various caveats<sup>61</sup>) were as follows:

Attribution	Impact on targeted population	
	20%	50%
1%	£52,236,245	£92,310,069
50%	£2,611,812,260	£4,615,503,474

Table 1 – from ‘*Regulatory Impact Assessment: Commissioning Framework for Health and Wellbeing*’ page 15

- C47. The figures above are presented on the basis that the fully implemented JSNA would increase the health status of the targeted population by either 20% or 50% of a QALY<sup>62</sup> per year. In 2007 the QALY was monetised at being worth £30,000 per annum. The DH monetised value of a QALY has recently been revised to £60,000 per annum. Therefore in our current assessment would double the figures in table 1. The benefits are scaled by the degree to which this increase can be attributed to the implemented JSNA. As mentioned in the Commissioning For Patients impact assessment (see Annex A to the coordinating document), the changes to the commissioning process are expected to deliver benefits in terms of improved services that deliver better outcomes and a better experience for patients. An improved JSNA process, supported by the joint health and wellbeing strategy, is expected to reinforce these benefits by making commissioners decisions more responsive to local requirements. However, this impact assessment does not propose that the figures quoted above should be directly attributed to health and wellbeing boards or other White Paper policies. They are included as an example of the potential health benefits from performing and implementing a JSNA when they were

<sup>57</sup> See paras 5.21 – 5.27 in Consultation Response

<sup>58</sup> See paras 5.28 – 5.31 in Consultation Response

<sup>59</sup> [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_072604](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072604)

<sup>60</sup> [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH\\_072612](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_072612)

<sup>61</sup> For example: with clear guidance provided on how to undertake and implement a JSNA, 90% coverage, value of QALY = £30,000, extent to which the commissioning framework can be attributed to increases in health status. See [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH\\_072612](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_072612) for further discussion.

<sup>62</sup> QALY – Quality Adjusted Life Year. Standardised measure of health status.

originally introduced and so are the potential benefits from improved commissioning that an improved needs assessment process can incentivise.

- C48. The national CAMHS review suggested that the JSNA be improved, commenting that they “believe that all stakeholders should contribute to a comprehensive, multi-agency assessment of local need that is used.”<sup>63</sup> Undertaking the JSNA in the context of local democratic involvement is a step towards this.
- C49. The Association of Public Health Observatories, and its constituent regional Public Health Observatories published various regional reviews of the JSNA process which also included recommendations to improve the process<sup>64</sup>. In particular, North West Public Health Observatory noted that JSNAs have been hindered by a lack of coordination or alignment between local authorities and NHS partners and that JSNA reports often provided little detail on how partnerships are involving local communities. They recommended that a better coordination of local and regional planning between NHS and LA partners would contribute to the JSNA having a greater impact<sup>65</sup>. The proposals for functions and the underpinnings of health and wellbeing boards, as highlighted in figure 1, aim to cater for these recommendations, creating the opportunity for improved JSNA processes for all equality groups.
- C50. It is useful also to examine the recommendations of the Association of Public Health Observatories (and in particular of the North West Public Health Observatory). The recommendations and comments from local JSNA partnerships are answered for by the proposals for health and wellbeing boards. In particular those performing JSNAs should:
- “draw in a wider collection of exiting community research to ensure coverage of local issues.” (Page 33).
  - “more clearly identify that they are developing broader inter-agency partnerships, so that there is: closer involvement of local communities; better links and integrated working with plans and programmes; and inclusion of the NHS and all directorates from local authorities (e.g. housing, transport, leisure and education/children services).” (Page 34).
- C51. The underpinnings of cost and benefit model outlined in figure 1, in particular the inclusion of relevant local specialists on community issues in the health and wellbeing board and aligning the JSNA more closely with the wishes of patients, through democratic involvement, creates the opportunity for these recommendations to be met and improved JSNAs to be realised.
- C52. The intention of the health and wellbeing boards is that they can strengthen the JSNA process and shape the commissioning plans of commissioners through the joint health and wellbeing strategies. Performing a more effective JSNA, with a local joint health and wellbeing strategy, with better engagement from patients and the public, locally elected representatives and local HealthWatch, could help flag the needs of the local population, including groups who are not accessing services at the moment. Commissioners will have a duty to have regard to the JSNA and joint health and wellbeing strategy, to help ensure that this follows through in to improved commissioning outcomes for patients that are more reflective of their requirements. Having health and wellbeing boards at a local level in local authorities also mitigates the possible risk of potentially diverse clinical commissioning groups not working together on the strategic needs of a local population.

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<sup>63</sup> ‘Children and young people in mind: the final report of the National CAMHS Review’ November 2008

<sup>64</sup> See <http://www.apho.org.uk/resource/aphosearch.aspx>

<sup>65</sup> ‘Joint Strategic Needs Assessment North West Regional Review’, *North West Public Health Observatory*, June 2009.

C53. A specific example of the JSNA informing local areas to take action in dealing with local needs was delivered in a survey by ‘North West Joint Improvement Partnership’<sup>66</sup>. Various respondents to the survey provided the following examples, many with particular reference to equality characteristics:

- “The JSNA has underpinned our approach to involvement and commissioning in neighbourhoods as key to (tackling) a widening health inequalities gap. A health working group was established, comprising residents and a broad range of partners including housing, police etc., to jointly identify and fund holistic solutions.” (Page 17);
- Will be increased focus and spend on wellbeing/prevention and services to support ageing population including looking at the broader determinants of health including housing/affordable warmth etc. (Page 23);
- So far major change is £6 million investment (£3m from LA, £3m from PCT) to provide free leisure to all in the locality to address low leisure/activity take-up statistics. (Page 23);
- Increasing focus on well-being interventions and practical support schemes, looking at suitable housing, adaptations, affordable warmth, leisure, etc. (Page 24);
- In partnership with the local NHS and Equalities Partnership we have consulted with migrant workers, the Gypsy community, and the Eastern European community regarding health, housing, social cohesion issues.

C54. A further example of the impact of the JSNA process on improved local commissioning based upon local needs is Wiltshire. The local Government Improvement and Development Agency report on JSNA progress<sup>67</sup> outlined the following:

- “The JSNA has helped partners to identify new areas of need including:
  - i. The health and social care needs of members of the armed forces and their families (Wiltshire has a high concentration of soldiers and their families);
  - ii. The interrelationship between alcohol related crime and antisocial behaviour and alcohol related ill-health; and
  - iii. The lack of access to NHS dentistry.
- It has also already influenced commissioning decisions. For example, £1.4million has been allocated to dentistry following local concerns over access to NHS dentists.” (Page 10.)

C55. These examples show how the current JSNA process creates improved tailoring of services to meet local needs. An improved, better informed JSNA and joint health and wellbeing strategy, which involves the relevant partners across a local area, is underpinned by democratic involvement and has clear duties on the relevant commissioners, has the potential to further and strengthen these examples across the country, leading to improved outcomes for patients.

C56. As mentioned in their individual examination, the underpinning characteristics and the improved JSNA process will create the opportunity to improve the ability to deliver the other statutory functions of health and wellbeing boards. As shown in figure 1, these functions increase the potential and opportunity for holistic approaches across health and social care, including integrated working, and pooled budget arrangements. These outcomes have benefits in themselves that have increased opportunity under the proposed arrangements for health and wellbeing boards. The next paragraphs examine the potential benefits from these outcomes.

C57. Integrated working has the potential to provide benefits that impact directly on patients. In particular are those highlighted in figure 1, whereby improved working together has the potential to guide more cost-effective commissioning of health services, improved outcomes and higher quality services provided to patients and the public. There are many examples in the literature of

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<sup>66</sup> ‘Commissioning Services out of Joint Strategic Needs Assessment’, North West Joint Improvement Partnership (2009), See: <http://www.northwestroadmap.org.uk/docs/Commissioning%20Services%20out%20of%20JSNA.pdf>

<sup>67</sup> IDeA, 2009, ‘JSNA – Progress so Far’, see: <http://www.idea.gov.uk/idk/core/page.do?pageld=9616134>

many different types of integrated working between services and organisations that work very well. There is agreement that in part the best solutions will vary depending on geography and local circumstances<sup>68</sup>.

C58. The academic literature on integrated working between services and organisations points towards two different types of efficiency gain:

- **Transaction costs.** These prevent separate bodies from interacting efficiently, preventing them from achieving the efficiencies that could be achieved if their resources were more integrated. In particular:
  - i. **Economies of scale** can be realised where the same services are provided and where neither services handles a sufficient volume of patients in order to be fully efficient.
  - ii. **Economics of scope** can be realised where different services are operated, but where they rely on common inputs that could be shared between the services and used more efficiently.
- **Incentives.** Combined services or organisations will have an improved incentive to coordinate, allocating resources more efficiently across services and internalising their impacts on each other.

C59. There is a growing body of evidence to suggest that integrated health and wellbeing services can realise significant financial benefits. In particular, studies have illustrated that integrated early intervention programmes can generate resource savings of between £1.20 and £2.65 for every £1 spent (looking at POPPs, LinkAge Plus, Supporting People and self care schemes).<sup>69</sup> These resource savings can then be reinvested in other services, creating a benefit for a wider range of patients. In turn this improves the aggregate outcomes for patients from the same level of spending.

C60. The Department of Health's '*Evidence Base for Integrated Care*' (2006)<sup>70</sup> suggests that integrated working can be 'an effective way of delivering health care and that it can provide opportunities to breakdown barriers between primary and secondary health care, as well as health and social care.' The literature review provided certain lessons to take from the literature, of which those of specific relevance to the proposals for health and wellbeing boards are:

- Ensuring local contexts are supportive of integration;
- Being aware of local culture differences; and
- Strong local partnerships are vital to successful integration.

C61. Furthermore, Enthoven and Tollen (2004)<sup>71</sup> describe the importance of integrated working developing "organically", a process that is supported by the more effective JSNAs and the joint health and wellbeing strategies that the boards work on. Health and wellbeing boards provide a statutory framework that is flexible enough to develop organically dependent on local priorities and need, taking account of local views through democratically elected representatives and bringing together the relevant professionals in a certain local area are in a very strong position to act upon these lessons.

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<sup>68</sup> See Ham, C, 2009i; '*Only connect: policy options for integrating health and social care*', The Nuffield Trust and Imison, C, 2009; '*Shaping PCT provider services*', King's Fund: London.

<sup>69</sup> Taken from the '*Turning Point Connected Care Report*', 2010. See: <http://www.turning-point.co.uk/commissionerszone/centreofexcellence/Documents/Benefitsrealisation2010.pdf>

<sup>70</sup> See: [http://www.dhcarenetworks.org.uk/library/Resources/ICN/ICN\\_advice/The\\_evidence\\_base\\_for\\_Integrated\\_care.pdf](http://www.dhcarenetworks.org.uk/library/Resources/ICN/ICN_advice/The_evidence_base_for_Integrated_care.pdf)

<sup>71</sup> Enthoven, A.C., & Tollen, L.A. (Eds.) (2004), '*Towards a 21st Century Health System*', Jossey Bass : San Francisco.

C62. Pooled budgeting arrangements are a specific form of integrated working, where partner organisations contribute resources to a common budget, with staff given a say in how resources are to be used<sup>72</sup> that the health and wellbeing board will be able to provide increased opportunities for through the JSNA and joint health and wellbeing strategy process. The Audit Commission (2009i) identified the process as being a central part and way of working together. Specifically, “pooled budgets allow partners to bring funds together to achieve economies of scale (particularly administration costs) from resources that would be too small to make a difference by themselves.”<sup>73</sup> The report also highlights the barriers in the current system to pooled budget arrangements, specifically a poor understanding of others’ financial planning and governance arrangements, internal financial pressures and confusing accountability to different government departments. Health and wellbeing boards will be in a strong position to discuss these issues, by bringing together the relevant partners, public and professionals across the local area, and finding solutions that are best placed to meet local requirements.

## v. Assessment of costs

C63. This section summarises the costs associated with the establishment and running of health and wellbeing boards.

### *Implementation costs*

C64. The White Paper represents a shift in power to health professionals. This shift in power corresponds to and requires a shift in personnel to support bottom up ownership and decision-making. Coupled with this, the White Paper outlined the obligation for the NHS to reduce waste and transform productivity, simplifying the architecture of the health and care system. PCTs will be replaced by clinical commissioning groups, strategic health authorities will be abolished, public bodies will be restructured and the Department of Health will reduce its own NHS functions. Representing a major de-layering, these changes will incur transitional costs from the disruption and loss of jobs.

C65. The individual policies, and the overarching assessment, highlight the transition costs covering both the redundancies and the additional costs associated with the changes proposed in the White Paper and Health and Social Care Bill. The transition costs are associated with redundancy costs and re-organisation costs as taken from the NAO report “Re-organising central government,”<sup>74</sup> and are covered in greater detail in the overarching impact assessment.

C66. The other annexed individual policy assessments present costs, using the analysis in the overarching assessment, as their implementation creates redundancy and non-redundancy costs. This impact assessment argues that this is not the case for the implementation of health and wellbeing boards.

C67. This assessment assumes that very few staff will be transferred from bodies in the current system (PCTs, SHAs etc) to fulfil the functions of the health and wellbeing board. Currently the functions of the health and wellbeing board are not formalised, with inadequate coordination and communication between local authorities and commissioners. The statutory framework aims to formalise the current situation with health and wellbeing boards providing a more robust relationship and stronger incentives for integrated working. There is currently some joint input to

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<sup>72</sup> See Glendinning, C., Hudson, B. & Means, R., (2005), ‘Under Strain? Exploring the Troubled Relationship between Health and Social Care’, *Public Money & Management* 25, pp. 245-251.

<sup>73</sup> Audit Commission (2009i), ‘*Working better together: managing local strategic partnerships*’, see: [http://www.audit-](http://www.audit-commission.gov.uk/nationalstudies/localgov/workingbettertogether/pages/workingbettertogether.aspx)

[commission.gov.uk/nationalstudies/localgov/workingbettertogether/pages/workingbettertogether.aspx](http://www.audit-commission.gov.uk/nationalstudies/localgov/workingbettertogether/pages/workingbettertogether.aspx)

<sup>74</sup> National Audit Office, 2010, ‘*Re-organising central government*’, see: [http://www.nao.org.uk/publications/0910/reorganising\\_government.aspx](http://www.nao.org.uk/publications/0910/reorganising_government.aspx)

the proposed functions for health and wellbeing boards from both the local authority and the PCT, with the PCT generally providing input (particularly to the JSNA) on commissioning aspects<sup>75</sup>. The local authority staff who currently work on these process will remain in the local authority with the same job role but will support the health and wellbeing board rather than the local authority itself. The NHS staff in the PCT currently working on these functions are assumed therefore to transfer to clinical commissioning groups, where they can input to the JSNA, joint health and wellbeing strategy and opportunities for more integrated working through the clinical commissioning groups' representation on the health and wellbeing board. The costs associated with these transfers are covered in the commissioning impact assessment (see annex A of the coordinating document).

C68. The transfer of staff to the local authority as a result of the health and wellbeing board, and therefore the transition cost, will therefore be minimal, with a best estimate of zero. The White Paper reforms will mean that some staff transfer to local authorities but this will be as a direct result of the creation of the Public Health Service and the reallocation of the Directors of Public Health in local authorities. The costs associated with these transfers is covered in the Public Health Service impact assessment (see annex F to the coordinating document).

### *Running costs*

C69. The statutory framework proposed for health and wellbeing boards does not necessarily create new roles on top of those in the current system, instead the framework aims to find a solution to the problems above (see 'problem under consideration') by formalising the current situation proving a more robust relationship between local authorities and local commissioners.

C70. As mentioned in this impact assessment there are current examples of health and wellbeing boards already in existence. The current health and wellbeing arrangements, such as those in Birmingham, have operated and delivered successes without additional funding<sup>76</sup>. By formalising current roles and removing the current disincentives to perform the health and wellbeing board's functions, the proposed approach is assumed to create no additional running costs above those currently present. As mentioned in the assessment of the benefits the proposals provide a greater opportunity for increased benefits. They are consistent with the Government's agenda for reducing bureaucracy and creating efficiency as health and wellbeing boards have the potential to create improved immediate outcomes using the same financial resources. These improved immediate outputs (as signified with a red line in figure 1) create the opportunity to transmit through to improved outcomes for patients from improved commissioning.

C71. The proposed framework is adaptable to local needs in its design. It provides health and wellbeing boards and local authorities flexibility to expand the roles of the boards. This means that there is the possibility for increased running costs for the boards. However any additional funding will be as a result of local decisions and the reallocation of local authority and local NHS budgets<sup>77</sup>, rather than additional costs to the system as a whole. Furthermore, as mentioned in the previous paragraph, current examples of health and wellbeing boards have operated providing improvements for patients and the public without additional funding. This provides flexibility at a local level to cater for local needs whilst remaining committed to reducing bureaucracy and creating efficiencies.

C72. This impact assessment therefore argues, as with transition costs mentioned above, that as current roles and functions are being formalised rather than significant new ones being created,

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<sup>75</sup> Based upon DH contact with JSNA teams in local authorities.

<sup>76</sup> See: <http://www.bhwp.nhs.uk/Apps/Content/HTML/ViewContent.aspx?id=29>

<sup>77</sup> Including Commissioning groups allocations and the public health ring-fenced budget, if applicable to the nature of the health and wellbeing board's proposed expanded role



the running costs of health and wellbeing boards will be minimal compared to current running costs, with a best estimate of zero.

### *Summary and overall assessment*

C73. Health and wellbeing boards have the potential to realise further opportunities in integrated working, joint commissioning and making services more tailored to local area requirements. These opportunities are possible because of their underpinning design:

- the membership of the boards bringing relevant local professionals and representatives together;
- their position in local authorities allowing them to work closely with other 'general determinants of health; and
- their inclusion of locally elected representatives when assessing needs and agreeing joint health and wellbeing strategies.

C74. It is the conclusion of this impact assessment that health and wellbeing boards will have a net benefit; their benefits will outweigh their costs. Whilst the benefits described above cannot be monetised, they reinforce the potential benefits from the Commissioning and Public Health impact assessments. Furthermore as the statutory framework builds upon current examples of health and wellbeing boards, the transition costs to the new system for health and wellbeing boards are assessed to be low and significantly outweighed by the opportunity for benefits.

C75. As a recent report by the Audit Commission (2009ii) highlights, 'central government could do more to support joint working'<sup>78</sup>. The proposals for health and wellbeing boards represent an opportunity for this to occur.

## **vi. Risks**

C76. This section outlines the potential risks in implementing the proposed health and wellbeing boards that may affect the assessment of the costs and benefits.

C77. In general the risks relating to the benefits of increasing local democratic legitimacy are relatively small and arise from the introduction of democratic involvement at a local level to underpin and improve processes that are already in place. The responses consultation highlighted some potential risks of the proposals. The design of the final proposals for health and wellbeing boards has been informed by the responses to the consultation and various measures, such as the proposals for joint health and wellbeing strategies, have been designed to mitigate such risks. The Government's Response to the Consultation<sup>79</sup> sets this out in more detail.

C78. There is a risk that increased local democratic involvement may increase the likelihood of decisions and recommendations being made that are political rather than based upon the local needs. Whilst introducing locally elected representatives into the decision making has the potential for decisions to better reflect local needs, but raises the potential for local party politics to impinge on NHS business<sup>80</sup>.

C79. Local health professionals and representatives of HealthWatch sitting on the boards could find themselves mired in national-local disputes if the political complexion of central and local authorities differed. They could also suffer from discontinuities of political leadership due to political turbulence, or a clear lack of leadership if councils did not have a clear party majority.

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<sup>78</sup> Audit Commission (2009ii), '*Means to and end: joint financing across health and social care*', see:

<http://www.audit-commission.gov.uk/nationalstudies/health/financialmanagement/Pages/91029meanstoanend.aspx>

<sup>79</sup> See consultation response. *Liberating the NHS: Legislative framework and next steps*.

<sup>80</sup> Thorlby R, Lewis R and Dixon, J; 2008, 'Should Primary Care Trusts be made more locally accountable?', King's Fund



One of the main aims of the White Paper was to reduce the day-to-day political interference in commissioning decisions by creating a statutory basis for the NHS Commissioning Board and clinical commissioning groups, to protect them from interference in commissioning decisions at both a local and national level. To ensure their autonomy, both the Commissioning Board and clinical commissioning groups remain solely responsible for their commissioning decisions, and neither are obligated to gain approval from local councils or health and wellbeing boards for their commissioning decisions.

- C80. Increasing local democratic legitimacy has to consider the problem of low turnout and the related risk that there would be only limited 'reach' into all sections of the community. This risk is especially strong in elections with poor turnout<sup>81</sup>. However, the potential for the limited 'reach' into the all sections of the community is mitigated by the wider membership of the board. The locally elected representatives are not the sole representatives of the public on the health and wellbeing board. While not democratically elected, the inclusion of representatives from local HealthWatch and clinical commissioning groups, as well as the potential to include representatives from other local authority responsibility areas looking at 'general health determinants' ensures that different sectional interests are represented, and reduces the risk that limited 'reach' to the voting public becomes a detrimental effect.
- C81. There is also a risk, as with the other policies in the Health and Social Care Bill, that the transition costs will be higher than as stated in the individual impact assessments. This includes the possibility of initial reduced performance than expected. However, the following will help mitigate this risk:
- reissuing the JSNA guidance in light of Coalition policy;
  - working with the Local Government Improvement and Delivery (LGID) and other partners to provide good practice support during the transition;
  - the encouragement of "early implementer" health and wellbeing boards operating in 2011/12;
  - the measures taken to phase the implementation of the health and wellbeing boards with shadow running in 2012/13; and
  - the fact that the proposals aim to formalise the current situation and provide a more robust local relationships rather than create many new functions.
- C82. Furthermore, there is the risk that the running costs of the health and wellbeing boards will increase in the future as they decide at a local level to take on more responsibilities to meet local priorities. However, any increased cost of health and wellbeing boards will have to be financed through agreed budgets and be subject to the same budgetary responsibilities as currently exist, reallocating funding from local authority and NHS budgets<sup>82</sup>. Also, as mentioned in the costs section (see paragraphs C69 and C72) current examples of health and wellbeing boards have operated providing improvements for patients and the public without additional funding, reducing the chance of this potential risk.
- C83. On particular transition risk that the consultation responses highlighted was the concern that existing pooled budget arrangements, particularly in mental health and learning disability services, could fall automatically as a result of the abolition of PCTs and the proactive needs for clinical commissioning groups to establish new arrangements in time. This creates the risk of lower quality care being delivered to patients during the transition. To mitigate this risk, as mentioned in the Government's response to the consultation, the Government plans to make a provision whereby all existing arrangements that have not been addressed as part of the transition planning are saved after 1 April 2013, prior to commissioning groups and local

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<sup>81</sup> *ibid.*

<sup>82</sup> See also paragraph 67

authorities entering into new arrangements. This will reduce the transition risk on patient outcomes.

C84. However, it is not believed that these risks will be significantly detrimental to the outcomes proposed in this impact assessment. Other system structures, the changes to the initially proposed policy and the measures aiming to assist the transition to the new system have the potential to mitigate these risks. These are shown in the Equality Analysis action plan.

## Annex 1: Post Implementation Review (PIR) Plan

**Basis of the review:** [The basis of the review could be statutory (forming part of the legislation), it could be to review existing policy or there could be a political commitment to review];

Please see coordinating document Post-Implementation Review section.

**Review objective:** The purpose is to investigate whether the expected outcomes from the formalisation of health and wellbeing boards are being delivered: both changes to system for needs assessment and the promotion of holistic approaches across health and social care and joined-up commissioning and the extent to which these changes have improved patient outcomes.

**Review approach and rationale:** The approach will examine information held by the bodies in the new system. It will then analyse the impact of health and wellbeing boards on service change and the impact on service users.

**Baseline:** The approach will examine information from the system as it stands in 2015 and compare this to information from bodies that preceded. For example, PCTs and SHAs.

**Success criteria:** That the policy meets the objectives outlined on the front page. It will be challenging to fully attribute these solely to the individual policies within the Health and Social Care Bill, given their interlinked and mutually reinforcing nature. Further criteria will be judged by any improvements to the Joint Strategic Needs Assessment process that the proposals drive and the improvements in patient and public involvement that local health and wellbeing boards create.

**Monitoring information arrangements:** The key accountability of local health and wellbeing boards is to the local citizens they serve. Some arrangements will be developed locally, with local involvement. The overarching Post Implementation Review may also develop a core suggested set of information. For more information, please see Post Implementation Review information for overarching impact assessment.

**Reasons for not planning a review:** N/A

<b>Title:</b> <b>HealthWatch</b> <b>Lead department or agency:</b> <b>Department of Health</b> <b>Other departments or agencies:</b>	<b>Impact Assessment (IA)</b>
	IA No: 6033
	Date: 25/08/2011
	Stage: Final
	Source of intervention: Domestic
	Type of measure: Primary legislation

## Summary: Intervention and Options

### What is the problem under consideration? Why is government intervention necessary?

Frontline clinicians and healthcare service managers can have differing opinions about what constitutes a good quality service for the patient. This situation can lead to needs and expectations not being fully met, and has the potential to lead to inequalities in healthcare provided. Engaging the public well has been shown to deliver better value for money and this currently is not being fully achieved.

Some people lack the information and/or skills to make health care choices (around 500,000 people currently use the Primary Care Trust Patient Advice and Liaison Service each year) and complain when a service does not meet their expectations/acceptable standards (around 13,000 use the Independent Complaints Advocacy Service each year).

### What are the policy objectives and the intended effects?

1. To give people a real input into decision making about the shape of health and care services, both nationally and in local communities.
2. To ensure that (where necessary) people are supported to make choices and complain about health and care services.
3. To reduce variation across England in both access to these services and the chance of an issue about an individual's care being addressed. This should in turn address inequalities in healthcare provided and lead to a better patient experience, improved health for people and increase the cost effectiveness of services.
4. To reduce the likelihood of significant adverse events, such as high mortality rates at a specific hospital.

### What policy options have been considered? Please justify preferred option (further details in Evidence Base)

1. Do nothing
2. Create a HealthWatch system to represent, at national level and local levels, people using health and social care services and move NHS complaints advocacy to local arrangements.

Creating a HealthWatch system is the preferred option as it will strengthen existing functions for patient voice (Local Involvement Networks) and help improve NHS complaints advocacy arrangements by bringing them within local arrangements and making better routes for patients to shape care and access health related complaints advocacy services.

<b>Will the policy be reviewed? It will be reviewed</b> <b>What is the basis for this review? PIR</b>	<b>If applicable, set review date 04/2015</b> <b>If applicable, set sunset clause date N/A</b>
<b>Are there arrangements in place that will allow a systematic collection of monitoring information for future policy review?</b>	Yes

**SELECT SIGNATORY Sign-off** For final proposal stage Impact Assessments:

***I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) the benefits justify the costs.***

Signed by the responsible Minister: ..... *Harriet* ..... Date: ..... *1.9.11* .....

# Summary: Analysis and Evidence

# Policy Option 2

## Description:

Creation of HealthWatch

Price Base Year 2010	PV Base Year 2010	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: -139.9	High: 175.5	Best Estimate: 12.9

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	9.8	2	12.5	<b>119.9</b>
High	11.0		13.4	<b>129.7</b>
Best Estimate	11.0		13.4	<b>129.7</b>

### Description and scale of key monetised costs by 'main affected groups'

Staff for provision of national and local HealthWatch, accommodation, communications and expenses for volunteers.

Costs on government budgets are multiplied by 2.4 to reflect opportunity costs of health gains foregone, (see note below). Therefore, while financial transition cost of establishing HealthWatch is £4.6m, where the economic cost used for the IA is £11m (£4.6m\*2.4). Similarly for ongoing costs.

### Other key non-monetised costs by 'main affected groups'

No other key non-monetised cost

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	0	N/A	-1.2	<b>-10.3</b>
High	0		35.1	<b>305.3</b>
Best Estimate	0		17.0	<b>142.5</b>

### Description and scale of key monetised benefits by 'main affected groups'

Improvements to the patient experience and health outcomes stemming from stronger public voice and changes in the cost of providing these services to the exchequer.

### Other key non-monetised benefits by 'main affected groups'

Improved services and patient confidence as a result of more people being given complaints advocacy. Reduced likelihood of significant adverse events through better information flows.

### Key assumptions/sensitivities/risks

Discount rate (%)

3.5%

The key risks are:

1. local authorities may choose not to fully fund local HealthWatch.
2. local HealthWatch being accountable to and funded by local authorities under contractual arrangements could reduce their independence and effectiveness.
3. output over the transition period may be reduced because of the introduction of new service providers and establishment of HealthWatch structures.

A full set of risks and analysis of impact and mitigation is given in paragraphs D96-D121. Costs on government budgets are multiplied by 2.4 to reflect opportunity costs of health gains foregone, which are 2.4 times greater than the Exchequer cost (see DH technical guidance for explanation of calculation). The 2.4 multiplier has been applied to the cost and cost saving estimates above.

Direct impact on business (Equivalent Annual) (£m):

Costs: 0

Benefits: 0

Net: 0

In scope of

No

Measure classified as

NA

## Enforcement, Implementation and Wider Impacts

What is the geographic coverage of the policy/option?	England				
From what date will the policy be implemented?	01/10/2012				
Which organisation(s) will enforce the policy?	Local Authorities & Care Quality Commission				
What is the annual change in enforcement cost (£m)?	0				
Does enforcement comply with Hampton principles?	Yes				
Does implementation go beyond minimum EU requirements?	No				
What is the CO <sub>2</sub> equivalent change in greenhouse gas emissions? (Million tonnes CO <sub>2</sub> equivalent)	<b>Traded:</b> 0		<b>Non-traded:</b> 0		
Does the proposal have an impact on competition?	No				
What proportion (%) of Total PV costs/benefits is directly attributable to primary legislation, if applicable?	<b>Costs:</b> 100		<b>Benefits:</b> 100		
Annual cost (£m) per organisation (excl. Transition) (Constant Price)	<b>Micro</b> 0	<b>&lt; 20</b> 0	<b>Small</b> 0	<b>Medium</b> 0	<b>Large</b> 0
Are any of these organisations exempt?	No	No	No	No	No

## Specific Impact Tests: Checklist

Set out in the table below where information on any SITs undertaken as part of the analysis of the policy options can be found in the evidence base. For guidance on how to complete each test, double-click on the link for the guidance provided by the relevant department.

Please note this checklist is not intended to list each and every statutory consideration that departments should take into account when deciding which policy option to follow. It is the responsibility of departments to make sure that their duties are complied with.

Does your policy option/proposal have an impact on...?	Impact	Page ref within IA
<b>Statutory equality duties</b> <a href="#">Statutory Equality Duties Impact Test guidance</a>	Yes	EA Annex D
<b>Economic impacts</b>		
Competition <a href="#">Competition Assessment Impact Test guidance</a>	No	n/a
Small firms <a href="#">Small Firms Impact Test guidance</a>	No	n/a
<b>Environmental impacts</b>		
Greenhouse gas assessment <a href="#">Greenhouse Gas Assessment Impact Test guidance</a>	No	n/a
Wider environmental issues <a href="#">Wider Environmental Issues Impact Test guidance</a>	No	n/a
<b>Social impacts</b>		
Health and well-being <a href="#">Health and Well-being Impact Test guidance</a>	Yes	96-112
Human rights <a href="#">Human Rights Impact Test guidance</a>	Yes	EA
Justice system <a href="#">Justice Impact Test guidance</a>	No	n/a
Rural proofing <a href="#">Rural Proofing Impact Test guidance</a>	Yes	EA
<b>Sustainable development</b> <a href="#">Sustainable Development Impact Test guidance</a>	No	n/a

## Evidence Base (for summary sheets) – Notes

Use this space to set out the relevant references, evidence, analysis and detailed narrative from which you have generated your policy options or proposal. Please fill in **References** section.

## References

Include the links to relevant legislation and publications, such as public impact assessment of earlier stages (e.g. Consultation, Final, Enactment).

### No. Legislation or publication

- 1 Health and Social Care Bill 2011
- 2 Equity and excellence: liberating the NHS, white paper July 2010  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_117353](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353)
- 3 Consultation “Liberating the NHS: Increasing democratic legitimacy in health” –  
[http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH\\_117586](http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_117586)
- 4 Consultation “Liberating the NHS: commissioning for patients”  
[http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH\\_117587](http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_117587)
- 5 Government response to the NHS Future forum report  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_127444](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127444)

## Evidence Base

### Annual profile of monetised costs and benefits\* - (£m) constant prices

	Y <sub>0</sub>	Y <sub>1</sub>	Y <sub>2</sub>	Y <sub>3</sub>	Y <sub>4</sub>	Y <sub>5</sub>	Y <sub>6</sub>	Y <sub>7</sub>	Y <sub>8</sub>	Y <sub>9</sub>
<b>Total Transition costs</b>	0.0	3.4	7.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0
<b>Total Annual recurring cost</b>	0.0	0.0	9.6	16.8	18.0	18.0	18.0	18.0	18.0	18.0
<b>Total annual costs</b>	0.0	3.4	16.3	16.8	18.0	18.0	18.0	18.0	18.0	18.0
<b>Total Transition benefits</b>	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
<b>Total Annual recurring benefits</b>	0.0	0.0	6.7	13.4	19.6	23.8	26.0	26.8	26.9	26.6
<b>Total annual benefits</b>	0.0	0.0	6.7	13.4	19.6	23.8	26.0	26.8	26.9	26.6

### One In One Out

From 1st September 2010 all INs (new regulation) that impacts the private sector and civil society organisations (formerly known as 3<sup>rd</sup> sector) must have balancing OUTs (removal of old regulation; recast regulation to reduce burdens; and simplifications). The proposals around HealthWatch are out of scope of this.

