



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 Impact Assessments, which correspond to the Annexes listed above and have been published as a separate document.

Title: Commissioning for patients (GP commissioning and the NHS Commissioning Board) Lead department or agency: Department of Health Other departments or agencies:	Impact Assessment (IA)
	IA No: 6030
	Date: 30/11/2010
	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 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)

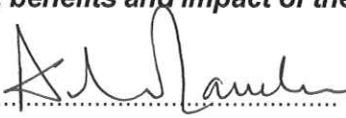
1. GP Commissioning and NHS Commissioning Board. GP Commissioning will give consortia of GP practices greater freedom to design services around patients to improve patient experience and quality of care. Aligning clinical and financial responsibility creates incentives to ensure commissioning decisions provide value for money through efficient prescribing and referral patterns.

An independent NHS Commissioning Board will be set up to support consortia and provide national leadership on commissioning for quality improvement. It will allocate and account for NHS resources, and hold consortia 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 SELECT SIGNATORY:  Date: 18/1/11

Summary: Analysis and Evidence

Policy Option 1

Description:

Transfer responsibility for commissioning from PCTs and SHAs to GP consortia and the NHS Commissioning Board.

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

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	£949m	3	0	£932m
High	£1,465m		475	£1,448m
Best Estimate	£1,201m		0	£1,141m

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 GP consortia and the NHS Commissioning Board, as set out in the coordinating document.

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	0		£1,060m	£8,832m
High	0		£1,060m	£8,832m
Best Estimate	0		£1,060m	£8,832m

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.

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 GP 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:

- GP Consortia not having the capacity and capability to engage with and deliver clinical commissioning;
- Potential conflicts of interest between GP consortia as providers and commissioners of patient care;
- Potential higher transaction costs as we change the number of organisations commissioning services
- The ability of GP consortia 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?					
What is the annual change in enforcement cost (£m)?					
Does enforcement comply with Hampton principles?		Yes			
Does implementation go beyond minimum EU requirements?		No			
What is the CO ₂ equivalent change in greenhouse gas emissions? (Million tonnes CO ₂ equivalent)		Traded:		Non-traded:	
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:		Benefits:	
Annual cost (£m) per organisation (excl. Transition) (Constant Price)	Micro	< 20	Small	Medium	Large
Are any of these organisations exempt?	Yes/No	Yes/No	Yes/No	Yes/No	Yes/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
Statutory equality duties¹ Statutory Equality Duties Impact Test guidance	Yes	EIA 2
Economic impacts		
Competition Competition Assessment Impact Test guidance	No	27
Small firms Small Firms Impact Test guidance	No	27
Environmental impacts		
Greenhouse gas assessment Greenhouse Gas Assessment Impact Test guidance	No	27
Wider environmental issues Wider Environmental Issues Impact Test guidance	No	27
Social impacts		
Health and well-being Health and Well-being Impact Test guidance	Yes	6-25
Human rights Human Rights Impact Test guidance	No	27
Justice system Justice Impact Test guidance	No	27
Rural proofing Rural Proofing Impact Test guidance	No	27
Sustainable development Sustainable Development Impact Test guidance	No	27

¹ 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	
2	
3	
4	

+ Add another row

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

	Y ₀	Y ₁	Y ₂	Y ₃	Y ₄	Y ₅	Y ₆	Y ₇	Y ₈	Y ₉
Transition costs	0	610	591	0	0	0	0	0	0	0
Annual recurring cost	0	0	0	0	0	0	0	0	0	0
Total annual costs	0	610	591	0	0	0	0	0	0	0
Transition benefits	0	0	0	0	0	0	0	0	0	0
Annual recurring benefits	0	513	961	1,246	1,314	1,314	1,314	1,314	1,314	1,314
Total annual benefits	0	513	961	1,246	1,314	1,314	1,314	1,314	1,314	1,314

* 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 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. GP 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 GP commissioning.

Objective of the Policy

- A4. GP Commissioning will give consortia of GP practices 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. An independent NHS Commissioning Board will be set up to support consortia. It will be responsible for allocating and accounting for NHS resources, including holding consortia 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 consortia, 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. GP Consortia will begin to come together in shadow form (building on practice based commissioning) in 2010/11. In 2011/12, a comprehensive system of shadow GP consortia will be in place. Consortia will start to be established as statutory bodies from 2012/13, prior to taking on full statutory responsibilities from April 2013.

Background

A8. The White Paper, *Equity and excellence: Liberating the NHS*, outlined the Government's vision for clinical commissioning. Consortia of GP practices, working with other health and social care professionals, and in partnership with local communities and local authorities, will commission the great majority of NHS services. GP Consortia 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 fund holders. Under this scheme, volunteer general practices (and thus may lead to 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, 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 and 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:
- 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.^{2 3}
- 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.^{4 5} However, it remained difficult to extract and transfer resources from secondary to primary care.⁶
- A18. The evidence base suggested that in many instances, smaller and single practices performed better financially than larger practices.^{4,5} This suggested 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 accounts 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 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.

