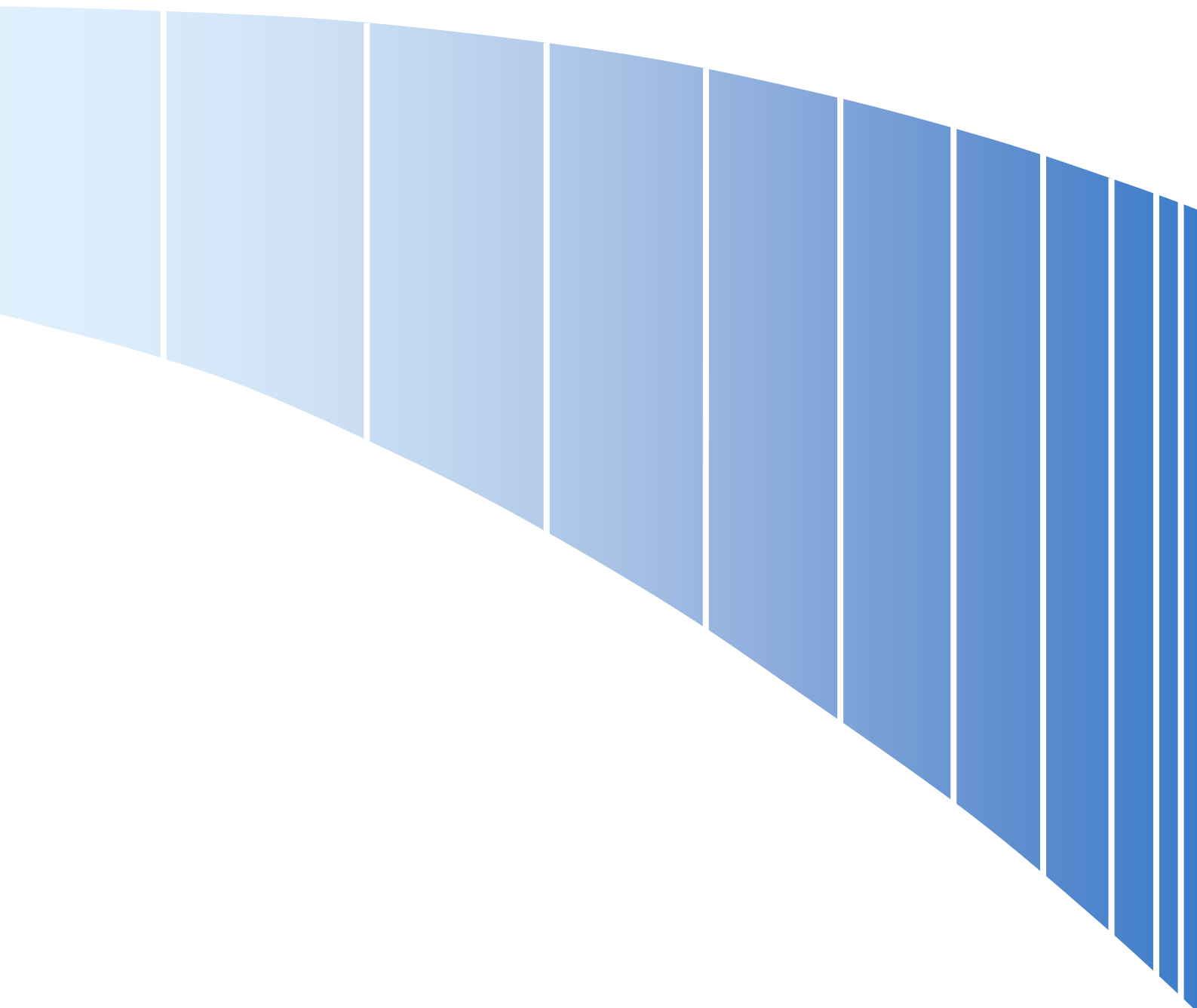


Health reform in England: update and commissioning framework



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Foreword

by Patricia Hewitt

Health reform in England: update and commissioning framework

The NHS has made significant strides since 1997. Waiting times have fallen to record lows, clinical outcomes for cancer and cardiac disease have improved and saved over 160,000 lives since 1996, and our facilities are cleaner and more modern. None of this could have happened without the dedication and hard work of NHS staff, backed by unprecedented investment and reform.

We can however do much more. Waiting times are shorter, but not short enough. Most patients' experience of the NHS has seen improvement but this is still not good enough.

The NHS today and in the future has to face the rising expectations of the public, the demographic challenge of an ageing population and a revolution in medical technology. All of this means we can do far more for patients, but what we can do often costs more.

This document builds upon *Health reform in England: update and next steps*, published in December 2005. It focuses upon the development of first-rate commissioning to create an NHS where patients have more choice as well as a real voice in the design of their services. Commissioners need to work with providers to secure the best health outcomes and the best services with the best value for the public's money.

Drawing on best practice already operating in many parts of the NHS, it outlines how practice-based commissioning will empower GPs to develop new services, flexible to reflect patients' needs and delivered closer to people's homes. This will also avoid unnecessary hospital admissions, particularly for those with long-term conditions. It describes the role of Primary Care Trusts and Strategic Health Authorities and their relationship with GP practices, and it emphasises the central importance of clinicians and other health professionals, in their relationship with their patients.

Finally, it reaffirms our commitment to a diverse provider base, including strong NHS Foundation Trusts, within a regulated framework, supported by the tariff system and good information.

This next stage of reform will be critical in creating a truly patient-led NHS, in which the whole system reinforces what staff themselves do daily – to offer the best possible care to each individual patient. It will require a radical shift in emphasis, from top-down targets and performance management, to bottom-up leadership and innovation.

Despite the record investment that we are making in the NHS, financial pressures make this a difficult and anxious time for staff. Over-spending in a minority of places is having an impact everywhere as the service returns to financial balance. But right across the country, I continue to meet staff who are providing outstanding care, and finding new ways to improve services, often with better value for money. The changes set out here will help the NHS to do that everywhere. Above all, they will safeguard the founding values of the NHS – a universal and equitable system, funded through taxation, free at the point of use and provided according to clinical need rather than ability to pay - for another generation.