## A. What is the problem under consideration? Summary of analytical narrative

- D1. Frontline clinicians and health/care service managers can have different views of a good quality service from service users. This can lead to sub-optimal delivery in meeting user needs and expectations, and has the potential to lead to health inequalities.
- D2. This is because there is a lack of exchange of information: on some occasions views from patients are not sought, not shared appropriately, or do not influence behaviour of some health and care professionals. In particular, while current arrangements help the collection and feeding in of local/community views to those who make the decisions, there are no ways of ensuring those views lead to changes that better meet patient/public need.
- D3. Currently there is lots of local intelligence on service user concerns and suggestions, but this is not always pieced together effectively in a way that best channels local action. In addition, some aspects of system development in health and social care are suboptimal, and in some instances a failure to involve service users is a contributory factor.
- D4. Alongside this, enquiries into significant local health system problems, such as high mortality rates and poor patient experience at Mid-Staffordshire NHS Foundation Trust, suggest that problems developed and persisted because of failings with organisational accountability and lack of scrutiny.
- D5. And, Local Involvement Networks (LINks) have delivered an estimated £116 million of improvements to the value of health and social care services in 2009-10 (source: Local Involvement Networks annual reports 2009-10 – see paragraphs D69-D77 for details).
- D6. There are high levels of variation in productivity and efficiency at the moment:
- For complaints advocacy, the average cost per case in 2009-10 of £939 (source: Independent Complaints Advocacy Service (ICAS) management information). After adjusting for the different mix of cases, there is more than a three-fold variation in cost per case (from £414 to £1,282).
  - Support for choice, from data of five PCT Patient Advice Liaison Services (PALS) services, they provide again around a three-fold variation in cases per member of (full time) staff, from 647 to 1,917.
  - From the LINK annual reports 2009-10, in some areas, the LINK sought and received views on health and care services from 3% the population, but some areas very few people (under ½%) were engaged. Similarly, while some LINKs were able to demonstrate examples of where they had influenced local decision making, over half of LINKs reported that what they had done had not led to service change.
- D7. Some people lack the information and/or skills to make choice of local health care services and complain when a service does not meet their expectations/acceptable standards. This may be due to a lack of awareness of sources of information or lack of access to these sources, or support to make sense of the information. We do not know the exact scale of the problem, though of the 152,000 complaints made to the NHS, the ICAS service provided advocacy support for 12,000 people, an increasing number in recent years.
- D8. On support for choice, around 3.8 million people change GP practice each year (Source: Exeter Payments system), most of whom have moved house. While 25% people say they only have one GP practice close enough to travel to (Ipsos-MORI primary care tracker survey), this leaves 2.9 million people who move practice who could potentially make choices of GP practice. Only 70 per cent of people have online access (source: National Statistics options survey 2009), leaving 870,000 people who could potentially need support that is not on-line. Plus there are significant inequalities associated with this access: only 35% of people aged 65+ have ever used the



internet and while 95% of people with a degree level qualification live in a household with internet access, only 52% of people with no formal qualifications do so.

## Rationale for intervention

- D9. Without a scrutiny function, there is an increased risk of significant problems, such as seen in mid-Staffordshire, emerging. There is evidence that where health and care users help shape services, this can improve quality and value for money for services. Government support can help realise these benefits in a way that reduces variation across England and improves flows of information, both from service users and around the system.
- D10. There are a range of existing services that champion the voice of health and care users and support them (where necessary) in making complaints or exercising choice over their care. These services maintain equality of service provision across society, but are relatively low benefit and are unlikely to be established organically without Government support.
- D11. The evidence base below gives more details on these claims.

## B. What are the policy objectives and the intended effects?

- D12. **HealthWatch England** will be set up as a statutory committee of the Care Quality Commission (CQC), with a role in representing, at a national level, people using health and social care services.
- D13. HealthWatch England will have a role in identifying concerns about services that are underperforming. To achieve this in a way that does not duplicate CQC's functions in relation to this, it will use evidence from Local HealthWatch to identify concerns about poorly performing services. It will then be able to advise CQC that they review those services. This gives the public, through HealthWatch England, a major voice in identifying concerns and ensuring action is taken.
- D14. HealthWatch England will provide national leadership and support to Local HealthWatch organisations. It will be able to advise the Secretary of State for Health, the proposed NHS Commissioning Board, local authorities and regulators, including CQC itself. The Bill requires the CQC to respond to advice from its HealthWatch England committee, and the Secretary of State to consult HealthWatch England on the mandate to the NHS Commissioning Board.
- D15. HealthWatch England will have to be consulted about any new commissioning guidelines developed by the NHS Commissioning Board on which could include guidelines on choice and competition and by Monitor, who will have a duty to involve people in decision about the exercise of its functions and we envisage HealthWatch England could facilitate such involvement. Thus, HealthWatch England will be able to influence national strategy, policy and operations, as well as the registration and regulation of services.
- D16. **Local HealthWatch organisations** will be the local consumer champion across health and social care; they will potentially have a role in new arrangements for healthcare complaints advocacy, which will replace arrangements with Independent Complaints Advocacy Service and will provide support to people to help them make health and social care choices. There will be a duty on the person appointing members to seek to secure that its membership is representative of local people and service users – this will include carers. Local Involvement Networks will cease to exist. Local HealthWatch organisations will:
- retain LINKs' existing responsibilities to promote patient and public involvement, and to seek views on services which can be fed back into local commissioning;
  - have continued rights to enter and view provider services and to make recommendations;
  - continue to be able to comment on changes to local services.

- D17. The White Paper proposes giving Local HealthWatch additional functions and funding, for supporting individuals to exercise choice. In addition, local authorities may contract with Local HealthWatch to provide NHS complaints advocacy services.
- D18. Local HealthWatch will be able to report concerns about the quality of local health and social care services to HealthWatch England independently of their host authority, to inform the need for potential regulatory action.
- D19. **Local authorities** will fund local HealthWatch organisations and contract for their services. They will have an important responsibility holding Local HealthWatch or hosts, where involved, to account for delivering services that are effective and value for money. In the event of under-performance, we expect they will intervene and, in appropriate cases, will be able to terminate arrangements and enter into new arrangements. They will be able to apply to the Secretary of State for an order abolishing Local HealthWatch jointly with HealthWatch England.
- D20. Each local authority will have to establish a health and wellbeing board covering representatives of health, public health and adult social care. The board will include a Local HealthWatch representative, to ensure that feedback from patients and service users can be reflected in commissioning plans.
- D21. Local authorities will assume responsibility for arranging NHS complaints advocacy, currently provided as a national function under the Independent Complaints Advocacy Service (ICAS) contract. They will be able to commission complaints advocacy through Local HealthWatch.
- D22. **Clinical Commissioning Groups** will have a duty of public and patient involvement, and will need to engage patients and the public in their neighbourhoods when planning commissioning arrangements or proposing changes to those arrangements that will have an impact on service delivery. Commissioners (and service providers and others) will have a duty to have regard to findings from Local HealthWatch. As such, commissioners and service providers will need to establish and nurture new relationships with Local HealthWatch and with HealthWatch England, as will the NHS Commissioning Board.

## C. What policy options have been considered?

### 1. Organisational form for HealthWatch England

- D23. Options considered were making HealthWatch England
- a standalone organisation,
  - part of the NHS commissioning board,
  - a statutory committee of the Care Quality Commission.
- D24. We are making HealthWatch England statutory committee of CQC because it builds on CQC's focus on using patient experience to influence the regulation of services. It is usual for regulators to have a formal consumer representative body. This also makes good economic sense in today's financial climate, and will enable us to establish HealthWatch England more quickly, so that it can provide support and leadership Local HealthWatch as it develops.
- D25. The main risk for setting up HealthWatch England within CQC is that it would not be an independent body in its own right. To address this, we will need to ensure that HealthWatch England has a clear identity within CQC i.e. is a statutory committee with specified functions that will need to be exercised by it. We can also encourage HealthWatch England to have clear and transparent processes for ensuring patient views count.

## 2. Role of HealthWatch England

- D26. Having made the decision to place HealthWatch England within CQC, there is also a decision to be made about the size of HealthWatch England and its role. Options considered ranged from:
- An independent function within CQC with strong leadership and support role for local HealthWatch to set and support standards;
  - A small secretariat for a committee of CQC, with a national leader but no role in supporting local HealthWatch or analysing and representing patient views.
- D27. Following consultation, HealthWatch England will be set up as a statutory Committee of CQC. HealthWatch England's membership will be provided for in regulations. We intend that the Chair of HealthWatch England will be a Non-Executive Director of CQC, and will also sit on CQC's Board.
- D28. CQC, LINKs and the voluntary sector will be engaged to invite views on how the other members of the HealthWatch England committee should be appointed. A clear message from the consultation is that the HealthWatch England committee should include elected representatives from local HealthWatch groups. Subject to the outcome of engagement, it is anticipated that the Committee will include appointed and representative members.
- D29. CQC will engage stakeholders to set out proposals for how HealthWatch will operate within CQC so that it maximises synergies with existing roles and responsibilities alongside its distinct role – for example alerting Monitor and the NHS Commissioning Board to concerns raised by patients.

## 3. Organisational form of local HealthWatch

- D30. Options considered were to
- Use a host/volunteer relationship as exists for LINKs;
  - Create Organisational entities "HealthWatch <place>".
- D31. As local HealthWatch organisations will have responsibilities for helping individuals by advising people about services and accessing advocacy services it is proposed that they will become bodies corporate. As an organisation in its own right, the role of hosts may need to change, but it is possible that hosts will be involved in the arrangements for Local HealthWatch. We will work with local government, the voluntary sector and LINKs to discuss models of working for Local HealthWatch, including the role of hosts.

## 4. Routes for funding local HealthWatch

- D32. Options considered were to fund:
- As part of local authority allocations;
  - As part of public health allocation to local authorities;
  - Outside local authorities and distribute direct to local HealthWatches.
- D33. The independent NHS Future Forum report concluded that funding for Local HealthWatch should not be ringfenced and that local authorities will be held to account through the new health and wellbeing boards and overview and scrutiny committees. The Future Forum added that the onus was on Local HealthWatch to be transparent and clear in their areas of focus as the most likely route for providing value for money and secure funding. As such, it will be preferable for them to be part of the local authority funding envelope.

## **5. Accountabilities of local HealthWatch**

D34. Options considered were that local HealthWatches are:

- contracted by local authorities and accountable to them for performance;
- contracted by local authorities, but accountable for performance to HealthWatch England;
- wholly accountable to HealthWatch England.

D35. Following consultation, and based on the importance of localism, arrangements for local HealthWatch will be contracted by and accountable to local authorities. HealthWatch England will provide leadership and support. We envisage this will be in the form of standards against which local authorities and Local HealthWatch organisations themselves will be able to benchmark their performance.

## **6. Roles and responsibilities in provision of NHS complaints advocacy**

D36. Options considered were:

- Local authorities can contract accredited organisations to provide these services;
- Local authorities can commission their local HealthWatch or HealthWatch England to provide this service;
- Local HealthWatch employ people and directly provide this service.

D37. There were strong opinions about this and it is proposed that from April 2013 local authorities will commission NHS complaints advocacy services, which are delivered through Local HealthWatch organisations or another provider. This will continue to meet high standards for NHS complaints advocacy.

## **7. Roles and responsibilities in provision of information to support choice**

D38. Options considered were that this role would:

- be fulfilled by employees of local HealthWatch;
- be fulfilled by volunteers;
- be fulfilled by a combination of employees of local HealthWatch and volunteers;
- subsume existing PCT PALS information and choice functions into local HealthWatch.

D39. Feedback on this was less than expected, though with the development of clinical commissioning groups, the possibility that some PALS work for primary care could be provided by local HealthWatch was raised. However, this would not cover services provided by hospital PALS service. It is ultimately up to local HealthWatch how it exercises this function, but we will help local HealthWatch develop their model based upon the feedback from the engagement exercise and bearing in mind responses to the consultations on choice and information.

## **8. Representation of HealthWatch on local authority health & wellbeing boards**

D40. Options considered were to:

- To include HealthWatch on local authority health and wellbeing boards;
- Omit Local HealthWatch on Boards.

D41. It was decided following the consultation that Local HealthWatch should be members of the health and wellbeing board. This will be a new role.

## D. Option 2 Impacts, Costs and Benefits

### Assessment of costs

D42. This section summarises the estimated costs associated with the establishment and running of national and local HealthWatch.

### HealthWatch: total funding

D43. Total funding for the functions of HealthWatch is estimated to be £60.5m/£68.8m/£66.1m/£66.6m over 2011-12 to 2014-15. New funding is likely to be £1.4m/£9.7m/£7.0m/£7.5m in these years.

### Local HealthWatch: Existing Funding

D44. It is our intention to redirect funding for the following activities to local authorities:

- *NHS Complaints advocacy*: The Department of Health currently holds a central budget of £11.7 million for the Independent Complaints Advocacy Service for this. The ICAS contract will be maintained in 2011-12 and 2012-13. From 2013-14, the funding will be transferred to local authorities to commission complaints advocacy which will be delivered through local HealthWatch or another provider;
- *Existing functions of Local Involvement Networks*: DH allocates a grant of £27m to local authorities for LINKs, plus £1m for regional LINKs support through the Government Offices. In addition, DH spends £50,000 on LINKs exchange information sharing website;
- *Helping the public with health related decisions*. Based on the estimated cost of the Primary Care Trust (PCT) PALS function, the cost of this activity is £19.3 million per year. This is calculated using an evaluation of PALS (source: National Evaluation of Patient Advice and Liaison Services Final Report, Evans & al. Jan 2008) as follows:

(a) from this report, the average cost of a PCT PALS service (updated to 2009-10 costs) is £169,000.

(b) The report also states that time spent dealing with functions other than providing information and signposting to enable people to make better choices is around 35% of staff time.

(c) Assuming that staff costs account for 70% of the total costs, this suggests that the signposting role accounts for an estimated 75% of existing spend by PCTs i.e. around £127k per PCT at 2009-10 prices

To check the quality of this estimate, the Department is collecting data as part of NHS annual accounts on the current spending by PCTs on their PALS functions. This may change the estimate of the cost of the functions transferring to and the total funding envelope for HealthWatch. This figure will be used to estimate the funding required by HealthWatch and does not indicate a change in arrangements to provide PALS services.

### Local HealthWatch: New funding

- *Lost economies of scale* in commissioning complaints advocacy services: there is currently one advocacy office for six local authorities so commissioning advocacy services by local authorities will result in a loss of economies of scale and additional training costs. This is estimated to be £2.5m per year.
- *Increased demand for choice*: we expect that patient demand for help to make choices will increase with the new arrangements. Patients currently search for different routes for

information and support. The aim of HealthWatch is to make this easier and clearer for patients. We have allowed funding of £0.5m/£1m/£1.5m over 2012-13 to 2014-15 for an annual increase of 2.5% above the existing spend.

### HealthWatch England: New funding

- D45. We have made an initial estimate of the new functions for HealthWatch England of a maximum of £3.5m to fund staff (and associated costs) to undertake the functions outlined above.
- D46. There will also be *additional start up costs* for HealthWatch in 2011-12 and 2012-13 including staff recruitment/training, office set up and branding. Total cost is £4.6m, split £1.4/£3.2 over these two years. This is additional funding for this to avoid disrupting current delivery of existing services.

**Table 1: Summary of financial costs**

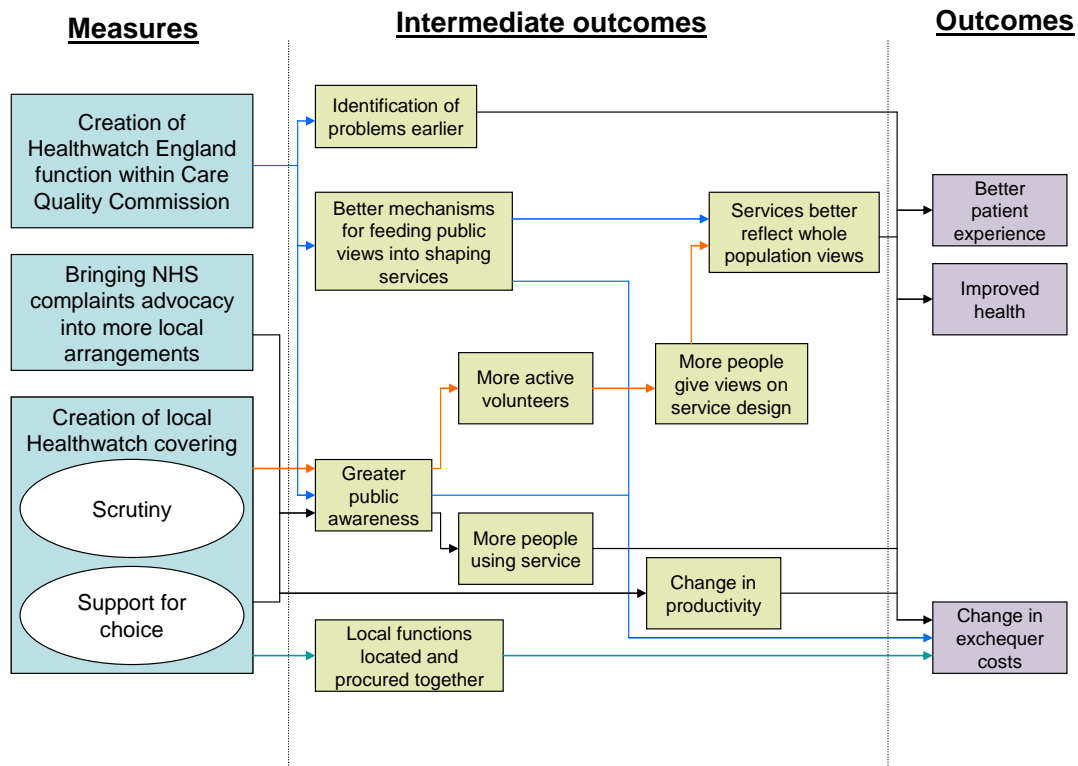
£m	2011/12	2012/13	2013/14	2014/15
<b>Existing HealthWatch funding</b>				
LINKs	28.1	28.1	28.1	28.1
Independent Complaints Advocacy Service	11.7	11.7	11.7	11.7
PALs expenditure in PCTs	19.3	19.3	19.3	19.3
<b>TOTAL</b>	<b>59.1</b>	<b>59.1</b>	<b>59.1</b>	<b>59.1</b>
<b>Additional SR funding</b>				
Lost economies of scale	0	2.5	2.5	2.5
Increased demand for choice and complaints	0	0.5	1	1.5
New HealthWatch England functions	0	3.5	3.5	3.5
Start up costs	1.4	3.2	0	0
<b>TOTAL</b>	<b>1.4</b>	<b>9.7</b>	<b>7</b>	<b>7.5</b>
<b>Total transition costs</b>	<b>1.4</b>	<b>3.2</b>	<b>0</b>	<b>0</b>
<b>Total ongoing costs</b>	<b>59.1</b>	<b>65.6</b>	<b>66.1</b>	<b>66.6</b>
<b>Total funding for HealthWatch</b>	<b>60.5</b>	<b>68.8</b>	<b>66.1</b>	<b>66.6</b>

- D47. The additional Spending Review funding in table 1 is the financial cost of implementing the changes proposed. As the additional costs fall on the Exchequer (i.e. on public finances), the opportunity cost of these impacts are included for the purpose of the Impact Assessment. The costs presented on page 93 therefore reflect the opportunity cost of the additional HealthWatch funding – applying the DH multiplier of 2.4 to additional public financial costs – rather than the financial costs presented in table 1. See page 93 for a further explanation of why an opportunity cost multiplier is used.

### Assessment of benefits

- D48. The model below captures the possible effects of introducing HealthWatch.

# Cost and benefit model for HealthWatch



D49. This section will summarise available evidence of the extent to which these expected links and outcomes are likely, in particular:

- (1) HealthWatch England will provide a mechanism to feed the views of the public into regulators assisting regulators in the early identification of problems;
- (2) Creation of HealthWatch will mean more people using complaints advocacy, support for choice services and volunteering to help in scrutiny role;
- (3) More people involved in scrutiny leads to services better shaped by the public;
- (4) There is a link between public influence over service design and outcomes such as improved health, better patient experience and changes in exchequer costs;
- (5) There is a link between complaints advocacy and experience/quality of services;
- (6) There is a link between support for choice and experience/quality of services;
- (7) There is a reduction in variation across England in the productivity of services.

D50. This will help explain which are the parts of the proposals key to delivering better outcomes and value for money and the key risks.

- (1) [HealthWatch England will provide a mechanism to feed the views of the public into regulators assisting regulators in the early identification of problems;](#)

D51. Enquiries into significant local health system problems, such as in mid-Staffordshire suggest that problems developed and persisted because of failings with organisational accountability and lack of scrutiny. In February 2010, the National Quality Board published a report “Review of Early Warning Systems in the NHS”. This spelt out roles in reducing the chance of these problems happening in future. The CQC were asked to develop a Quality and Risk Profile System bringing together a range of local intelligence and nationally benchmarked data.



- D52. What HealthWatch can add to this is to provide more intelligence through HealthWatch England into the Quality and Risk profiling system. In particular, where it is felt that patients are not being responded to and services are failing, HealthWatch England will be able to advise CQC about what is happening, creating an additional safeguard in the system. It can also provide a way to potentially share advice from the central system to inform the role of local HealthWatch in recommending investigations. Given the importance of independent intelligence in preventing these problems, HealthWatch could play a key role. To do so, there needs to be mechanisms for giving advice both ways between HealthWatch England and local HealthWatch.
- D53. This also suggests that some skills in analysing intelligence will be needed by local HealthWatch in order to prioritise their work in an effective way. This will need to form part of the training for local HealthWatch members.
- D54. There are risks with duplication of effort in targeting work relating to service review (between local HealthWatch and CQC and Monitor). The National Quality Board has been asked to review the Early Warning System guidance, given the planned changes to the health service architecture. To ensure clarity of roles, it is important that HealthWatch is covered by this guidance.
- D55. In addition, the Parliamentary and Health Service Ombudsman plays an important role in complaints about the NHS. Following the Ombudsman's public consultation, which was published in April 2010, the Health and Social Care Bill will allow the Ombudsman to share her complaints investigation reports and statements of reasons for not investigating more widely. Adding this kind of information to the picture of care for a provider of NHS care should further contribute to the early identification (and prevention) of significant problems.
- (2) [Creation of local HealthWatch and the changes to arrangements for NHS complaints advocacy services will mean more people using NHS complaints advocacy services, demanding support for choice and volunteering to help in scrutiny role.](#)
- D56. For a public facing demand led service, such as support for choice, brand awareness is an important determinant of the demand for that service. One PCT PALS service gathered information about how users found out about their service. This suggests that the majority of users are recommended the service by people with knowledge of what it does (MPs, frontline clinicians and other health organisations account for 72%). An expansion of referrals from these groups is likely to depend on the scope of the offer from HealthWatch.
- D57. Of particular relevance is the recent announcement around widening the scope of choices available to people about their healthcare services [“Liberating the NHS: greater choice and control – Government response – Extending patient choice of provider” published on 19<sup>th</sup> July 2011]. This is likely to increase the demand for support for choice services. In addition, clinical commissioning groups will be under a specific duty, in the exercise of their functions, to act with a view to enabling patients to make choices with respect to aspects of health services provided to them. The impact assessment for the choice consultation and the consultation on changes to GP practice boundaries give more details.
- D58. If marketed well, the creation of local HealthWatch should build a higher public facing brand than current arrangements. An example of this was the move to set up Walk in Centres. Following their introduction, there was a 14% rise in service users on urgent care services. While this is not directly indicative of the scale of rise in the case of local HealthWatch, it is the closest example.
- D59. Most people who volunteer do so by being directly asked to (source: Citizenship survey, plus see equality analysis). This suggests that there will be little increase in the number of volunteers as a direct result of an increased brand awareness in the public. This is reinforced by information from



a LINK that shows how people found out about it: The vast majority (83%) were directly from LINKs activity (Richmond LINK annual report 2009-10).

D60. The risk here is that the people who would benefit from local HealthWatch the most are crowded out by demand from people who could get the gain from information or complaints through other routes. It is will be important that HealthWatch market their services in a way to ensure coverage of those who will benefit most. The fact that the Bill now has an explicit requirement in relation to Local HealthWatch's membership and that Local HealthWatch itself has a requirement that the persons with whom it makes arrangements for the exercise of its functions or to assist it, are representative of the local population should help.

(3) [More people involved in scrutiny leads to services better shaped by the public.](#)

D61. Analysis of 2009-10 LINKs annual reports suggests no relationship between a greater number of LINKs members, participants or active volunteers and the extent to which services were changed following LINK inspired studies.

D62. What the analysis of the LINKs reports revealed was that there was only one issue that was linked to LINKs inspiring service change. This was them delivering reports and recommendations to commissioners. Therefore, this suggests reducing variability in this between local HealthWatch will be key to them delivering high levels of benefit.

(4) [There is a link between public influence over service design and outcomes such as improved health, better patient experience and changes in exchequer costs](#)

D63. There is not a strong evidence base around this area (Source: Invest for Engagement website, Picker Institute, 2010). However, there is an emerging set of information.

D64. Analysis of over 50 changes to health services since 2005 suggests that in the vast majority of examples it is clear that public engagement (done well) improves value for money by improving quality. This led to a more detailed study of 14 case studies where engagement with the public in shaping services also led to reduced exchequer costs (Source: An Economic Case for Patient and Public Engagement in Healthcare: Decision Making Report. Frontline consultants, March 2010). This found benefits from engaging with the public to include:

- reduced waiting times
- improved quality of care
- improved safety
- improved economic productivity and reduction in benefit claims
- patient and carer experience and satisfaction
- improved quality of life
- improved access and equitable access
- improved choice
- organisational reputation and improved relationships with the local community
- valuing ongoing engagement as a precursor for further economic benefit
- improved staff satisfaction, motivation and development in terms of a better understanding of the patient perspective.

D65. The study found that "In many cases, engagement was not linked to direct savings, but more closely linked to other benefits. However, many people spoken to suggest that patient and public engagement [PPE] was the 'enabler' to release savings; that without the 'engagement key' the lock to the door containing the room full of savings could not be opened".

D66. There is also evidence from social care that people being involved in designing and controlling their own care support leads to better value for money (greater satisfaction) and also to lower

spending (source: evaluation of personal budgets). This evidence is clear for younger users but equivocal for older users (where initial care packages are much smaller). There is also evidence (evaluation of direct payments support fund) that the benefits are greater when there is a reliable source of advice and support locally.

- D67. Finally, information from LINKs 2009-10 annual reports allows us to estimate the scale of benefit achieved by LINKs. There are many ways that LINKs can improve the health and care of people in their area. Some are indirect or it is difficult to establish direct causation between LINKs input and benefit achieved. Included in the LINKs annual reports or submitted to the Department separately are case studies of times LINKs have inspired local service change.
- D68. Given the latest analysed reports cover LINKs' second year of operating, there are a limited number of case studies where service change has been made and the effects of that change seen. To estimate the scale of benefit, we have quantified the gain from three case studies that have actually delivered.

### **Case study 1: Sefton LINK**

- D69. Service user research identified problems with hospital discharge. The LINK led research with patients, carers and hospital Trust, set up & led working group, developed collaborative list of actions and publicised actions to service users.
- D70. This led to improved discharge procedures and reductions in delayed discharge. Days of delayed discharge for the Sefton area were 5,232 in 2008-09, dropping to 3,468 in 2009-10<sup>83</sup>. This is a fall of 1,764. A parliamentary enquiry estimated the cost of a day of delayed discharge as £144 in 2001-02<sup>84</sup>. Given an increase in health costs of approximately 3.5% per year since then, an estimated cost of delayed discharge in 2010-11 is £196. Using this information, the estimated saving from improved discharge in Sefton is £346,000 per year.

### **Case study 2: Wakefield LINK**

- D71. A new hospital had lower bed capacity and there was little momentum in setting up intermediate care alternative. The LINK set up a public meeting to gather evidence, researched inspection reports and reported findings to the PCT. As a result of the LINK action, new intermediate capacity was set up.
- D72. This reduced length of stay at the main hospital, balancing the costs of setting up the intermediate care unit. In addition, there was a reduction in cancelled ops: there were 1,316 cancelled operations in 2008-09, but only 786 in 2009-10 (a reduction of 530)<sup>85</sup>. Given the cost of a cancelled operation in 2008-09 was £456 (Payment by results tariff S22), this suggests a saving of £242,000 per year.
- D73. There may also be reductions in delayed discharge or readmissions, though information was not available about these LINK aspects to quantify the savings.

### **Case study 3: Blackburn with Darwen LINK**

- D74. They identified a problem with hospital signage leading to "did not attend" & potential health problems in emergencies. They arranged a public meeting, attended the Overview & Scrutiny Committee and conducted further research including enter & view. They reported their concerns and made proposals for change to the hospital trust. The trust made changes to signs inside and outside the hospital.

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<sup>83</sup> Source: Vital Signs Monitoring Return (VSMR) data, Department of Health

<sup>84</sup> <http://www.parliament.the-stationery-office.co.uk/pa/cm200102/cmselect/cmhealth/617/61704.htm#n22>

<sup>85</sup> Quarterly Activity Statistics, Department of Health

D75. This led to reductions in “did not attends”: In quarter 4 of 2008-09, there were 4,913 did not attends of the 45,841 people due to attend an outpatient appointment (10.7%). In quarter 4 of 2009-10, there were 5,240 did not attends of the 51,942 people due to attend an outpatient appointment (10.1%)<sup>86</sup>. Given that in 2009-10 there were 161,321 people due to attend an outpatient appointment, the reduction of 0.6% in the did not attend rate equates to a reduction of 1,148 did not attends. Given the average cost of this is £100, this represents a saving of £115,000 per year.

D76. There may be other savings or improvements associated with this change that are not quantified.

### **Calculation of total benefit and return on investment**

D77. The average benefit across quantified examples is £271,000 per year. From the LINKs annual reports 2009-10, there were 426 LINK inspired service changes. Assuming these quantified changes were representative of all 426, the total benefit delivered through this part of LINKs activity is £116 million.

D78. Given spend on LINKs was £24.7 million in 2009-10, this suggests a net benefit of £91 million, a return on investment of £3.70 for every pound spent on LINKs. An investigation of the LINKs inspired service changes reported in the 2009-10 annual reports suggests the gain delivered is split 33% on changes that predominantly deliver cost savings while improving quality, 22% on changes that mainly improve health and 44% on changes that improve user experience. Therefore, in the calculation of total benefit, the 33% of benefit attributable to cost savings is multiplied by 2.4 to reflect opportunity costs of reducing exchequer spend (as described and applied to costs on page 93).

D79. However, a 2010 study by PriceWaterhouse Coopers found these benefits will be maximised only when certain conditions exist. Those particularly relevant here are

- Board level support for public engagement;
- Engagement is included in Service Level Agreements with other providers;
- Organisations have ongoing networks with key user groups.

D80. Part of the role of HealthWatch is to promote these conditions.

D81. The calculation of net benefit stemming from the scrutiny role of local HealthWatch assumes that LINKs currently inspiring low levels of change will improve at a faster rate when they become Local HealthWatch than under the current system. Our assumption is that Local HealthWatch organisations inspiring fewer than three changes per year will increase:

- Under the do nothing scenario, 40% of LINKs will move from 0 to 1 change, 1 to 2 changes and 2 to 3 changes each year (apart from in 2012-13 when we assume this is 25%, as LINKs contracts would be re-tendered in that year);
- under the low benefit scenario, 40% of Local HealthWatch organisations will move from 0 to 1 change, 1 to 2 changes and 2 to 3 changes each year (apart from in 2012-13 when we assume this is 20%, as local HealthWatch is established in that year);
- under the high benefit scenario, 70% of Local HealthWatch organisations will move from 0 to 1 change, 1 to 2 changes and 2 to 3 changes each year (apart from in 2012-13 when we assume 50%).

D82. This gives a negative benefit of £1.3-£1.8 million per year under the low benefit scenario and £40-55 million benefit per year under the high benefit scenario (after 2013-14).