² Le Grand J, Mays N, Mulligan J-A (1998) *Learning from the NHS Internal Market*, p52-54, King's Fund

³ Audit Commission (1996) *What the Doctor Ordered: a study of GP Fundholding in England and Wales*, London:HSMO.

⁴ Lewis R (2004) *Practice-Led Commissioning: Harnessing the power of the frontline Kings' Fund*.

⁵ 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*.

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

- 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 suggests that in terms of financial savings, success was limited, with 70% of consortia and independent practices leads reported they had achieved no savings within their indicative PBC budget. Of the 30% who did report savings, data on the actual level of these were 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'*. 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, but on business cases the speed of PCT decision making and quality of PCT feedback were much lower at 29% and 33% respectively.
- A24. There was also a mixed response in terms of the influence of and involvement of PBC groups. Leads had great or fair influence over clinicians in their PBC group (85%), with the PCT (56%) but less so with secondary care clinicians (24%) and secondary care managers (15%). Similarly, while the PCT involved 90% 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.
- A25. Some respondents to the White Paper 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, more autonomous and accountable consortia would work better

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 consortia 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 consortia within PCTs which are considered to be 'strong' at engaging in commissioning have lower activity growth rates than those consortia within PCTs which are considered to be 'weak' at engaging in commissioning. There was nevertheless significant variation within the averages for the results of 'weak' and 'strong commissioners', but a scenario analysis showed no change in the trend.⁷
- A27. We were unable to identify significant trends with respect to PBC Consortia sizes. However, membership data on PBC clusters 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.

⁷ 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 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.

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, GP Consortia will not need to engage in contract price negotiations thereby reducing potential transaction costs. Going forward, Monitor will take on the role of economic regulator, both setting prices and ensuring competition 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, again after a number of iterations, 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 hard budgets for GP Consortia;
- Patients can exercise choice of GP – they are no longer constrained to registering with a local GP.
- Significant improvements in access / waiting times for example due to the 18 week target, which limits a GP Consortia's ability to differentiate themselves from competing / neighbouring consortia;
- A better funded healthcare system.

Options

A29. This impact assessment presents the preferred option of a move to commissioning by GP Consortia 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 GP Consortia and others by the Board. The following sections includes 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 GP Consortia Commissioning

A30. By giving GPs freedom to design services around patients, GP 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;
- Alignment of financial and clinical incentives and accountability, with expenditure decisions more closely aligned to budget holders, and limiting incentives for poor performing GPs to free ride;
- 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;
- Higher levels of patient decision-making.

- 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;
 - 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. GP Commissioning should also, provide Consortia 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 GP consortia 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. In an era of low waiting times and financial austerity, clinicians are better placed than managers to assess patients' needs and incentivise GPs to maintain and justify clinical thresholds. Therefore, demand management will be seen more favourably by patients and will be more effective.
- A36. GP 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 which deliver the highest quality outcomes for a pre-determined price.
- A37. Compared to earlier versions of GP led commissioning, commissioning by GP Consortia is more likely to deliver benefits due to:
- The fact that each Consortia will hold hard budgets;
 - The fundamental changes to the system architecture outlined above; and in particular the flexibility PBR provides to ensure Consortia which that make savings for example by successfully reduce admission rates accrue to the responsible Consortia rather than remaining with the provider;
 - The universal implementation of clinical commissioning as all practices will be part of consortia; and
 - Transaction costs will be limited via the introduction of a management cost allowance.

Estimating potential benefits from improved commissioning

- A38. It is difficult to quantify the savings associated with an improvement in commissioning. The text above talks about why GP consortia 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,⁸ 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 in this instance.
- 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 potential cost-savings, is around better commissioning. For the reasons given above, GP consortia (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. Given the Department has not routinely collected information on the cost of commissioning, the following table summarises the analysis undertaken to estimate the current cost of running PCT commissioning arms.

Table A1: Current costs of commissioning

PCT Commissioning Arm Staff Costs	£1.93 billion	2009/10 FIMS national summary minus £138 million for PCT Commissioning Arm element of 2010/11 management cost savings
PCT Commissioning Arm Non-Staff Costs	£2.01 billion	2009/10 Summarised accounts total PCT Non-Staff Costs of £4.34 billion minus £1.92 billion estimate of PCT Provider Arm Non Staff Costs from 2009/10 FIMS national summary and £419 million of 3 rd party grants (assumed to be 80% Provider)
Less Adjustments	-£0.35 billion	Depreciation, Amortisation, Cost of Capital (55.8% Commissioner Arm) and Impairments, Income (20% Commissioner Arm) - 2009/10 summarised accounts
Total non-ring fenced Commissioning Arm baseline	£3.59 billion	
Ring fenced depreciation and amortisation	£0.19 billion	This is not included within the baseline for PCT spend set out here, or in the coordinating document.