13 July 2006

1. The reform programme

Introduction

- 1.1 We are now six years into a ten-year programme of NHS investment and reform, beginning with the NHS Plan,¹ a programme that has already delivered substantial improvements for patients and the public. In December 2005 we published *Health reform in England: update and next steps*, setting out a high-level framework for the next stage of reform of the health system. A significant further step in January 2006 was the publication of the White Paper *Our health, our care, our say*. Together, these publications describe the reform direction for health and social care in England.
- 1.2 This document concentrates on commissioning, in other words using the available resources to achieve the best outcomes by securing the best possible health and care services for local people. Commissioning is not new and there is already much good practice in the NHS and local government. But we now have an opportunity to build on achievements and to ensure that first-rate commissioning becomes the norm everywhere.
- 1.3 The process of reconfiguring Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) is reaching its conclusion, with new PCT chief executives set to take up their positions and practice-based commissioning (PBC) coming into place. PCTs will have a critical role in leading the redesign of services needed to achieve the 18-week target so that, by the end of 2008, no-one should wait more than 18 weeks from GP referral to hospital treatment. So this is the right time to develop the vision of first-rate commissioning and provide further guidance on the tools commissioners can use to carry out their vital role.
- 1.4 As promised last December, this document also gives an update about the other elements of the reform programme: choice, provider reform, workforce, system management, tariff and other financial incentives and information. This update provides an overview of all these issues. The annex deals in detail with commissioning.
- 1.5 At the recent NHS Confederation conference, the Secretary of State for Health and the Acting Chief Executive, Sir Ian Carruthers, both stressed the importance of consultation in the development of reform policies. This document sits in that context: as part of a discussion with the public and the NHS about the policies that are best placed to deliver the patient-led, world-class NHS that we all seek.

¹ *The NHS Plan: A plan for investment, a plan for reform*, Department of Health, July 2000.

- 1.6 We are inviting views on a number of issues relating to the detailed development of the new system. The points on which we would welcome views are highlighted in the text with a  in the right margin.
- 1.7 Views and other feedback can be sent to nhs.reform@dh.gsi.gov.uk by 6 October 2006.

Why reform?

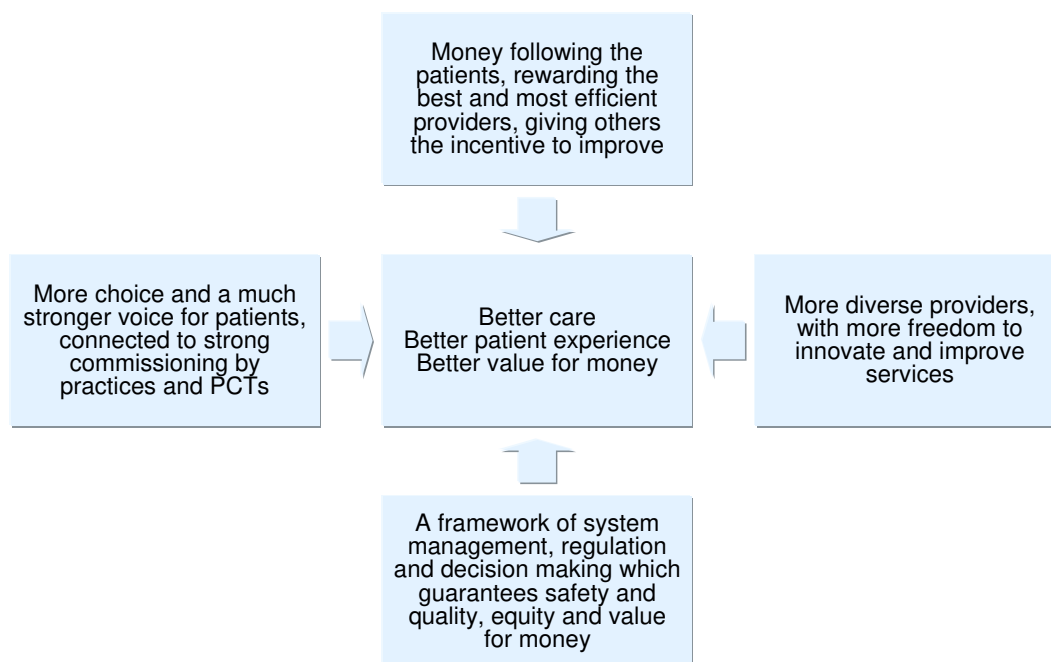
- 1.8 The NHS is based upon fundamental values: a universal, tax-funded service, with equal access for all, free at the point of use and provided according to clinical need rather than the ability to pay. These values are enduring. They inform all that we do and they will not change.
- 1.9 The challenge for the reform programme is to embed these values in an NHS that is not only true to its past but also able to face the significant challenges of the future:
 - > **Rising expectations:** the public wanting more from their public services, to match the choice, customer service and personalisation they get elsewhere, and wanting services to be more local and convenient too.
 - > **The demographic challenge:** with an ageing population and increasing numbers of people with long-term conditions including serious disabilities, needing the health and care system to focus far more effectively on promoting good health, independence and wellbeing.
 - > **The revolution in medical technology:** transforming the ability of the NHS to prevent, cure and manage diseases, alleviate suffering and extend life expectancy, but also creating new costs – needing an NHS that is faster and more flexible in reconfiguring how and where care can best be delivered.
 - > **Continuing variations in the safety and quality of care:** needing an NHS that delivers care of the highest possible safety and quality in every place and at every time, in particular through honest and open information about the outcomes achieved by our primary, community and secondary care providers.

- 1.10 To address these challenges, we have a clear vision: **to develop a patient-led NHS that uses available resources as effectively and fairly as possible to promote health, reduce health inequalities and deliver the best and safest possible healthcare.**
- 1.11 We are making real progress towards this goal. Patients are already seeing much shorter waiting times and much better services from their NHS. But we are still some distance from meeting people's expectations for a patient-led, high-quality, responsive service. To achieve this we must continue to match investment with reform.

Health reform driven locally

- 1.12 The new NHS will not be created in the old way through command and control. National standards will always be necessary, to protect people against a postcode lottery and widening inequalities. But in the next stage of improvement and reform, we need a decisive shift from top-down to bottom-up as we develop a devolved and self-improving health service where the main drivers of change are patients, commissioners and clinicians, rather than national targets and performance management.
- 1.13 This revitalised, patient-led and locally-driven NHS is designed to achieve a central goal: improving dramatically the quality of patient care and the value we get from the public money spent on health services.

The organising framework for the health reforms



1.14 Our aim is to see the following:

- > More choice and a stronger voice for patients and service users who will be able, in consultation with their clinicians, to choose the highest quality of care appropriate for their needs.
- > Practices and PCTs as commissioners using their knowledge of local communities and extensive public and patient involvement to get the best value within available resources. Commissioners working to improve the health of their population, reduce health inequalities, guarantee choice and secure the best possible services. An NHS that works in partnership with local authorities and other local services to deliver improvements and to promote equality, inclusion and respect.
- > More freedom for providers to innovate and improve services in response to the needs and decisions of patients, GPs and commissioners. Further expansion of NHS Foundation Trusts; a continuing role for PCT direct provision; more opportunities for voluntary sector, social enterprise and private sector providers where they can help deliver better services with better value for money.