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<sup>86</sup> Quarterly Activity Statistics, Department of Health

(5) [There is a link between complaints advocacy and experience/quality of services](#)

D83. This was explored in the impact assessment for the reform of the complaints system published in February 2009. This found that there was not enough evidence to quantify patient benefits, however it did identify these to be around patient confidence in the NHS and service providers.

D84. We have calculated exchequer benefit by an assumption of reduction in the variation between areas in the cost per case. Under the low benefit scenario, organisations with a cost per case above the average move 5% of the way towards the average each year (under the high benefit scenario this is 10%). Total benefits under the low scenario cumulate each year, reaching £270,000 after 10 years (under the high scenario this is £539,000 after 10 years).

(6) [There is a link between support for choice and experience/quality of services](#)

D85. Support for choice is about improving the information people have to make health related decisions. Quality of information or signposting is important, as it will make the patient feel better supported to manage their health. The majority of patients (85%) who feel that the information they received was poor, do not feel supported by local services and organisations.

D86. Quality of information seems to be driven by the level of trust people have in the source, with over 75% of information from friends and colleagues being seen as good, compared to just over 50% from leaflets/posters (source: self care survey, Department of Health/Ipsos-MORI 2009). Therefore, it is important that local HealthWatch brands itself as a trustworthy source of information, perhaps building on its *independent patient champion* role.

D87. We can quantify the benefit: the value people would be prepared to pay on average for choice of GP practice is estimated to be £3.37 (source: Cheraghi-Sohi S, Hole AR, Mead N, McDonald R, Whalley D, Bower P et al. What Patients Want From Primary Care Consultations: A Discrete Choice Experiment to Identify Patients' Priorities. *Annals of family medicine* (2008)).

D88. There is no national figure for the number of people who are given information to support choice. However, using data from eight PALS annual reports and scaling up based upon the population they cover, there are an estimated 455,000 queries dealt with by PCT PALS each year. Many of these queries are not about choice of GP practice (for those PALS annual reports containing this data, around half were about choice of dentist and a quarter about GP practices). However, assuming other calls are of the same value, this suggests a total estimated benefit to patients of this information of £1.5 million per year. Given the proposed extra spend on support for choice of £1.5 million by 2014-15, this should deliver an additional benefit of £294,000 per year by then.

D89. The average cost per query for information for choice services from PCT PALS is £42 [source: available PCT PALS annual reports]. This is above what we would expect: the average cost of NHS Direct's service for information about health conditions is £32.52. Therefore, there is some scope for efficiency gain. This also suggests that support for choice service in local HealthWatch needs to market the service to ensure coverage of people who are most likely to gain.

D90. So, the additional benefit is calculated by an assumption of reduction in the variation between areas in the cost per case. Under the low benefit scenario, organisations with a cost per case above the average move 2.5% of the way towards the average each year (under the high benefit scenario this is 5%). Total benefits under the low scenario cumulate each year, reaching £585,000 after 10 years (under the high scenario this is £1.17 million after 10 years).

(7) [There is a reduction in variation across England in the productivity of services](#)

D91. There is considerable variability across England in the impact of Local Involvement Networks (LINks), efficiency of Independent Complaints Advocacy Service (ICAS) and productivity of the PCT Patient Advisory & Liaison Service (PALS). Details are given in paragraph D6 above.

- D92. In the support for choice role, there is a very strong relationship in that more productive areas are those who undertake more activity. This is perhaps related to the variability in service workload across the year and suggests there are some economies of scale in providing this service less locally or merging with other information provision services. This does not hold for either complaints advocacy (where cases are resolved over a slower timetable) or for scrutiny.
- D93. Other factors driving variation in productivity are partly things HealthWatch has no control over, such as the socio-demographics of the population, configuration of health and care services. However, variation in productivity is also caused by differences in interpretation of role and organisational form, in performance management, in quality of staff and how services are marketed.
- D94. This suggests there is significant scope to improve productivity and efficiency of HealthWatch compared to existing functions. In particular, we can:
- Propose common organisational forms for local HealthWatch, which will be achieved by setting it up as a corporate body;
  - Develop staff and volunteer competencies and discuss with HealthWatch England how training can be made available for HealthWatch employees and volunteers; and
  - Work with CQC to establish core standards for the delivery of Local HealthWatch functions.
- D95. There is clearly a need to ensure independence for local HealthWatch for it to be able to set its own priorities and have its voice heard,, though we need to ensure there are systems in place for HealthWatch to account for the money it spends. A common framework for reporting around outcomes and efficiency should allow organisations to compare their activity with others and potentially reduce variation. This will need to be part of HealthWatch England's leadership role and can also be considered in issuing directions on matters to be addressed in annual reports.

## E. Risks

- D96. There are a number of risks associated with the implementation of HealthWatch. The section below summarises the key risks identified, implementation options to address these risks or decisions on the way HealthWatch will be set up.
- (1) [There is a risk that local authorities may limit the extent to which they fund local HealthWatch.](#)
- D97. In 2009-10, from the £27 million distributed to local authorities for LINKs, £24.3 million was received by LINKs and host organisations (source: LINKs annual reports 2009-10). However, the context is that there is a significant cost pressure upon local authorities over the coming years and a number of priorities.
- D98. Funding for HealthWatch was proposed to be taken from overall local authority allocations, meaning there is not a legal obligation to spend all this money on local HealthWatch. However, the functions of local HealthWatch will be a legal obligation and need to be funded. Given that complaints advocacy and support for choice are demand led roles, the likely consequence, therefore, of lower levels of funding for HealthWatch would be to a reduced scrutiny role.
- D99. Here, there is a weak relationship between level of funding and outcomes. The only statistically significant relationship is that LINKs with more funding tend to deliver more reports and recommendations (Pearson's product-moment correlation coefficient  $r=0.21$  for healthcare,  $r=0.36$  for social care).
- D100. There is a weak (non-statistically significant) correlation that suggests LINKs receiving a greater proportion of funding are likely to have:

- more members (and active members) per head of population ( $r=0.07$  ( $r=0.14$  for active))
- undertake more activity ( $r=0.12$  for requests for information);
- inspire more service reviews and changes ( $r=0.13$  for service review,  $r=0.12$  for service changes).

D101. This suggests that reductions in funding could directly impact upon what local HealthWatch delivers, though other means of ensuring good value are equally as important.

D102. This is being mitigated against by continuing to provide a legal obligation for local authorities to make arrangements for provision of the functions of local HealthWatch, including some existing functions. Further mitigations against this risk are currently being considered.

#### (2) Cross England variations seen for LINKs continue or worsen in HealthWatch

D103. Variation is expected, given the different needs of areas across England. However, as quantified above, the reach and impact of LINKs currently depends on where you happen to live.

D104. Two separate funding routes for national and local HealthWatch could create a lack of cohesion. If there were inadequate leadership or support by HealthWatch England, this is likely to significantly reduce the benefits coming from giving advice based on intelligence from local communities and mean greater levels of variation.

D105. This is assessed earlier in the impact assessment, together with considering the financial mitigations above.

#### (3) There is a risk that tying local HealthWatch into local authorities could reduce their independence and effectiveness.

D106. The Health and Social Care Bill would result in a duty on Local Authorities to fund local HealthWatch arrangements. This may be perceived as a conflict of interest, given the role of local HealthWatch in relation to scrutiny. Work is underway to map out the concept of independence for Local HealthWatch and use this to promote the arrangements as accountable to local government for performance and to local citizens for the issues raised with commissioners and providers.

#### (4) There may not be capacity for change, given other changes in the Health sector and reductions in administrative support in local authorities and Government Offices

D107. The White Paper proposed a significant number of changes for the healthcare system. The Comprehensive Spending Review laid out reductions in budgets for local authorities. To mitigate this risk, the Department of Health has worked with stakeholders involved in the proposed functions of HealthWatch to produce an agreed transition plan. This was published on 30th March 2011, see link [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_125582](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_125582). In considering the issues in moving from the Independent Complaints Advocacy Service to this function being the responsibility of local authorities, the decision was taken to delay the move until April 2013. Following the report from the NHS future forum, the functions of HealthWatch will now begin in October 2012 rather than April 2012. A revised transition time line is being developed and will be published.

#### (5) Short term reductions in effectiveness associated with change.

D108. In 2008-09, LINKs were developing membership, relationships with local communities and their governance arrangements. As a consequence, many LINKs struggled to report what they achieved and when they reported, levels of membership and activity were relatively low. In 2009-

D109. Hosts, that support LINKs, were initially on a three year contract, so with or without the move to HealthWatch, there is the potential for a degree of change. It is important that there is learning from current LINKs/hosts about how Local HealthWatch organisations become effective quickly. This is one of the issues being addressed by HealthWatch pathfinders.

D110. Part of the accountability to local authorities could be performance measures that, while reflecting some disruption as local HealthWatches form, are still stretching.

(6) [HealthWatch England may have conflicting roles.](#)

D111. This stems from the fact that we are setting up roles in feeding into official channels (in CQC, NHS Commissioning Board) and HealthWatch England being independent.

D112. We need to be clear on roles across the system, so people are clear where HealthWatch England stands and how to strike the balance between independence and being an active part of the health and care system.

(7) [There is potential duplication of HealthWatch England functions.](#)

D113. HealthWatch England will have the power to advise the CQC on the views of people, local HealthWatch and other persons and as part of this could advise the CQC to carry out reviews based upon emerging concerns from intelligence gathered by local HealthWatch and other sources. This may be local, regional or national concerns. Others, particularly CQC and Monitor have formal inspectorate functions. There may be potential duplication in functions around analysis of intelligence and in review work, with the CQC, but also the Health and Social Care Information Centre in collecting intelligence. Clarity on roles is vital for CQC.

D114. A report from the National Quality Board in February 2010 spelt out roles in a quality and risk profiling system. This had crucial roles for SHAs and PCTs and needs to be rewritten for the new health and care service architecture. This new work should include the role of HealthWatch.

D115. There needs to be a similar distinction of roles within CQC between HealthWatch England and other parts of CQC. This is to some extent clarified in the Bill with a requirement for HealthWatch England to exercise specified functions and for CQC to respond to advice from its HealthWatch England committee.

(8) [People who would benefit from HealthWatch the most are crowded out](#)

D116. This is where, in a service open to all, demand from people who could use other routes to get the get information they need crowd out those who truly need the service. It is will be important that local HealthWatch markets their services in a way to ensure coverage of those who will benefit most.

(9) [There is potential for duplication or conflicting working between local HealthWatches.](#)

D117. There will be times where providers of health or care services cross local authority boundaries. It is an important leadership role for HealthWatch England to ensure local HealthWatches work together to look into common areas of interest.

(10) [Clinical commissioning groups may not have the capacity to respond effectively to reports from local HealthWatch](#)



- D118. People are much more likely to be involved if they feel they can have an influence over decisions (source: Citizenship survey 2008-09). The formal way LINKs inspire change is by making reports and recommendations to commissioners (currently Primary Care Trusts and Local Authorities). Considering and acting upon recommendations from local HealthWatch takes management resource, which is being reduced. Currently there are 150 LINKs and 152 Primary Care Trusts, whereas there may be significantly more Clinical Commissioning groups. There are likely to be cases where multiple commissioners are significant contractors of the same service provider.
- D119. This is being mitigated in the new Bill: commissioners and providers (among others) will have a duty to have due regard to views, reports and recommendations from local HealthWatch, though the making of reports etc. will sometimes need to be considered with CQC to avoid duplication.
- (11) [There is potential duplication/conflict between local HealthWatch and the formal health and care sector](#)
- D120. Providers and commissioners of health and care services already (and will continue to) take an active role in public and patient participation. As this develops in the new health care architecture alongside health and wellbeing boards having duties in relation to local public involvement, there may be different organisations in the same areas looking into the same issue.
- D121. It is important to have ways of sharing intelligence locally on what service users value. This suggests building relationships is an important role and competency for HealthWatch staff and it is important think through further other ways to make these local links stronger.



## Annexes

Annex 1 should be used to set out the Post Implementation Review Plan as detailed below. Further annexes may be added where the Specific Impact Tests yield information relevant to an overall understanding of policy options.

### Annex D1: Post Implementation Review (PIR) Plan

A PIR should be undertaken, usually three to five years after implementation of the policy, but exceptionally a longer period may be more appropriate. A PIR should examine the extent to which the implemented regulations have achieved their objectives, assess their costs and benefits and identify whether they are having any unintended consequences. Please set out the PIR Plan as detailed below. If there is no plan to do a PIR please provide reasons below.

<p><b>Basis of the review:</b> [The basis of the review could be statutory (forming part of the legislation), it could be to review existing policy or there could be a political commitment to review];</p> <p>This review is to get better value from HealthWatch, and will at a minimum be based on the annual reports of local HealthWatch organisations and HealthWatch England.</p>
<p><b>Review objective:</b> [Is it intended as a proportionate check that regulation is operating as expected to tackle the problem of concern?; or as a wider exploration of the policy approach taken?; or as a link from policy objective to outcome?]</p> <p>The purpose is to investigate whether the expected outcomes from the introduction of HealthWatch are being delivered: both changes to system for patient voice (e.g. are there more people engaged in shaping services and making choices) and the extent to which these changes have improved patient outcomes.</p>
<p><b>Review approach and rationale:</b> [e.g. describe here the review approach (in-depth evaluation, scope review of monitoring data, scan of stakeholder views, etc.) and the rationale that made choosing such an approach]</p> <p>The approach will examine data held by HealthWatch. It will then analyse the impact of HealthWatch on service change and the impact on service users.</p>
<p><b>Baseline:</b> [The current (baseline) position against which the change introduced by the legislation can be measured]</p> <p>The approach will examine data held by HealthWatch and compare this to information from Local Involvement Networks, Independent Complaints Advocacy Service and Patient Advice &amp; Liaison Services that preceded HealthWatch</p>
<p><b>Success criteria:</b> [Criteria showing achievement of the policy objectives as set out in the final impact assessment; criteria for modifying or replacing the policy if it does not achieve its objectives]</p> <p>HealthWatch will be a success if the views and feedback from patients and carers are taken account of better in local commissioning decisions in health and social care and users feel better supported to make choices and complain about these services when necessary.</p>
<p><b>Monitoring information arrangements:</b> [Provide further details of the planned/existing arrangements in place that will allow a systematic collection systematic collection of monitoring information for future policy review]</p> <p>The key accountability of local HealthWatch is to the public they serve and local authorities with whom they are working. These arrangements will be determined locally, though national HealthWatch may develop a suggested core set of information to help understand the overall impact of HealthWatch.</p>
<p><b>Reasons for not planning a PIR:</b> [If there is no plan to do a PIR please provide reasons here]</p> <p>N/A</p>

<b>Title:</b> <b>The Department of Health's Public Bodies Impact Assessment</b>  <b>Lead department or agency:</b> <b>Department of Health</b> <b>Other departments or agencies:</b>	<b>Impact Assessment (IA)</b>
	IA No: 6034
	Date: 25/08/2011
	Stage: Final
	Source of intervention: Domestic
	Type of measure: Primary legislation

## Summary: Intervention and Options

### What is the problem under consideration? Why is government intervention necessary?

Changes being made to the wider health system have offered opportunities to review the sector, to ensure it is both value for money and fit-for-purpose as the system around it evolves. As part of this, DH has identified anomalies in organisational structure, areas of duplication and inefficient use of resources. While the ALB sector delivers functions that are vital in rectifying the market failures that exist in the healthcare market, it is possible that this can be delivered more affordably. In the case of the Office of the Health Professions Adjudicator (OHPA), please see [http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH\\_122293](http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_122293)

### What are the policy objectives and the intended effects?

The objectives and intended effects of this policy are: to streamline the ALB infrastructure by reducing the numbers of ALBs, and by reducing duplication of functions and processes; reduce central bureaucracy and ensure practical demonstration of the principles of good regulation; reduce intervention to release more time for frontline staff to improve the delivery of services; and drive up efficiency in order to reduce the costs of the sector and ensure value for money.

In the case of OHPA, please see

[http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH\\_122293](http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_122293)

### What policy options have been considered? Please justify preferred option (further details in Evidence Base)

Two options have been considered:

Option 1: Do nothing, maintain the status quo of 18 ALBs and continue to establish the Office of the Health Professions Adjudicator (OHPA).

Option 2: Pursue the proposals set out in "Liberating the NHS: Report of the arm's length bodies review" and no longer proceed with the creation of OHPA (for the full outline of OHPA proposals please see [http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH\\_122293](http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_122293))

This is the preferred option because it will bring about efficiencies and alignment with other changes to the health sector, while maintaining or improving the quality of services currently provided by the ALBs.

Will the policy be reviewed? It will be reviewed	If applicable, set review date 01/2014
What is the basis for this review? duty to review	If applicable, set sunset clause date
Are there arrangements in place that will allow a systematic collection of monitoring information for future policy review?	Not applicable

**SELECT SIGNATORY Sign-off** For final proposal stage Impact Assessments:

*I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) the benefits justify the costs.*

Signed by the responsible Minister: ..... *Harvz* ..... Date: ..... *1.9.11* .....

# Summary: Analysis and Evidence

# Policy Option 2

## Description:

Pursue the proposals outlined in DH's ALB Review which require primary legislation and abolish OHPA

Price Base Year 2010	PV Base Year 2010	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: Optional	High: Optional	Best Estimate: 433.0

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate	43.5	7.8	105.5

### Description and scale of key monetised costs by 'main affected groups'

Transition costs to DH of implementation includes the relocation of staff, establishing staff on new HR/IT systems, redundancy payments, and early exit of estate costs. Costs on government budgets have been multiplied by 2.4 to reflect opportunity costs and are included in the estimates above. Ongoing annual costs are to private doctors, professional registrants and the GMC following changes to the CQC, CHRE, GSCC and OHPA. Costs are split into separate ALBs and OHPA in Tables 3a, 3b, 4a, 4b and 4c.

### Other key non-monetised costs by 'main affected groups'

Indirect costs of organisational change (loss of stakeholder assurance, disenchanted workforce) are also considered.

In the case of OHPA, avoidance of OHPA and GMC transition costs, producing a saving for the Department of Health, and reduction in operating costs leading to a saving for GMC registrants.

BENEFITS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate	35.1	61.1	538.4

### Description and scale of key monetised benefits by 'main affected groups'

The main monetised benefits are Grant in Aid reductions and synergy savings to merging organisations. Savings to government budgets are multiplied by 2.4 to reflect opportunity costs and are included in the estimates above.

### Other key non-monetised benefits by 'main affected groups'

Proposals to extend NICE's remit into social care is expected to be positive and received positive feedback in responses to the White Paper consultation. The introduction of voluntary registers by CHRE will impact on those who decide to register, and patients and the public are expected to benefit by being assured of the quality and safety of those registered.

### Key assumptions/sensitivities/risks

Discount rate (%) 3.5

For ALBs, in absence of detailed cost information assumptions are used for transition costs and benefits to inform our estimates. There is a risk therefore, that costs could be underestimated, or benefits overstated and ranges used to mitigate this. In some cases, the full detail for implementation of the proposed policies has not been determined, and so some of the costs and benefits are indicative at this stage.

In the case of OHPA, OHPA baseline has been provided based on the current, pre-operational form. Comparison against this baseline assumes accurate projections of future costs and activities by OHPA.

Direct impact on business (Equivalent Annual) £m):			In scope of OIOO?	Measure classified as
Costs: 0	Benefits: 0	Net: 0	No	NA

## Enforcement, Implementation and Wider Impacts

What is the geographic coverage of the policy/option?		United Kingdom			
From what date will the policy be implemented?		01/04/2012			
Which organisation(s) will enforce the policy?		DH			
What is the annual change in enforcement cost (£m)?		0			
Does enforcement comply with Hampton principles?		Yes			
Does implementation go beyond minimum EU requirements?		N/A			
What is the CO <sub>2</sub> equivalent change in greenhouse gas emissions? (Million tonnes CO <sub>2</sub> equivalent)		Traded: 0		Non-traded: 0	
Does the proposal have an impact on competition?		Yes			
What proportion (%) of Total PV costs/benefits is directly attributable to primary legislation, if applicable?		Costs: 0		Benefits: 0	
Annual cost (£m) per organisation (excl. Transition) (Constant Price)	Micro	< 20	Small	Medium	Large
Are any of these organisations exempt?	No	No	No	No	No

## Specific Impact Tests: Checklist

Set out in the table below where information on any SITs undertaken as part of the analysis of the policy options can be found in the evidence base. For guidance on how to complete each test, double-click on the link for the guidance provided by the relevant department.

Please note this checklist is not intended to list each and every statutory consideration that departments should take into account when deciding which policy option to follow. It is the responsibility of departments to make sure that their duties are complied with.

Does your policy option/proposal have an impact on...?	Impact	Page ref within IA
<b>Statutory equality duties</b> <sup>87</sup> <a href="#">Statutory Equality Duties Impact Test guidance</a>	Yes	EA Annex E
<b>Economic impacts</b>		
Competition <a href="#">Competition Assessment Impact Test guidance</a>	Yes	153
Small firms <a href="#">Small Firms Impact Test guidance</a>	Yes	154
<b>Environmental impacts</b>		
Greenhouse gas assessment <a href="#">Greenhouse Gas Assessment Impact Test guidance</a>	Yes	156
Wider environmental issues <a href="#">Wider Environmental Issues Impact Test guidance</a>	No	156
<b>Social impacts</b>		
Health and well-being <a href="#">Health and Well-being Impact Test guidance</a>	Yes	155
Human rights <a href="#">Human Rights Impact Test guidance</a>	No	156
Justice system <a href="#">Justice Impact Test guidance</a>	No	156
Rural proofing <a href="#">Rural Proofing Impact Test guidance</a>	No	157
<b>Sustainable development</b> <a href="#">Sustainable Development Impact Test guidance</a>	No	157

<sup>87</sup> Race, disability and gender Impact assessments are statutory requirements for relevant policies. Equality statutory requirements will be expanded 2011, once the Equality Bill comes into force. Statutory equality duties part of the Equality Bill apply to GB only. The Toolkit provides advice on statutory equality duties for public authorities with a remit in Northern Ireland.

## Evidence Base (for summary sheets) – Notes

Use this space to set out the relevant references, evidence, analysis and detailed narrative from which you have generated your policy options or proposal. Please fill in **References** section.

### References

Include the links to relevant legislation and publications, such as public impact assessment of earlier stages (e.g. Consultation, Final, Enactment).

No.	Legislation or publication
10	DEFRA (2002) “Developing DEFRA: A report on the merger for people who lead and manage change”
11	DH (2010) “Equity and Excellence: Liberating the NHS”
12	DH (2010) “Liberating the NHS: Report of the arm’s length body review”
13	Annual Reports and Accounts from Arm’s Length Bodies

### Evidence Base

Ensure that the information in this section provides clear evidence of the information provided in the summary pages of this form (recommended maximum of 30 pages). Complete the **Annual profile of monetised costs and benefits** (transition and recurring) below over the life of the preferred policy (use the spreadsheet attached if the period is longer than 10 years).

The spreadsheet also contains an emission changes table that you will need to fill in if your measure has an impact on greenhouse gas emissions.

### Annual profile of monetised costs and benefits\* - (£m) constant prices

	Y <sub>0</sub>	Y <sub>1</sub>	Y <sub>2</sub>	Y <sub>3</sub>	Y <sub>4</sub>	Y <sub>5</sub>	Y <sub>6</sub>	Y <sub>7</sub>	Y <sub>8</sub>	Y <sub>9</sub>
<b>Total Transition costs</b>	3.9	9.0	30.1	0	0	0	0	0	0	0
<b>Total Annual recurring cost</b>	0	0.6	5.4	10.3	10.3	10.3	10.3	10.3	10.3	10.3
<b>Total annual costs</b>	3.9	9.6	35.6	10.3	10.3	10.3	10.3	10.3	10.3	10.3
<b>Total Transition benefits</b>	0	35.1	0	0	0	0	0	0	0	0
<b>Total Annual recurring benefits</b>	0	1.5	55.1	79.1	79.1	79.1	79.1	79.1	79.1	79.1
<b>Total annual benefits</b>	0	36.6	55.1	79.1	79.1	79.1	79.1	79.1	79.1	79.1
<b>Business transition costs</b>	0	0	0	0	0	0	0	0	0	0
<b>Business annual recurring costs</b>	0	0	0	0	0	0	0	0	0	0
<b>Business annual costs</b>	0	0	0	0	0	0	0	0	0	0
<b>Business transition benefits</b>	0	0	0	0	0	0	0	0	0	0
<b>Business annual recurring benefits</b>	0	0	0	0	0	0	0	0	0	0
<b>Business total annual benefits</b>	0	0	0	0	0	0	0	0	0	0

\* For non-monetised benefits please see summary pages and main evidence base section; note that rounding aggregate figures may result in minor rounding errors. Non-exchequer impacts are all impacts on individuals through changes to registration fees brought about by the changes to CHRE and GSCC.

## Introduction

- E1. This impact assessment considers the result of the arm's length bodies (ALB) Review report, *Liberating the NHS: Report of the arm's length bodies review*, focussing on a number of key interventions described in the report. This assessment also considers changes to the National Information Governance Board (NIGB) and the Joint Committee on Vaccination and Immunisation (JCVI). These proposals have been made within the context of the wider changes envisaged for the NHS set out in the White Paper *Equity and Excellence: Liberating the NHS* and the cross-government agenda to increase accountability and transparency, while reducing the number and costs of public bodies.
- E2. This impact assessment sits alongside other impact assessments as part of the Health and Social Care Bill, including those on commissioning and provision; this document is Annex E of the co-ordinating document. This impact assessment discusses the changes to the Department of Health's (DH) public bodies which require primary legislation in the Health and Social Care Bill, and reflects changes in the Bill following its passage through the Commons. This impact assessment is an update to the text and figures used in the original assessment rather than substantive changes. This is because the overall policy on ALBs has remained the same, although some of the detail has changed during the passage of the Bill through Committee.
- E3. This Impact Assessment also discusses the costs and benefits for the proposal to no longer proceed with the Office of the Health Professions Adjudicator (OHPA). The monetised effects are given in Tables 3a, 3b, 4a, 4b and 4c which can be found after paragraph E135. A more thorough analysis of the proposal to no longer proceed with OHPA is covered in a separate impact assessment<sup>88</sup>, and it is not otherwise discussed below.
- E4. The Review's intention was to create an ALB sector that achieves better outcomes, is more responsive to patient's needs, has increased autonomy and clear accountability at every level, and ensures value for money. The Review aimed to guarantee that, in future, ALBs only undertook functions that needed to be done at arm's length from the Department. Some functions were to be transferred to other parts of the health and social care system, so that they were delivered at the most appropriate place in the system. Some bodies will undergo further detailed work to identify how to achieve better outcomes.
- E5. This IA is structured as follows:
- A description of the current landscape is discussed from page 119;
  - The problem under consideration is discussed at page 121;
  - A description of the sectors and groups affected is discussed from page 121;
  - Our adopted methodology is discussed at page 123;
  - Our policy objectives and intended effects are discussed at page 123;
  - Option one and its associated costs and benefits is discussed from page 124;
  - The costs and benefits of our preferred Option 2, divided by each ALB/public body are discussed from page 124;
  - The Post Implementation Review plan is referred-to in Annex 1 at page 148;
  - A description of current ALBs with figures for headcount and administrative funding is at Annex 2 from page 149;
  - An assessment of the impacts of these proposals on equality is included within the separate Annex to the coordinating document, that deals with all of the equality analysis;
  - Specific impact tests including impacts on competition, small firms, health and greenhouse gas admissions is at Annex 3 from page 153;

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- Detail of our assumptions and sources used to inform some of our cost and benefit estimates is at Annex 4 at page 158; and
- A discussion of the methodology and approaches used is at Annex 5 from page 159.

## Current Landscape

- E6. The current health and social care ALB sector is made up of 18 organisations, of which 9 are Executive Non-Departmental Public Bodies (ENDPBs), 8 are Special Health Authorities (SpHAs) and 1 is an Executive Agency. These are set out in alphabetical order in Table 1 below and a short biography for each ALB is attached at Annex 2. ALBs vary widely in size, but normally have boards, employ staff and publish accounts; they are accountable to DH and sometimes directly to Parliament; and most receive substantial funding from DH. A number of ALBs have a UK-wide remit; others cover England only, or England and Wales, and may have separate arrangements with Scotland and Northern Ireland.
- E7. This network of ALBs has been created at national level, but at “arm’s length” from DH, and they exist 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.
- E8. Table 1 below sets out the proposals taken from the ALB Review report for each of the 18 ALBs. These changes are expected to take place over the next two years, with the majority during 2012, although this will differ for each individual ALB depending on the different policies and legislation involved. This impact assessment and equality analysis covers only those changes set out below that require primary legislation at this stage.

**Table 1: The Department of Health’s 18 ALBs, September 2010**

#	ALB Name	Acronym	Review Proposal
1	Alcohol Education and Research Council	AERC	<b>Abolish</b> 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.
2	Appointments Commission	AC	<b>Abolish</b> as an ALB in view of the substantial reduction in the number of appointments required. Remaining appointments will revert back to the DH and Privy Council. The Secretary of State will direct local appointments to another NHS body, most likely a special health authority..
3	Care Quality Commission	CQC	<b>Retain</b> as quality inspectorate across health and social care, operating a joint licensing regime with Monitor. It will also be the host organisation for HealthWatch England. Current responsibility of assessing NHS commissioning moves to the NHS Commissioning Board. In the future, it will receive functions from NIGB, and may also receive functions from other organisations, e.g. HTA and HFEA. If this is the case, this will be covered in future impact assessment(s).
4	Council for Healthcare Regulatory Excellence	CHRE	<b>Remove</b> from the sector. This will be made a self-funding body, by charging a levy on regulators. Its role will be extended role to set standards for and quality assure voluntary registers.
5	General Social Care Council	GSCC	<b>Abolish and transfer</b> the role of the regulation of social workers in England to the Health Professions Council (HPC) which will be renamed the Health and Care Professions Council (HCPC) to reflect its remit across health and social care.

6	The Health and Social Care Information Centre	IC	<b>Retain</b> , in principle. The proposal is to abolish the IC as a Special Health Authority, but to establish a new body in primary legislation to take on similar functions. The IC will be a national repository for data collection across health care, public health and adult social care. It will have a clearer focus on data collection, with a close working relationship with the NHS Commissioning Board. It will also have its own powers to collect data for a number of bodies other than NHS Commissioning Board and Secretary of State, and a duty to minimise the burden of data collection.
7	Health Protection Agency	HPA	<b>Abolish</b> as a statutory organisation and transfer functions to the Secretary of State as part of the new Public Health England (PHE).
8	Human Fertilisation and Embryology Authority	HFEA	<b>Abolish</b> as an ALB. DH will consult on proposals for transfer of functions to other bodies. Analysis of these proposals will be covered in a separate impact assessment.
9	Human Tissue Authority	HTA	<b>Abolish</b> as an ALB. DH will consult on proposals for transfer of functions to other bodies. Analysis of these proposals will be covered in a separate impact assessment.
10	Medicines and Healthcare products Regulatory Agency	MHRA	<b>Retain</b> , with the expectation that it will undertake its regulatory duties in the most cost effective way.
11	Monitor	Monitor	<b>Retain</b> and make an economic regulator, operating a joint licensing regime with CQC.
12	National Institute for Health and Clinical Excellence	NICE	<b>Retain</b> , in principle. The SpHA will be abolished, and a body corporate will be established to take on similar functions. Its remit will be expanded to include adults' and children's social care.
13	National Patient Safety Agency	NPSA	<b>Abolish</b> as an ALB. Some safety functions will be retained, with the responsibility for them moved to the NHS Commissioning Board. DH will transfer National Research Ethics Service (NRES) functions to a new Health Research Authority <sup>89</sup> . National Clinical Assessment Service (NCAS) will become self-funding over the next two to three years. Confidential Enquiries will sit with the National Clinical Audit Patient Outcome Programme, managed on behalf of the Department by the Healthcare Quality Improvement Partnership (HQIP).
14	National Treatment Agency for Substance Misuse	NTA	<b>Abolish</b> as an ALB, and transfer functions to the Secretary of State as part of the new Public Health England.
15	NHS Blood and Transplant	NHS BT	<b>Retain</b> , and commission an in-depth review of opportunities to make more commercially effective. Transfer the Bio-Products Laboratory out of NHS BT into a DH owned company.
16	NHS Business Services Authority	NHS BSA	<b>Retain</b> in the short term, and commission commercial review to identify potential for increased commercial opportunities, including the potential to remove functions from the ALB sector.

<sup>89</sup> HMT and BIS (2011): *The Plan for Growth*, at p92



17	NHS Institute for Innovation and Improvement	NHSi	<b>Remove</b> from the ALB sector. Functions that will support the NHS Commissioning Board in leading for quality improvement will be moved to the Board. DH will review the potential for its remaining functions to be delivered through alternative commercial delivery models.
18	NHS Litigation Authority	NHS LA	<b>Retain</b> , and commission an industry review to identify potential opportunities for greater commercial involvement.