- A43. There will be some additional costs associated with current SHA level commissioning (for specialised services, for example). Total SHA staff costs were £233m in 2009/10 (plus £33m estate costs) but only a minority of these staff are involved in commissioning – the largest

⁸ A full list of the QIPP workstreams is available at <http://www.dh.gov.uk/en/Healthcare/Qualityandproductivity/QIPPworkstreams/index.htm>.

component relates to education and training with other functions including Public Health, support to providers, hosted programmes, and finance and performance management. A national breakdown of spending on these categories is not available but we estimate that the costs of the commissioning, finance and performance management functions at SHAs are less than £100m. Therefore, the reduction in costs from current SHA commissioning functions are assumed to be minimal compared to overall commissioning costs, and are excluded from the estimate of reduction in cost of commissioning.

- A44. The cost estimates in Table A1 cover all non-provider services carried out by PCTs, not simply activity directly related to commissioning healthcare, e.g. public health functions. Sensitivity analysis, using an alternative methodology and range of assumptions suggested PCT Commissioner Arm and SHA commissioning running costs range from £3.2 billion and £3.9 billion.
- A45. The Comprehensive Spending Review set the admin baseline for 2011/12 onwards for the Department of Health, SHAs, PCTs (excluding provider arms) and Arms Length Bodies which is 33% lower in real terms (27% in cash or nominal terms) than 2010/11 baselines.
- A46. Whilst the allocation of this total administration budget is not yet determined, this impact assessment follows the assumptions of the coordinating document. It therefore assumes that the 33% reduction in real terms will be applied to the PCT commissioning element, suggesting an administration budget for the commissioning arms of PCTs for 2014/15 of approximately £2.4bn⁹. This also assumes that the trajectory of the reduction is the same as that set out in Table 2 of the coordinating document. Table A2 below summarises the baseline spending for PCTs and SHAs, and what a one-third reduction would mean in terms of cost-savings.

Table A2: 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)	3,588	3,588	3,588	3,588	3,588	3,588	3,588	3,588	3,588	3,588	
SHA budgets at 2010/11 level (£m)	353	353	353	353	353	353	353	353	353	353	
Total commissioning budget (£m)	3,941	3,941	3,941	3,941	3,941	3,941	3,941	3,941	3,941	3,941	
Real commissioning budget running costs (£m)	3,941	3,428	2,980	2,695	2,627	2,627	2,627	2,627	2,627	2,627	
Saving per annum (£m)	0	513	961	1,246	1,314	1,314	1,314	1,314	1,314	1,314	10,604

- A47. Therefore, the future costs of commissioning will be £1.3bn less than existing costs, per annum.

⁹ In 2010/11 prices.

Costs

Cost of GP Commissioning

Transition Costs

- A48. There will be transition costs associated with reducing the cost of commissioning as outlined above.
- A49. The non-staff transition costs are estimated to be approximately £323m. This includes Estates and IT costs associated with transferring staff from PCT to Consortia premises and systems. In addition, there will be double running/start up costs for Consortia, including management and new premise search costs. Table A3 below gives a breakdown of this:

Table A3: Estimated transition costs per PCT

	Cost per PCT
IT	£950k
Relocation	£55k
Accommodation Search	£40k
Double Running Costs	£653k
Estate costs	£400k
Dilapidations	£38k
Total	£2,136k

- A50. The £2.1m for moving to GP consortia is an estimation based on the following assumptions or data.
- An analysis of a sample of PCTs produced an average IT spend per year of £1.89m per year. Assuming setting up a new IT system and transferring the old one will be equivalent to six months' work, it will cost £950k;
 - Costs of relocation of staff from old to new premises is assumed to be £250 per capita = £55k per PCT;
 - Assuming searching for new accommodation costs £10k per organisation for new accommodation, gives a search cost of £40k per PCT (which assumes four GP consortia per PCT – this is likely to be at the highest end of estimates, but is included here to show the worst case scenario);
 - There are likely to be double-running costs (resulting from a duplication of functions during the transition) or start-up costs at the outset. These costs have been estimated by looking at current PCT spend in key areas and making an estimate of the cost of start-up by estimating a period of “double-running”. For example, we do not expect new payroll services to switch off at PCT level and switch on at GP consortia without any start-up cost. This is estimated at £653k¹⁰;
 - The PCT estate costs £137m per annum. At present, it is impossible to know how much of the PCT estate will be used by the new successor organisations and how much will be vacated;
 1. Vacating all or 50% of the estate will have significant costs as some of the leases run for several years beyond 2013/14
 2. Vacating 50% of the PCT estates will incur a total extra cost of £60m (£0.4m per PCT) to maintain paying leases until they expire – this is an additional assumed double-running cost.

¹⁰ The elements of assumed double running are payroll (assumed three months double running, costing an additional £44,000), HR policy and procedure (6 months, £57,000), primary care administration (3 months, £34,000) and management costs (6 months, £518,000). This gives the total of £653,000 per PCT.