- > Clinicians and other staff leading change, with greater freedom and support to focus on the quality of patient care, with new roles emerging to respond more swiftly to patient need, new treatment methods and technological change.
- > Effective management of the system, backed by regulation that assures national core standards and focuses intervention on services most in need.
- > A financial framework, including tariffs, that incentivises improvements in patient care, supports the development of care integrated around patient need (especially long-term care needs), and promotes financial responsibility and best value within allocated resources.
- > Extensive, comparable information on the quality and safety of care. This will give patients and commissioners a real understanding of the choices available to them, practices the capability to track and plan care across the whole patient pathway, and provides a proper understanding of their activity and quality of care.

Benefits

1.15 Achieving these reforms will not be easy, but the prize will be great.

The benefits of reform for the public and for patients

- > Much better **information** on how to keep yourself healthy and the best place to seek treatment.
- > More **choice** and control over how and where you receive care.
- > A more **personalised** service as GPs working through practice-based commissioning shape your care around your needs.
- > Faster, more **convenient** and more local care.
- > Care that is better **integrated** and 'joined up'.
- > Better, more **sensitive provision** for more vulnerable and potentially excluded members of society.
- > More say over the way local services are run through **local consultation** and NHS Foundation Trust **membership**.
- > Your **experience** counts as hospitals, community and primary services listen more to what you say about your care.
- > Guaranteed **core standards** of safety and quality, however and wherever you choose to be treated.

The benefits of reform for staff

- > More **freedom** from Whitehall, with less central direction and fewer targets.
- > The opportunity for **new roles and responsibilities** as NHS training and professional development supports continuous learning and new approaches to patient care.
- > Greater emphasis on the **quality of patient care**.
- > A greater ability to **work collaboratively** across clinical divides to construct care pathways around the individual needs of patients.
- > More scope for **clinical leadership and engagement** for nurses, midwives, GPs, consultants and other health professionals to shape services.

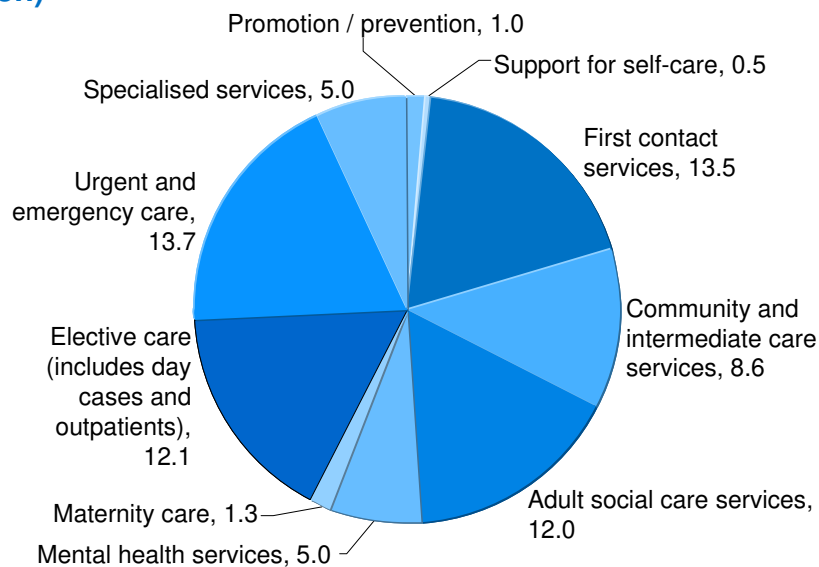
The benefits of reform for taxpayers

- > Ensuring a **modern NHS**, so that we all benefit from the high-quality services we fund collectively as taxpayers.
- > A more **productive and efficient NHS**, with a continual focus on achieving the best possible care with the best possible value.
- > A **strong and effective NHS**, contributing to the health of the nation and the health of our economy.

2. The right reforms for the right services

- 2.1 Health services are not ‘one size fits all’. The NHS is a large and complex organisation covering many different services – health prevention and promotion; ‘first contact’ services such as GPs, pharmacies and NHS Direct; community and intermediate care; acute care in hospitals; specialist services; and many others. Each of these has different characteristics, different kinds of staff, and is provided through different kinds of organisations.

Types of health and social care service and approximate spend (£ billion)²



- 2.2 For all services, our objectives are to:

- > improve health and wellbeing and reduce health inequalities and social exclusion;
- > secure access to a comprehensive range of services;
- > improve the quality, effectiveness and efficiency of services;
- > increase choice for patients and ensure a better experience of care through greater responsiveness to people’s needs; and
- > achieve best value within the resources provided.

² Note: segments overlap. Sources: DH *Departmental Report, 2006*, and reference cost data.

- 2.3 But just as health is not ‘one size fits all’, so health reform should not be either. For each service to achieve these fundamental objectives, we need to find the right balance of levers and incentives that will appropriately support the delivery of the highest quality of care, within budget, in each area. Thus, the blend of policies appropriate for improving the quality of planned, elective care (for example choice, competition, tariff) will need to be different for other services. Improving A&E, for example, will obviously rely less on choice.
- 2.4 The drive to improve clinical care is a fundamental part of good professional practice. In addition, provider organisations have corporate responsibilities for the safety and quality of care. In terms of external drivers, we can distinguish three approaches:
- > **patient-driven** through choice, voice and competition;
 - > **commissioner-driven** through contracting, contestability and service redesign; and
 - > **nationally-driven** through standards, targets, agencies and regulatory approaches.
- 2.5 In the table that follows, we describe how each of these approaches can work to improve quality, patient experience and value for money, and the circumstances where they are likely to be most effective.