### What is the problem under consideration?

E9. The Government is committed to reducing unnecessary central bureaucracy and shifting power from national organisations to the frontline, patients and the public where this is appropriate to do so. Given the wider changes being made to the wider health system, it is important to ensure that the Department's ALB sector is both fit-for-purpose and provides value for money. As part of this, the Department has identified anomalies in organisational structure, areas of duplication and inefficient use of resources. Furthermore, some organisations do not fully exploit commercial opportunities, placing unnecessary pressure on public finances. While the ALB sector delivers functions that are vital in rectifying the market failures that exist in the healthcare market, it is possible that this can be delivered using a more affordable financial structure.

### Sectors and Groups affected

E10. The Review set out to change the landscape of the ALB sector. As ALBs are responsible for supporting the existing health system, and providing guidance, these proposals will affect a number of bodies, organisations, sectors and groups. All are discussed briefly below, so that the reader can see the full context. However, only those requiring primary legislation are covered in detail by this impact assessment and equality analysis.

#### ALBs

E11. There is the potential for all 18 ALBs to be influenced by changes set out in the ALB Review. Although some ALBs will only experience small changes themselves, they may be affected by changes to other bodies, due to the collaboration they have with other ALBs. The proposals and changes for each individual ALB will be discussed in the cost and benefit analysis below from paragraph E28.

#### Providers

E12. ALBs work in connection with a variety of health and social care providers, and their work has an impact on their day to day workings. Therefore, on the basis of the changes set out in this impact assessment, both health and social care providers will be affected by:

- changes to the regulatory system in the instance of self-employed health professionals (GSCC and CHRE);
- changes to administration costs from interacting with fewer bodies (CQC taking on NIGB, IC taking on all national data collections); and
- a clearer understanding of the focus of the ALB landscape and lines of accountability (moving leadership and Periodic Review functions to NHS Commissioning Board).

#### Private Sector

- E13. Many ALBs also work with private sector organisations and providers. For example, CQC regulates adult social care homes and independent and voluntary hospitals. Therefore, examples of changes covered in this impact assessment will affect private sector organisations by:
- NICE guidance, such as Quality Standards, concerning social care. This may include guidance on care in residential settings, for example; and
  - exploiting the benefits of a voluntary regulatory system (through CHRE's new role in accrediting voluntary registers).

#### Department of Health

- E14. The Department of Health will be directly affected by all the policies outlined below. Principally, changes to the financial basis of organisations will lead to reductions in the grant in aid that DH provides, in addition to changes to the relationships and sponsorship roles between ALBs and DH. Furthermore, DH will become responsible for managing any residual national public appointments following the proposed abolition of the AC. These impacts are covered in greater detail for each ALB from paragraph E30.

#### Other Government Departments (OGDs)

- E15. Whilst some ALBs work only with DH, others work across government with OGDs and may receive additional grant in aid. For example, the AC has the power to work with any OGDs on a fee basis. Therefore, of the changes covered in this impact assessment, OGDs will be affected by:
- reducing the number of ALBs they can work with (e.g. abolition of the AC);
  - easier access to health and social care data through the IC, facilitating the potential of evidence-based policy making in the future; and
  - NICE's remit is being extended to include children's social care which is the responsibility of the Department for Education.

#### Devolved Administrations (DAs)

- E16. Whilst some ALBs provide services only across England, others provide UK wide services, and some supply services to selected areas. For example, CQC regulates health and social care providers in England only, whereas the CHRE is UK wide.
- E17. DAs sometimes also provide additional public funding to ALBs. Therefore, they will potentially be affected both by a change in the level of funding they are required to provide, and by a potential shift in functions. A shift of a function to another ALB with a different geographical remit will need to be considered and managed. The Department of Health has engaged with its DA counterparts in Wales, Scotland and Northern Ireland, and identified and gained agreement on policy issues relevant to each DA.

#### Patients, Service Users and the Public

- E18. Patients, service users and the public are affected by ALBs both directly through the services they provide to the NHS, social care and DH; and indirectly through the guidance and publications they issue, and the assurance they provide by regulating health and social care services and the individuals providing them. The policy proposals covered within the preferred option will generate efficiency savings, while ensuring that the necessary functions continue to be provided, and in future by the most appropriate organisation.
- E19. Where functions are proposed to be delivered by an alternative means, it is assumed that no value will be lost. Therefore, of the changes covered in this impact assessment, patients, services users and the public will be affected by:

- expected improved collaboration between the health and social care sectors, through NICE's expanded remit;
- less bureaucratic process around supervised community treatment, through changes to CQC; and
- assurance of the standard and quality of certain health and social care professional and occupational groups with the introduction of voluntary registers accredited by the CHRE.

## Methodology

- E20. DH has worked within the framework of proposals laid out in the White Paper and has considered how these changes might offer us opportunities for additional transformation. The Department has considered the functions of ALBs to find ways to rationalise and simplify them. In addition, test criteria have been applied to ensure that only functions which should be in the ALB sector remain in the ALB sector. These criteria have guided the decisions about the ALB proposals set out in Option 2. A more detailed explanation of our methodology is included in Annex 5.
- E21. As set out in the Review report, the functions of some ALBs are still in need of further research and reviews to determine their future. This is explained further from paragraph E28.

## Objectives and intended effects of the ALB Review

- E22. There are four main objectives of the ALB Review. These are set out below along with their intended effects.
- **A streamlined sector:** A reformed ALB landscape with ALBs undertaking functions that should only be done at a national level. Each ALB will have clearly defined functions and responsibilities which will be set out in legislation and Framework Agreements. ALBs will be held to account for delivery of objectives set by the DH and their stewardship of public funds and will be expected to comply with requirements set out by the DH and Government. Clarity of functions and the expectation that the organisations will deliver only what is agreed with the DH should reduce mission creep in the system.
  - **Less bureaucracy:** Key to the effective and efficient delivery of ALBs' 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 that is far more positive, consistent and cost-effective than the sum of their individual activities. Having fewer organisations, empowered to simplify and streamline bureaucratic process, will reduce the burden of regulation and hence the cost to the sectors regulated.
  - **Reduced intervention:** Where appropriate, the level of intervention by ALBs will be rolled back, for example, integrated licensing and proportionate regulation using a risk-based approach to the frequency of inspections, and drawing on the same sources of information about compliance and professional behaviour.
  - **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, including exploiting commercial opportunities where the private sector are better placed to delivery the functions more efficiently and effectively.

## ALB Options assessment

- E23. This impact assessment considers two options.
- **Option 1:** The "do nothing" option. The status quo of 18 ALBs would be maintained within the same structure and financial basis as of April 2010.

- **Option 2:** The preferred option - “The streamlined ALB sector”. This reduces the number of ALBs in the sector, ensures alignment with wider system changes, and drives up efficiency and value for money through removing duplication and ensuring that each function is performed by the most appropriate organisation.

E24. The cost-benefit analysis for the two options will be as follows: firstly, Option 1 will be discussed; secondly, Option 2 will be analysed, taking each ALB in turn.

### **Option 1: The “do nothing” option and associated costs and benefits**

E25. Option 1 is the “do nothing” option. This reflects the *status quo* of 18 ALBs in the sector with running costs of £804 million in 2009/10<sup>90</sup>. Of this, £522m is classed as “non-frontline” spending, as outlined in the coordinating document.

E26. Option 1 is the baseline against which Option 2 is assessed. This means that all ALBs continue to exist with the same remit and the same grant in aid as that in 2009/10.

E27. However, with the proposed system architecture changes, leaving the ALB sector alone would create a confusion of roles. For example: both the NHSi and the NHS Commissioning Board would have roles in improving healthcare; both CQC and the NHS Commissioning Board would have a remit over the performance of commissioners; and the HPA and the proposed Public Health England would have overlapping roles in relation to improving and protecting public health. This reflects both the current overlap in functions and those that will result from the proposed modernisation of the health system. The burden on healthcare providers to comply with a number of regulatory requirements and information requests would still exist, in addition to high levels of bureaucracy in the sector.

### **Option 2: The preferred option and associated costs and benefits**

E28. The assessment of our ALBs as set out in the Review report means that the Department intends to make a number of changes to the ALB sector. These changes constitute our preferred option and are summarised as follows:

- CQC, Monitor, IC and NICE have a clear future as ALBs but their functions will be changing to reflect the new system architecture. From paragraphs E31, E38 and E93 the impact of the changes to NICE, CQC and IC respectively are considered. The expanding role of Monitor to cover economic regulation will be discussed in the Provision impact assessment in Annex B of the coordinating document, so is not included here. The same applies to joint licensing between Monitor and CQC.
- CHRE will be moved out of the sector to operate on a full-cost recovery basis and have new roles in accrediting voluntary registers of certain health and social care workers. CHRE’s role in overseeing regulators will be expanded to cover the oversight of the regulation of social workers in England. The analysis of the impact of this proposal is considered in paragraphs E53-E72;
- GSCC will be abolished and the role of the regulation of social workers in England will be transferred to the HPC. The analysis of the impact of this proposal is considered in paragraphs E73-E89;
- AC, AERC, NPSA and NHSi will be abolished or removed from the sector. However, this impact assessment will only cover the changes that require primary legislation in the Health and Social Care Bill: the abolition of AC and AERC, and the functions transferring to the NHS Commissioning Board from NPSA and NHSi. The analysis of the impact of these proposals is considered in paragraphs E90-92; E98-E111; E114-E125 and E126-E130. The changes to the remaining functions of the NPSA and NHSi will be dealt with separately;

<sup>90</sup> DH finance data, baseline revenue funding

- The Department intends to transfer the functions of the HFEA and the HTA to other organisations by the end of the current Parliament in order to achieve greater synergies where appropriate, and these two organisations will be abolished at that stage. These proposals will be taken forward outside the Health and Social Care Bill, and will be covered in separate impact assessments and equality analysis in due course;
- HPA will be abolished as a statutory organisation and its functions will be transferred to the Secretary of State as part of the new Public Health England (PHE). The analysis of this proposal and an assessment of the impact of this change is presented in Annex F;
- The functions of the NTA will be transferred to the Secretary of State. The NTA will be abolished through secondary legislation in due course which will revoke existing statutory instruments, therefore it is not appropriate to do any further analysis in this impact assessment;
- Section 250 of the NHS Act 2006 will be repealed in the Health and Social Care Bill. This will effectively remove the power from the Secretary of State to establish standing advisory committees in statute. One consequence of this would be the abolition of the Joint Committee on Vaccination and Immunisation (JCVI), but the Bill includes a saving provision to prevent this. The intention is for JCVI to be abolished as a statutory body at a future date, although Secretary of State intends to use his existing powers under Section 2(1)(b) of the NHS Act 2006 to reconstitute the JCVI as a non-statutory advisory body performing similar functions. The Department understands that the JCVI chair and members will be invited to become members of the new non-statutory committee when that is established. Therefore, we expect any impact of this change to be minimal and thus it is not appropriate to provide any further analysis in this impact assessment;
- NHS LA, NHS BSA and NHS BT will be subject to a further commercial review by industry experts to identify potential opportunities for greater efficiency through outsourcing, divestment and contestability and/or employee ownership. Therefore, it would not be appropriate to include in this impact assessment;
- MHRA has a clear future as an ALB, continuing to operate in the most cost effective and efficient way.
- Separately, the government has announced<sup>91</sup> that it will establish a Health Research Authority (HRA) . It will create the HRA first as a Special Health Authority with the National Research Ethics Service as its core<sup>92</sup>. It proposes later to establish the Authority in primary legislation transferring to it functions which are at present scattered across other organisations.

E29. The proposals and associated impacts that will be discussed in this impact assessment are summarised in Table 2 below.

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<sup>91</sup> *Plan for Growth*, published by HM Treasury and Department for Business, Innovation and Skills: March 2011

<sup>92</sup> see para E114 below

<b>Table 2: Summary of proposals covered in this Impact assessment</b>	
1	Expand the role of NICE to cover children's and adult social care
2	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.
3	Move some functions of the National Information Governance Board (NIGB) into CQC
4	CHRE to become funded by fees from regulators, expansion of its role to cover social worker regulation and voluntary registers
5	GSCC abolished and the role of the regulation of social workers transferred to the HPC, funded through registrant fees
6	Abolish the AERC as an ALB. The existing council intends to transfer the research fund to a new charitable body.
7	Expand the role of IC to become the main repository of national data collections
8	Abolish the AC
9	Abolish the NPSA and move responsibility for some of the work currently undertaken by the Patient Safety Division, relating to reporting and learning from patient safety incidents, to the NHS Commissioning Board
10	Transfer relevant functions from the NHSi to the NHS Commissioning Board

E30. The costs, benefits and cash releasing savings the Department expects to result from Option 2 will be discussed below for each individual ALB proposal. These are then summarised in Tables 3a, 3b, 4a, 4b and 4c which follow paragraph E135 below. The discussion of each ALB is grouped under headings according to its activity as follows:

- Raising standards - NICE
- Rationalising the regulatory landscape – CQC, NIGB, CHRE and GSCC
- Public welfare - AERC
- Information - IC
- Public appointments - AC
- Quality and safety improvement – NPSA and NHSi

### ***Raising Standards***

#### **National Institute for Health and Clinical Excellence (NICE) to be re-named as the National Institute for Health and Care Excellence**

E31. NICE is a Special Health Authority, established to improve the quality of care that patients receive and to reduce the variation in the quality of care. In future, its advice and guidance will be key to supporting the work of the Secretary of State and to the NHS Commissioning Board including developing quality standards along each part of the patient pathway with outcome indicators for each step. To do this, NICE intends to rapidly expand its existing work programme to create a broad library of quality standards for all the main pathways of care. The Health and Social Care Bill contains provision to establish NICE in primary legislation and extend its remit to social care. Its name will change to the National Institute for Health and Care Excellence to reflect its extended remit into social care.

E32. At present, NICE's guidance improves the information available to decision-makers. In the absence of NICE, commissioners would have to undertake their own evaluations which may be based on inadequate information due to budget constraints and scarcity of expertise. This could therefore lead to a misallocation of funds and reduce social equity. NICE centralises this activity, carrying out full evaluations and communicating its findings to commissioners, clinicians and other interested parties in a transparent way. Commissioners are currently mandated to fund new pharmaceutical products and other specific technologies receiving a positive NICE appraisal for all eligible patients in the NHS, thus eliminating any local discrepancies in funding policies for

these treatments. A Health Select Committee Report in 2008 noted that the appraisal processes used by NICE were commended by the World Health Organisation, with some of their guidance “regarded as the international gold standard of medical practice”.<sup>93</sup> Expanding the remit of NICE to cover social care would promote a consistent approach across health and social care, tap into NICE expertise on quality standards and exploit potential economies of scale. The Health and Social Care Bill contains provisions to ensure the NHS continues to fund drugs and treatments approved by NICE.

- E33. NICE's future activities in respect of social care are not yet fully defined, so it is not possible to definitively estimate the cost impacts of the proposals. For example, the role of the Social Care Institute for Excellence (SCIE) is knowledge capture and dissemination rather than issuing guidance. NICE will be issuing guidance, including quality standards and implementation tools and will have a different methodology to SCIE. NICE will incur costs in rebranding its organisation to reflect its wider remit. While NICE will retain the same acronym, transition cost estimates for website alterations, signs and so on are unlikely to be significant and are estimated at approximately **£9,000**.
- E34. SCIE currently incurs costs of around £4m per annum in performing its functions. It is likely that at least some of this funding will be transferred to NICE. Hence, since money will be transferred from SCIE to NICE, the net cost impact on the Exchequer will be zero. NICE also receives funding of approximately £1m from other Government departments (OGDs) and Devolved Administrations (DAs)<sup>94</sup>.
- E35. There will be impacts on SCIE following the removal of this funding. These could include impacts on staff, such as a potential negative impact on the productivity of staff over the transition period. There could also be impacts on the priorities of the organisation and there could be changes in efficiency, positive or negative, as the organisation becomes more focussed on delivering a smaller set of functions. Through implementation, SCIE intends to identify the best ways to adapt to the changes in its remit and funding, to ensure that it offers best value for money within the revised system. It is not possible to predict in advance how SCIE will change, and hence quantification of such costs and benefits are not possible.
- E36. Providing guidance for the social care sector on treating and caring for people with certain conditions is expected to improve the ability of social care organisations to allocate their budgets to the services that provide the greatest benefit to their recipients. The degree to which its guidance will beneficially influence budget allocation is difficult to estimate, and it is therefore not possible to monetise the magnitude of the benefits to be expected. The Department anticipates that this benefit could be substantial and would be large enough for the benefits of this policy to justify the costs. The total budget spent on social care, and which NICE's guidance might be expected to influence, is £16bn<sup>95</sup>. Hence, even a very small change in the way that social care funds are allocated following NICE guidance could deliver significant benefits.
- E37. From the impacts outlined above, total economic cost and benefit figures over the appraisal period have been calculated and are summarised in tables 3a and 3b. For this part of the proposal, as funding and functions are transferred, the only quantifiable impact is the transition cost of NICE re-branding in 2012/13, which has an estimated financial cost to the Exchequer of around **£9,000** (see table 3a). To reflect the benefits this money could have bought if deployed

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<sup>93</sup> House of Commons Health Select Committee First Report on NICE, January 2008, available from <http://www.publications.parliament.uk/pa/cm200708/cmselect/cmhealth/27/2702.htm>

<sup>94</sup> Source: NICE Annual Report and Accounts 2009-10

<sup>95</sup> Source: Information Centre's "Personal Social Services Expenditure and Unit Costs", 2008-9

elsewhere in the NHS, the Exchequer costs of £9000 are multiplied by 2.4<sup>96</sup> to give an Exchequer opportunity cost of **£21,600** (see table 3b).

### ***Rationalising the regulatory landscape***

#### **Care Quality Commission (CQC) – a single quality inspectorate**

- E38. There are two changes to the CQC that are covered here: the removal of its Periodic Review of NHS Bodies function; and changes to the requirements in the Mental Health Act 1983 for treatment of supervised community treatment to be approved by second opinion appointed doctors (SOADs) in the case of Supervised Community Treatment. These are each considered below. The Health and Social Care Bill also includes changes to CQC in relation to joint licensing with Monitor, and the creation of HealthWatch as a statutory committee within CQC. The impacts of these proposals are considered in other impact assessments supporting the Bill (Annex B for joint licensing, and Annex D for HealthWatch).
- E39. To prevent duplication within the new system, the ALB Review proposed transferring periodic reviews of NHS Bodies, which have previously been undertaken by the CQC, to the NHS Commissioning Board. This impact assessment considers the impacts on the CQC only, but the impact of this policy on the NHS Commissioning Board and other bodies will be covered elsewhere.
- E40. Periodic Reviews of NHS Bodies were halted by the CQC in July 2010 after agreement with ministers. Staff that previously were responsible for Periodic Reviews (of NHS Bodies) have now been redeployed elsewhere within the organisation and hence there is currently no resource within CQC to deliver this function. This policy does not therefore result in any changes to the benefits or costs associated with CQC, and there is no change to grant in aid funding.
- E41. There are also provisions in the Health and Social Care Bill for the removal of the requirement in the Mental Health Act 1983 for Second Opinion Appointed Doctors (SOADs) to approve the treatment of patients on Supervised Community Treatment (SCT) who are consenting to the treatment in question. In England, SOADs are appointed by the CQC and since the introduction of SCT in November 2008, demand for SOAD visits has grown significantly. There are therefore three main impacts of this policy: impact on CQC resources, impact on SOAD employment; and the impact on the mental health sector.
- E42. There are approximately 15,000 requests for SOAD visits each year in England (based on 2009/2010), around 18% of which (2,700) relate to SCT patients who are thought to be consenting to the treatment in question<sup>97</sup>. Assuming the level of requests remains the same until changes are introduced, the amendments made by the Bill will mean that CQC will have some 18% fewer requests to process.
- E43. CQC resource for processing SOAD requests is small - around 4-5 people - and DH does not expect this to change. Compared to the do nothing option, the CQC will also save money in not having to make payments to SOADs for visits. As noted above, we assume that the annual number of SOAD requests will fall by 2,700. We estimate the average cost per SOAD request to be £224 in 2010/11.<sup>98</sup> Overall savings are thus estimated to be around **£0.6m** pa from 2011/12 onwards. This provision will also apply to Wales and, in the absence of detailed information, a proportion of costs relative to the populations of England and Wales<sup>99</sup> have been added. Hence,

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<sup>96</sup> See Annex 4 for basis on the 2.4 opportunity cost assumption

<sup>97</sup> DH internal analysis.

<sup>98</sup> According to CQC, the 2009/10 price per SOAD was £217.3. Inflation between 2009/10 and 2010/11 was 2.9% (source: HMT GDP deflator, [http://www.hm-treasury.gov.uk/data\\_gdp\\_fig.htm](http://www.hm-treasury.gov.uk/data_gdp_fig.htm)).

<sup>99</sup> Source: Office of National Statistics: [http://www.statistics.gov.uk/downloads/theme\\_population/mid-09-uk-eng-wales-scot-northern-ireland-24-06-10.zip](http://www.statistics.gov.uk/downloads/theme_population/mid-09-uk-eng-wales-scot-northern-ireland-24-06-10.zip)



there will also be a small benefit to the Healthcare Inspectorate Wales<sup>100</sup>, assuming they have similar costs to CQC.

- E44. There will be an impact on SOADs themselves compared to the option of doing nothing. Because there will be fewer requests, there will be fewer visits to be made, and therefore the income of SOADs will fall. As above, the payments foregone as a result are estimated to be approximately **£0.6m** pa from 2011/12 onwards. There are around 120 SOADs at present (hired by the CQC) and DH does not expect any reductions in the number of SOADs. Many work part-time or are semi-retired and given current trends in demand, it is expected that the CQC will in fact increase their panel of SOADs rather than reduce it although each SOAD will be undertaking fewer visits. Hence, there are assumed to be no impacts associated with redundancies.
- E45. The removal of this requirement will also have an impact on the mental health sector. Mental health providers incur a burden from having to provide papers and information in preparation of a SOAD visit. The level of burden per case is not reduced, but – as noted above - we assume that the number of cases would be reduced by approximately 18%<sup>101</sup> compared to the option of doing nothing. In addition, there will be a benefit to those SCT patients, who feel the current process is inconvenient and even that it is offensive for their wishes to be second-guessed by a SOAD. These benefits are both unquantifiable.
- E46. There is a risk that this policy could have a detrimental impact on safeguarding patients, in that fewer treatments will now have to be approved by a SOAD. However, this risk is small because treatment approved by a clinician without the involvement of a SOAD may only be given with the patient's informed consent. The patient may withdraw consent at any time – in which case the treatment could not be continued unless the patient were recalled to hospital, at which point a SOAD certificate would be required (unless the treatment were immediately necessary, or was being continued to prevent serious suffering by the patient).
- E47. From the impacts outlined above, total economic cost and benefit figures over the appraisal period have been calculated and are summarised in tables 3a and 3b. As SOADs will no longer be paid by CQC, this is estimated as an annual cost of around **£0.6m** from 2011/12 onwards to the SOADs themselves, which counts as a non-Exchequer cost. Conversely, the same amount, over the same profile, is a financial saving to the Exchequer. However, to reflect the benefits generated by deploying this money in the NHS, the Exchequer savings are multiplied by 2.4<sup>102</sup> to give a total economic opportunity benefit of **£1.5m** pa from 2011/12 onwards.

### **National Information Governance Board (NIGB)**

- E48. The Health and Social Care Bill contains proposals to move some functions of the National Information Governance Board (NIGB) into the CQC, initially to be overseen by a statutory committee. This aims to reduce duplication, improve efficiency, and bring similar processes together under one organisation. The NIGB is a statutory body that monitors the information governance performance of NHS and social care organisations, to publish advice on how to improve performance and to advise the Secretary of State on specific information governance matters.
- E49. DH does not anticipate any substantial costs arising from this proposal. Some functions can be absorbed into CQC without any legal powers, while other functions will require small changes to CQC's communications and publications. It is expected that the costs of these changes will be

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<sup>100</sup> The responsibility of SOAD services is formally given to Welsh Ministers, but in practice it is delegated to the Healthcare Inspectorate Wales.

<sup>101</sup> Based on an assumed reduction of 2700 out of 15000 SOAD requests. This is 18%.

<sup>102</sup> See Annex 4 for basis of 2.4 assumption

minimal. It is possible that staff may transfer from the NIGB to the CQC or other organisations, but this is not yet certain.

- E50. The main benefit of bringing NIGB into CQC is removing duplication in the system. As well as NIGB, the CQC also monitors NHS and Social Care Information Governance performance and seeks to drive improvements, albeit with limited access to information governance expertise. This policy would therefore bring both processes together, leading to potential cost savings.
- E51. The NIGB currently receives £1m from DH towards staff costs and delivering these functions. Given that CQC is able to take these functions on, it is conceivable that some or all of this funding could be saved, for example by reduced staffing and administrative costs. In the absence of more complete information, there is a potential cost annual saving of £0 - £1m, with a best estimate (mid-point) of **£0.5m**, from 2012/13 onwards.
- E52. From the impacts outlined above, total economic cost and benefit figures over the appraisal period have been calculated and are summarised in tables 3a and 3b. Annual cost savings are estimated at **£0.5m** from 2012/13 onwards. To reflect the benefits generated by deploying this money in the NHS, the Exchequer savings are multiplied by 2.4<sup>103</sup> to give a total economic opportunity benefit of **£1.2m** from 2012/13 onwards (see table 3b).

### **Council for Healthcare Regulatory Excellence (CHRE)**

- E53. The ALB review report signalled the Government's intention to remove the CHRE from the ALB sector, and make it self-funding through a levy on the regulators it oversees. This is in line with the long-standing principle that regulators should be independent of both the Government and those they regulate. The funding of CHRE through a statutory, compulsory levy on the nine professional regulators satisfies both of these principles.
- E54. The levy will be compulsory - otherwise there would be a risk of an actual or a perceived compromise of CHRE's independence from the regulators. This is particularly important in view of CHRE's role in providing assurance that professional regulation is performed in a way that protects people who use services and other members of the public. Furthermore, a compulsory levy will prevent the risk of regulators benefiting from some of CHRE's services, such as the sharing of good practice, without paying the levy, which would weaken their incentive to fund CHRE.
- E55. The levy will cover the cost of all of CHRE's functions in respect of statutory professional regulation ('chargeable costs'). Specific commissions for advice will continue to be funded separately by the Secretary of State and the devolved administrations (DAs).
- E56. It is assumed that CHRE's chargeable costs will be in the region of **£2.75m**<sup>104</sup> per year<sup>105</sup>. In meeting CHRE's chargeable costs, there are several options for determining the proportion to be paid by each of the regulators. The formula for determining the levy on each regulator will be set out in secondary legislation, and DH anticipates that fees will be reviewed and set annually.
- E57. The regulators will be free to choose whether to pass on the cost of the levy to their registrants, or absorb it. For illustration, if each regulator were charged a flat rate on the basis of its number of registrants, and chose to pass this cost to its registrants, then each registrant would pay

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<sup>103</sup> See Annex 4 for basis of 2.4 assumption

<sup>104</sup> The level of CHRE's funding from the DH and the DAs in 2009/10

<sup>105</sup> This should be interpreted as a proxy for chargeable costs, as some of the work CHRE performs within this budget may be commissioned separately in future. Furthermore, CHRE's costs will vary from year to year, and so costs in 2009/10 may not be typical of its chargeable costs in future years. In particular, we would expect some increase in CHRE's costs due to its future role in the quality assurance of social worker regulation, its new role in appointments to the regulators and to its own Council, and any other future changes to its statutory role.

around £2 per year<sup>106</sup>. Registrants' fees are tax deductible, and contribute to pressure on the public sector pay bill. To the extent that regulators choose to pass on the cost of the levy, any subsequent increase in registrants' fees will also be tax deductible and contribute to upward pressure on wages. The magnitude of these effects is estimated below.

- E58. If the levy were passed on in full to registrants, and all registrants paid a marginal rate of income tax of either 20% or 40%, then the cost to the exchequer would be between £0.55m and £1.1m (**£0.83m** is taken as the best estimate, as the midpoint). Since CHRE currently receives all of its chargeable costs as grant in aid, this yields a net saving to the exchequer of between £1.65m and £2.2m<sup>107</sup>. Even if the costs were passed on in full to registrants, we consider that an increase in the cost per registrant of around £2 per year would not have any significant impact on the labour supply of professionals. Similarly, while any increase in registration fees would contribute to upward pressure on the public sector pay bill, the size of the change means that any effect would be negligible.
- E59. It is intended that CHRE will also have an expanded remit in quality assuring the professional regulation of social workers in England. The regulation of social workers will transfer from the GSCC to the HPC, which is overseen by CHRE. Although DH does not anticipate that this change will lead to any significant changes to CHRE's processes, the increase in its volume of work is likely to lead to a small increase in operating costs.
- E60. CHRE will have new powers to refer social worker final fitness to practise decisions to court when it believes a decision is too lenient. Therefore, the volume of final fitness to practise decisions it reviews will increase. The majority of CHRE's costs in reviewing fitness to practise decisions are incurred when cases are referred to court. Very few cases are referred per year, (for example, two cases were referred in 2009/10) and the number varies from year to year. As it is not possible to predict the number of annual court referrals, it is not possible to predict the resultant increase in CHRE's costs. However, in time as the benefits from CHRE's scrutiny of social worker fitness to practise decisions are realised, we expect the number of referrals to fall.
- E61. Oversight of social worker regulation in England by CHRE is likely to impose some costs on social work regulation and social workers. In preparing for CHRE scrutiny, there will be costs to the HPC that were not incurred by the GSCC (these costs are being reflected in assumptions about fee levels being made by the HPC).
- E62. Through its annual performance reviews of the HPC, and its scrutiny of final fitness to practise decisions made about social workers in England, CHRE's oversight of social work regulation in England will lead to more effective regulation. This added level of scrutiny will improve the safety and quality of social work, and maintain the confidence of the public, service users and employers in the social work profession.
- E63. For some groups working in the health and social care sectors, statutory regulation may be a disproportionate response to the level of risk to the public. In some cases, an assured system of voluntary registration could serve to both set and enhance standards of professional and occupational competence.
- E64. The Department therefore proposes to expand CHRE's remit to enable it to set standards for voluntary registration and to quality assure the systems used to deliver it. It will be for CHRE to determine its quality assurance processes, but on the basis of discussions with CHRE, DH

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<sup>106</sup> Including social workers, there will be around 1.37 million registrants of regulators overseen by CHRE. Therefore, each registrant would pay £2.75million/1.37million = £2.00.

<sup>107</sup> If all registrants pay a marginal rate of income tax of 20%, the cost to the exchequer would be 20% of £2.75million = £0.55million. Therefore, the saving in grant-in-aid would be £2.75million – £0.55million = £2.2million. If all registrants pay a marginal rate of income tax of 40%, the cost to the exchequer would be 40% of £2.75 = £1.1million. Therefore, the saving in grant-in-aid would be £2.75million - £1.1million = £1.65million.

anticipates initial set-up costs of **£100,000** in the first two years, which will be funded by the DH. CHRE expects that the annual cost will continue to be around **£100,000**, which in subsequent years will be funded through fees from the voluntary registers it accredits. The number of registers seeking accreditation is likely to increase over the first few years of the accreditation scheme. Based on previous experience of organisations taking on new professional regulation functions, DH expects CHRE to reach full cost recovery within three years.

- E65. Oversight of voluntary registers by CHRE may impose some costs on voluntary registers and their registrants. Voluntary registers will incur costs in preparing for scrutiny by CHRE, and this scrutiny may lead to more robust voluntary registration, increasing the costs of compliance for registrants. However, as registration will be voluntary, both registrants and the registering bodies will only participate where the benefit of doing so warrants the costs.
- E66. Assured voluntary registration should lead to improved standards of education, proficiency and conduct. It will also improve the ability of employers and people who use services to distinguish between workers who have met nationally accredited standards and those who have not.
- E67. The Appointments Commission (AC) currently makes appointments on behalf of the Privy Council to the health professions regulatory bodies. The costs of the appointment process are fully met by the regulatory bodies. In future, the Department proposes that the Privy Council will ask each of the regulatory bodies to manage their own recruitment process. The regulators would be free to arrange with a third party to manage this process. The CHRE would advise on good practice in appointments made to the regulatory bodies, and would provide assurance that good practice in the appointments process has been followed. Privy Council would then make the appointment.
- E68. The Department does not expect that the cost of the appointments process will change significantly under these proposals. The regulatory bodies will continue to meet the costs of the appointments process, either by making arrangements with a third party or managing the appointments process themselves.
- E69. From the impacts outlined above, total economic cost and benefit figures over the appraisal period have been calculated and are summarised in tables 3a and 3b. The estimated transition costs include the cost of CHRE's proposed role in appointments to the regulatory bodies (DH estimate of **£20,000**) incurred in 2012/13, and the cost of a quality assurance process for voluntary registration over 2011/12 and 2012/13 (**£100,000** per year). In total, transition costs add up to £0.22m, and are costs to the Exchequer. The annual financial cost to the Exchequer from 2013/14 onwards is the **£0.83m** loss in tax income from deductible fees. To reflect the benefits this money could have bought if deployed elsewhere in the NHS, the Exchequer costs are multiplied by 2.4<sup>108</sup> to give total economic opportunity costs of **£0.53m** one off (over 2011/12 and 2012/13) and **£2m** annually from 2013/14 onwards.
- E70. Whilst the **£0.83m** is an annual financial cost to the Exchequer from 2013/14 onwards, this figure represents a non-Exchequer benefit, over the same time profile, for registrants through reduced tax bills.
- E71. The annual benefits to the Exchequer are the **£2.75m** financial savings to DH through the removal of grant in aid, from 2013/14 onwards. To reflect the benefits generated by deploying this money in the NHS, the Exchequer savings are multiplied by 2.4<sup>109</sup> to give a total annual economic opportunity benefit of **£6.6m** from 2013/14 onwards (see table 3b).