- 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 £8.6m. An additional £18m is assumed to be incurred, as SHA buildings are currently on long leases.
- A52. Therefore, the total PCT and SHA non-staff transition costs are estimated to be approximately £349 million. As per the coordinating document, these costs are assumed to be incurred in 2011/12 and 2012/13.
- A53. As outlined within the coordinating document, redundancy costs across PCTs and SHAs are estimated to be £600m if 70% of staff transfer to the new system architecture, £852m if 60% of staff transfer and £1,116m if 50% of staff transfer. This is a transition cost, and, as with the non-redundancy costs outlined above, is assumed to be incurred in 2011/12 and 2012/13. 60% is taken as the best estimate at this stage.

Running Costs

- A54. The commissioning functions currently undertaken by PCTs, and which will be retained, will transfer to either GP Consortia, the NHS Commissioning Board or Local Authorities. Paragraphs A42-A47 set out the expected reduced administration budgets and future costs of commissioning. This section addresses the risk that GP Consortia may not be able to perform their commissioning duties effectively within these lower running costs, and that some of the £1.3bn a year savings from reduced administration costs may be offset.
- A55. At this time, analysis of future running costs of GP commissioning is difficult until there is greater clarity of the number, size and form that GP Consortia 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)

- A56. 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.
- A57. GP Consortia will generally be responsible for these functions. However, this will 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.
- A58. If all GP Consortia, 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 GP Consortia 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

- A59. The main function is managing contracts with Primary care practitioners. This function will transfer to the NHS Commissioning Board, which may benefit from some economies of scale.

Running costs: other statutory functions

- A60. There are a range of statutory functions, such as assurance and risk management, complaints handling and medical records management.
- A61. 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

- A62. These functions include general administration functions, such as Human Resources (HR), Finance, Estates, IT and informatics that provide support to the commissioning organisation.
- A63. 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 GP Consortia perform each of these functions independently. However, GP Consortia may be able to mitigate this utilising shared resources. Those functions that move to the NHS Commissioning Board, may benefit from economies of scale, and for the functions that transfer to Local Authorities, opportunities may exist for them to be undertaken at marginal cost.
- A64. Overall, the future costs are dependent on a number of factors, particularly the number and size of GP Consortia, on which the Department is not being prescriptive. Ultimately, the extent to which GP Consortia can and will join together to perform functions will be the determinant of future costs. Preliminary analysis suggests that if GP Consortia 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. This could mean that the savings of £1.3bn a year from reduced administration costs may be partially offset by up to £475 million.¹¹
- A65. However, the level of GP Consortia administration costs will provide a strong incentive for GP Consortia to undertake their commissioning role in an efficient manner. Therefore, GP Consortia are expected to work together to perform some functions in order to carry out their commissioning responsibilities and deliver savings of £1.3bn a year as outlined in paragraphs A42-A47 above. Additional risks associated with GP Consortia carrying out functions with this level of running costs are addressed below.

Issues and risks

Risks of Clinical Commissioning

- A66. **Capacity and Capability** The greatest risk in terms of policy delivery is the capacity and capability of GP Consortia to deliver effective clinical commissioning, given the reduction in the resources available. This is enhanced 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 GP Consortia.

¹¹ Based on a sample of 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 Consortia with an assumed average population size of 100,000 would increase costs by 17%.

- A67. 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. Caution is required in interpreting these figures due to the difficulty of consistently allocating costs of functions in different organisations, but the analysis showed that the PCT with the lowest running costs was 3.1% of total healthcare spend, which is 30% less than the average running costs of 4.5% of total healthcare spend. This indicates that GP Consortia will be able to deliver effective clinical commissioning with lower running costs.
- A68. **Engagement of GPs** To provide appropriate incentives for GP Consortia to effectively commission, it is proposed that a proportion of GP practice income – in the form of a ‘quality premium’, - should be linked to the outcomes that are achieved collaboratively through commissioning consortia and the effectiveness with which they manage financial resources. Further work is required to determine the exact design of such a premium and the indicators on which any premium is based.
- A69. 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.
- A70. The NHS Commissioning Board will be able to intervene in the event that a consortium 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 consortium’s commissioning responsibilities or assigning them to a third party (for example a neighbouring consortium).
- A71. In terms of within Consortia sanctions, whilst professional peer review play an important role, ultimately Consortia will be able to apply to the NHS Commissioning Board to be dissolved should members be unable to agree whether all members of the Consortium are performing to the required standards.
- A72. The forthcoming Bill will introduce the basic powers necessary to allow a quality premium, but the Government will discuss further with the British Medical Association (BMA) and the wider profession how to ensure that these arrangements create the right incentives for collaborative work between practices to improve quality and outcomes and enable GPs to make the right clinical judgements for individual patients
- A73. **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.
- A74. **Fragmentation** LAs and GP Consortia 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 GP Consortia will overlap.
- A75. **Cream Skimming** Should patients choose to switch to a GP in an alternative Consortium, 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.
- A76. **Conflicts of Interest.** There will be opportunities for GP Consortia to commission new services from one or more of their constituent practices, where this would provide best value in terms of quality and cost. 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 will impose a prohibition on anti-competitive behaviour. The Economic

Regulator will also have powers to intervene in relation to anti-competitive behaviour and where there is a breach of the procurement rules.