	How does this work to improve quality, patient experience and value for money?	When is it most suitable?
Patient-driven (choice, voice and competition)	Because of choice, providers will have to take more notice of patient views about services. Patients will know much more about the quality and outcomes of care between different providers.	Patient voice will be important for all services. Choice and competition are likely to be appropriate to services where real choice of provider is possible and good information is available to support patient choice. The quality and responsiveness of elective care; maternity care; primary, community and intermediate care; health prevention; and large elements of mental health services could all be improved by this approach.
Commissioner-driven (contracting, contestability and service redesign)	GPs and PCTs will understand the immediate and long-term needs of the patients they serve. They will translate this understanding into robust contracts as well as patient-focused clinical pathways. Poor performance will be contested.	Likely to be appropriate where choice of provider is limited or local competition is not possible, but where services can still be effectively commissioned at a local level. Urgent and emergency care, and emergency mental health services could benefit from elements of this approach.
Nationally-driven (national standards, targets, agencies and regulatory approaches)	Wherever you live, wherever you go for care, you can be assured of receiving care under a national health service.	All services need to be provided within a regulatory environment that guarantees core standards of safety and quality.

2.6 None of these approaches is completely self-contained. In reality there will be a blend of incentives in all service areas but usually one of these approaches is likely to be more dominant. And of course there will be national standards in all areas, guaranteeing safety, equal access and quality of care for all. We start with a preference for patient-driven approaches because that is what will drive greater responsiveness of

care, putting choice and control in the hands of patients and users. But the balance of approach needs to be appropriate to the service in question.

- 2.7 Many patients receive care across service or organisational boundaries. For them, the planning and integration of care around their individual needs is an important feature of their experience of care, and the health outcomes that the NHS achieves. And as the number of people with long-term and complex conditions rises, so this is likely to become an ever more important feature of the delivery of personalised, high-quality care.
- 2.8 Health reform will help to bring about this integration of care around the needs of patients in a number of ways.
- > Practices and PBC will play a central role in the future health system as the integrator of services for patients. They will ensure the most appropriate and best-value care, personal to each patient, delivered seamlessly across institutional boundaries.
 - > To achieve this, practices will have indicative budgets for most services. Practices will be discussing and shaping services with health professionals across primary and secondary care, social services and parts of local government. Patients will have available to them high-quality health and care services that best serve their needs.
 - > PCTs, practice-based commissioners and providers will agree clinical protocols and pathways for seamless care for groups of patients, drawing on clinical networks, local authorities and advice from others as appropriate.
 - > Forward-looking health providers of all types will begin to offer care that is better integrated.
 - > The National Programme for IT (NPfIT) individual care record will enable the planning and delivery of care around the individual patient in a way that has not been possible before.

- 2.9 So these reforms are ambitious, and cannot be done all at once. But it is essential to keep making progress. This next stage of the reform programme reflects this differentiation and highlights the practical ways that practices and PCTs can integrate care on behalf of their patients.

3. Choice and commissioning

Choice

More choice and a stronger voice for patients and service users who will be able, in consultation with their clinicians, to choose the highest quality of care appropriate for their needs.

- 3.1 Choice is a normal and natural feature of people's lives nowadays. People welcome their greater ability to take control over their own lives – to shape for themselves the services on offer. Health services should be no different.
- 3.2 So we see choice as being a normal and natural part of the NHS too. We have already introduced choice of provider at referral in elective care, which has proven popular with patients. Sixty-seven per cent of people offered choice through the London Patient Choice project and 50% of those offered choice through the Coronary Heart Disease scheme chose another hospital for their treatment.³ In their evaluation,⁴ Dr Foster and the University of Nottingham found that patients valued being offered choice, even if eventually they still chose to be treated at their local hospital.
- 3.3 Choice of hospital helped slash waiting times for elective operations. Last November, we introduced choice for patients waiting more than six months for a diagnostic scan; in April 2006, this was extended to patients waiting more than five months. Combined with choice of provider for elective procedures, choice of scan will be critical to achieving the 18 week target.
- 3.4 In the autumn we will publish a framework which will set out the next steps in extending choice in both elective care and other service areas.

³ *'Patients' experience of choosing where to undergo surgical treatment*
Evaluation of London Patient Choice Scheme
www.pickereurope.org/Filestore/News/LPC_final_report.pdf

⁴ *Implications of offering Patient Choice for routine adult surgical referrals* Dr Foster and the University of Nottingham, March 2004 www.dh.gov.uk/assetRoot/04/07/92/39/04079239.pdf

3.5 The framework is likely to focus on:

- > Policy guidance for free choice in elective care for 2008, and scoping of the opportunities to introduce choice at other 'decision points' along the elective care pathway, for example at referral to community care or specialised services.
- > The publication of relevant and meaningful information and support for patients and clinicians to inform their choices about healthcare and services. This would include a particular focus on developing information on clinical measures and patient outcomes that can be used to compare the performance of different providers of the same service, whether they be an NHS hospital, a community or primary care provider, or a provider from the private or third sectors. This will build on the achievement of the Society for Cardiothoracic Surgery and the Healthcare Commission in publishing risk-adjusted outcomes for adult cardiac surgery.⁵
- > Priorities for extending choice beyond elective care into other service areas, such as mental health, maternity, end-of-life care, cancer and long-term conditions.



3.6 To support this, we are developing a set of principles for choice across access to all NHS-funded services. While different services will rightly adopt different models of choice, applying these principles will help us to ensure a consistent approach across NHS care. And in a national health service, PCTs will always need to set some boundaries around choice, as they ensure that individual choices are deliverable within a system of care that is fair to all, within available resources.






⁵ heartsurgery.healthcarecommission.org.uk/

Draft principles for choice

- > Everyone is entitled to express a choice about their healthcare and services.
- > Choices offered should reflect the individual's beliefs, values and preferences as well as clinical need.
- > Choice should be about type of treatment as much as about the place of care.
- > Choices should be offered at 'decision points' along the patient's care pathway where this improves the patient's experience and is clinically safe.
- > The choices offered should be clinically appropriate and in accordance with professional guidelines and meet NHS core standards.
- > Appropriate information and advice should be available to empower people to make informed choices.
- > Patients exercising informed choices should also take some responsibility for their choices.
- > The choices offered should be affordable within the NHS budget.
- > The choices an individual makes should not prejudice the treatment they receive.

3.7 Questions for consultation:

1. Are the draft principles the right ones on which to base choice in health? 
2. Are there other 'decision points' along the elective care pathway, in addition to GP referral to a consultant-led service, at which choice should be offered? 

3. What should the priorities be for extending choice beyond elective care? 
 4. What are the 'decision points' along the care pathway in other services where people want choice? 
 5. How can choice help in the promotion of fairness, inclusion and respect for all members of society? 
 6. What should the priorities be for developing information to support choice? 
- 3.8 To steer this policy development, we have set up a Reference Group co-chaired by Mayur Lahkani, Chairman of Council at the Royal College of GPs, and David Pink, Chief Executive of the Long-term Medical Conditions Alliance. The membership of the Group includes clinicians, patient representatives, NHS and independent sector representatives and academics.
- 3.9 Throughout the summer, we will be talking to patient groups, clinicians and staff providing NHS care across the country. We are seeking views both on the draft principles and on other key elements of the policy. Please send any comments or feedback to nhs.reform@dh.gsi.gov.uk. 