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<sup>108</sup> See Annex 4 for basis of the 2.4 opportunity cost assumption

<sup>109</sup> See Annex 4 for basis of 2.4 assumption

E72. The annual non-Exchequer financial costs are the **£0.1m** running costs of the voluntary registration scheme (to be recovered through fees) and the **£2.75m** of annual fees incurred by registrants, both incurred in each year from 2013/14 onwards.

### General Social Care Council (GSCC)

- E73. The ALB Review report announced the intention to transfer the role of the regulation of social workers in England to the Health Professions Council (HPC) and abolish the GSCC. This will move the regulation of social workers out of the ALB sector to make it operationally and financially independent of government. The proposed reforms are intended to ensure that social workers in England are regulated in an effective and sustainable way that maintains confidence in the profession and credibility with the public, service users and employers. The HPC will also take on the GSCC's function in relation to the approval of courses for people who are, or wish to become, approved mental health professionals in England for the purposes of the Mental Health Act 1983.
- E74. The HPC is an experienced regulator with a proven track record of providing effective, safe and value for money regulation for 15 professions. In its Performance Review Report 2010/11<sup>110</sup> the CHRE described the HPC as "an effective and efficient regulator for the diverse range of professions that it regulates. This is particularly notable as it has had to manage the challenges associated with the likely expansion in the number and type of professions that it will regulate in future".
- E75. The Government is confident that the HPC is well placed to take on the regulation of social workers and that this option will be best in the long-term for the public, social workers and their employers by delivering independent and sustainable regulation.
- E76. The GSCC estimated that they would require grant in aid funding of £21 - £25 million for 2010/11<sup>111</sup>.
- E77. Based on this level of funding including assumed fees received from the 83,464 social workers and the 17,418 student social workers on the GSCC register as at 31<sup>st</sup> March 2010<sup>112</sup> (charged £30 and £10 per year respectively). it was estimated that it would cost the GSCC £235 - £274 per registrant to regulate the 100,882 social workers and social work students on its register. This compares unfavourably with the HPC, which regulates its registrants at a cost of £76 per year per registrant.
- E78. Under the proposals in the Bill, once the HPC takes over the regulation of social workers, their fees will fully fund the costs of their regulation. This includes any additional staff that may be required at HPC to register the additional professionals. This means that the grant in aid that the Department currently makes available to the GSCC, which is estimated by the GSCC as £23m<sup>113</sup> for 2010/11, is a financial cost saving. As the transfer will occur no earlier than July 2012, only **£17.25m** (three quarters of the annual £23m) of grant in aid will be saved in 2012/13, and the full **£23m** will be saved from 2013/14 onwards.
- E79. It is estimated that the HPC will need approximately **£0.24m** in 2010/11 and 2011/12, and **£0.06m** in the first quarter of 2012/13, for transition costs, in order to prepare their systems and processes. It is expected that the HPC will be able to take on the regulation of social workers in England with some staff transferring over from the GSCC on protected terms of employment.

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<sup>110</sup> [http://www.chre.org.uk/\\_img/pics/library/110623\\_Final\\_-\\_CHRE\\_Performance\\_Review\\_report\\_2010-11\\_\(Colour\\_for\\_web\\_-\\_PDF\\_version\).pdf](http://www.chre.org.uk/_img/pics/library/110623_Final_-_CHRE_Performance_Review_report_2010-11_(Colour_for_web_-_PDF_version).pdf)

<sup>111</sup> Provisional figures for 2010/11 are suggesting that, excluding the education support grant, the GSCC actually drew down £16.4 million from the available DH grant. This does not represent the steady state funding of the organisation, but does illustrate that the organisation is scaling down its function and savings are starting to be realised in the interim period.

<sup>112</sup> As at 31 March 2010 – GSCC Annual Report and Accounts 2009/10

<sup>113</sup> Mid point figure between GSCC estimated costs for 2010/11 of £21m-£25m

However, it is likely that the HPC will require fewer staff to undertake its functions than the GSCC does, as it is anticipated to operate more efficient systems (such as online registration) and will benefit from economies of scale with core support functions being applied across all groups it registers. Estimated redundancy payments for staff at the GSCC are up to **£4.6m**<sup>114</sup> (which reflects the worst-case scenario), depending on how GSCC and HPC handle the transfer of staff. DH intends to cover the existing GSCC pension liability deficit estimated at 31<sup>st</sup> March 2010 at **£6.9m**<sup>115</sup>.

- E80. When transferring function, there will be an increased level of regulatory activity as within a two-month period the HPC plan to ensure all social workers are registered with them. This is not expected however to impact on registered social workers whose registration with the GSCC will be transferred to the HPC automatically. For the HPC this is part of their core business, which will be accounted for through the levy on registrants.
- E81. Currently the GSCC charges an annual fee of £30 per registrant. The HPC estimates that the total cost of registration will work out at around £76 per registrant per year (the same fee charged to all its current registrants) when the regulation function is transferred to the HPC in 2012/13, and the grant in aid is removed. Following the model for the regulation of other professional groups, this will be funded entirely by individual social workers, meaning that social workers are likely to be required to pay an additional £46 per year under these proposals. By this estimate, the total cost to social workers in England of the transfer would be **£3.8m**<sup>116</sup>.
- E82. Whilst it is understood that the majority of social workers work in the public sector it is difficult to establish an exact figure. However, the key point is that HPC's fee will fall on the individual and it will be for both public and private sector employers to decide whether to reflect the increase in registration costs to individuals in the terms and conditions of employment. Therefore, it is assumed that the increase in registration fees of £46 will be a reduction in social workers' income rather than an increase in their overall pay of £46, and that there will be no additional costs imposed on public sector finances.
- E83. Economic theory suggests that if a barrier to entry (for example, registration fees) is raised then supply into the market (in this instance, for social workers) will fall. However, given the size of the change, which translates to less than £1 per week, there is not expected to be a significant impact on the supply of social workers.
- E84. Indirect costs are anticipated. For example, it is anticipated that there may be a fall in productivity while the changes are implemented. Monetising this is not straightforward, but using the assumptions in Annex 4, this is estimated to have a cost of **£0.2m** in 2010/11, 2011/12 and **£0.06m**<sup>117</sup> in the first quarter of 2012/13 before the transfer. There may also be a loss of stakeholder confidence during the transfer, and a drop in workforce morale can be expected, but these effects are not quantifiable. We also expect them to be mitigated by the joint work the GSCC and HPC are undertaking to engage with stakeholders during the transition period.
- E85. The GSCC currently holds a voluntary register of student social workers. The Health and Social Care Bill 2011 will enable the HPC to hold voluntary registers, including a voluntary register of student social workers. It is intended that the GSCC's voluntary register of students will be transferred to the HPC pending a full consideration of the best approach to assuring the safety and standards of social work students. The HPC has committed to undertaking a review of the risks in relation to students of all the

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<sup>114</sup> Estimate is based on the number of GSCC permanent staff, 210, assuming a maximum 10 years of service since 2001 when GSCC was created, and an average annual salary of £26,000. The redundancy scheme gives staff one month's salary for every year of service, therefore  $210 \times (10/12) \times £26k = £4.55m$  worst case scenario.

<sup>115</sup> As of 31<sup>st</sup> March 2010 – GSCC Annual Report and Accounts 2009/10

<sup>116</sup> This is from the future proposed fee of £76 minus the existing fee of £30, which gives £46. This is then multiplied by 83,464 social workers, to give £3.8m.

<sup>117</sup> One quarter of the annual £0.2m cost.

professions it regulates including social work students. The outcome of this process will set out the risks and issues relating to social work students.

- E86. Making social worker regulation in England independent of government and placing it with a proven successful and efficient regulator is in keeping with the Hampton Principles<sup>118</sup>. This should lead to better regulation and improved public safety through delivering some of the outstanding recommendations from CHRE's 2009 review of GSCC's conduct function<sup>119</sup>. The recommendation include the use of more streamlined and effective systems and the application of a full fitness to practise system which will be able to look at a social workers competence and conduct in the round and will enable the imposition of a wider range of sanctions such as conditions on registration. Additionally, oversight of social worker regulation by CHRE will lead to greater external scrutiny over the regulation of social workers and this should ultimately improve the safety and quality of social workers. This benefit is, however, unquantifiable.
- E87. There may be further costs that are not quantifiable at this stage. For example, a change in the regulator may lead to some familiarisation costs for social workers, before they get used to the new system. This is likely to have a small effect, which we expect will be minimised by the work the HPC will undertake to ensure registrants are aware of new processes. In addition, as a result of the transfer of the regulation of social workers to the HPC the process for social workers appealing against the decisions of the regulator will change. This impact of this is being explored as part of the Justice Impact Assessment.
- E88. Given the transfer will occur no earlier than July 2012, and the impacts outlined above, total economic cost and benefit figures over the appraisal period have been calculated and a summarised in tables 3a and 3b. Transition costs to the Exchequer include HPC's costs of preparation (**£0.5m** over 2010/11-2012/13), redundancy payments (**£4.6m** in 2012/13) and coverage of pension liabilities (**£6.9m** in 2012/13). Total financial Exchequer costs are therefore estimated at £11.7m.<sup>120</sup> To reflect the benefits this money could have bought if deployed in the NHS, the Exchequer costs are multiplied by 2.4<sup>121</sup> to give an opportunity cost of £28.2m in 2011/12, (HPC preparation of **£1.3m**, redundancy payments of **£10.9m** and coverage of pension liabilities of **£16.5m**).
- E89. Annual financial Exchequer cost savings result from the removal of grant in aid. These savings are estimated at **£17.25m** in 2012/13 and **£23m** per year from 2013/14 onwards. As above, this is multiplied by 2.4 to give annual opportunity cost savings of **£41.4m** in 2012/13 and **£55.2m** from 2013/14 onwards. Non-exchequer transition costs from an expected dip in productivity are estimated at **£0.46m** and incurred over 2010/11, 2011/12 and the first quarter of 2012/13. Annual non-Exchequer costs of registration are estimated at **£3.8m** from 2012/13 onwards.

## **Public Welfare**

### **Alcohol Education and Research Council (AERC)**

- E90. The Review report proposed to abolish the AERC as an ALB and remove from the sector. This is because the current ALB sector governance arrangements are disproportionate to the size and scale of the organisation, which employs three people, and it does not satisfy the criteria to remain as an ALB. The existing Council has established a separate charitable body to which all staff and the full Alcohol Education and Research Fund were transferred in March 2011.

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<sup>118</sup> Source: <http://www.bis.gov.uk/files/file22988.pdf>

<sup>119</sup> Report and Recommendations to the Secretary of State for Health on the conduct and function of the GSCC. CHRE. 2009

<sup>120</sup> Note that rounding aggregate figures may result in minor rounding errors. In this case, £0.3m, £4.6m and £6.9 add up to £11.8m, but the underlying unrounded figures add up to a figure that is rounded to £11.7m.

<sup>121</sup> See Annex 4 for basis of the 2.4 opportunity cost assumption

- E91. Provisions in the Health and Social Care Bill will enable the Secretary of State to dissolve the Council and enable the repeal of the 1981 Act, which created the AERC and remove references to AERC in other primary legislation.
- E92. The AERC receives no government funding and therefore the direct costs associated will be zero. The new charitable body intends to use the Fund to develop a more ambitious research programme to inform some of the key questions on alcohol policy. This will indirectly benefit patients and providers through the provision of better evidence on effective alcohol policies and its benefits for health, though this is unquantifiable. Therefore, there are no monetised costs or benefits included in this assessment.

## **Information**

### **Health and Social Care Information Centre (IC)**

- E93. The review recommended the centralisation of data returns in the IC, leading to streamlining data collection functions across the health and social care sectors. The aim is to remove inefficiencies and duplication in the system around data collection and dissemination by reducing the number of separate demands from different ALBs. This will enable marginal savings by the various data providers (including organisations providing care themselves) in the process of supplying that data via one return to the IC. The forthcoming consultation report on the Fundamental Review of Data returns will discuss the impact of this on staff in the NHS in more detail.
- E94. The Bill proposes to make the NHS more autonomous, with clearer lines of accountability. In line with this, the review also recognised the Government's intention to establish the Information Centre in primary legislation. Accordingly, the status of the IC is to change from a Special Health Authority (SpHA) which is directed by Secretary of State, to an Executive Non-Departmental Public Body (ENDPB) with some autonomous powers. This change in status does not require any transfer of staff or change in building location and will not attract any transitional costs.
- E95. The Information Centre will become the main repository for national data collections across health care, public health and adult social care, with lead responsibility for data collection and assuring the quality of the data it publishes. It will have a specific duty to have regard to the need to promote the effective, efficient and economic use of resources in the provision of health services or adult social care. It must exercise its own functions with this goal in mind to minimise any establishment costs for its new role and the burdens it imposes on others. In future, it will work with the DH and proposed NHS Commissioning Board in a focussed effort to ensure that central returns will provide greater value to the NHS through the insight they provide to justify any cost burden they add. In addition, at least once every three years, the Secretary of State will request the Information Centre's advice about ways in which information collection burdens may be reduced.
- E96. The Information Centre will also continue to uphold standards for confidentiality of every individual's personal data, to make person-level as well as aggregate data available subject to any necessary information governance approvals. It will make aggregate data available in a standard format for use by third parties, meeting the needs of a multiplicity of customers including the proposed new Public Health England (PHE), the NHS, local authorities, social care, regulators, researchers, the Office for National Statistics (ONS), the public and Parliament. This will allow information intermediaries to analyse and present the data to patients in an easily understandable way. The Information Centre will also have specific powers to give advice to various bodies on issues relating to the collection, analysis, publication or other dissemination of information. This is needed because bodies might otherwise not adhere to national requirements, leading to inconsistent methods of information collection that would undermine the value and purpose of the collection, and its use.



E97. The future role of the Information Centre will also be affected by proposals included in the consultation document *Liberating the NHS: An Information Revolution*. Existing information standards and ways to harness new technology are being explored through the consultation to improve the accuracy of data with a focus to maximise the use of operational systems to collect data once at the point of care for re-use many times. National standards for record keeping and data standards for electronic recording are also likely to be required. In addition, the principle of openness and transparency and the work associated with it is expected to supplant some of the IC's existing functions to provide and support analytical and presentation tools. This will allow the IC to become the advisor and supplier of more access to raw data to a wider market of information intermediaries who can generate fresh insights for the NHS and its patients. The proposals about changing the work that the IC does will be subject to economic impact assessments as part of the government's response to that consultation.

## **Public Appointments**

### **Appointments Commission (AC)**

- E98. Following the structural changes outlined in the White Paper *Equity and Excellence: Liberating the NHS*, SHAs and PCTs will be abolished and all NHS Trusts will become, or be part of, Foundation Trusts (FTs). This will essentially mark the end of local NHS public appointments, and therefore public appointments will no longer be in sufficient volume to justify having a separate organisation to manage the process. As a result, the ALB Review report proposed to abolish the AC during 2012.
- E99. Of the approximately 2,700 public appointments, around 180 may continue into the future<sup>122</sup>. Final estimates are still dependent on the future of some public bodies, and how some others are to be constituted. Options considered for the recruitment and selection of the remaining appointments included delivering the function in-house or using external private recruitment consultants. Internal analysis showed average costs of £11,200 - £21,000 for recruiting members to a public body using private recruitment consultants, with costs of Chair recruitment often extending well beyond this range.
- E100. Based on estimates of resources employed by other Government Departments to manage recruitment internally, the costs are lower than when private recruitment consultants are used<sup>123</sup>. Restrictions on the use of head-hunters and advertising is therefore anticipated to result in a more efficient and streamlined appointments process undertaken in-house. Other elements of the management of the wider public appointments function cannot be delegated to a private company, such as agreeing job descriptions and terms of appointment, formally making the appointment, managing a personal performance appraisal, and the suspension or termination of an appointment.
- E101. The review report proposed that accountability for the remaining public appointments should 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. DH intends to use a small internal function to support Ministers in making any appointments that remain. The final costs of delivering this function will be partly dependent on systems, to be established by Cabinet Office, where Departments can draw on alternatives to more expensive advertising, to publicise posts and attract talent. Based on the information above, the Department expects the costs to be lower than current average recruitment costs.

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<sup>122</sup> DH estimate (unpublished) – some 95 appointments to ALBs and 85 to ANDPBs

<sup>123</sup> Estimate based on the need for Departments to continue to have an in-house role for those functions which cannot be delegated.

- E102. It is estimated that all of the AC's staff will be need to be redeployed or made redundant<sup>124</sup> at a total cost of around £1.51m (£0.43m incurred in 2010/11, £0.09m in 2011/12 and £0.99m in 2012/13)<sup>125</sup>. There was a reduction in staffing levels of around 20% by 1<sup>st</sup> April 2011, with remaining staff to be made redundant or redeployed by October 2012 or on closure of the organisation.
- E103. There may be a public perception in some quarters that the abolition of the AC will result in future appointments not being made on merit, in an open and transparent way and that Ministerial involvement may result in political bias. This will not be the case, as the Commissioner for Public Appointments regulates most public appointments, and it is a requirement that these appointments are made on merit. Departments must also comply with clear guidance with regard to how Ministers are involved.
- E104. The AC has offered fee-based services to Other Government Departments (OGDs) including the Home Office, Ministry of Justice, Cabinet Office and Department of Education. In the future, OGDs can choose to use a private provider or undertake the services in-house. Therefore, the main impact on OGDs will be the loss of one provider from the market. This could reduce the choice for OGDs when they make public appointments, leading potentially to lower quality service in the recruitment of public appointments<sup>126</sup>. However, as there are significantly fewer public appointments to be made, this is not viewed as a significant risk. The OCPA Code also ensures that strict requirements are met during the process of making a public appointment; additionally, the Cabinet Office's guide to *Making and Managing Public Appointments* provides further advice about best practice to be followed when making public appointments.
- E105. The abolition of the AC may have an impact on the costs of recruitment for FTs that have used the AC for public appointments as AC has tended to provide cheaper rates than other recruitment agencies. However, it is not yet possible to determine this, as the impact of the large reduction in the number of public bodies and appointments on the supplier side of the recruitment services market is not yet quantifiable. In addition, the rates charged by external agencies may reduce due to more competition for limited opportunities.
- E106. Whilst the AC has a UK geographical scope, it receives no funding from DAs, and therefore DH expects the impact on DAs to be minimal.
- E107. Other costs to the system include the potentially negative impact on the staff that are made redundant following the proposals published in the report. This is discussed in further detail in the Health impact assessment, which can be found in Annex 3. All staff will have access to support for finding new opportunities including advice on writing CVs and interview techniques. Meeting the needs of staff will be critical to maintain morale and ensure they can continue to deliver a professional service.
- E108. Nevertheless, it is likely that the AC will experience fluctuations in productivity over the transition period up until its abolition in 2012. Whilst productivity dips from staff turnover and uncertainty can be expected, productivity may rise as the organisation becomes more streamlined and essential functions are performed with less resource. It is also expected that a new online recruitment system will help the organisation to be more robust in delivering activity with considerably fewer staff. Due to the unpredictable nature of this process, this change in productivity is unquantifiable.

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<sup>124</sup> Includes mutually agreed resignation scheme and early retirement

<sup>125</sup> This is an estimate provided by the AC and costs incorporate pension liabilities, £0.34m of the £0.99m cost in 2012/13 are estimated redundancy costs for staff that will be transferred to other organisations for a time limited period, thus the costs may differ and will not be incurred by the AC.

<sup>126</sup> This is on the assumption that competition improves performance

- E109. By abolishing the AC, the Department will save grant in aid funding of **£1.8m** in 2012/13 and **£3.6m** per annum from 2013/14 onwards. Furthermore, this proposal is consistent with DH Ministers being directly accountable for their appointments, as is the case for Ministers in other Departments. These benefits are also unquantifiable.
- E110. From the impacts outlined above total economic cost and benefit figures over the appraisal period have been calculated and summarised in tables 3a and 3b. The Exchequer faces financial transition costs of **£1.51m** over 2010/11 to 2012/13 resulting from redundancy or redeployment of AC staff (see table 3a). Cash releasing savings are made, as DH will no longer provide grant in aid funding. It is estimated that the annual Exchequer benefits of this amount to **£1.8m** in 2012/13 and **£3.6m** pa from 2013/14 onwards.
- E111. To reflect the opportunity costs of Exchequer funding, the Exchequer impact is multiplied by 2.4<sup>127</sup>. The opportunity cost of transition Exchequer costs is thus **£3.6m** (£1.0m in 2010/11, £0.2mm 2011/12 and £2.4m in 2012/13), while annual opportunity cost savings to the Exchequer amount to **£4.3m** in 2012/13 and **£8.6m** from 2013/14 onwards (see table 3b).

### **Quality and Safety Improvement**

- E112. Currently, functions associated with quality and safety improvement are distributed across a number of ALBs 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.
- E113. In future, the NHS Commissioning Board will provide national leadership on commissioning for quality improvement. It is proposed that some essential functions supporting this role from the NPSA and the NHSi should be brought together within the mainstream work of the NHS Commissioning Board, to exploit the benefit that commissioning would provide in placing quality and safety at the heart of patient care.

### **National Patient Safety Agency (NPSA)**

- E114. The ALB review report proposed the abolition of the NPSA, with some of the work of the Patient Safety Division (PSD) function becoming part of the remit of the NHS Commissioning Board. The Review report also proposed making the National Clinical Assessment Service (NCAS) operate on a full-cost recovery basis, while indicating the future of the National Research Ethics Service (NRES) would be dependent on the outcome of a report on a possible research regulator by Academy of Medical Sciences (AMS)<sup>128</sup>.
- E115. In its report<sup>129</sup> published in January 2011, AMS recommended creating a new agency to rationalise the regulation and governance of all health research. The Plan for Growth<sup>130</sup> published alongside the Budget on 23 March 2011 responded by announcing “the Government will create a Health Research Authority to combine and streamline the approvals for health research which are at present scattered across many organisations. As a first step, the Government will establish this year a Special Health Authority with the National Research Ethics Service at its core”. This will reduce the regulatory burden on research-active businesses, universities and trusts, improving the timeliness of decisions about research projects and hence the cost-effectiveness of their delivery in the UK. The function of managing the delivery of the Confidential Enquiries (now known as the Clinical Outcomes Review Programmes - CORP), with the relevant provider organisations will transfer from the NPSA to the Healthcare Quality Improvement Partnership (HQIP). Only some of the functions relating to the PSD will require

<sup>127</sup> See Annex 4 for basis of the 2.4 opportunity cost assumption

<sup>128</sup> *Liberating the NHS: Report of the arm's-length bodies review*, p18

<sup>129</sup> AMS 2011. *A new pathway for the regulation and governance of health research*

<sup>130</sup> HM Treasury, Department for Business Innovation & Skills (2011): *The Plan for Growth* p92

primary legislation in the Health and Social Care Bill, so our analysis below considers only this aspect of policy. All other changes will be dealt with separately.

- E116. The ALB review argued that the functions of the organisation, while necessary, do not need to be performed at arm's length from the Department and could be delivered elsewhere in the system. Moving the responsibility for reporting and learning from patient safety incidents to the NHS Commissioning Board would provide an opportunity to preserve the synergy between learning and operational practice that already exists in the system.
- E117. The NHS Commissioning Board will be uniquely placed in the system to utilise the information gathered by the reporting and learning function to support, encourage and enable safety improvement in the NHS. It will be able to combine insight from safety reporting with operational knowledge, leadership, authority and system oversight, to ensure appropriate levers, initiatives and support are provided to the NHS to improve safety. The NPSA, as an Arm's Length Body, never had the authority or position to fully exploit the information contained in the National Reporting and Learning System (NRLS). The NHS Commissioning Board will be in such a position.
- E118. Following discussions with the NPSA, it is estimated that part of the patient safety function will be transferring to the NHS Commissioning Board at a total transitional cost of up to **£50,000** in 2011/12 in relocation costs. An analysis of assets shows there are likely to be costs of **£275,000** in 2011/12 incurred during the process of writing off and transferring fixed assets, such as IT. There would also be costs of up to **£3.9m** incurred from redundancies<sup>131</sup> over a two year period (**£1.1m** in 2010/11 and **£2.8m** in 2011/12).
- E119. The PSD also houses the Patient Environment Action Team (PEAT), which already has a contract with the IC for the collection of data from NHS providers on overall patient environment. In the short term, NPSA's responsibility for the annual PEAT survey of in-patient care facilities will be undertaken by the IC whilst it remains a special health authority. Longer term, subject to the passage of the Health and Social Care Bill through Parliament, it is anticipated that in its newly established form the IC will carry out this data collection.
- E120. Moving relevant PSD functions of the NPSA to the NHS Commissioning Board DH will save the current grant in aid spend on these functions. However, the NHS Commissioning Board will then face the costs of carrying out certain PSD functions, including securing the NRLS. This is therefore a transfer within the overall administrative spending of the system, which is discussed within the coordinating document. It is not yet possible to estimate the overall net effect on the Exchequer.
- E121. The NPSA receives funding from Devolved Administrations (DAs). Where PSD functions are moving to the NHS Commissioning Board, the DAs may choose to continue to fund this. The Department expects the impact on DAs to be minimal.
- E122. By abolishing the NPSA the Department anticipates that there will be indirect costs, such as a loss in output caused by the underperformance of a disenchanted workforce during the transition period. In addition, we anticipate that in the short term, there will be a loss of NPSA stakeholder assurance. However, these costs are unquantifiable. The NPSA has made every effort to provide staff with clarity on the future, has undertaken a structured reduction in workforce to align staffing with the needs of the transition year, and the staff have demonstrated a professional and mature attitude to the situation. They have for example been clear that the transition year will not be one of 'business as usual' but rather one of consolidation of their legacy and support for core patient safety functions moving to the NHS Commissioning Board, i.e. the NRLS. However, the NPSA is unable to prevent talented staff from securing alternative employment and many have done so.

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<sup>131</sup> Redundancy figure estimates provided by NPSA

If staffing issues were to become critical, the Department has been clear that it would seek to provide appropriate support to ensure functions continue.

- E123. There is a possible risk that bringing the PSD functions into the NHS Commissioning Board will lead to reduced importance for patient safety as this function will no longer be performed by an ALB that was set up to lead and contribute to improved, safe patient care. This is not expected to be the case; *Equity and Excellence: Liberating the NHS* makes it clear that “A culture of open information, active responsibility and challenge will ensure that patient safety is put above all else.” Furthermore, the transfer of some staff to the NHS Commissioning Board, along with the transfer of the national reporting and learning function, will ensure that expertise in patient safety is retained. This will help to ensure that the commitments in *Equity and Excellence: Liberating the NHS* around the role of patient safety – and the importance that patients place on safety under NHS care – are achieved.
- E124. From the impacts outlined above total economic cost and benefit figures over the appraisal period have been calculated and are summarised in tables 3a and 3b. The Exchequer faces financial transition costs of £4.2m over 2010/11 and 2011/12 (**£3.9m** resulting from redundancies, **£50k** from relocation and **£275k** from the process of writing off and transferring fixed assets) (see table 3a).
- E125. To reflect the opportunity costs of Exchequer funding (i.e. the benefits this money could have bought if deployed elsewhere in the NHS), the Exchequer impact is multiplied by 2.4<sup>132</sup>: the opportunity cost of transition Exchequer costs is thus £10.1m. (Redundancy costs of **£2.6m** in 2010/11 and **£6.7m** in 2011/12, transfer costs of **£120k** and removal of corporate services **£660k**).

#### **NHS Institute for Innovation and Improvement (NHSi)**

- E126. The ALB Review proposed to transfer some functions to the NHS Commissioning Board that will support the Board in leading on quality improvement and building capacity within the wider system. The NHS Commissioning Board will assume a leadership role in commissioning for quality improvement and be responsible for improving outcomes at every level of the NHS. Some of this function is currently performed by the NHSi, which is proposed to transfer to the NHS Commissioning Board as part of the Board’s general improvement function. This will support the Board in fulfilling its duty to promote innovation in both the provision and commissioning of services. As a result, as the body with responsibility for commissioning practice, the Board will be in a stronger position to translate innovation into practice for example through the guidance it will produce for commissioning consortia and its functions in developing national tariffs.
- E127. Using the assumptions in Annex 4, it is estimated that the transfer of staff from NHSi will cost around £6,000. This figure takes into account relocation costs; it is assumed that HR and IT costs and internal legal, finance and accommodation resources will have been incurred by the NHS Commissioning Board. An alternative possibility is that the functions remain provided by, and staff employed by, the new enterprise under a contract to provide the leadership for commissioning improvement services directly to the NHS Commissioning Board.
- E128. The Review also proposed to abolish the NHSi as an ALB, with a view to determining whether opportunities exist for alternative commercial delivery models, such as a social enterprise. This policy will be covered through secondary legislation and hence a separate impact assessment will consider the costs and benefits of doing so in due course.
- E129. It is likely that the removal of NHSi from the ALB sector will generate sufficient benefits to justify the costs of this policy, as NHSi currently receives over £65m grant in aid. However, since this

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<sup>132</sup> See Annex 4 for basis on the 2.4 opportunity cost assumption

impact assessment covers only proposals requiring primary legislation and only those impacting on NHSi, it is not possible to give a complete picture of the costs and benefits of the changes to NHSi at this time as the business model is still in development.

- E130. From the impacts outlined above total economic cost and benefit figures over the appraisal period have been calculated and summarised in tables 3a and 3b. The transition costs of moving staff to the NHS Commissioning Board are estimated to amount to a one off financial cost of **£6,000** in 2012/13, and will be borne by the Exchequer. To reflect the benefits this money could have bought if deployed elsewhere in the NHS, the Exchequer costs are multiplied by 2.4<sup>133</sup> to give total economic opportunity costs of **£14,400** in 2012/13 (see table 3b).

## Summary cost and benefit table for Option 2

- E131. Tables 3a and 3b summarise the monetised costs and benefits from each of the interventions outlined above over time. As indicated at paragraph E3 above, this also includes costs and benefits for the proposal to no longer proceed with the Office of the Health Professions Adjudicator (OHPA). Table 3a is purely financial costs, while table 3b accounts for the opportunity cost of Exchequer funding. Where costs and benefits affect funds taken from budgets that could otherwise be used elsewhere in the NHS, their true value derives from the benefits foregone from alternative uses - which can be calculated by applying the standard 2.4 opportunity cost multiplier for government spending.
- E132. Tables 4a, 4b and 4c separate out impacts on the Exchequer and non-Exchequer respectively. Therefore, to get the total financial costs, the figures in tables 4a and 4c should be added together. The figures presented in the summary sheets of this Impact Assessment are the aggregation of those in tables 4b and 4c.
- E133. Note that the figures in tables 4a, 4b and 4c are presented as an average over ten years with 2010/11 as base year. As can be seen in tables 3a and 3b, some costs may not be incurred for two or three years in the future<sup>134</sup>. Hence, when annual estimates are divided over a 10-year horizon, this will generate an average annual cost that is lower than the estimates identified in the previous sections detailing the proposals for each organisation.
- E134. The estimates in tables 4a, 4b and 4c could be interpreted to show that for some policy interventions the benefits may not be sufficiently large to justify the costs. There are two reasons behind this; firstly it has not been possible to monetise every aspect of each policy intervention and hence the tables only cover impacts which have been quantified. Secondly, this Impact Assessment must be taken in perspective with wider system changes to the health sector and includes only policies that require primary legislation. Hence, all policies discussed in paragraph E27 that are planned but not covered in this impact assessment must also be considered.
- E135. These figures do not precisely match up with the figures for the ALB sector within the coordinating document. This is because the changes proposed in the Bill do not cover all of the changes to the ALB sector that were put forward within the ALB review. Some of these do not require legislation, whereas some are not being legislated for at this stage. Therefore, the figures within this document are a subset of those displayed within the coordinating document. The figures included within the coordinating document are to be able to provide estimates for the overall costs of the transition and the number of redundancies, and are included as an indication at this stage.