- A77. **High Transaction Costs** The transaction costs of GP fundholding were very high and were a significant practical objection to the schemes. 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 dramatic reduce the burden associated with transaction costs.
- A78. **Consortia Size** There is no consensus on a minimum size to handle the financial risk. Inter-GP relations and peer review are strong forces and can counter the effects of higher statistical risk in smaller consortia for many services. However, while some high risk are best covered at a more regional level, risks could be shared by consortia grouping together to form their own risk pools.

Rationale, costs and benefits of the NHS Commissioning Board

- A79. 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.
- A80. 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 GP Consortia. It will also perform functions, which it would be unviable for GP Consortia to have individual responsibility for.
- A81. 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 consortia, providing tools and incentive to enable them to commission effectively and intervening where appropriate.
- A82. 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 GP consortia and holding them to account
 - commissioning certain services that are not commissioned by consortia
 - allocating and accounting for NHS resources
- A83. 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 consortia 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 consortia, hosting some commissioning networks, for example for cancer, targeted health services for ill and disabled children, and cardiovascular disease.

- A84. 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 GP consortia, 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 want to achieve whilst providing stability and reassurance for clinicians to enable them to concentrate on taking clinical decisions in the best interests of patients.
- A85. 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 GP consortia or for providing financial assistance to individual GP consortia.
- A86. We therefore consider it is essential for the NHS Commissioning Board has independent responsibilities for establishing GP consortia 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 consortia 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 consortium. This could include special arrangements as to how they exercise certain functions, or it could if necessary enable the Board itself – or another consortium acting on behalf of the Board – to exercise certain functions for a limited period while the consortium develops the necessary capacity.
- A87. Similarly, it is essential that there is independent financial accountability for GP consortia. 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 consortium responsible for their share of the total funding allocation, and this will include the duty to achieve financial balance.
- A88. The NHS Commissioning Board will also have responsibility for:
- assessing the financial preparedness of consortia before they are established;
 - holding consortia 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.
- A89. 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 consortia allocations in future years to reflect previous overspends or underspends, so that there are further incentives for good financial management.

A90. 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 GP Consortia commissioning and the NHS Commissioning Board

A91. The principle behind the changes to commissioning architecture are to enable Consortia 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.

A92. 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 consortia 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 or maternity where majority of care led by midwives;
- where there is a potential conflict of interest in consortia commissioning a service.

Commissioning and budget holding

A93. 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 GP Consortia. 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

A94. 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.

A95. 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)

A96. 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

- A97. 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 consortia. This might suggest that the duty to commission primary medical services should sit with the commissioning consortia.
- A98. 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 commissioning consortia 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 consortia 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 consortia members. Whether this risk is theoretical or real it is an open invitation to accusations of protectionism.
- A99. 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.
- A100. 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.
- A101. This would not preclude GP consortia 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.
- A102. 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

- A103. 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).
- A104. 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).
- A105. 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.
- A106. 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.
- A107. 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.

- A108. 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.
- A109. 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 GP Consortia.
- A110. 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

- A111. 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.
- A112. 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.
- A113. 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.
- A114. 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.
- A115. 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 GP consortia to commission dental services.
- A116. 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 consortia. 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.
- A117. 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

- A118. 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.

A119. Most other eye care is likely to be commissioned by GP consortia.

Commissioning Secure Mental Health Services

A120. 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.

A121. 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.

A122. 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

A123. 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).

A124. 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.

A125. 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 for 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.

A126. 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 A4: Breakdown of current budgets for specialised commissioning

Service	Planned Funding 2010/11 £m (rounded)	Comment
National Specialised Services	509	Commissioned by the National Specialised Commissioning Team
Regional Specialised Commissioning	5,025	Commissioned in line with Specialised Services National Definition Set through the Specialised Commissioning Groups
PCT commissioning	4,247	Commissioned in line with Specialised Services National Definition Set by PCTs

Commissioning Prison Health

- A127. 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.
- A128. 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.
- A129. 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 ringfence.
- A130. 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.
- A131. 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 local consortia.

Commissioning Secondary Care for HM Forces Personnel

- A132. 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.
- A133. 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.
- A134. 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.
- A135. 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.
- A136. 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.
- A137. 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 GP consortia 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>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]; 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>Review objective: [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 GP Commissioning has delivered an effective system for planning and commissioning healthcare designed around patients.</p>
<p>Review approach and rationale: [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 GP Consortia.</p>
<p>Baseline: [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>Success criteria: [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] GP Commissioning has improved processes and outcomes of commissioning.</p>
<p>Monitoring information arrangements: [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>Reasons for not planning a PIR: [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 GP commissioning are unlikely to have an inequitable impact on rural areas or people. GP Commissioning will give consortia 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 consortia and provide national leadership on commissioning for quality improvement. It will allocate and account for NHS resources, and hold consortia to account. The intention is to give GP practices flexibility to decide how they come together to form consortia, 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: Provision - provider liberalisation, economic regulation and joint licensing Lead department or agency: Department of Health Other departments or agencies:	Impact Assessment (IA)
	IA No: 6031
	Date: 30/11/2010
	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?