Commissioning

Practices and PCTs as commissioners using their knowledge of local communities and extensive public and patient involvement to get the best value within available resources. Commissioners working to improve the health of their population, reduce health inequalities, guarantee choice and secure the best possible services. An NHS that works in partnership with local authorities and other local services to deliver improvements and to promote equality, inclusion and respect.




- 3.10 Commissioning is the means by which we secure the best value for patients and taxpayers. By 'best value' we mean:
- > the best possible health outcomes, including reduced health inequalities;

- > the best possible healthcare; and
 - > within the resources made available by the taxpayer.
- 3.11 As an annex to this overview, we are publishing the first phase of a commissioning framework. Its focus is on the commissioning role of PCTs, in partnership with practices, principally in relation to the commissioning of hospital services. Other aspects of commissioning, including commissioning for primary care services, health and wellbeing, long-term conditions, and joint commissioning with local government, will be addressed in more detail in a second phase of the commissioning framework to be published in December 2006.
- 3.12 The framework describes how we expect commissioners to behave in those circumstances where provision is either unavailable or failing to meet required standards. Commissioners will be encouraged to use open tendering as a way of ensuring innovation, quality and value, and to offer real choice to people who use services. Any willing provider will be free to compete in this process. This will include the participation of providers from the public, the private and third sectors and will be especially relevant in areas experiencing health inequalities or where there is inequality in accessing services.
- 3.13 The position on direct provision of services by PCTs remains as set out in the White Paper, *Our health, our care, our say*. Where PCTs provide services, as the majority now do, they will need to put in place clear governance procedures that ensure no undue influence by the provider side on commissioning decisions. These procedures will include independent scrutiny by the SHA and will be transparent to all potential contractors and staff.
- 3.14 In delivering their commissioning responsibilities, PCTs and their practices, working with local authorities, have two roles:
- > as advocates for patients; and
 - > as custodians of taxpayers' money.
- 3.15 While commissioning itself is not new, stronger PCTs and the acceleration of PBC, together with the incentives introduced by health reform, provide the opportunity for more effective commissioning that will over time lead to:

- > improvements in health and wellbeing;
 - > reductions in health inequalities and social exclusion;
 - > better access to a comprehensive range of services;
 - > improved quality, effectiveness and efficiency of services;
 - > increased choice for patients and a better experience of care; and
 - > improved integration of health and social care.
- 3.16 PBC will be critical in enabling PCTs to achieve the best value for patients. Through PBC, practices will have indicative budgets and the freedoms and incentives to exercise devolved responsibility for aspects of the commissioning and redesign of services. Many practices are already forming commissioning consortia to take advantage of PBC.
- 3.17 PCTs will support the development of PBC by providing information, budgets, public health needs assessment, analysis of cost-effectiveness of interventions, and training and development for practices. Practices will develop, through their business plans, proposals for the redesign of services and for releasing resources.
- 3.18 The commissioning framework will strengthen PBC by:
- > Clarifying the approach to **tendering** for services proposed under PBC. *In many cases the services can be delivered through existing contracts without the need for tender.* Uncertainty on this issue has held back development of PBC in some areas.
 - > Encouraging PCTs to set up **local PBC incentive schemes** in addition to the national incentives. Such schemes should be cash-releasing and focus on the implementation of proven service redesign techniques. Investing relatively small sums of money in this way can release significant resources for reinvestment.
 - > Seeking comments on a proposed **governance and accountability framework for PBC** which makes explicit the accountability arrangements for PBC, reinforces the freedoms for practices under PBC, and emphasises the principle of GPs using their knowledge and judgement to best meet patients' needs.

The next steps

3.19 Delivering effective commissioning raises a number of real challenges for the way we manage the NHS. The Department of Health is seeking views from the NHS and partner organisations on:

1. **contracts:** their role, which elements should be specified nationally and which defined locally, levels of specificity and control, and how they should be taken forward in the 2007/08 operating framework (see appendix C of the commissioning framework annex); 
2. **governance of PBC:** to ensure the widest possible engagement in PBC and that primary care has the maximum possible opportunity to innovate to meet patient needs, within a framework of standards and probity (see appendix D of the commissioning framework annex); and 
3. **public engagement:** arrangements and 'triggers' for community petitions and wider input into PCT and practice decision making (see appendix E of the commissioning framework annex). 

4. Provider reform

Providing the best services for the best possible value

More freedom for providers to innovate and improve services in response to the needs and decisions of patients, GPs and commissioners. Further expansion of NHS Foundation Trusts; a continuing role for PCT direct provision; more opportunities for voluntary sector, social enterprise and private sector providers where they can help deliver better services with better value for money.

- 4.1 The stronger role for commissioning described in the previous section will present both a challenge and an opportunity for the provider side of the healthcare system. Reform of the provider side is designed to support healthcare organisations to change, so that:
- > NHS hospitals, NHS Foundation Trusts (NHS FTs), community providers and the wide range of other providers are able to continue to innovate and improve, as expectations rise and patient choices start to drive change; and
 - > new ways of delivering care can be more rapidly developed and introduced on the ground.

Strengthening NHS providers to innovate and improve

- 4.2 NHS FTs have been very successful:
- > They are good for patients.

The Royal Marsden used its surplus to appoint 'patient navigators' to work with clinical teams in care units in SW London, so that system delays are addressed early, waits are shorter and care is now better tailored to individual needs.

- > They are good for the taxpayer.

Monitor's most recent returns for the end of year 2005/06 performance for 32 NHS FTs show that 31 of those Trusts have generated a £12 million surplus for reinvestment in patient care. Where financial problems have emerged, they have been dealt with transparently and promptly.

- > They are good for staff and the local community.

At Chesterfield Royal Hospital, 10,000 staff and community members had their say on plans to adopt controlled visiting hours to achieve balance between visitor access and control of infection. They have also contributed to the hospital's plans to become fully smoke-free.