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<sup>133</sup> See Annex 4 for basis of the 2.4 opportunity cost assumption

<sup>134</sup> For instance, cost savings from removing the grant in aid to the AC will not be realised until 2012/13, hence the estimate of £3.56m will be realised for 8 years of the 10 year horizon of this Impact Assessment.

**Table 3a: Time Profile of Monetised Costs and Benefits for Option 2, in £m (excluding opportunity cost i.e. financial cost<sup>135</sup>)**

<b>Costs</b>												
Organisation	Category	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	Total
NICE	Rebranding name	0.00	0.00	0.01	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.01
CQC	Income loss (SOADs)	0.00	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60	5.43
CHRE	Fees (Registrants)	0.00	0.00	0.00	2.75	2.75	2.75	2.75	2.75	2.75	2.75	19.25
CHRE	Setting up Appointments Committee	0.00	0.00	0.02	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.02
CHRE	Quality Assurance, Voluntary Regulation	0.00	0.10	0.10	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.20
CHRE	Voluntary Regulation fees (registrants)	0.00	0.00	0.00	0.10	0.10	0.10	0.10	0.10	0.10	0.10	0.70
CHRE	Lost tax income	0.00	0.00	0.00	0.83	0.83	0.83	0.83	0.83	0.83	0.83	5.78
GSCC	Fees (Registrants)	0.00	0.00	3.84	3.84	3.84	3.84	3.84	3.84	3.84	3.84	30.72
GSCC	Preparing HPC Systems	0.24	0.24	0.06	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.54
GSCC	Redundancy payouts for staff	0.00	0.00	4.55	0.00	0.00	0.00	0.00	0.00	0.00	0.00	4.55
GSCC	Pensions liability	0.00	0.00	6.86	0.00	0.00	0.00	0.00	0.00	0.00	0.00	6.86
GSCC	Dip in productivity (workforce)	0.22	0.22	0.06	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.50
AC	Redundancy payouts for staff	0.43	0.09	0.99	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.51
NPSA	Relocation costs	0.00	0.05	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.05
NPSA	Redundancy payouts for staff	1.10	2.80	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	3.90
NPSA	Writing off fixed assets	0.00	0.28	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.28
NHS III	Moving staff to NHSCB (Exchequer)	0.00	0.00	0.01	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.01
OHPA	Additional GMC costs	0.00	0.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	8.00
Total (undiscounted)		1.99	4.38	18.09	9.12	9.12	9.12	9.12	9.12	9.12	9.12	88.28
Present Value (discounted at 3.5%)		1.99	4.23	16.89	8.22	7.95	7.68	7.42	7.17	6.92	6.69	75.15
<b>Benefits</b>												
Organisation	Category	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	Total
NIGB	Reduced duplication (CQC)	0.00	0.00	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	4.00
CQC	Savings from less SOAD requests	0.00	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60	5.43
CHRE	Removal of grant in aid	0.00	0.00	0.00	2.75	2.75	2.75	2.75	2.75	2.75	2.75	19.25
CHRE	Tax deduction savings	0.00	0.00	0.00	0.83	0.83	0.83	0.83	0.83	0.83	0.83	5.78
GSCC	Removal of grant in aid	0.00	0.00	17.25	23.00	23.00	23.00	23.00	23.00	23.00	23.00	178.25
AC	Removal of grant in aid	0.00	0.00	1.78	3.56	3.56	3.56	3.56	3.56	3.56	3.56	26.73
OHPA	Reduction in operating costs	0.00	3.90	6.80	5.30	5.30	5.30	5.30	5.30	5.30	5.30	47.80
OHPA	Avoidance of Transition Costs	0.00	11.60	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	11.60
OHPA	Avoidance of GMC Transition Costs	0.00	1.40	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.40
Total (undiscounted)		0.00	17.50	26.94	36.54	36.54	36.54	36.54	36.54	36.54	36.54	300.24
Present Value (discounted at 3.5%)		0.00	16.91	25.15	32.96	31.85	30.77	29.73	28.72	27.75	26.81	250.64
Benefits - costs (Net Value)		-1.99	13.13	8.85	27.43	27.43	27.43	27.43	27.43	27.43	27.43	211.96
<b>Net Present Value</b>		-1.99	12.68	8.26	24.74	23.90	23.09	22.31	21.56	20.83	20.12	175.49

<sup>135</sup> Note that aggregated figures in the text may not exactly match figures in the table due to rounding.

**Table 3b: Time Profile of Monetised Costs and Benefits for Option 2, in £m (including opportunity cost of Exchequer funding) <sup>136</sup>**

<b>Costs</b>												
Organisation	Category	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	Total
NICE	Rebranding name	0.00	0.00	0.02	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.02
CQC	Income loss (SOADs)	0.00	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60	5.43
CHRE	Fees (Registrants)	0.00	0.00	0.00	2.75	2.75	2.75	2.75	2.75	2.75	2.75	19.25
CHRE	Setting up Appointments Committee	0.00	0.00	0.05	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.05
CHRE	Quality Assurance, Voluntary Regulation	0.00	0.24	0.24	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.48
CHRE	Voluntary Regulation fees (registrants)	0.00	0.00	0.00	0.10	0.10	0.10	0.10	0.10	0.10	0.10	0.70
CHRE	Lost tax income	0.00	0.00	0.00	1.98	1.98	1.98	1.98	1.98	1.98	1.98	13.86
GSCC	Fees (Registrants)	0.00	0.00	3.84	3.84	3.84	3.84	3.84	3.84	3.84	3.84	30.72
GSCC	Preparing HPC Systems	0.58	0.58	0.14	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.30
GSCC	Redundancy payouts for staff	0.00	0.00	10.92	0.00	0.00	0.00	0.00	0.00	0.00	0.00	10.92
GSCC	Pensions liability	0.00	0.00	16.45	0.00	0.00	0.00	0.00	0.00	0.00	0.00	16.45
GSCC	Dip in productivity (workforce)	0.22	0.22	0.06	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.50
AC	Redundancy payouts for staff	1.03	0.21	2.37	0.00	0.00	0.00	0.00	0.00	0.00	0.00	3.62
NPSA	Relocation costs	0.00	0.12	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.12
NPSA	Redundancy payouts for staff	2.64	6.72	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	9.36
NPSA	Writing off of fixed assets	0.00	0.66	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.66
NHS III	Moving staff to NHSCB	0.00	0.00	0.01	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.01
OHPA	Additional GMC costs	0.00	0.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	8.00
Total (undiscounted)		4.47	9.35	35.71	10.27	10.27	10.27	10.27	10.27	10.27	10.27	121.44
Present Value (discounted at 3.5%)		4.47	9.04	33.34	9.27	8.95	8.65	8.36	8.08	7.80	7.54	105.48
<b>Benefits</b>												
Organisation	Category	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	Total
NIGB	Reduced duplication (CQC)	0.00	0.00	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	9.60
CQC	Savings from less SOAD requests	0.00	1.45	1.45	1.45	1.45	1.45	1.45	1.45	1.45	1.45	13.04
CHRE	Removal of grant in aid	0.00	0.00	0.00	6.60	6.60	6.60	6.60	6.60	6.60	6.60	46.20
CHRE	Tax deduction savings	0.00	0.00	0.00	0.83	0.83	0.83	0.83	0.83	0.83	0.83	5.78
GSCC	Removal of grant in aid	0.00	0.00	41.40	55.20	55.20	55.20	55.20	55.20	55.20	55.20	427.80
AC	Removal of grant in aid	0.00	0.00	4.28	8.55	8.55	8.55	8.55	8.55	8.55	8.55	64.15
OHPA	Reduction in operating costs	0.00	3.90	6.80	5.30	5.30	5.30	5.30	5.30	5.30	5.30	47.80
OHPA	Avoidance of Transition Costs	0.00	27.84	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	27.84
OHPA	Avoidance of GMC Transition Costs	0.00	3.36	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	3.36
Total (undiscounted)		0.00	36.55	55.13	79.13	79.13	79.13	79.13	79.13	79.13	79.13	645.57
Present Value (discounted at 3.5%)		0.00	35.31	51.46	71.37	68.96	66.62	64.37	62.19	60.09	58.06	538.43
Benefits - costs (Net Value)		-4.47	27.20	19.41	68.85	68.85	68.85	68.85	68.85	68.85	68.85	524.12
<b>Net Present Value</b>		-4.47	26.28	18.12	62.10	60.00	57.97	56.01	54.12	52.29	50.52	<b>432.95</b>

<sup>136</sup> Note that aggregated figures in the text may not exactly match figures in the table due to rounding..



**Table 4a: Monetised Costs and Benefits for Option 2 (Exchequer Impacts, excluding opportunity cost - i.e. financial cost)<sup>137</sup>**

ALB/Public Body	Costs		Benefits	
	Transition	Average Annual (over 10 years)	Transition	Average Annual (over 10 years)
NICE	£0.009m	£0	£0	£0
CQC	£0	£0	£0	£0.5m
NIGB	£0	£0	£0	£0.4m
CHRE	£0.2m	£0.6m	£0	£1.9m
GSCC	£11.9m	£0	£0	£17.8m
AERC	£0	£0	£0	£0
AC	£1.5m	£0	£0	£2.7m
IC	£0	£0	£0	£0
NPSA	£4.2m	£0	£0	£0
NHSi	£0.006m	£0	£0	£0
OHPA	£0	£0	£13m	£0
<b>Total</b>	<b>£17.9m</b>	<b>£0.6m</b>	<b>£13m</b>	<b>£23.4m</b>

**Table 4b: Monetised Costs and Benefits for Option 2 (Exchequer Impacts, including opportunity cost)**

ALB/Public Body	Costs		Benefits	
	Transition	Average Annual (over 10 years)	Transition	Average Annual (over 10 years)
NICE	£0.02m	£0	£0	£0
CQC	£0	£0	£0	£1.3m
NIGB	£0	£0	£0	£1.0m
CHRE	£0.5m	£1.4m	£0	£4.6m
GSCC	£28.7m	£0	£0	£42.8m
AERC	£0	£0	£0	£0
AC	£3.6m	£0	£0	£6.4m
IC	£0	£0	£0	£0
NPSA	£10.1m	£0	£0	£0
NHSi	£0.01m	£0	£0	£0
OHPA	£0	£0	£31.2m	£0
<b>Total</b>	<b>£43.0m</b>	<b>£1.4m</b>	<b>£31.2m</b>	<b>£56.1m</b>

**Table 4c: Monetised Costs and Benefits for Option 2 (non-Exchequer Impacts)**

ALB/Public Body	Costs		Benefits	
	Transition	Average Annual (over 10 years)	Transition	Average Annual (over 10 years)
NICE	£0	£0	£0	£0
CQC	£0	£0.5m	£0	£0
NIGB	£0	£0	£0	£0
CHRE	£0	£2.0m	£0	£0.6m
GSCC	£0.5m	£3.1m	£0	£0
AERC	£0	£0	£0	£0
AC	£0	£0	£0	£0
IC	£0	£0	£0	£0
NPSA	£0	£0	£0	£0
NHSi	£0	£0	£0	£0
OHPA	£0	£0.8m	£3.9m	£4.4m
<b>Total</b>	<b>£0.5m</b>	<b>£6.4m</b>	<b>£3.9m</b>	<b>£5.0m</b>

<sup>137</sup>Figures may not sum due to rounding.

E136. Table 5 brings the overall figures together from the above tables (note figures may not sum exactly due to rounding) to summarise the best estimate of the costs and benefits of Option 2. The Present Discounted Value estimates discount future cost/benefit estimates by 3.5% over a 10 year period.

<b>Table 5: Total Costs and Benefits for Option 2</b>				
	<b>Transition Costs</b>	<b>Average Annual Costs</b>	<b>Transition Benefits</b>	<b>Average Annual Benefits</b>
<b>Total</b>	£43.5m	£7.8m	£35.1m	£61.1m
<b>Present Discounted Value</b>	£105.5m		£538.4m	
<b>Net Present Value</b>	£433.0m			

E137. The total benefits and costs, and the net present value, displayed in the tables above give a benefit: cost ratio of 5:1. This could be construed as very high, given that the interventions are predominantly a change to the regulatory landscape. The reason is that the proposed changes represent a rationalisation of the structures and the costs of the ALB sector, but not, largely, of the functions that are currently performed by the sector. The vast majority of the functions that are currently performed by the sector will remain, albeit within different organisations.

## Key risks and sensitivities

- E138. In the absence of detailed information from some ALBs on possible costs and savings, The Department has relied upon assumptions to form our estimates. The assumptions used in this impact assessment were developed through working with DH Finance, DH Accommodation and Estates, and DH Business Support teams, all who had experience of government reorganisations. The Department also used assumptions previously applied by DEFRA to reflect our work requirements. These assumptions are explained in more detail in Annex 4.
- E139. Although the Department believes that these are sensible assumptions to make, there is a risk that the benefits could be overstated, or the costs underestimated. To mitigate these risks the Department has used ranges, and in some instances have shown the worst-case scenario as our best estimate. In doing this, the Department has still presented that the benefits outweigh the costs with a Net present Value (NPV) of £433.0m.
- E140. The Department has assumed that there will be minimal loss in the value of functions as the Department is mainly proposing to move the functions elsewhere in the sector or the health and social care system, where they are better placed. However, there could be a risk that these functions will not be delivered as effectively during the transition stage, whilst organisations adapt to changes. Furthermore, by increasing the functions of some ALBs (CQC, NICE, IC), there is a potential risk that these organisations will become overstretched and that this will detract from the essential delivery of their current functions. The Department believes that these risks will be mitigated through the removal of duplication in the system and greater synergies, ensuring that functions are delivered in the most efficient way and at the most appropriate level. Furthermore, DH intends to consider carefully the timeline for transfer of functions, so as not to coincide with other significant deliverables such as the CQC registration of primary care services.
- E141. Where DH proposes to abolish a function or body, DH risks not receiving the full cost savings as the function may still be performed elsewhere using money provided by the Department. This risk applies, for instance, to the proposal to abolish the AC. However, there will only be a residual number of public appointments required after the abolition of PCTs and SHAs and this small

number will be handled by the Department and an NHS body, most likely to be a special health authority.

E142. Where the detail of new policies for some ALBs has not been fully decided yet, it is not possible to carry out a complete analysis. Furthermore, there is a risk that other parts of the system, such as the new NHS Commissioning Board or the removal of PCTs, will not be established in the way in which DH has envisaged. In these instances, DH has used the best estimates available to support our analysis, ensuring that both internal and external stakeholders are involved in the development of these estimates. DH also intends to review the implementation process in 2014.

### **One in One Out**

E143. The Department has considered non-legislative approaches for delivering the objectives outlined in paragraph E23 (i.e. streamlining ALB sector, reducing duplication and central bureaucracy.) Such non-legislative approaches include voluntary regulation or self-regulation. Fundamentally, though, primary legislation will be needed to change the structure of the ALB landscape.

E144. Where the present policy results in changes to the regulatory burden placed on the private sector and/or civil society organisations – e.g. in terms of form filling, background checks and so on – these changes would fall within the remit of the recently developed One In One Out framework.

E145. DH has attempted to quantify such changes as far as possible. Notably, the implementation of the present policy will lead to some increases in regulatory burden resulting from:

- a. the abolition of the GSCC and the transfer of the role of the regulation of social workers to the Health Professions Council (HPC). As explained in paragraph E81, this will lead to an increase in fees payable by registered social workers from 2012/13 onwards.
- b. Fees levied by CHRE on professional regulators which may be passed on to the registrants of those regulators (see paragraph E65).

E146. Note that the above increases in burden are borne either by the professionals registered with professional regulators or by the professional regulators themselves. They do not constitute a burden on business or civil society organisations, but on individuals or public bodies. As such, these increases in regulatory burden are out of scope of One In One Out.

E147. As explained in paragraph E45, there will be a reduction in regulatory burden put on mental health providers: requirements for a SOAD request will see a reduction in the frequency of applications and preparation for visits. This reduction in the regulatory burden on mental health providers constitutes an OUT in the One In One Out framework, but has not been quantified.

### **Administrative Burden**

E148. Administrative burdens are back office activities that private and third sector organisations must undertake in order to comply with statutory regulations. DH has not identified any areas from the changes listed above that will have an impact on administrative burdens. There may be a small reduction in administrative burdens from the AERC no longer needing to comply with ALB requirements, but this will be negligible due to the size of the organisation.

## Annexes

Annex 1 should be used to set out the Post Implementation Review Plan as detailed below. Further annexes may be added where the Specific Impact Tests yield information relevant to an overall understanding of policy options.

### Annex 1: Post Implementation Review (PIR) Plan

A PIR should be undertaken, usually three to five years after implementation of the policy, but exceptionally a longer period may be more appropriate. A PIR should examine the extent to which the implemented regulations have achieved their objectives, assess their costs and benefits and identify whether they are having any unintended consequences. Please set out the PIR Plan as detailed below. If there is no plan to do a PIR please provide reasons below.

<p><b>Basis of the review:</b> [The basis of the review could be statutory (forming part of the legislation), it could be to review existing policy or there could be a political commitment to review]; Please see coordinating document Post-Implementation Review section.</p>
<p><b>Review objective:</b> [Is it intended as a proportionate check that regulation is operating as expected to tackle the problem of concern?; or as a wider exploration of the policy approach taken?; or as a link from policy objective to outcome?]</p>
<p><b>Review approach and rationale:</b> [e.g. describe here the review approach (in-depth evaluation, scope review of monitoring data, scan of stakeholder views, etc.) and the rationale that made choosing such an approach]</p>
<p><b>Baseline:</b> [The current (baseline) position against which the change introduced by the legislation can be measured]</p>
<p><b>Success criteria:</b> [Criteria showing achievement of the policy objectives as set out in the final impact assessment; criteria for modifying or replacing the policy if it does not achieve its objectives]</p>
<p><b>Monitoring information arrangements:</b> [Provide further details of the planned/existing arrangements in place that will allow a systematic collection systematic collection of monitoring information for future policy review]</p>
<p><b>Reasons for not planning a PIR:</b> [If there is no plan to do a PIR please provide reasons here]</p>

## Annex 2: Description of the current ALBs

ALB	Function	Headcount (Month 12 Monitoring returns from ALBs, 2009/10)	DH funding (admin budget 2010/11 <sup>138</sup> ) £000	Is it covered in the Health and Social Care Bill?
<b>National Institute for Health and Clinical Excellence (NICE)</b>	NICE 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. NICE provides national guidance on public health, health technologies, clinical practice and interventional procedures.	482	37,423	Yes
<b>Care Quality Commission (CQC)</b>	The CQC is an executive non-departmental body (NDPB) which registers health and social care providers against essential levels of safety and quality. It has significant powers of enforcement, undertakes inspections and special reviews and is also responsible for protecting the rights of people subject to the Mental Health Act 1983, and for appointing second opinion appointed doctors (SOADs) to carry out functions under that Act.	2,089	99,593	Yes
<b>Monitor</b>	Monitor is currently responsible for authorising and regulating NHS Foundation Trusts.	94	16,500	Yes – but in the Regulating Providers IA in Annex B of the Coordinating Document.
<b>Medicines and Healthcare products Regulatory Agency (MHRA)</b>	The MHRA 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 MHRA provides advice to the Secretary of State on medicines and devices, and leads the negotiation and implementation of the Medicines Act and European legislation.	993	11,069	No
<b>Health Protection Agency - HPA</b>	The Health Protection Agency is an ALB set up in 2003 as a UK wide body. It aims to protect the public from threats to their health from infectious disease and environmental	4,100	149,609	Yes

<sup>138</sup> 2010/11 Admin Budget, starting point for ALBs at the beginning of the financial year 04/2010. There has since been a subsequent 3% efficiency applied and some non-recurrent budget additions.

	hazards			
<b>Human Tissue Authority (HTA)</b>	The HTA 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 HTA 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.	67	1,093	No
<b>Human Fertilisation and Embryology Authority (HFEA)</b>	The HFEA 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 HFEA separates sensitive issues from government and its independence is trusted. The HFEA's functions satisfy the criteria for being undertaken by an arm's-length body.	86	2,200	No
<b>Council for Healthcare Regulatory Excellence (CHRE)</b>	The CHRE is an Executive Non-Departmental Public Body responsible for scrutiny and quality assurance of the nine health care professions regulators in the UK. At present, CHRE performs the following functions: <ul style="list-style-type: none"> <li>• Quality assurance of professional regulation</li> <li>• Audit of fitness to practise cases</li> <li>• Reviewing fitness to practise decisions under Section 29 of the NHS Reform and Health Care Professions Act 2002</li> </ul>	19	1,876	Yes
<b>General Social Care Council (GSCC)</b>	The GSCC is an Executive 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.	198	21,000-25,000 <sup>139</sup>	Yes
<b>Alcohol Education and Research Council (AERC)</b>	The AERC was established as an Executive Non-Departmental Public Body in the Licensing (Alcohol Education and Research) Act 1981. The Alcohol Education and Research Fund has charitable status and is administered by the Council to support research into the prevention of alcohol-related harm. The Department does not provide funding for the Council.	3	n/a	Yes

<sup>139</sup> Figures based on GSCC's forecast and subject to the approval of their business case.

<b>NHS Blood and Transplant (NHS BT)</b>	NHS BT 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 BT 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 BT also manufactures therapeutic plasma products, which are supplied on a commercial basis to the NHS and world markets.	5,568	n/a – no admin budget, all frontline services.	No
<b>National Treatment Agency for Substance Misuse (NTA)</b>	The NTA is a Special Health Authority established in 2001 to improve the availability, capacity and effectiveness of drug misuse in England	195	11,147	No
<b>Health and Social Care Information Centre (IC)</b>	The Health and Social Care Information Centre (IC) was established as a Special Health Authority in April 2005. Its primary functions have been around the collection and publication of certain national and official statistics, and the delivery of information products and services used by NHS managers and clinicians in the collection of data and used to compare and contrast performance.	632	35,868	Yes
<b>Appointments Commission (AC)</b>	The AC provides recruitment services and related functions (eg. managing suspensions) at reasonable costs, provides value for money and has built up considerable NHS expertise.	62	3,564	Yes
<b>National Patient Safety Agency (NPSA)</b>	The NPSA 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. In addition, the NPSA houses the National Clinical Assessment Service, the National Research Ethics Service and three confidential inquiries.	348	23,867	Yes – but only some of the work of the Patient Safety Division (PSD) is moving to the NHS Commissioning Board
<b>NHS Institute for Innovation and Improvement (NHSi)</b>	The NHSi 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	194	66,027	No – However, the transfer of the leadership function to the NHS Commissioning Board is covered.

	results.			
<b>NHS Litigation Authority (NHS LA)</b>	The NHS LA is a Special Health Authority, responsible for the management and settlement of large current and future liabilities attached to NHS bodies. These liabilities accrue predominantly, but not wholly, as a result of clinical negligence claims.	147	3,948	No
<b>NHS Business Services Authority (NHS BSA)</b>	The NHS BSA 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 BSA 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.	2,676	131,800	No



## Annex 3: Specific Impact Tests

### Competition Assessment

E3.1. Using the checklist of impacts from the Office of Fair Trading website<sup>140</sup> the following questions are considered:

1) *Would the policy directly limit the number or range of suppliers?*

E3.2. This policy will have an impact on the market for public appointments; following the proposal to abolish the AC. Removing the AC from the recruitment sector will therefore directly reduce the number of suppliers in this sector by one. However, the removal of the AC from the sector, along with wider system changes, will in fact encourage competition because private providers will have to compete to attract the business of bodies that used the AC for their public appointments. In addition, fewer public appointments (as a result of wider system changes) will encourage competition further and prevent collusive outcomes.

2) *Would the policy indirectly limit the number or range of suppliers?*

E3.3. The proposed changes to the GSCC may have an indirect impact on social workers in England. The recruitment and retention of social workers is affected by many different factors impacting on actual numbers. The supply of social workers has not been constant nor followed a trend over time. Annual Reports from the GSCC has shown that the total number of registered social workers (which, since registration is required for employment, is a sufficient proxy for the total supply of social workers) shows that recent levels of registrants have fluctuated by up to 6,000 per year (from 2008/09 to 2009/10). It is difficult to pin down precise reasons behind these changes, and hence we cannot be certain whether the number of registrants will be adversely affected by the increase in fees.

E3.4. The proposed changes may impose a burden on the 83,464 social workers currently registered with the GSCC. This is because the function of social work regulation as undertaken by GSCC is heavily subsidised by DH resulting in social workers in England paying £30 a year as a registration fee. Following the transfer the regulation of social workers in England will no longer be subsidised by Government and their fees are expected to rise to £76 a year.

E3.5. The HPC delivers its regulatory function through a model financed by its registrants. It is estimated that the annual registration fee for a social worker will increase by £46 per person (from £30 to £76) from the level of fees charged in 2010/11. It will bring the fees paid by social workers in line with other HPC registrants such as dietitians, occupational therapists, and physiotherapists and paramedics and nurses who are regulated by the Nursing and Midwifery Council. This compares favourably with the expected annual registration fee which the GSCC would need to charge social workers in England if it was to become self-funding.

E3.6. Social workers typically earn between £20,000 and £30,000 – this is similar to many of the professions currently registered by the HPC and DH would not expect that an additional £46 a year would act as a significant disincentive to those wishing to become or return to practise as social workers.

E3.7. For the CHRE, the compulsory levy on the regulators may result in a very small increase in the registration fee paid by registrants. This is very unlikely to have any effect on the number or range of registered professionals.

E3.8. Quality assurance of voluntary registers by CHRE may have an indirect effect on the number and range of health and social care practitioners. Members of a quality assured voluntary

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<sup>140</sup> Link: [http://www.offt.gov.uk/shared\\_offt/reports/comp\\_policy/oft876.pdf](http://www.offt.gov.uk/shared_offt/reports/comp_policy/oft876.pdf)

register will meet specified standards of training and competence, and their registration status means that this will be easily verifiable by employers and the public. Therefore, being registered is likely to be an advantage when seeking employment. Not being registered may, over time, result in a rise in the threshold for entry to certain occupations, which would be expected to raise standards of practice.

### 3) *Would the policy limit the ability of suppliers to compete?*

E3.9. There is currently no competition between suppliers since many of the ALBs are created to deliver a certain function. The policy does not have the intended effect of providing or changing competition, so this policy will not limit supplier's ability to compete.

E3.10. In terms of indirect effects, the Department does not believe this policy will limit the ability of the health sector to compete. Quality assurance of voluntary registers by CHRE places no limits on the ability of practitioners to compete in the labour market. Practitioners are free to choose whether to join a quality assured voluntary register.

### 4) *Reduce suppliers' incentives to compete vigorously?*

E3.11. The public bodies in the remit of this policy are not intended to compete with other ALBs or any other organisation. This characteristic will not change on implementation of this policy and hence this policy will not reduce suppliers' incentives to compete vigorously.

## **Small Firms Impact Test**

E3.12. The Small Firms Impact Test (SFIT) considers any impacts on small businesses or their customers as a result of government policy. Specifically, the SFIT asks whether "the proposal affect[s] small business, their customers or competitors"<sup>141</sup> where a small business is defined as a business with a headcount of less than 50. The changes to the GSCC and CHRE may result in impacts on small organisations but they are out side the definition of "small firms".

E3.13. The transfer of the role of the regulation of social workers to the HPC and abolition of GSCC may result in an increase in social workers registration fees of £30 to £76, an increase of £46.

E3.14. This would lead to an additional cost on registered social workers in England. The additional cost would fall on individual social workers rather than on their employers and we do not therefore expect that there will be a significant impact on small firms. Of the 83,464 registered social workers the majority<sup>142</sup> are employed by local authorities and agencies who will fall outside the definition of a "small business".. This cost will fall on individuals and it will be for individual employers to decide whether to reflect the increase in registration costs to social workers in their terms and conditions of employment. Note that as outlined at Para 146 this increases in burden does not constitute a burden on business or civil society organisations, but on individuals or public bodies. As such, these increases in regulatory burden are out of scope of One In One Out and thus the definition of "small firm". The increase of costs may have a comparatively disproportionate impact on smaller organisations if they choose to pay the increased fees of the social workers they employ but DH would not expect the impact even for smaller firms to be large or significantly detrimental.

E3.15. In considering the impact, DH also needs to factor in the benefits that the small organisations will gain from social workers being regulated by a more efficient regulator and the confidence this provides to them in delivering safe, effective, social care services to their users.

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<sup>141</sup> Link: <http://www.bis.gov.uk/files/file49614.doc>

<sup>142</sup> State of the adult social care workforce in England 2010. Skills for care. 2010

- E3.16. For the CHRE, the compulsory levy on the regulators may result in a very small increase in the registration fee paid by registrants. This is very unlikely to have any effect on registered professionals or their employers, even in the case of sole traders, the self-employed, or those who work for small businesses.
- E3.17. Quality assurance of voluntary registers may have some impact on small firms and their customers. It is anticipated that the prospect of quality assurance by CHRE may encourage professional and occupational groups to enter into voluntary registration. The registration fees that these groups would pay may contribute to upward pressure on wages. Although this may have a disproportionate effect on small employers, no employer will be compelled to employ registered practitioners. Similarly, where small businesses choose to pass the cost of registration on to their customers through higher prices, those customers will be free to go elsewhere. Therefore, although quality assurance of voluntary registration will create new costs, because registration is voluntary, these costs will only be incurred where practitioners, their employers and customers judge that the benefit warrants the cost.

### **Health Impact Assessment**

E3.18. The Department of Health guidance on health impact assessments<sup>143</sup> focus on three screening questions:

- 1) *Will your policy have a significant impact on human health by virtue of its effects on the following wider determinants of health? Income, Crime, Environment, Transport, Housing, Education, Employment, Agriculture, Social cohesion*

E3.19. The policies analysed above could have an impact on human health by virtue of changes to income and employment status of individuals made redundant from these changes. For organisations where redundancies will occur, there would be some provision to ensure career development is supported. For instance, with the AC, all staff will have access to support for finding new opportunities including advice on writing CVs and interview techniques. Meeting the needs of staff will be critical to maintain morale and ensure they can continue to deliver a professional service. There is unlikely to be any impacts on the other determinants of health.

- 2) *Will there be a significant impact on any of the following lifestyle related variables? Physical activity; Diet; Smoking; Drugs; Alcohol use; Sexual behaviour; Accidents and stress at home or work*

E3.20. In cases where staff are made redundant there are likely to be impacts on stress at home. While redundancy will have a serious impact on those who are made redundant, the number of people made redundant is unlikely to have a significant impact on these lifestyle variables. It is expected that detailed transition plans by individual organisations would ensure a smooth transition to the new public body landscape and mitigate any additional stress placed on people who become unemployed.

- 3) *Is there likely to be a significant demand on any of the following health and social care services? Primary care; Community services; Hospital care; Need for medicines; Accident or emergency attendances; Social services; Health protection and preparedness response*

E3.21. The restructuring of the public bodies sector may place extra demand on Primary care services where staff have been made redundant, as increased stress at home or work could have a negative effect on their health. However, as stated above, all organisations will ensure that any health impacts are mitigated as far as possible and ensure that staff have services available to them to maximise the chance of re-employment.

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<sup>143</sup> Link: [http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Healthassessment/DH\\_4093617](http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Healthassessment/DH_4093617)

## **Greenhouse Gas Assessment**

- E3.22. The Greenhouse Gas Assessment considers the impact this policy will have on greenhouse gas emissions. The policies put forward propose movements of functions and individuals from one organisation to another. As such, it is necessary to consider two different factors in the movement of public bodies: the difference in energy efficiency from certain buildings; and the carbon emissions resulting from the transportation of desks, computers, files, etc from one building to another.
- E3.23. The logistics behind the transportation of equipment from one building to another are not fully clear and hence are unquantifiable. DH expects the impacts on greenhouse gas emissions to be minimal and incur only during the transition phase.

## **Wider Environmental Issues Assessment**

- E3.24. Using guidance from DEFRA, the Department does not believe this policy will have a negative impact on any environmental issues. For this reason, a full Environmental Impact Assessment is not necessary.

## **Human Rights Assessment**

- E3.25. Using guidance from the Ministry of Justice, DH concludes the policies analysed in this Impact Assessment do not contravene any Articles of the Human Rights Act 1998 and is compatible with all domestic and European legislation.