In order to deliver the efficiency gains needed to ensure continued high quality health services, provider freedom to respond to patient needs and provider entry and exit (or at least contestability - the potential for new entry) from particular markets need to be a reality. Currently, the economic regulation of health service providers resides primarily within DH. There is a conflict of interest as DH owns large providers (acute trusts) and acts as sector regulator (e.g. sets prices and the competition rules/framework). Monitor regulates Foundation Trusts, who are subject to a statutory regime that limits their operational freedom and ability to innovate. Change is necessary to provide a more transparent regulatory regime which applies to all providers, overseen by a regulator free from government and provider influence.

What are the policy objectives and the intended effects?

Establish a transparent and provider neutral regulatory regime with a clear incentive structure that encourages innovative providers to expand their service offer, without compromising patient safety and service quality. To capture the efficiency benefits of competition through:

- 1) More fluid entry and exit by providers into the markets for health and adult social care services
- 2) Removal of political uncertainty and interference, leading to increased innovation/operational autonomy
- 3) A fairer playing field - so that all provider types have a fairer opportunity to compete.

Achieving these objectives should result in improved 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 (the Do Nothing option). There is minimal effective economic regulation of health services and the institutional responsibility for economic regulation remains unchanged (i.e. largely within DH).

Option 2. Establish Monitor as an independent economic regulator for the health sector with a revised regulatory framework. The revised framework will include providers being subject to an 'economic licence' - this will be issued under a joint process with CQC (responsible for issuing licences to operate from a quality perspective). Some statutory restrictions on Foundation Trusts will be removed so that they can respond innovatively to the new system.

Preferred Option is Option 2 because it should enable the potential significant benefits from greater provider autonomy and competition between providers to be captured.

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

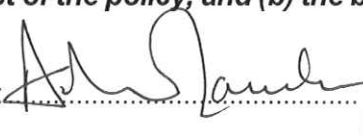
Are there arrangements in place that will allow a systematic collection of monitoring information for future policy review?

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 SELECT SIGNATORY:

 Date: 18/11/11

Summary: Analysis and Evidence

Policy Option 2

Description:

Establish Monitor as an independent economic 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: Optional	High: Optional	Best Estimate:

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	£29m *1	£178m *2	

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

The principal direct costs are the annual operating cost of the new economic regulator and the risk pool. A bottom-up estimate gives an annual operating cost of £72m. The profile of costs is estimated at £52m in 2011/12, rising to £80m in 2013/14, falling to £72m at end-state, post 2014/15. The annual cost of the risk pool is uncertain, and depends on the extent of provider failure. The central estimate of cost per provider failure is £26m, including £22m of risk pool funding. The estimated transition cost of organisational change to establish the new regulator is £5m. An estimate of the cost of supporting new FT governance arrangements is a one-off cost of £7m and an annual cost of £2.1m.

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

Maximum of 5 lines

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			

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

Benefits have not been monetised

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

There is evidence from industry studies that greater commercial freedoms and competitive intensity impact positively on productivity. For example, Nickell 1996 finds that firms facing more competition have significantly greater productivity growth than those facing more muted competition; the difference between the 80th and 20th percentile is 4% points. In 2009, Mckinsey estimated that the NHS could achieve recurrent annual efficiency gains of £13-20bn within 3-5 years. 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) x 2.4

*2 Annual running cost of Monitor – (£72m) plus annual cost of new governance arrangements (£2m) x 2.4.

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

Note: the multiplication by 2.4 above reflects the opportunity cost of health gains foregone, which are 2.4 times greater than the Exchequer cost (see DH technical guidance for explanation of calculation).

Work is ongoing to determine the risk of failure in the new system and the funds that should be put aside to cover this risk.

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

Costs:

Benefits:

Net:

In scope of

Yes

Measure classified as

IN

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?					
What is the annual change in enforcement cost (£m)?					
Does enforcement comply with Hampton principles?	Yes				
Does implementation go beyond minimum EU requirements?	N/A				
What is the CO ₂ equivalent change in greenhouse gas emissions? (Million tonnes CO ₂ 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
Statutory equality duties Statutory Equality Duties Impact Test guidance	Yes	EIA 26
Economic impacts		
Competition Competition Assessment Impact Test guidance	Yes	63
Small firms Small Firms Impact Test guidance	No	
Environmental impacts		
Greenhouse gas assessment Greenhouse Gas Assessment Impact Test guidance	No	
Wider environmental issues Wider Environmental Issues Impact Test guidance	No	
Social impacts		
Health and well-being Health and Well-being Impact Test guidance	Yes	63
Human rights Human Rights Impact Test guidance	No	
Justice system Justice Impact Test guidance	No	
Rural proofing Rural Proofing Impact Test guidance	No	
Sustainable development Sustainable Development Impact Test guidance	Yes	63