- 4.3 The Government intends to build on the success of NHS FTs. A key objective of the new SHAs will be to work closely with NHS Trusts to get them into a good position and give them the opportunity to apply for FT status in 2008.
- 4.4 We expect there to be 70 NHS FTs, including up to 15 mental health trusts, by spring 2007, and potentially up to 100 by the end of next year. The programme will continue under the leadership of the new Director General of Provider Development, working with SHAs and local trusts to develop plans for applications to Monitor.
- 4.5 We want aspirant NHS FTs to have as much access as possible to the learning and experience of successful NHS FTs. That is why we are supporting the FT Network in their work with applicant FTs to establish 'buddying' arrangements with existing NHS FTs and to offer practical advice and guidance throughout the application phases. 'Buddying' arrangements supplement the diagnostic programmes run by SHAs.
- 4.6 The benefits of strong governance, financial freedoms and local accountability need not be restricted to acute and mental health services. In response to interest from PCTs, we are therefore working with Monitor to explore the feasibility of community NHS FT status for providers of community services, most of which are currently directly managed by PCTs. Community NHS FTs would need to have at their

centre incentives for innovation in care and for organisation of care around patients.

- 4.7 In principle, the Government is attracted to this model which would strengthen community services, keeping them wholly within the NHS, protecting staff terms and conditions, including pension provision. It would also enable staff, users and other members of the public to become members of the community NHS FT, with a role in its governance. Later this year, following discussions with national stakeholders, we will say more about whether the FT model could be suitably developed in this way. Community NHS FT status would then be an option for PCTs to consider, with their provider side, and staff and local stakeholders, when reviewing the future of community provision.
- 4.8 Where commissioners locally consider they need to bring in new or different providers to improve quality of care in the community or in particular services provided within acute settings, we are interested in discussing with the FT Network how NHS FTs can be flexible and responsive beyond their own localities and outside of traditional acute settings. This will mean that NHS FTs may develop or bid to provide intermediate care or community services (excluding 'list-based' primary care services) offering integrated care for patients. Commissioners will always need to ensure that these arrangements achieve best use of resources and that service quality and value are periodically reviewed.
- 4.9 Care for NHS patients in future will not, of course, be provided exclusively by NHS FTs:
- > PCTs will continue to be able, with appropriate governance arrangements, to provide community services directly where this is best for patients in terms of quality and value for money;
 - > the great majority of general practice is already provided by independent practitioners; and
 - > the private and independent sector, including independent sector treatment centres (ISTCs), are offering choice to patients, helping the NHS to reduce waiting times for planned care and bringing additional innovation, investment and challenge to the NHS.

- 4.10 Third sector providers are also vital partners in delivery of care, for example in both inpatient and outpatient mental health services, sexual health services, drug rehabilitation and palliative care. Many smaller voluntary organisations also play a crucial part in the delivery of community services, particularly for vulnerable and excluded groups, and are often able to bridge divides between statutory services. Hence our policy is to support greater participation by the third sector in the delivery of health and social care, and we are committed to taking forward the recommendations of the Third Sector Commissioning Task Force, published this month.
- 4.11 We also want to support the emergence of new types of provider organised along ‘social enterprise’ lines,⁶ as they offer the potential to organise care more closely around the needs of individuals, particularly in the community. A social enterprise can bring strong engagement with patients and the public, greater ownership and involvement by staff and, as has been the experience in social care, the ability to adapt swiftly to meet changing needs. The DH Social Enterprise Unit will spearhead this work and will shortly issue a call for between 10 and 15 ‘pathfinder’ social enterprises as demonstrator projects.

New ways of delivering care

- 4.12 The *Our health, our care, our say* White Paper promised a shift of care closer to home. We are now making this happen.
- > We are working with the Royal Colleges, professional bodies and others on shifting care in six key hospital specialties: dermatology, ear, nose and throat services, general surgery, gynaecology, orthopaedics and urology. The aim is to shift care and diagnostic procedures into settings that are more convenient for patients, using existing good practice and evaluating what already works.

⁶ A social enterprise is a business with primarily social objectives whose surpluses are re-invested in the business or in the community. It can be constituted in many ways, most commonly as a mutual, a co-operative, Community Interest Company or a Company Limited by Guarantee.

- > In July 2006 we announced £750 million in extra capital funding to invest in community hospital services. This will enable NHS Trusts to build or renovate community hospitals to bring blood tests, diagnostic scans, minor operations and many other services closer to patients' homes.
- 4.13 PCTs have the responsibility to ensure that primary and community services meet local needs and use a range of contracts (PMS and APMS) currently available to them to best effect. DH will be reviewing how these contracting arrangements are working, as anticipated in the White Paper.
- 4.14 Although more services will increasingly be offered in the community or even in patients' own homes, acute hospitals will remain an essential part of the NHS. But they will also need to continue changing in response to patients' needs and new medical technologies. Many will adapt services in recognition of the opportunities to reduce length of stay and of the alternatives available in the community. Others will become more specialised. And providers will more often need to work together to meet commissioner and patient expectations.
- 4.15 In recognition of this need to adapt, the National Leadership Network recently produced a report, *Strengthening Local Services: The Future of the Acute Hospital*.⁷ Published in March 2006, it contains extensive analysis and advice for hospitals on the implications of the reform agenda. It also suggests some new approaches for strengthening the accountability and governance of joint working arrangements: networks, joint ventures and a 'principal provider' model, where a single provider sub-contracts elements of the care pathway to other providers.
- 4.16 In response to these recommendations, DH, with the national clinical directors, the NHS Confederation and others from the health service, is now taking forward two pieces of work on which we will report later in the year:
- > **Joint provision:** good clinical governance and accountability arrangements for the 'principal provider' model, for joint ventures and franchising; and

⁷ See www.nationalleadershipnetwork.org

- > **Clinical co-location:** advice on the services optimally available with A&E departments of different types.

Whatever form it takes, co-operative provision, in its various forms, in future will need to be in line with commissioners' requirements, in the interests of patients and not anti-competitive.

Workforce

Clinicians and other staff leading change, with greater freedom and support to focus on improving patient care, with new roles emerging to respond more swiftly to patient need, new treatment methods and technological change.

- 4.17 Reform will create major new opportunities for the workforce, building on the Government's record levels of investment in expanding the workforce and in modernising pay for most staff groups. The biggest workforce challenge faced by the NHS is no longer insufficient capacity caused by under-investment, including in pay. It is how to empower staff to deliver year-on-year improvements in the quality and responsiveness of care for patients within finite resources, with employers making best use of the new workforce contracts to reward the development of new skills.
- 4.18 Agenda for Change and the new contracts for GPs and consultants have created the right foundation for a well-paid, high-quality and flexible workforce. New forms of practitioner are being developed such as emergency care practitioners and anaesthesia practitioners. The Government will want to ensure that those schemes proving successful can be implemented widely.
- 4.19 There will still need to be an important system management role in ensuring that health services have access to a workforce with the skills and competencies needed in the future. This role will be performed primarily by SHAs and their important new workforce functions. SHAs will build effective partnerships with NHS providers and higher education institutions so that the supply of education, and the provision of training, better meet service needs.