## **Justice Impact Assessment**

- E3.26. A new policy, particularly those which involve a change in legislation, can have an impact on the justice system. These impacts need to be considered, anticipated and planned for at an early stage to make the best use of public funds. The Justice Impact Test<sup>144</sup> is a tool for assessing the impact of policy across the justice system – civil and criminal – and covers; legal aid, courts and tribunals, prisons and probation services, prosecuting bodies, the judiciary. A Justice Impact Test has been undertaken for the Public Bodies policy and a summary of the impact is given below.
- E3.27. Within the Public Bodies policy, the only change affecting the justice system is caused by the abolition of the General Social Care Council (GSCC) and its function of regulating social workers in England being transferred to the Health Professions Council (HPC), which will be re-named the Health and Care Professions Council. This will bring benefits to taxpayers and the public in England by making the regulation of social workers financially and operationally independent of Government. This is expected to be implemented in 2012.
- E3.28. As a result, the appeals mechanism that is applied in relation to decisions made about the registration and fitness to practise of social workers in England will change. The current GSCC model provides that all appeals are to the first-tier tribunal whereas the HPC model broadly provides for appeals against registration decisions to be heard through an internal process (with a further appeal to a county court) and appeals against fitness to practise decisions to be heard by the High Court.
- E3.29. As a consequence, there will be no appeals against registration or fitness to practise decisions taken in relation to social workers in England to the first-tier tribunal, resulting in a decrease in its case workload. The use of the HPC appeal model is likely to result in a net decrease in the overall number of applications to the first-tier tribunal, and subsequently the upper tribunal, and a small gross increase in the number of cases heard by the High Court. The disparity between

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<sup>144</sup> <http://www.justice.gov.uk/guidance/docs/justice-impact-assessment-guidance-doc.pdf>

the number of cases which the first-tier tribunal and upper tribunal will lose and the number of additional cases which the High Court will gain can be explained by a combination of first appeals against registration decisions in relation to social workers in England being heard internally by the HPC, the differences between the approaches of the GSCC and the HPC to dealing with concerns raised about registrants and the internal review mechanisms of the HPC. These are anticipated to reduce the number of cases being appealed to an external adjudicatory body.

- E3.30. The appeal to the High Court is part of the HPC's wider fitness to practise process, which considers an individual's conduct and competence in the round in contrast to the General Social Care Council's approach which considers conduct only. The HPC also has a wider range of sanctions available to it than the GSCC, such as being able to place conditions on registration. These differences are important because, for the first time, it allows for a social worker's conduct and competence to be considered in the round and for remedial action to be taken to improve their practice. This wider consideration of an individual social workers "fitness to practise" provides them with confidence that their cases will be fully considered and a suitable sanction imposed.
- E3.31. We are working with the Ministry of Justice to assess and monitor the impact and agree how these impacts will be managed.

### **Rural Proofing Test**

- E3.32. Having considered the guidance from the Rural Proofing Toolkit, DH do not believe there will be a disproportionately adverse effect on rural areas and hence a full Rural Proofing Test is not required.

### **Sustainable Development Test**

- E3.33. The Department does not believe there will be any significant environmental impacts of our policy proposal over and above those mentioned in the Greenhouse Gas Assessment. There are no impacts that fall disproportionately on future generations and the distribution of costs and benefits over time is relatively flat. For these reasons, a full Sustainable Development Test has not been completed.

## Annex 4: Assumptions and sources used for cost and benefit estimations

E5.1. This Annex sets out the assumptions that have been made in this Impact Assessment and sources for these assumptions where possible. Where possible DH has engaged with the respective organisations to get an accurate estimate for cost and benefit estimations. However, in some areas these estimates have not been fully developed, so the assumptions below are used in lieu of other estimates. The Department believes these assumptions are appropriate for this analysis.

### Transition Costs

E5.2. A range of different sources are used as the basis for transition costs.

1) Developing DEFRA report<sup>145</sup>: A report by DEFRA details the costs (retrospectively) of merging functions into DEFRA. A transfer of 700 staff incurred accommodation costs of £640,000, or £900 per staff member.

2) Internal DH cost estimates: Estimates from the DH Accommodation and Estate team place an estimate of £1,000 per FTE to relocate from one location to another. This estimate has been chosen instead of the £900 as extracted from the DEFRA report so that the cost is not underestimated.

E5.3. *Assumption*: With these sources in mind, the figure of £1,000 has been selected to move an individual from one organisation/building to another.

### Indirect Costs

E5.4. There is very little direct quantifiable evidence of the indirect costs that are considered for some interventions in this Impact Assessment. This Impact Assessment only considers possible losses in productivity for policies where functions are being moved from one organisation to another. A report by the Institute for Government<sup>146</sup> uses an assumption that, for all the staff affected by the change in organisation, 20% of staff experience a complete loss of productivity for 20% of the period of the transition. This is equivalent to 4% of salary costs for all staff affected. The Institute for Government report indicates this is a conservative estimate, but it is considered for the purpose of this Impact Assessment.

E5.5. To fully reflect the impact of any particular policy, it is important to consider the effect of reallocating funds away from this alternative use. The impact of reallocation is the policy's true cost – or “opportunity cost” – that must be measured in Impact Assessments. To calculate the impact of reallocating funds – out of the fixed budget of the NHS – to a new policy, it is necessary to determine how much benefit would have been realised from the alternative use of those funds. At the margin, NHS treatments have been estimated to provide health at a cost of £25,000 per Quality Adjusted Life Years (QALYs). Importantly, however, society is currently estimated to *value* these QALYs more than twice as highly - at £60,000. This means that any policy which involves spending £1 from the NHS budget will deprive society of an alternative use worth £2.4. Conversely, each £1 saved in the NHS is assumed to be used elsewhere in the NHS to a benefit of £2.4. Note that this opportunity cost ratio of 2.4:1 is assumed to be constant across the public sector.

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<sup>145</sup> Source: “Developing DEFRA: A report on the merger for people who lead and manage change”, DEFRA, August 2002 <http://www.parliament.uk/deposits/depositedpapers/2009/DEP2009-2410.pdf>

<sup>146</sup> Source: [http://www.instituteforgovernment.org.uk/pdfs/making\\_and\\_breaking\\_whitehall\\_departments.pdf](http://www.instituteforgovernment.org.uk/pdfs/making_and_breaking_whitehall_departments.pdf), footnote 43

## **Annex 5: Methodology used and Approaches considered**

E5.1. Below the methodology adopted whilst reviewing the ALB sector is set out. This includes working within the framework of the white paper proposals, using test criteria from the Cabinet Office, and producing a functional mapping to identify duplication and potential areas where rationalisation would be possible. These separate elements are explained below.

### White Paper proposals

E5.2. The main changes proposed in the White Paper which will have an impact on the current role and function of the ALB sector are:

- shifting power from national organisations to the frontline, and to patients and the public. This allows us to consider ideas such as passing a larger share of NHS finances direct to the frontline and empower them to decide how to spend it;
- an information revolution, leading to opportunities for a more strategic review of the use of information, and to streamline information functions within the ALB sector;
- the establishment of an NHS Commissioning Board, leading to opportunities to consolidate functions currently carried out in ALBs, such as CQC's commissioner assurance function;
- 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 CQC as an inspectorate, with a role in strengthening the collective voice of patients and service users (via HealthWatch);
- an expanded role for NICE and its conversion into a ENDPB; and
- the creation of a Public Health England, within the Department, providing a home for functions from the HPA and NTA.

### Test Criteria

E5.3. The wider structural changes set out in the White Paper provided us with an opportunity to undertake a detailed review of the functions of each ALB, 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.

E5.4. DH used these three criteria to consider the current ALB sector's functions. These criteria are consistent with those issued by the Cabinet Office for use in developing policy for the Public Bodies (Reform) Bill that went into Parliament 28th October 2010.

### Functions

E5.5. In addition to applying the test criteria, other factors might give preference to retaining functions at a national level, such as economies of scale and the need for consistency and standardisation. To consider these factors, DH established a functions map, which was quality assured by ALBs, to set out the main activities of ALBs along 3 dimensions:

- The aim of the function, i.e. what is the ALB trying to achieve;
- The process used to deliver the function, to spot synergies between bodies; and
- The client groups involved, i.e. who the function is "done to" and "done for".

E5.6. This mapping helped us to see that there is scope to rationalise functions that are being performed by multiple bodies in the ALB sector. 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; and
- change is required to achieve greater alignment with the wider system changes and to deliver a more responsive service.



<b>Title:</b> <b>Public health elements of the Health and Social Care Bill</b> <b>Lead department or agency:</b> <b>Department of Health</b> <b>Other departments or agencies:</b> <b>Health Protection Agency</b>	<b>Impact Assessment (IA)</b>
	IA No: 3023
	Date: 25/08/2011
	Stage: Final
	Source of intervention: Domestic
	Type of measure: Primary legislation

## Summary: Intervention and Options

### What is the problem under consideration? Why is government intervention necessary?

The current public health system is fragmented. A new national approach to organisation and delivery of public health services is required to streamline existing health protection and improvement bodies and functions and thereby improve the health of the population by bringing together a number of different organisations in Public Health England. Significant structural changes in the health sector will necessitate new arrangements for public health delivery. Nationally, a clear line of accountability to the Secretary of State for Health is required to ensure better protection of the population.

### What are the policy objectives and the intended effects?

The overarching policy objective is to protect the public and to improve the healthy life expectancy of the population, by establishing a public health service, incorporating both national and local structures. In order to accomplish this within the Health and Social Care Bill, the policy objectives are:

1. At a national level, abolishing the Health Protection Agency (HPA) and transferring the responsibilities and associated workforce to Secretary of State for Health. The intention is to establish Public Health England as an executive agency of the Department of Health.
2. At a local level, transferring the responsibilities for health improvement, and the post of Director of Public Health, from NHS Primary Care Trusts (PCTs) to local authorities

### What policy options have been considered? Please justify preferred option (further details in Evidence Base)

For both policy objectives, the options are to:

1. Do nothing
2. Legislate.

The preferred option is to legislate. Given the wider system changes to the NHS, we need to ensure that the public health service is fit for purpose. At a national level, legislation is needed to dissolve the HPA. At a local level, much of the public health workforce is currently located in PCTs and Strategic Health Authorities (SHAs). The disestablishment of PCTs and SHAs will necessitate the transfer of their public health responsibilities to another organisation. The preferred option is for this to be local authorities, given their influence over the wider determinants of public health. As the public health responsibilities of the NHS are set out in legislation, transferring the responsibilities to local authorities will therefore require legislation.

<b>When will the policy be reviewed to establish its impact and the extent to which the policy objectives have been achieved?</b>	See Annex A
<b>Are there arrangements in place that will allow a systematic collection of monitoring information for future policy review?</b>	Yes

**Ministerial Sign-off** For final proposal stage Impact Assessments:

*I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) the benefits justify the costs.*

Signed: .....  ..... Date: ..... 1.9.11 .....

# Summary: Analysis and Evidence

# Policy Option 2

## Description:

Legislate to move the Health Protection Agency into the Department of Health, and transfer Directors of Public Health to local authorities.

Price Base Year 2010	PV Base Year 2010	Time Period 10 Years	Net Benefit (Present Value (PV)) (£m)		
			Low: [REDACTED]	High: [REDACTED]	Best Estimate: [REDACTED]
<b>COSTS (£m)</b>	<b>Total Transition</b> (Constant Price) Years		<b>Average Annual</b> (excl. Transition) (Constant Price)	<b>Total Cost</b> (Present Value)	
Low	[REDACTED]		[REDACTED]	[REDACTED]	
High	[REDACTED]		[REDACTED]	[REDACTED]	
Best Estimate	[REDACTED]		[REDACTED]	[REDACTED]	
<b>Description and scale of key monetised costs by 'main affected groups'</b>					
<p>Transition costs: Transfer of HPA staff to Department of Health – [REDACTED] Transfer of directors of public health and some public health PCT staff to local authorities - Low: [REDACTED]</p> <p>Annual costs: Increased employer pension costs - [REDACTED]. Extra funding needed to deliver the same public functions as currently (due to loss of HPA income generation): [REDACTED]</p> <p>Costs associated with the new clauses on fluoridation and registration of births and deaths are likely to be small and will be considered in detail in a later IA accompanying secondary legislation.</p> <p>We have redacted figures, as they could compromise the commercial activity of the HPA or prejudice negotiations with staff prior to formal consultation.</p>					
<b>Other key non-monetised costs by 'main affected groups'</b>					
<b>BENEFITS (£m)</b>	<b>Total Transition</b> (Constant Price) Years		<b>Average Annual</b> (excl. Transition) (Constant Price)	<b>Total Benefit</b> (Present Value)	
Low	Optional		Optional	Optional	
High	Optional		Optional	Optional	
Best Estimate					
<b>Description and scale of key monetised benefits by 'main affected groups'</b>					
Not applicable					
<b>Other key non-monetised benefits by 'main affected groups'</b>					
A public health service, incorporating both national and local structures, should provide a streamlined and efficient service, which will make a positive impact on health and improve health outcomes.					
<b>Key assumptions/sensitivities/risks</b>				<b>Discount rate (%)</b>	3.5%
<p>This assessment does not include any costs or benefits arising from the reduction in administration costs across the ALB sector as a whole, the Department or the NHS.</p> <p>Salaries of staff transferring into the Department will not rise at greater than the rate of inflation</p> <p>The value of HPA income generating function would not have risen faster than the rate of inflation</p> <p>The cost of pension liabilities resulting from contractual changes as part of the transition for HPA staff to civil service contracts and the transition for directors of public health and other PCT staff to local authority contracts is a key sensitivity.</p> <p>Key risks include the loss of the skilled and specialist workforce and the potential loss of HPA's income generating function.</p>					
<b>Direct impact on business (Equivalent Annual) £m):</b>			<b>In scope of OIOO?</b>	<b>Measure classified as</b>	
Costs:	Benefits:	Net:	No	NA	

## Enforcement, Implementation and Wider Impacts

What is the geographic coverage of the policy/option?		England (+ small aspects UK)			
From what date will the policy be implemented?		01/04/2013			
Which organisation(s) will enforce the policy?		NA			
What is the annual change in enforcement cost (£m)?		NA			
Does enforcement comply with Hampton principles?		N/A			
Does implementation go beyond minimum EU requirements?		N/A			
What is the CO <sub>2</sub> equivalent change in greenhouse gas emissions? (Million tonnes CO <sub>2</sub> equivalent)		<b>Traded:</b>		<b>Non-traded:</b>	
Does the proposal have an impact on competition?		No			
What proportion (%) of Total PV costs/benefits is directly attributable to primary legislation, if applicable?		<b>Costs:</b>		<b>Benefits:</b>	
Annual cost (£m) per organisation (excl. Transition) (Constant Price)	<b>Micro</b>	<b>&lt; 20</b>	<b>Small</b>	<b>Medium</b>	<b>Large</b>
Are any of these organisations exempt?	N/A	N/A	N/A	N/A	N/A

## Specific Impact Tests: Checklist

Set out in the table below where information on any SITs undertaken as part of the analysis of the policy options can be found in the evidence base. For guidance on how to complete each test, double-click on the link for the guidance provided by the relevant department.

Please note this checklist is not intended to list each and every statutory consideration that departments should take into account when deciding which policy option to follow. It is the responsibility of departments to make sure that their duties are complied with.

Does your policy option/proposal have an impact on...?	Impact	Page ref within IA
<b>Statutory equality duties</b> <sup>147</sup> <a href="#">Statutory Equality Duties Impact Test guidance</a>	Yes	EA Annex F
<b>Economic impacts</b>		
Competition <a href="#">Competition Assessment Impact Test guidance</a>	No	
Small firms <a href="#">Small Firms Impact Test guidance</a>	No	
<b>Environmental impacts</b>		
Greenhouse gas assessment <a href="#">Greenhouse Gas Assessment Impact Test guidance</a>	No	
Wider environmental issues <a href="#">Wider Environmental Issues Impact Test guidance</a>	No	
<b>Social impacts</b>		
Health and well-being <a href="#">Health and Well-being Impact Test guidance</a>	Yes	179
Human rights <a href="#">Human Rights Impact Test guidance</a>	No	
Justice system <a href="#">Justice Impact Test guidance</a>	No	
Rural proofing <a href="#">Rural Proofing Impact Test guidance</a>	No	179
<b>Sustainable development</b> <a href="#">Sustainable Development Impact Test guidance</a>	No	

<sup>147</sup> Race, disability and gender Impact assessments are statutory requirements for relevant policies. Equality statutory requirements will be expanded 2011, once the Equality Bill comes into force. Statutory equality duties part of the Equality Bill apply to GB only. The Toolkit provides advice on statutory equality duties for public authorities with a remit in Northern Ireland.

## Evidence Base (for summary sheets) – Notes

Use this space to set out the relevant references, evidence, analysis and detailed narrative from which you have generated your policy options or proposal. Please fill in **References** section.

### References

Include the links to relevant legislation and publications, such as public impact assessment of earlier stages (e.g. Consultation, Final, Enactment).

No.	Legislation or publication
1	Equity and Excellence: liberating the NHS; July 2010
2	Health Profile for England 2009 ( <a href="http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_114561">http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_114561</a> )
3	Marmot review 2010 ( <a href="http://www.marmotreview.org/">http://www.marmotreview.org/</a> )
4	A Healthier Nation 2010 ( <a href="http://www.conservative.com/News/News_stories/2010/01/A_Healthier_Nation.aspx">http://www.conservative.com/News/News_stories/2010/01/A_Healthier_Nation.aspx</a> )
5	National Audit Office report "Reorganising central government" (March 2010) ( <a href="http://bit.ly/aymAGx">http://bit.ly/aymAGx</a> )
6	Healthy Lives, Healthy People, Our strategy for public health in England; November 2010
7	Healthy lives, healthy people: update and way forward, July 2011 ( <a href="http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_128838">http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_128838</a> )
8	Healthy Lives, Healthy People: Consultation responses, July 2011 ( <a href="http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_128838">http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_128838</a> )

### Annual profile of monetised costs and benefits\* - (£m) constant prices – Redacted text marked by [R]

	Y <sub>0</sub>	Y <sub>1</sub>	Y <sub>2</sub>	Y <sub>3</sub>	Y <sub>4</sub>	Y <sub>5</sub>	Y <sub>6</sub>	Y <sub>7</sub>	Y <sub>8</sub>	Y <sub>9</sub>
Total Transition costs (low)	[R]									
Total Transition costs (high)	[R]									
Total Annual recurring cost (low)	[R]	[R]	[R]	[R]	[R]	[R]	[R]	[R]	[R]	[R]
Total Annual recurring cost (high)	[R]	[R]	[R]	[R]	[R]	[R]	[R]	[R]	[R]	[R]
Total annual costs (low)	[R]	[R]	[R]	[R]	[R]	[R]	[R]	[R]	[R]	[R]
Total annual costs (high)	[R]	[R]	[R]	[R]	[R]	[R]	[R]	[R]	[R]	[R]
Total Transition benefits										
Total Annual recurring benefits										
Total annual benefits										
Business transition costs	[R]	[R]	[R]	[R]	[R]	[R]	[R]	[R]	[R]	[R]
Business annual recurring costs	[R]	[R]	[R]	[R]	[R]	[R]	[R]	[R]	[R]	[R]
Business annual costs	[R]	[R]	[R]	[R]	[R]	[R]	[R]	[R]	[R]	[R]
Business transition benefits	[R]	[R]	[R]	[R]	[R]	[R]	[R]	[R]	[R]	[R]
Business annual recurring benefits	[R]	[R]	[R]	[R]	[R]	[R]	[R]	[R]	[R]	[R]
Business total annual benefits	[R]	[R]	[R]	[R]	[R]	[R]	[R]	[R]	[R]	[R]

\* For non-monetised benefits please see summary pages and main evidence base section

## Scope of this impact assessment

- F1. This impact assessment considers the public health elements of the Health and Social Care Bill. The Bill sets out the legislative framework for enabling the creation of Public Health England by:
- abolishing the Health Protection Agency (HPA) and transferring the responsibilities and associated workforce to Secretary of State for Health, and
  - transferring the responsibilities for health improvement, and the post of Director of Public Health (DPH), to local authorities.
- F2. Additionally this impact assessment has been updated to reflect the new clauses on fluoridation and registrations of births and deaths. These clauses seek to maintain the status quo for these two areas as far as possible despite the closure of SHAs and PCTs by:
1. transferring SHA responsibilities for consulting on fluoridation to local authorities;
  2. transferring the responsibility for contracting for fluoridation schemes from SHAs to the Secretary of State;
  3. transferring local registrar responsibilities to inform births and deaths to the local PCT to the local authority. Additionally this clause will allow Public Health staff transferring to local authorities to receive essential data such as births and deaths data.
- F3. The legislative interventions considered in this impact assessment are integral to, and should be read in conjunction with, the impact assessments that have been prepared in connection with *Healthy Lives, Healthy People*, the public health white paper.

### **Introduction**

- F4. As a nation, we are living longer, healthier lives than ever before. However, too many of us damage our health through the choices we make in living our lives and vigilance is needed to protect people from hazards to health (such as infectious diseases) where individuals cannot readily protect themselves.
- F5. There is no single accepted definition of what constitutes public health services. In broad terms they are concerned with the health of the population in general, rather than the provision of specific diagnosis or treatment services to individuals. For example, vaccination and screening (e.g. breast cancer screening) are services provided across the whole of the population, or a sub-group, where public health experts contribute to scientific and technical expertise resulting in an intervention (usually implemented by NHS funded services) applied to the members of a group.
- F6. Public health services need to be organised, generally commissioned and, in some cases (particularly for health protection), provided by the Government. They confer significant population benefits, but there is little incentive for private providers to provide such services. Particularly in the case of health protection and public health emergencies, there would be a substantial downside if such services were not provided in an effective and co-ordinated way.

### **Background - Current public health system**

- F7. At present, activity to improve public health and provide health protection (i.e. protection from the infectious disease, contamination and environmental hazards) is generally seen as distinct from

the diagnosis and treatment of disease, but is the responsibility of various different bodies within England:

- The Secretary of State for Health (SofS) and various NHS bodies have a role within health improvement as part of the existing healthcare system. For example, SHAs provide certain public health interventions that require a certain scale to be technically deliverable, such as management of fluoridation schemes. Primary Care Trusts (PCTs) commission various services for their local populations (e.g. stop smoking support; weight management) and GPs may choose to refer people into these services, or to provide brief interventions themselves. Additionally registrars currently register births and deaths in a local area with the PCT. Hospital Trusts may also provide health improvement interventions for their patients, such as helping people who are due to undergo surgery to quit smoking, or to provide weight management support for people undergoing bariatric surgery.
- Various NHS bodies also have a role with respect to health protection, for example, delivering immunisation and vaccination programmes that help to protect the local population from disease, and ensuring effective plans are in place for emergencies.
- Local authorities have existing roles in relation to health protection and, in practice, have responsibility for a number of areas that can affect public health (e.g. housing, environmental services). Many local authorities also work closely with the Health Protection Agency (HPA) with regard to health protection, for example, monitoring tuberculosis outbreaks.
- The HPA has significant responsibility for health protection, including an advisory and expert role, with the frontline responsibility for health protection activity divided between the HPA, PCTs and local authorities.
- The National Treatment Agency for substance misuse (NTA) has responsibilities with regard to the health improvement issues surrounding drug abuse. They provide advice and support to NHS bodies to develop interventions that are more effective in helping people who are addicted to drugs.

F8. Public health interventions are different from other health interventions – generally they involve an assessment of the health related needs, patterns and demands for a whole population or group, rather than a physician-level identification of need for treatment in specific individuals. It is important to recognise, though, that the healthcare system already provides a significant level of public health type interventions, and will continue to do so in a future where a unified public health service has been set up.

### **Context for action**

F9. The overall policy of setting up a new system depends on and is integrally related to the changes in the health service domain, including the NHS and (other) providers. This is set out in *Equity and Excellence: Liberating the NHS*. These plans entail disestablishing existing NHS bodies where some public health workforce currently resides, namely Strategic Health Authorities (SHAs) and PCTs.

F10. Following the introduction of the Health and Social Care Bill into Parliament and subsequent parliamentary scrutiny, we have updated the bill to include clauses that attempt to maintain the status quo for consulting on fluoridation and registrations of births and deaths following the abolition of SHAs and PCTs by transferring these responsibilities to local authorities and Secretary of State. We do not expect the transfer of fluoridation responsibilities will make fluoridation more or less likely. Access to data on births and deaths will be dealt with by different officials, but this will not have any impacts on privacy as the data will remain confidential as it is now and existing guidelines and legislation on the sharing of information will continue to apply.

### **Rationale for Government intervention**

- F11. The current public health system has grown up piecemeal and as a result is fragmented, and does not make the most of potential synergies across services. This could lead to inefficiencies due to overlapping responsibilities and activities as well as loss of opportunities to make a more positive impact on public health through the lack of clear accountability. Public Health England will bring together the following range of organisations into one organisation to provide a more streamlined public health system:
- the Health Protection Agency;
  - the National Treatment Agency for substance misuse;
  - the Regional Directors of Public Health and their teams in the Department of Health and Strategic Health Authorities;
  - the regional and specialist Public Health Observatories;
  - the Cancer Registries and the National Cancer Intelligence Network;
  - the National Screening Committee and Cancer Screening Programmes.
- F12. At the national level there is a clear rationale for accountability for health protection to rest with central government, as the nature of various threats to health (ranging from infectious disease to terrorist attacks) are not generally amenable to individual or local action. Instead, they require clear “command and control” arrangements, resting on a clear line of sight from the centre of government down to local services. This requires a system, that is more integrated and less dispersed than the present one. Disestablishing the HPA and transferring its responsibilities to the Secretary of State for Health will help achieve this.
- F13. Although disestablishing the NTA and transferring its responsibilities to the SofS will also enable a unified, effective and efficient public health service to be set up, it will not require a legislative intervention within the Health and Social Care Bill and so is not considered directly in this impact assessment. This move should help to tackle the dependency problems of individuals and, together with services provided by local authorities, help to address the entire range of issues that drug users face. The full recovery of these people back into society, housing and employment will provide significant benefits to all.
- F14. Regarding health improvement functions, there is currently little freedom for local communities to design and deliver local solutions for the particular challenges they face, within a rigorous framework of evidence and evaluation. Centrally designed and developed approaches, such as national campaigns, may be ill-suited to meet the needs of particular groups within a population. This may lead to a waste of resources and lack of effective interventions for particular groups, which could exacerbate inequalities.
- F15. There is the potential for public health expertise to be overlooked in the healthcare dominated NHS organisations leading to fewer public health specialists, reduced spend on public health overall, and poor understanding of how to use public health evidence to deliver or commission appropriate interventions.
- F16. Since 2002, the primary responsibility for commissioning NHS and public health services has been led by PCTs. However, there is evidence that combining the responsibility for commissioning health services and public health services under PCTs has meant that only a low priority has been given to public health. For example, in 2005-6 when PCT budgets were under pressure, public health budgets were severely cut to provide for cutting deficits in acute trusts and PCTs. This argues for ensuring there is a clearer focus locally on public health, undistracted by the demands of commissioning acute and other health care.
- F17. Last year a report from the King’s Fund suggested “NHS staff may... lack the skills necessary to interpret (data) accurately and use it to develop or adapt behaviour change interventions. As well as drawing on local health professionals’ knowledge (whether GPs, health visitors, or other

primary and community care staff), PCTs should be making full use of available data on the local population from a wide range of sources. To do so, they should ensure they have the necessary skills to interpret this data and to develop targeted interventions using the insights provided by the data.”<sup>148</sup>

- F18. Although local authorities have statutory duties to work in partnership with PCTs and others to achieve improvements in public health, and do have wider powers affecting well-being in the non-health area, working together with the health sector to tackle public health issues has not always been a priority. However, many of the wider determinants of health (for example, housing, economic development, transport) can be more easily impacted by local authorities, who have overall responsibility for improving the local area for their populations. Local authorities are in principle well-placed to take a very broad view of what services will impact positively on the public's health, and combine traditional "public health" activities with other activity locally to maximise benefits. The introduction of health and wellbeing boards (see Annex C for more information) will help to ensure that there is not a disjoint between public health, when it is undertaken by local authorities, and the health sector.
- F19. Therefore, a unified public health service, incorporating both national and local structures, is needed to achieve the overarching objective to protect the public and to improve the healthy life expectancy of the population.

### ***Options for the structure, funding and functions of the public health service***

- F20. There are a number of ways in which the public health service could operate in the future, if the proposed national and local legislative changes outlined above are implemented. We have considered these under the following broad headings:
- a. Structure: how the public health service fits with the existing Department of Health;
  - b. Funding: how the public health section of current NHS funding will be protected;
  - c. Commissioning: how public health interventions will be designed and purchased
  - d. Outcomes framework: how accountability will operate in the new system; and
  - e. Information and intelligence: how the national public health service will support the local public health service
- F21. Each of these is considered in the impact assessments accompanying the public health white paper and command paper<sup>149</sup>, which are integral to this impact assessment.

### ***Interventions in the Health and Social Care Bill***

- F22. In order to establish a unified public health service the main legislative interventions in the Bill are:
- at a national level, disestablishing the Health Protection Agency (HPA) and transferring the responsibilities and associated workforce to Secretary of State for Health;
  - at a local level, transferring the responsibilities for health improvement and the post of Director of Public Health, from NHS Primary Care Trusts (PCTs) to local authorities.
- F23. The intended benefits of these legislative changes are to enable a unified, effective and efficient public health service to be set up. This should have benefits for the general public in terms of improving public health outcomes and to the taxpayer in reducing use of healthcare services, as well

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<sup>148</sup> Boyce, T, Commissioning and behaviour change, Kicking Bad Habits final report, Kings Fund, 2008

<sup>149</sup> [http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH\\_128838](http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_128838)



as efficiency savings from the public health system as less duplication and more effective use of corporate services can occur within a unified service. Furthermore, we anticipate that transferring health improvement responsibilities to local authorities will allow for local areas to make a major impact on people's health and wellbeing through commissioning of more effective and locally-tailored interventions at a local level, and through an increased awareness of the public health aspects of other locally-determined policies, such as planning, housing and transport.

F24. It is not possible to implement the policy as outlined above without legislation. We have therefore only considered the options of doing nothing versus implementing the objectives through legislation.

### ***Do nothing option***

F25. The "do nothing" option is not viable because:

- SHAs and PCTs will be abolished, as set out in Annex A of the impact assessment, and their current functions will be transferred to new organisations, as well as the transfer to local authorities of public health functions;
- in view of the need to achieve significant cost efficiencies in order to respond to the financial challenge facing the public sector, we need to maximise use of corporate services and minimise duplication in activity across different organisations.

### ***Preferred policy option***

F26. The preferred policy option is to use the Bill to:

- Disestablish the Health Protection Agency and transfer its responsibilities to SofS;
- Transfer responsibilities for health improvement, and the role of Director of Public Health from NHS PCTs to local authorities.

F27. In all these cases, we anticipate the workforce and assets associated with the responsibilities will transfer to the Department of Health (the Department) and to local authorities respectively.

F28. The preferred option means the Health and Social Care Bill sets out the public health functions and duties that will be led in future by SofS through Public Health England, including appointing Directors of Public Health (DsPH) jointly with local authorities. Additionally, the Bill provides for regulation-making powers to ensure current responsibilities around registration of births and deaths as well as the responsibility for consulting on and deciding on fluoridation can transfer to local authorities.

F29. The Bill sets out the legislative changes required to meet the objectives outlined above. We have considered the costs and benefits associated with each of the objectives in turn.

F30. It should be noted that the establishment of the public health system is far wider than the simple legislative changes in the Health and Social Care Bill. At the moment, there are many organisations with responsibility for public health functions. At an individual level these organisations work well but the approach is not as coordinated as it could be. The proposed system changes will bring greater accountability for the SofS and a better overview of the whole system. Bringing functions such as the HPA and NTA and other bodies into the Department will ensure better alignment with national strategy.

F31. The HPA is just one component of a public health system that is currently fragmented and relatively opaque, spread across central government, local government, the NHS and other arm's length bodies such as the Food Standards Agency (part of which has been recently integrated into the Department) and the NTA. The objective is a co-ordinated and coherent

public health service with clear leadership, accountable to Parliament and the electorate, that can respond quickly and flexibly to threats to public health. The SofS, in his role as chairman of the new Public Health Cabinet Sub-Committee, will also be able to bring to bear the combined expertise of Public Health England across government. To carry out that oversight and directional role effectively the SofS needs a public health service that he is able to deploy flexibly as needs arise and change, without further potentially costly reorganisations. That can best be delivered by a service which is integrated within the Department.

- F32. There is a requirement to achieve efficiency savings with respect to central government administration. Any changes to workforce and associated costs relevant to the relevant bodies will need to be considered along with the changes to the Department and its Arms Length Bodies. Further analysis on this point will be required in the context of the whole Department and therefore reductions in workforce as a part of efficiency savings have not been considered as part of this impact assessment.