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

2

3

4

+ Add another row

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

Evidence Base (for summary sheets)

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

- B1. Some White Paper policies (GP commissioning, the extension of Choice and the Information revolution) are designed, amongst other objectives, to facilitate a change in commissioning that will improve the quality and efficiency of care. GP commissioning alongside the extension of choice will allow patients (with their GPs) to choose the providers they wish to (with the help of information revolution). The full benefits of these changes will not be realised unless the providers are given the opportunity to adapt service delivery to reflect patient's wishes and there is a change to regulation to promote competition while ensuring essential service delivery. This will improve quality of care through a higher quality provider base whilst safeguarding essential services.
- B2. The most significant providers of NHS services at the moment are NHS Trusts and Foundation Trusts. These hospital groups have by and large been created through public sector investment (sometimes Private Finance Initiative (PFI) but with government guarantees). Historically, government has imposed statutory restrictions on them alongside a strict regulatory regime. This has limited provider freedom and motivation to invest and innovate to increase the quality and cost effectiveness of the services they provide. Specifically for Foundation Trusts, constraints such as the private patient cap have reduced the incentive for innovation and growth. Reducing the restrictions on providers will enable them to respond to patient wishes (as bolstered by commissioning closer to the patient, the expansion of choice, and the information strategy).
- B3. Choice policy for health services is designed to enable the benefits of provider competition to be captured. For some time, patients have had a choice of provider for elective care. Patients who are referred by their GP, dentist or optometrist for their first outpatient appointment with a consultant-led team may choose a registered provider anywhere in the country. For many services, including elective secondary services where patients have a choice of provider, payment is based on a fixed set of prices determined by the Department of Health (Payment by Results - PbR). This fixed price system ensures money follows the patient and is a key enabler of choice, and competition is on the basis of quality. There is little scope for price competition in this area. As the patient does not pay for the service directly, they are unlikely to take into account its price when deciding where to receive care.
- B4. Choice-based competition works best where good providers can expand their service offer and enter new markets, and poor providers are forced to contract or exit markets. Presently, good providers find it difficult to expand/enter the NHS market due to a lack of freedoms and barriers to entry, which means that those offering a poorer service can maintain reasonable patient volumes and revenues. Markets work best where there is contestability because entry and exit conditions are transparent and it is possible to expand/contract provision. In many health care markets, contestability is currently limited.
- B5. Not all health services are suitable for choice-based competition, often as a result of economies of scale and/or scope. In such cases, 'competition for the market' - competitive tendering to award a provider the right to provide a service to a given population over a specified time period - may be an effective mechanism to secure the benefits of competition. Consultations with private and voluntary providers reveal that their biggest concern with the current regulatory system is that they are often excluded from bidding for the right to offer a service and that incumbent providers appear to have an unassailable monopoly position. A recent report on market based reform in the NHS (Civitas 2010 – see details later) notes the power of incumbent providers vis-a-vis new entrants as an important barrier to efficiency improvement.

- B6. Currently, the economic regulation of health service providers resides primarily within DH. There is a conflict of interest as DH owns large providers (acute trusts) and acts as sector regulator (e.g. sets prices and competition framework/rules), at the same time as having responsibility for managing the system for commissioning of NHS services. The Cooperation and Competition Panel advises the Secretary of State for Health on competition issues in the health sector, but has no power to impose remedies. The current system is not transparent; there is a significant risk of short-termism and of political lobbying having undue influence on decision-making. This provokes suspicion of failing providers being inappropriately supported through public funding to avoid politically unpopular hospital closures or service reconfigurations.
- B7. In addition, independent providers of healthcare may have been deterred from entering the market for NHS services because they perceive that incumbent NHS providers are given certain advantages – for example an affordable pension scheme – which mean that they cannot compete on a fair playing field. An independent Economic Regulator, with the role of promoting competition, could help address these issues over time. The perceived degree of political interference in decisions about the commissioning and provision of NHS services is a further deterrent to new entrants because, even where entry barriers are removed and efforts are made to create a fairer playing field, the possibility of future political interference discourages long term investment.
- B8. Therefore, a move towards a more transparent system of regulation, free from political influence, is required. Government intervention is necessary to reform the current regulatory system, which puts statutory constraints on the operation of Foundation Trusts and creates barriers to entry and exit, with a more transparent regulatory regime overseen by an independent regulator free from political influence. The revised arrangements will leave Foundation Trusts free to react to patient wishes like other providers and enable provider entry and exit to a greater degree and more intense competition between providers. The regulator will be responsible for mitigating the risks inherent in a more competitive system, for example by ensuring that provider failure does not result in patients losing access to essential services.
- B9. It is probable that the current regulatory system does hamper efforts to meet the needs of certain groups and communities. Given that the current system restricts exit and entry, it favours large incumbent providers against smaller niche providers – for example providers from the voluntary sector. It is plausible that these niche providers will be adept at tailoring their services to the needs of groups whose access to health services is restricted – indeed, this is often their primary objective.