- 4.20 SHAs will also have a vital role in ensuring NHS staff have access to support and advice on making the best of the opportunities brought about by changing patterns of services, for example in support of the White Paper agenda.
- 4.21 The NHS is moving towards competency-based training to give staff the opportunity to develop new roles and closer working between professional groups. In this way staff will be freed up to shape the way they work to the needs of their patients.
- 4.22 DH is committed to ensuring that training and education will be valued and properly rewarded, regardless of the setting. The ongoing review of funding for the Multi-Profession Education and Training (MPET) levy will seek to improve cohesion across budgets, facilitate flexible and innovative use of these monies, and support interdisciplinary learning, while avoiding the destabilisation of local health economies.
- 4.23 Professional regulation needs to evolve to underpin patient safety. DH has undertaken comprehensive reviews of medical and non-medical regulation and will publish the findings shortly.
- 4.24 Working with stakeholders, we will develop these principles further into practical help later in the year, including:
- > a simple articulation of the different roles and responsibilities in the system in relation to the workforce;
 - > asking NHS Employers to develop best practice on devolving responsibility to clinical teams;
 - > new practitioner roles; and
 - > the forthcoming review of MPET budgets.

5. System management and regulation

Effective management of the system, backed by regulation that assures national core standards and focuses intervention on services most in need.

Strategic Health Authorities

- 5.1 SHAs will manage the effectiveness of local health systems through their oversight of Primary Care Trusts, which, in turn, will be improving services for patients through relationships and contracting arrangements with providers. SHAs will be held to account by DH.
- 5.2 SHA oversight must include assessment of how well commissioners are discharging their functions as set out in the commissioning framework. Assessing PCTs and then holding them to account is the key SHA system management role.
- 5.3 SHAs will also do the following:
 - > **Implement and maintain locally the integrity of national health reform rules.** This role will include promoting effective partnership working between local organisations. It will also involve providing, where necessary, informal dispute resolution between PCTs and NHS Trusts, engaging with Monitor as appropriate where NHS FTs are involved. In effect, the SHA will ensure reasonableness throughout the process of commissioning in all cases.
 - > **Provide help with major reconfigurations and capital developments.** The primary drivers of reconfiguration are the need to ensure clinical safety and improve clinical quality. Reconfiguration may also be important in securing best value and restoring financial balance, as well as preparing for full implementation of the European Working Time Directive. SHAs have an essential role in assuring the quality of service arrangements and community engagement.
 - > **Intervene and deal with failure in PCTs and NHS Trusts.** SHAs are able to do so on behalf of the Secretary of State (under sections 84A and 84B of the 1977 National Health Service Act).

- 5.4 In terms of **financial risk-pooling** (operating a ‘banking function’), the future role of SHAs will need to be considered further by DH, taking account of the Audit Commission’s forthcoming report to the Secretary of State on the NHS financial management and accountancy regimes. Such a function is likely to be an important element of effective system management. After the Audit Commission review, we shall be working up proposals with stakeholders and consulting in the autumn, including on which organisation is best placed to run this.

Regulation

- 5.5 Monitor has performed, and will continue in future to perform, a vital role exceptionally well in the authorisation of NHS FTs. It has exercised rigorous processes of review to ensure strong governance and financial sustainability, all in the interests of local patients.
- 5.6 The Healthcare Commission (HCC) has pioneered a new approach to quality assurance through its move to risk-based self-assessment. The assessment process is for the first time embedding core national standards right across the NHS. Other regulators, the Commission for Social Care Inspection (CSCI) and the Mental Health Act Commission (MHAC), have also put in place strong and effective regimes in the public interest. The Government has already announced its intention to merge HCC, CSCI and MHAC to share learning, provide scope for integrated regulation and achieve economies of scale.
- 5.7 In response to the wider regulatory review (WRR), we will work with all parties and the regulatory bodies to ensure clarity of roles, lack of duplication and enhanced effectiveness of a more streamlined regime.
- 5.8 Changes to the healthcare system as a whole will call for a refocusing of the role of regulation, with a stronger emphasis on guaranteeing even more effectively the clinical safety of services available to NHS patients.
- 5.9 The WRR drew on many excellent contributions, including from HCC, CSCI, MHAC, Monitor, the Audit Commission, the King’s Fund and the NHS Confederation. To ensure that we are fully taking into account all the perspectives, and placing them in the context of the commissioning framework, we will be continuing a process of discussion over the coming months.

- 5.10 In developing proposals for new regulatory arrangements, we intend to follow the 'Better Regulation' taskforce's five principles of good regulation, that it should be:
- > proportionate;
 - > accountable;
 - > consistent;
 - > transparent; and
 - > targeted.
- 5.11 During the course of the review, a number of 'regulatory functions' were proposed by participants as important, for example:
- > licensing providers against core standards;
 - > monitoring and enforcing licensing conditions (including withdrawal of licences) where conditions are not met;
 - > overseeing any competition rules, refereeing any unresolved disputes about unacceptable behaviour; and
 - > publishing objective information for the public, assessing the performance of providers and commissioners.
- 5.12 Working closely with stakeholders, DH will publish a consultation document in the autumn of 2006 setting out proposals for the future of independent regulation and for how functions might be discharged. Whatever the model agreed, effective regulation against core standards of safety and quality will be at its heart. This will provide the context for legislation to accomplish the previously announced merger of HCC, CSCI and MHAC.

6. Incentives, the tariff and information

A financial framework, including tariffs, that incentivises improvements in patient care, supports the development of care integrated around patient need (especially long-term care needs), and promotes financial responsibility and best value within allocated resources.