### **Costs and Benefits of Objective 1: At a national level, disestablishing the Health Protection Agency (HPA) and transferring the responsibilities and associated workforce to Secretary of State for Health**

#### **Discussion of the current strengths and weaknesses**

- F33. As presently constituted, HPA carries out a good deal of essential work. Some teams within the organisation have hard-won international reputations in their respective fields, and there are good examples of timely co-ordination with the Department to support national policy, involving appropriate and efficient division of labour. To give two examples:
- The volcanic ash incident in 2010 saw excellent coordination between the Department's Health Protection and Emergency Preparedness Divisions and the HPA's Centre for Radiation, Chemical and Environmental Hazards to produce a consolidated health risk assessment for specific scenarios generated by the Scientific Advisory Group for Emergencies (SAGE) and the Cabinet Office Briefing Room (COBRA) Situation Reports.
  - One of the major successes of the UK response to the 2009 Swine Flu pandemic was the investigation and database which followed a significant number of the early cases and their contacts, the so-called 'FF100'. This rested on the close working relationship between the surveillance experts at the HPA and the modellers both in HPA and the Department. This meant that the features of the raw data (i.e. reporting delays, laboratory delays) could be properly understood and incorporated into the analysis.
- F34. However, HPA's status as a separate body makes it more difficult to ensure that its activities match national priorities – that its work is addressing the questions that most need answering. At present, the Department funding for HPA activity comes from a mixture of core Grant-in-Aid (GiA), and funding for specific additional projects either through additional GiA or through research projects. In addition, HPA generates a significant amount of external funding. This can lead to loss of clarity in distinguishing between what HPA is doing as part of its core function, and what it is being contracted to do as additional project work.
- F35. Getting good value from project work is critically dependent on (a) setting up and agreeing contracts against well-defined specifications and (b) active and effective project-management thereafter, taking account of any changes in circumstances or policy needs. The former can be time-consuming to define and negotiate, while any failure to project-manage effectively risks wasted effort and production of work that does not meet policy needs. Although there are again

examples of good practice, the current situation is variable. Success is over-reliant on individual initiative by staff (in both organisations) rather than stemming naturally from the organisational structure. Such success is consequently vulnerable to changes in key staff. The risk is that there may be little systematic way of holding the parties to key deliverables and timelines, and to reporting of progress and early warning of difficulties or slippage. HPA staff are not directly accountable to the Department: they have their own management chain, and business priorities do not *necessarily* match the Department's – for example as to the relative importance of surveillance as compared to other tasks. Potentially, this risks delay in identifying and responding to public health problems.

- F36. The current arrangements for intelligence and analysis involve a wide range of bodies, including the HPA, Public Health Observatories and the Department. Whilst this has delivered rich sources of public health intelligence, there is also the possibility of duplication - for example, though production and use of separate Situation Reports. This is potentially wasteful, and also risks confusion as to whether (for example) HPA is providing independent information or speaking on behalf of Government. Taking a more systematic approach should also reduce the risk of “partially overlapping” roles leaving significant issues overlooked. At present, rapid sharing of information is also inhibited by lack of IT integration: for example, as a non-Civil Service body, HPA staff do not have gsi (government secure internet) email accounts, which restricts the material that can be exchanged between different organisations.
- F37. In summary, although there are considerable strengths in the current arrangements, the disjoints in the system could make it more difficult to spot emerging public health problems at the earliest possible opportunity and therefore to respond where necessary as early as could be the case.
- F38. In this respect, the proposed integration of HPA and the Department functions complements other steps to improve preparedness. In particular, the NHS Commissioning Board becoming directly responsible for assuring NHS preparedness and resilience, the related assurance and compliance mechanisms being put in place and the obligation to plan jointly with partner agencies (Public Health England itself, local authorities, Police and Fire services etc). This should deliver a more joined-up system with greater strength, clarity and accountability.

## Benefits

### Enhanced Use of Evidence

- F39. Effective use of evidence to underpin public health policy involves a number of steps, from research and generation of basic information through to provision of analytical policy advice<sup>150</sup>.

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#### <sup>150</sup> Using evidence to inform policy decisions: key steps

**Generation of data.** In the Public Health context, this includes the results of laboratory work (on animals, human samples or inanimate materials), surveillance activity (some of which is experimental, e.g. serological testing, some of which is observational). HPA currently generates some of this primary itself, or contracts others to do so.

**Interpretation of data into evidence** – e.g. testing for statistical significance.

**Information Management.** As well as generating primary data, HPA is also active in bringing together and organising data from other sources, dissemination activity etc.. This is also reflected in HPA's role in providing the scientific secretariat for various advisory committees.

**Modelling.** Although in some areas and for some purposes, information – e.g. statistical indicators – can be used to inform policy without much intervening analysis, there is more usually a need for modelling to provide the bridge between evidence and policy choices. Essentially, modelling may be needed to understand and assess: *the potential impact of a given threat to public health, bearing in mind inevitable scientific uncertainties (for communicable diseases, this includes capturing the epidemiology; the likely effect of potential intervention; the effective organisation of interventions (“operational” modelling); cost-effectiveness of alternative choices.* Note that

The key benefit of the proposed change in structure at national level is to ensure that this “evidential chain” works in its entirety, and in an integrated way. This forms one key strand of the Department’s evolving Public Health Information Intelligence and Research Strategy.

- F40. Achieving this requires an organisational structure that can combine – and to some extent balance - the integration of mechanisms to prioritise work and coherence and cost-effectiveness in information collection and management. For example, this would mean collecting each given piece of information only once then making it available for a wide variety of uses (subject to appropriate safeguards) with variety in the types and sources of information and analysis used, allowing cross-checking and “triangulation” using independent sources and methods.

### **Integration as a Means of Reducing Costs**

- F41. Abolishing various bodies and transferring their functions to Public Health England within the Department will facilitate savings to be made from back office and administrative functions during the Spending Review period. There is a process in place to identify the relevant figures for the bodies concerned. This is part of the overall one-third reduction in administrative spending across the system, as set out in the coordinating document.
- F42. It is arguable that the savings in non-frontline costs could be made in the bodies concerned without integration. This is potentially true. However, the main purpose of integration is not to make savings, rather it is to improve accountability and develop a streamlined, integrated public health service which can maintain and enhance current performance but at significantly lower cost. Reducing the costs of the bodies without integration will make it challenging to do more than maintain existing performance, let alone make the improvements which can be delivered through integration. In addition, it is arguable that in the case of a smaller organisation reductions of this size would make it unsustainable. This further strengthens the case for integration.

### **Benefits associated with a reduction in duplication of activity and filling in of gaps**

- F43. Bringing the HPA and the NTA into the Department has the potential to reduce duplication in activity and, where appropriate, fill in the gaps that have previously fallen between organisations. This is particularly relevant with respect to information and intelligence, which currently operates across a number of organisations, including particularly the HPA and the existing Department.
- F44. The opportunity to integrate intelligence better may enhance the ability of the service to deliver what is needed and what works best. For example, there is robust cost-benefit evidence that prevention and early intervention can break down cycles of inequality running through generations of families (Marmot et al, 2009). The economic returns of early childhood interventions exceed cost by an average ratio of six to one (NICE, 2009). A number of studies have demonstrated significant cost benefits from early years interventions, and particularly for long-term outcomes (Karoly et al, 2005). Better alignment of information, analysis and intelligence, will help the Department to understand the most appropriate interventions and enable early intervention.

### **Benefits associated with better responsiveness**

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this will only be satisfactory if the previous stages have been adequately covered. (For communicable diseases, health economics needs to build on the epidemiology of transmission.)

*Providing policy advice* based on all the above, whether to DH policy teams or relevant Advisory Committees.

- F45. At the moment, there are many organisations with responsibility for public health functions. At an individual-level these organisations work well but the approach is not as coordinated as it could be. The proposed system changes will bring greater accountability for the SofS and a better overview of the whole system. Bringing functions such as the HPA and NTA and other bodies into the Department will ensure better alignment with national strategy.
- F46. Another potential benefit of drawing different public health bodies together is removing confusion and subsequent delays in responding to public health threats and emergencies. Having a streamlined public health service will improve clarity of accountability and remove the potential for duplication or gaps in activity due to lack of clear roles and responsibilities between different agencies and organisations.

### **Benefits associated with improved public health outcomes and a reduction in health inequalities**

- F47. Ultimately, the objective of this legislation and the associated policy changes outlined in the public health white paper is to improve the health of the population. In the Department's view, a first step to achieving this is to draw together under the SofS, all the different aspects of the public health system that could benefit from being part of a unified, professional public health service.
- F48. We will endeavour to monitor the effectiveness of the public health service once it is in operation both through monitoring progress against the public health Outcomes Framework and the effectiveness and efficiency of delivering health protection and emergency response functions. This work would be led by the public health service information and intelligence elements, but overseen by other parts of the Department, who will support Ministerial challenge of the service.

### **Risks and Mitigation**

- F49. Despite the arguments already set out in favour of the proposed integration at the national level, there is no guarantee that bringing the HPA into an integrated public health service will ameliorate the problems outlined above. Rather, the change in status should provide *an opportunity* to do so. Realising the advantages will require appropriate management strategies. For example, if at present good project management is often dependent on the existence of well-defined contracts between the separate organisations, removing this specific mechanism poses obvious risks. Mitigation is likely to require more robust processes for business management within the new structure.
- F50. The loss of HPA's (relative) independence also carries risks as well as benefits to the system. The public health system currently benefits considerably from a cadre of scientists in HPA able to do longer-term work, to publish extensively in peer-reviewed literature and offer advice that may be perceived as more objective. To minimise the potential loss of this resource, engagement with staff during the transition period will be essential, as will effort to ensure that responsiveness to policy needs does not squeeze out longer-term research excessively. In designing the new system the Government will be mindful of the need to build in safeguards to enable PHE scientists to continue to give robust, independent advice.
- F51. Once the new system is in place, it will be important to maintain centres of expertise with separation sufficient to allow analytical staff currently in HPA and the Department to peer-review each other's work. On the most important issues, it is highly desirable to have separate and independent analyses available, for example around modelling using different methods, to ensure robustness of conclusions. This was of great benefit during the 2009 Swine Flu

pandemic. At present, HPA has sufficient independence to provide such input, with academic researchers providing further alternative views. Loss of this role for HPA researchers would necessitate greater reliance on external sources of expertise that might prove more difficult to mobilise in an emergency.

F52. These issues will be kept in mind as the more detailed organisational design is considered. It may be that sufficient specialist autonomy can be retained within a fully-integrated system. Alternatively, the provisions set out in the public health white paper and Bill are sufficiently flexible to allow creation of other models for specific functions.

## Summary of risks and mitigation

- **Risk:** transition to new structures is financially costly in terms of changing people's terms and conditions.
- **Mitigation:** working with HR to develop an appropriate framework for transition, including looking to apply TUPE where appropriate to keep transition costs to a minimum. Any decisions about changing or maintaining terms and conditions will depend on the outcome of an HR framework and consultation.
  
- **Risk:** moving DsPH to local authorities reduces influence and access to information DsPH will have on commissioning and monitoring healthcare services from a population perspective, reducing leverage over whole care pathways for DsPH, but also for NHS commissioning in terms of reducing the cost-effectiveness of commissioning.
- **Mitigation:** working closely with professional public health organisations. Departmental colleagues and stakeholders involved in the design of the NHS commissioning board and supporting development of clinical commissioning groups to enable a joint solution that meets the need both of public health and healthcare commissioning.
  
- **Risk:** losing workforce during transition due to uncertainty and lack of clarity on their future roles.
- **Mitigation:** develop a clear transition plan for the workforce, and engage fully following publication of the white paper to manage expectations and formal consultation with those people currently working in the HPA, the NTA and other constituent parts that may contribute toward the public health service, such as regional tier NHS staff and public health observatories and disease registries staff.
  
- **Risk:** public health threats are not adequately managed during transition.
- **Mitigation:** Business as usual will be maintained throughout this process, with an emphasis on a smooth transition of functions from the HPA and other bodies to Public Health England. The functions of the HPA and other bodies will not be lost in the wake of its abolition. The HPA and other bodies will continue to contribute to the government's response to emergencies and other areas of responsibility, in the run up to integration in the Department – after which functions will be subsumed into Public Health England. In order to manage transition planning for emergency preparedness, each SHA will work with local health and social care economies to develop coherent plans, building where possible on existing sub-regional arrangements, for shared commissioning capacity and capability, with leadership and accountability arrangements that can be secured through the transition period. These will include how critical functions (including for example emergency planning) can be sustained through the transition.

## Cost

F53. The efficiencies in terms of any staffing, resource and duplicative activity reductions will not outweigh the one-off costs outlined below. However, the purpose of streamlining public health

organisations within the public health service is to improve public health outcomes significantly, leading in the long-term to reduced healthcare and social care costs.

F54. This policy will have impacts on and associated with the workforce of both the HPA and the NTA. These impacts could include:

- Costs associated with changing from NHS-type contracts to civil service contracts; and
- Costs associated with transferring from one organisation to another.

F55. Based on typical reorganisations covered in the National Audit Office (NAO) report "Reorganising central government" (March 2010), we estimate that transferring the HPA into the Department of Health will cost approximately [REDACTED], excluding the possibly significant costs associated with moving staff on to a Civil Service Pension scheme and assumes that there will be no redundancies. A higher estimate of [REDACTED] if the cost for more complex reorganisations from the NAO report is used. The costs of increased employer contributions from moving HPA staff from NHS to Civil Service pensions is estimated to be [REDACTED], (net present value of about [REDACTED] over a ten year horizon).

F56. HPA currently supplements its GiA financing with income from a wide range of activities which utilise its specialist resources. This is currently around £140m per annum. It is assumed, for the purposes of this impact assessment, that when HPA functions transfer to the SofS there may be some loss of HPA's income generation function and we are currently considering the options for managing this. If appropriate, we will publish an impact assessment alongside any policy announcements in this area. Additionally, there are potential risks to the fixed costs, which are funded by this income. It has been estimated that by moving the income generating activities into PHE, between [REDACTED] income per annum would be lost. Mechanisms within PHE's operating model and governance will provide some assurances around retaining the income. If all income generation ceased, manufacturing stopped and NHS testing services were outsourced, the overall net reduction in contribution to the fixed costs has been estimated at [REDACTED]. In order to mitigate against this loss to ensure the same level of public health services can be delivered in future it would be necessary to ensure that additional finance were available. However, whilst lost income generation is a risk, we would not anticipate that all income generation would cease, consequently, this case has not been considered in the Analysis & Evidence Summary section above. The Department will set up any necessary mechanisms to ensure the income generation capacity of the HPA is maintained.

F57. Over the past four years, the HPA has grown external income at 12.6%. However, it is uncertain that this could be sustained under any option. It has been assumed that without moving HPA into Public Health England external income would remain the same at constant prices in future years.

F58. In the long run, cost savings should arise from an overall reduction in corporate services where duplication exists between the merging organisations. Abolishing various bodies and transferring their functions to Public Health England within the Department will facilitate savings in non-frontline costs, to be made from back office and administrative functions. There is a process in place to identify the relevant figures for the bodies concerned. These savings will be considered as part of the overall reductions required as part of the Spending Review measures being taken by the Department. We have therefore not included an estimate of the savings in this impact assessment, which are discussed within the coordinating document.

F59. All the organisations relevant to consideration here are already undertaking efficiency programmes as part of their response to the efficiency agenda. This means the level of staffing,



resource and programmes ongoing at the time of this impact assessment may be different if and when the organisations are drawn together by Royal Assent of the Bill.

## **Costs and Benefits of Objective 2: At a local level, transferring the responsibilities for health improvement, and the post of Director of Public Health, from NHS Primary Care Trusts (PCTs) to local authorities**

### **Costs**

- F60. This policy will have impacts on and associated with the public health workforce currently located in PCTs. It will also have impacts on local authorities in terms of increased staff and responsibilities. These impacts will include:
- Costs associated with transferring from NHS contracts to local authority contracts
  - Costs associated with transferring from one organisation to another
- F61. A transition cost of £100,000 per PCT has been allowed. This totals approximately £15m across all PCTs. There is still some uncertainty about pension costs associated with the change from NHS contracts to local authority contracts.
- F62. Some longer-term savings can be expected in so far as local authorities already have staff with a public health focus, allowing some reduction in combined staffing levels.

### **Costs for local authorities in terms of new staff and responsibilities**

- F63. This policy will mean a new burden on local authorities both in terms of an increased workforce and more responsibilities. To meet this additional burden, the Department is planning to provide ring-fenced public health funding to local authorities. This funding will be taken from the existing health services budget. It will be allocated according to a needs-based formula and a health premium that recognises and rewards improvements in health outcomes made by local areas. The costs and benefits associated with the policy of a ring-fenced local public health budget are considered in the *Healthy Lives, Healthy People* impact assessments.
- F64. Costs are unlikely to be much affected by these changes. Evidence suggests that a consultation costs in the region of £150,000 to £200,000 and the set-up cost of a fluoridation scheme is about £5 per inhabitant in a local area. The regulations set out neither to make fluoridation more or less likely than previously and the actual impact may depend on the details set out in regulations. The costs they will be assessed in more detail in the impact assessment accompanying the regulations on fluoridation and registration of births and deaths.

### **Benefits**

- F65. The transfer of the role of the Director of Public Health, aims to give greater responsibility, backed by dedicated resources as outlined above, to local authorities to enable them to make a major impact on people's health and wellbeing. This could have significant benefits in terms of improving public health outcomes through commissioning of more effective and locally-tailored interventions at a local level, and through an increased awareness of the public health aspects of other locally-determined policies, such as planning, housing and transport. Whilst it is not possible at this stage to quantify the anticipated benefits of increased local leadership and accountability, we have considered the issues of local commissioning and public health outcomes in the public health white paper impact assessments.



- F66. Another benefit will be made possible by linking the public health focus with control of levers relevant to the wider determinants of health, such as transport and housing. This will enable the joining-up of service design and commissioning across public health (including the determinants of health). For example, the public health services commissioned to target obesity may be targeting the same groups of people already targeted by local authorities under wider services. There may therefore be a potential for i) more joined-up services for the citizen; and ii) more joined-up commissioning with the potential for economies of scope.
- F67. Furthermore, since local authorities have responsibility for commissioning some of the services which feed into the wider social determinants of health, local authorities may be better placed to plan service provision strategically across public health. There may also be cost savings from no longer having to cross organisational boundaries (for example between local authorities and PCTs) to plan service provision across the public health arena.
- F68. Regarding fluoridation, our intention is to maintain the status quo, as far as possible upon the abolition of SHAs, without making fluoridation more or less likely. We will put in place a fair and practical way to reallocate and amend powers for the fluoridation of water thereby maintaining legality of existing fluoridation schemes and providing for consultation on new schemes or variations on existing schemes. The new clauses transfer the responsibility for proposing, and conducting consultations on fluoridation schemes from Strategic Health Authorities (SHAs) to local authorities and transfer the responsibility for contracting for fluoridation schemes from SHAs to the Secretary of State.
- F69. Local authorities are more likely to propose that their water is fluoridated if their population of children has above average levels of tooth decay. Making local authorities responsible for consultations on fluoridation schemes would fit well with their responsibilities for public health. This could be derived from the Joint Strategic Needs Assessment (JSNA), and would help the consultations to become more democratically accountable. On the other hand, negotiating and managing contracts - or “arrangements” as in the legislation – is a complex legal and technical process. Because it is unlikely that any single local authority would have this expertise and it would be wasteful to try and replicate it across the fifty or so authorities with fluoridation schemes, we intend that Public Health England takes on these tasks. Please see Annex F2 for more details around fluoridation, which will be set out more fully in the impact assessment accompanying secondary legislation.
- F70. Currently, local registrars of births and deaths inform the local PCT of births and deaths, while also having access to the NHS births and death registers. The regulation making power seeks to maintain the status quo as far as possible by requiring that the local registrar must provide information on registered births and deaths to local authorities, the NHS Commissioning Board or GCCs, as prescribed in regulations. The provision also provides that births must be notified to one of those bodies, as to be described in regulations. These regulations will ensure that NHS staff transferring to local government will continue to be able to receive essential data such as births and deaths data, which would otherwise have been difficult because of legal restrictions on the dissemination of confidential births and deaths data.
- F71. Local authorities are more likely than clinical commissioning groups to face some of the social and cultural consequences of poor public health. For example, teenage pregnancy leads to higher costs of providing housing, and irresponsible alcohol consumption leads to crime and disorder. This may mean that local authorities have greater financial incentive to recognising any cross cutting issues and undertake some public health preventive activities, since they will see cost savings in other areas under their control.

F72. There is unlikely to be any direct impact on either the private or civic society sectors as a result of these changes. There may be indirect impacts if organisations in these sectors are commissioned by local authorities in the future to deliver specific public health interventions or support functions.

### **Risks and mitigation for Objective 2**

F73. **Loss of public health workforce:** It would be inappropriate to dictate whether all public health staff currently working in PCTs will transfer to local authorities as local authorities need to be able to determine workforce requirement in line with business need. There is the risk that uncertainties relating to future employment or dissatisfaction with proposed new terms and conditions could lead to staff choosing to leave. This may lead to local authorities not having the capacity to commission public health services effectively, which are of their nature challenging. In order to mitigate against this risk, extensive engagement with staff will take place.

F74. **Perception of 'postcode lottery':** The new system will make services more responsive to the needs of their local community. There will be local variation, but this is entirely justified because the populations of areas vary hugely and so the public health challenges will be different. Where there are mandated national programmes, for example immunisation, these will continue to be delivered consistently across the country.

F75. **Fragmentation:** Local authorities and clinical commissioning groups will need to continue to work together to ensure that public health and NHS care services are aligned. This may prove difficult, given different boundaries and different priorities. This may have implications for joint working and commissioning.

F76. **Consulting on Fluoridation:** There is a potential risk that local authorities in an area cannot agree whether to hold a consultation on whether to fluoridate their local water supply. If such a consultation goes ahead there will be question as to whether all councils in a local area share the cost of the consultation or not. Likewise, there are questions around who provides the capital cost for setting up a new scheme as well as for repair of existing schemes. All these issues will be addressed in the impact assessment that will accompany the regulations. This impact assessment will also take into account any additional burdens incurred by local authorities as a consequence of these regulations.

### **Other impacts**

#### *Equality analysis*

F77. This policy of streamlining and integrating public health functions and bodies is likely to have a broadly positive impact on equality dimensions in the medium to longer term through facilitating more effective delivery of public health services nationally and locally.

F78. In terms of the structural changes at a national level, there will be an impact on the workforce of the HPA and other bodies, and along with other colleagues forming the public health service they will be subject to cost reductions across the public sector, as part of the one-third reduction in administrative spending (to apply to non-frontline services only). Along with the broader reduction in staff at the Department of Health, this process will need to avoid any disproportionate impact on any particular group. This will need to be considered as part of the broader Human Resources policy of reducing the workforce of the Department of Health.

F79. In terms of the changes at a local level, local authorities are already well-versed in their responsibilities under equality rights legislation. The proposed changes will add further functions

across which they will exercise these responsibilities, supported by a ring-fenced budget to deliver those new responsibilities. Given that the rationale of the changes is that locating public health within local authorities will improve the focus of commissioning, and thereby the outcomes for populations, the overall impact on equality should be positive.

F80. A full screening for equality impacts, and an action plan, is published within the Equality Analysis document for the Health and Social Care Bill.

### **Health and Wellbeing impact test**

F81. Health and wellbeing impact test – this policy is likely to contribute to significant positive impacts on health and wellbeing of the population and indeed is the primary purpose of the overarching policy to create a unified public health service.

- **Will the proposal have a direct impact on health, mental health and wellbeing?**  
The overarching policy aim is to protect the public and improve the healthy life expectancy of the population. It will do this by establishing a unified public health service. This should ensure that health protection is clarified and enhanced and that health improvement is effectively led. The proposal should therefore have a positive impact on health, mental health and wellbeing.
- **Will the policy have an impact on social, economic and environmental living conditions that would indirectly affect health?**  
The transfer of health improvement functions to local authorities will unlock synergies with the wider role of local authorities in tackling the determinants of ill health and health inequalities. This would address problems with the current arrangements that separate health actions from other determinants of public health. Local authorities will have autonomy to make health improvement initiatives and innovations that encompass social, economic and environmental living conditions, which could have a positive impact on public health. The establishment of health and wellbeing boards in local authorities could also consider wider determinants of health are considered.
- **Will the proposal affect an individual's ability to improve their own health and wellbeing?**  
Local authorities are well placed to make decisions that take a broad view of the needs of their population. Local authorities can combine public health activities with other activities that could lead to an individual's ability to improve their own health and wellbeing.
- **Will there be a change in demand for or access to health and social care services?**  
A unified public health system should ensure that protecting and improving health will be provided in an efficient and cost-effective manner. This may lead to an increase in primary care services and a decrease in secondary care services with an overall reduction in demand for health and social care services.  
However, any changes in demand to access to health and social care services as a result of this policy would need to be considered in the wider context of changing demographics.

### **Rural Proofing**

F82. The policies on the development of the public health service can have a positive impact on rural areas or people as localism allows rural communities to focus on the public health areas that are most significant impact in a local area.

F83. The transfer of health improvement functions to local authorities will unlock synergies with the wider role of local authorities in areas such as transport or housing and could therefore lead to a positive

impact for rural areas, as with other areas.. In formulating their policies for public health interventions, local authorities would be expected to consider their impact on rural areas.

- F84. Health and Wellbeing boards, which will bring together health and the local level will, subject to Parliamentary approval, be a statutory requirement in every upper tier local authority. Health and wellbeing boards will have the flexibility to involve district councils in their membership, and to delegate functions to a more local level such as a district if that makes most sense. Early experience from local authorities with early implementer health and wellbeing boards suggest that the boards are keen to work with their local lower tier councils.

## Justice Impact Test guidance

- F85. Provisions are largely consequential and match the status quo by transferring powers and duties from the Health Protection Agency (HPA), Primary Care Trusts and Strategic Health Authorities to local authorities and SofS. This will not give rise to additional cost or increase the likelihood of judicial reviews.
- F86. Steps have been taken to minimise the potential impact on the justice system. For example, our initial policy intention was for the SofS to have the power to dismiss a director of public health (an employee of the local authority). In certain circumstances, employment law specialists advised that this would almost certainly constitute unfair dismissal and this provision has not now been included within the Bill.
- F87. The secondary legislation arising from the Bill is likely to be more complex than the primary legislation. We will produce IAs for the secondary legislation where appropriate and will consider any potential impact on the justice system.

## Annex F1: Post Implementation Review (PIR) Plan

A PIR should be undertaken, usually three to five years after implementation of the policy, but exceptionally a longer period may be more appropriate. A PIR should examine the extent to which the implemented regulations have achieved their objectives, assess their costs and benefits and identify whether they are having any unintended consequences. Please set out the PIR Plan as detailed below. If there is no plan to do a PIR please provide reasons below.

<p><b>Basis of the review:</b></p> <p>The review of the establishment of the Public Health Service will be addressed as part of the wider arrangements for the review of the Health and Social Care Bill. However, with regard to the Public Health Service, we will be able to review the transition arrangements.</p>
<p><b>Review objective:</b></p> <p>The national public health service will be in place in April 2013. We will be able to review the success of the transfer of functions and review whether this have taken place at an acceptable cost. It is however, too early to establish a detailed timeframe for assessing the performance against the indicators set out within the Outcomes Framework. Local authorities will not receive hard budgets until the 2013/14 financial year and it will be difficult to assess the impact on outcomes for a number of years.</p>
<p><b>Review approach and rationale:</b></p> <p>As Public Health England will be part of the DH, it would not be appropriate to conduct a formal review of status. However, the senior management team (SMT) of Public Health England will be part of the DH and will be accountable to the Secretary of State. There will also be strong links with the jointly appointed Directors of Pubic Health who will be able to give feedback on the success of the transfer at an operational level.</p>
<p><b>Baseline:</b></p> <p>The current baseline is that public health functions take place at a local level within PCTs and SHAs and that a national level, organisations such as the HPA and NTA are not part of the DH.</p>
<p><b>Success criteria:</b></p> <p>At a high-level, success would mean that staff and functions have transferred to the appropriate bodies at an appropriate cost and that progress is made against the Outcomes Framework.</p>
<p><b>Monitoring information arrangements:</b> Once in place, the indicators outlined within the Outcomes Framework will provide information on how the national and local public health service are achieving against the outcomes. Local authorities will be primarily accountable to their local populations.</p>
<p><b>Reasons for not planning a PIR:</b> N/A</p>

## Annex F2: OBJECTIVES, OPTIONS & CRITERIA

### Objectives

- F1. As before, in our final IA “Commissioning within the public health service”, the policy objectives are to align commissioning activities within those bodies which are most able to: plan effectively; take account of the needs of their population most effectively; get value for money; and take into account the full cost and benefit to society when planning a service. Hence the objectives to be pursued are:
1. effectiveness
  2. localism
  3. efficiency
  4. equity and comprehensiveness.
- F2. Effectiveness is about getting the biggest positive impact on health. Effectiveness needs to take account of: impacts of integration with other services; synergy with other services; avoidance of fragmentation; interfaces with other services; reliance on specific existing infrastructure and scarce expertise; and complementarities with other parts of the remit of the commissioner.
- F3. Localism is about empowering local communities. Localism needs to take account of: subsidiarity, and divergence of preferences geographically; where local knowledge is key or key knowledge is local; location of the information – both statistical data and tacit or softer intelligence – on which needs assessment and ensuring uptake relies; location of expertise and capacity for analysis in needs assessment and ensuring uptake; and whether key services take the form of local public goods that have a natural geographical spread.
- F4. Efficiency is about getting best value for money. Efficiency needs to take account of: economies of scale in commissioning and use of expertise; ability to exploit purchaser power to the public good; ability to address financial risks, eg due to variability; and economies of scope – eg it is more cost-effective to bundle together some ranges of services rather than to separate them.
- F5. Equity is about reducing health inequalities and fairness in provision of services. Comprehensiveness is about ensuring that all relevant and important factors are considered. Equity and comprehensiveness needs to take account of: views about reducing health inequalities; views about equality of access to services; ensuring consistency of quality; ability to clearly define and separate services from each other, to minimise scope for boundary disputes and cost-shifting; extent of spill-over or external effects; avoiding conflicts of interests and alignment of incentives.

### Options

- F6. This annex evaluates the options for transferring responsibility for contracting for fluoridation schemes from SHAs to another body, for which the options are:
1. Public health services could be commissioned or provided at the local level by local authorities, (or by groups of local authorities where they deemed this to be appropriate) using money from the ring-fenced grant for public health.
  2. Public Health England could consult on and procure fluoridation, funded by the public health budget.
  3. Public Health England could fund the NHS Commissioning Board to consult on and procure fluoridation.
  4. Clinical commissioning groups could consult on and procure fluoridation.
  5. There is no option to *do nothing* as the current commissioners of fluoridation schemes – SHAs – are being dissolved.
- F7. The table below sets out criteria as they might apply to fluoridation as an illustrative example.

**Table showing criteria**

Criteria		Options for commissioning route			
		1. LAs (or groups of LAs)	2. PHE (nationally)	3. NHSCB funded by PHE	4. Clin comm group
1. Effectiveness	Ability to integrate with other services, to join up and interface appropriately.	+ LAs might choose to commission fluoridation alongside other local services such as other dental public health responsibilities			
	Maximise impact of scarce expertise and specific existing physical infrastructure		++ PHE can utilise scarce national resources		
	Coherence in leadership, and avoidance of fragmentation		++ PHE can negotiate fluoridation schemes with large water companies once ensuring a consistent approach, rather than individual LAs approaching water companies ad-hoc.		
	Complementarities with other parts of the remit of the commissioner, and ability to exploit potential synergies				
2. Localism	Subsidiarity; and ability to reflect appropriate divergence of preferences				
	Location of the information – both statistical data and tacit or softer intelligence – on which needs assessment and ensuring uptake relies; local knowledge is key or key knowledge is local	++ LAs can use their wider community intelligence to ensure uptake of a fluoridation scheme.			
	Location of expertise and capacity for analysis in needs assessment and ensuring uptake	++ LAs can use their JSNA's to assess whether their particular area might benefit from a fluoridation scheme and then use this data to commission accordingly.			
	Ability to engage with services that		++		

	take the form of local public goods that have a natural geographical spread		Fluoridation would be delivered through geographically spread water supplies, which are often bigger than LA boundaries.		
3. Efficiency	Ability to exploit economies of scale in commissioning or use of expertise; reducing costs		++ PHE can negotiate fluoridation schemes with large water companies once and benefit from economies of scale		
	Ability to exploit purchaser power to the public good				
	Ability to address financial risks, eg due to variability		+ Cost for fluoridation might fluctuate, and where appropriate PHE would be better able to manage spikes in costs than an individual LA.		
	Economies of scope – eg it is more cost-effective to bundle together some ranges of services rather than to separate them; reducing costs				
4. Equity & comprehensiveness	Ability to reduce health inequalities	+ LAs might decide to fluoridate the water supply to seek to reduce health inequalities in their local area.			
	Ability to increase fairness of access to services and reduce inappropriate “post-code” differences				
	Ability to ensure consistent quality of services		++ PHE could negotiate national contracts and use its influence to ensure consistency of quality of services for all fluoridated areas.		
	Ability to clearly define and separate services from each other, to minimise scope for boundary disputes and cost-shifting				
	Ability to address spill-over or external effects				
	Ability to avoid conflicts of interests and align incentives with best				



	outcomes				
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