Incentives and tariff

- 6.1 In an NHS led by patients and commissioners, it is vital that the structure of incentives embedded in the financial system supports both patient choice and the commissioning of the best possible services at the best possible value.
- 6.2 In the past, hospital budgets were based on historic costs and reflected the negotiating skills of local managers. This masked large differences in the cost of equivalent services, leaving hospitals with minimal incentive to improve.
- 6.3 The national tariff is a fairer and more effective way of paying for NHS services. The principle has been broadly welcomed in the NHS. In its report *Early Lessons from Payment by Results*, the Audit Commission concluded that the overriding view of organisations that have already implemented the new payment system was that it is a 'positive change that should bring about genuine and long-lasting improvements to the NHS'.⁸
- 6.4 There is still a great deal to do to make the tariff fully fit for purpose. The forthcoming report from the independent review of the tariff-setting process in 2006/07 will make recommendations on technical aspects and better communication. We are also working with the service on options for strategic developments. This includes how best to balance, on the one hand, demands from the NHS to develop and improve the tariff rapidly, with, on the other, pressure to provide stability in the tariff to support medium-term business planning.
- 6.5 It is also important to ensure that the entire financial regime, including the allocation process and the capital regime, helps to incentivise the

⁸ *Early Lessons from Payment by Results*, Audit Commission Health National Report, October 2005.

delivery of high-quality care. Some of the issues, then, that are at the forefront of our work include:

- > Ensuring that the system of financial incentives effectively supports the development of continuous care pathways, particularly care for people with long-term conditions.
- > Over time, introducing tariffs that reflect best-practice models, and unbundling payments for specific components of care, where appropriate, to support the new patterns of care closer to home.
- > Structuring tariffs and other financial levers so that they reward appropriately those providers which invest in innovation that successfully improves quality of care and value for money.
- > Ensuring that the tariff regime fairly rewards providers of the most specialised services (for example, complex orthopaedics and specialist children's services) and effectively reflects the case-mix undertaken by different providers.

- 6.6 We are involving stakeholders every step of the way in developing this system, ensuring that clinicians and managers help to shape the evolution of both Payment by Results (PbR) and other financial mechanisms. In the autumn of 2006, therefore, we intend to publish proposals for consultation on the future of PbR from 2008/09 and beyond. Before that, later this month, we shall be making proposals for how the tariff will operate next year, including steps towards unbundling.

Information

Extensive, comparable information on the quality and safety of care. This will give patients and commissioners a real understanding of the choices available to them, practices the capability to track and plan care across the whole patient pathway, and providers a proper understanding of their activity and quality of care.

- 6.7 Information and good information systems are vital to health reform. Patient choice, effective commissioning, good quality provision and appropriate regulation all need extensive information on the quality and cost effectiveness of care – and the right IT to deliver these.

- 6.8 In 2002, we published *21st century IT Support for the NHS* and established the National Programme for IT (NPfIT). The programme exists to drive investment in the type of IT needed to deliver the vision of modern healthcare, namely one that is organised around the needs of patients as well as those who provide care. The journey to join up relevant information is being tackled through four main elements of the programme:
- > a robust infrastructure to support modernised health and social care, including a national approach to authentication, security and confidentiality;
 - > Choose and Book (the electronic booking of appointments);
 - > the Electronic Prescription Service (EPS); and
 - > the NHS Care Records Service.
- 6.9 Progress has been significant. In July 2006 there were:
- > **247,100** NHS staff registered to use the NHS Care Records Service;
 - > **2.25 million** prescriptions transmitted using the EPS;
 - > **675,000** bookings made using the Choose and Book system;
 - > **42 million** images created and stored using the Picture Archiving and Communications Systems (PACS); and
 - > **500,000** staff with fast broadband access at 15,000 NHS locations.
- 6.10 But the policy context evolves and it is timely to ensure that our approach to information and IT is fit for the future. For that reason, we have completed an assessment of the information needs flowing from the healthcare reform programme so that the NPfIT and other components of the existing information strategy can develop in a way that is consistent with changes in the wider environment.
- 6.11 We involved over 150 stakeholders representing a broad and influential cross-section of the NHS community. This confirmed wide support for the key aims of both the information strategy and the NPfIT. In particular,

an integrated health record that spans care environments and follows the patient pathway, rather than organisational boundaries, is central to patient care in the reformed NHS.

6.12 Overall, it is clear that the patient-centred approach of the current strategy is right and appropriate for the reformed NHS. So the NPfIT will continue to drive both sustained investment in IT and the adoption of technical and data standards by all those who form part of the reformed NHS.


6.13 In addition we have identified four areas for further attention:


- > **choice:** better information to support patients to make meaningful choices;
- > **commissioning:** better information and systems to strengthen commissioning and to enable closer integration of health and social care;
- > **providers:** improved finance and business information systems to support fit-for purpose providers; and
- > **stronger data standards and data quality.**

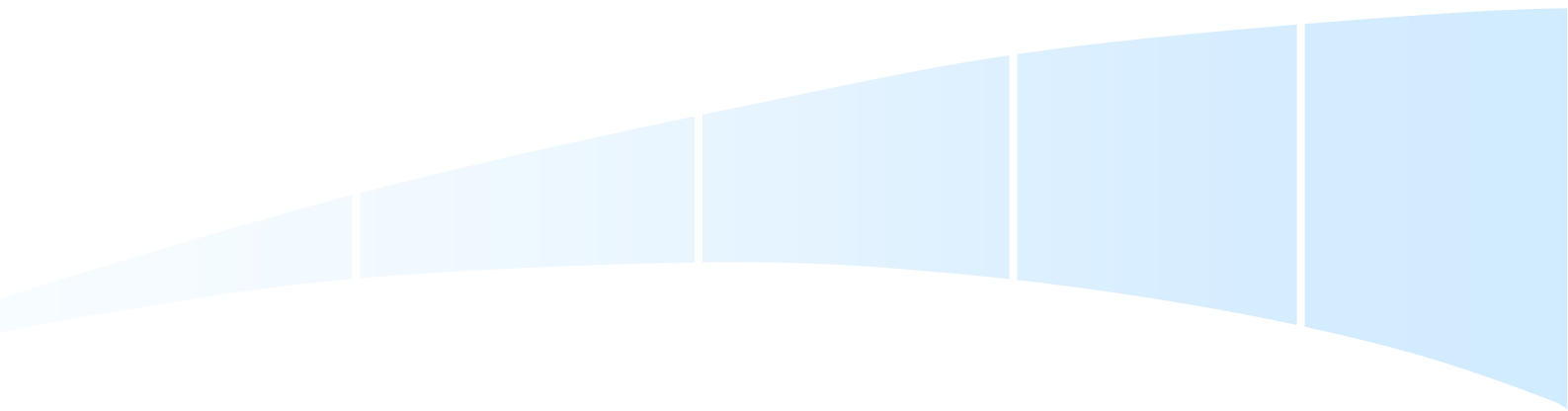
6.14 The next steps will be to work with patients and the service to:

- > elaborate what is needed;
- > integrate these needs into current policy and agree priorities; and
- > identify the best mix of national and local action to deliver.

6.15 Questions for consultation:

1. Are these the right areas for further work? 

2. In which ways should this work be developed? 



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