Summarise and put into context the analytical narrative.

- B10. There is very clear evidence from across services and countries that competition produces superior outcomes to centralised management and monopoly provision. Competition is more effective where markets are highly contestable and contestability requires that organisations are able to expand/enter the market and contract/exit particular markets in response to consumer preferences.
- B11. Much provision remains within NHS trusts which are accountable to government. Foundation Trusts are currently constrained by legislation so their incentives to increase efficiency (with regard to quality and cost) are weak. There are a number of reforms proposed in the White Paper that together, will give patients much more power to determine their health care, notably GP commissioning, the extension of choice, and the Information Strategy. To be able to respond to patient wishes, providers require more freedom to develop their services in innovative ways.
- B12. Elective acute care is already subject to choice-based competition and some other services are subject to 'competition for the market' (competitive tendering), but this is far from universal and commissioners are often faced with the problem of a limited number of viable providers. Competition in health services would be a more effective lever for efficiency improvement if it

were easier for good providers to expand their offer and enter new markets, forcing out inferior providers.

B13. The evidence tells us that:

- Innovation and investment by providers, appropriately incentivised, yields welfare gains to service users;
- Competition leads to greater efficiency, and can sustain quality improvement;
- In most markets, structural conditions and market failures mean that an element of regulation is required. This is very much the case in health where there are a number of market failures, which are explained below (please see paragraphs B37-B39 for a summary), that need to be taken in to account and corrected for;
- In health, there is strong evidence that competition with fixed prices leads to improved quality. Where competition is based on price and quality, and where quality is not transparent, there is a risk that price is driven down at the expense of quality¹²; and
- For services not subject to choice, there is often no competitive tendering process and alternative providers are unable to bid against incumbents for contracts. They are effectively excluded from the market.

B14. The implication of this is that value for money in the English health system could be improved by measures to enhance provider freedoms and a revised regulatory framework that supports the effective operation of competitive processes within a social market, whilst quality standards are maintained through a robust inspection regime (Care Quality Commission - CQC).

B15. Government intervention is necessary to establish a transparent and provider neutral regulatory regime, which is independent of ownership of any part of the provider system and of political influence. The regime will be based on a clear incentive structure that better supports expansion/entry by effective providers and contraction/exit by less effective ones. The independent regulator will also be responsible for managing the risks inherent in a more competitive system, and in particular, ensuring that patients retain access to essential services if providers fail.

B16. This leads us to define the following options:

1. Do Nothing
2. Liberalisation of providers, an independent regulator, new rules and regulatory framework

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

B17. As set out above, the specific area of concern is that the current system of provision by providers that are state owned or heavily constrained through their corporate form and tight regulation in the English health system does not encourage the operational effectiveness of provision (and has limited incentives for them to strive for greater efficiency) and hampers provider entry and exit. The result is that providers are restricted in their ability to respond flexibly to patient wishes and competitive processes are not as effective as they could be. Economic efficiency is below the level that could be achieved – the health system could produce better outcomes for the budget available if providers were more free to innovate and competitive processes worked better.

B18. To remedy this, changes to the regulatory system are envisaged to better enable providers to respond to patient demand, and for good provision to force out poor provision. The improved

¹² "The Proper Scope of Government: Theory and an Application to Prisons", O. Hart, A. Shleifer, R. Vishny, Quarterly Journal of Economics, November, 1997.

system of regulation should support a more vibrant supply-side for health services and greater competitive intensity. The existing low level of competitive intensity is a result of weak provider freedoms and incentives and barriers to exit and/or barriers to entry. The new regulatory regime will address these problems and in future, we should see more responsive providers and higher levels of exit and entry from provision of specific services by all provider types.

B19. The expected benefits for patients are:

- Services better tailored to their needs – the regulatory system will enable better providers to push out less effective and less innovative providers; and
- Higher quality services (in terms of clinical quality and patient experience) – as lower quality providers of a service will be forced to exit by commissioners and patients shifting demand to higher quality providers.

B20. For the taxpayer, a stronger and more diverse provider base should lead to more effective cost containment where providers are involved in competitive tenders. This should reduce pressures on the NHS budget going forward. All providers will have a greater incentive to constrain costs and generate revenue surpluses as there will be enhanced opportunities and freedoms to reinvest funds in innovation and new services. This should support future reductions in centrally administered prices relative to prices that would have prevailed in a less competitive system.

B21. It is important to note that more intense provider competition does not undermine the guiding principle of the English NHS; that care is provided free of charge on the basis of need. Nor does it imply that more NHS services will be necessarily provided by profit making organisations, although this could be the case if patients and commissions found they were able to offer better value for money.

B22. There are a number of risks and constraints that must be recognised in a system where providers have more freedom and competition is more intense. These are summarised as follows:

- The regulator will need to pay attention to geographical and vertical equity (i.e. that those in more remote areas or from lower socio-economic backgrounds may not have the access to services due to inability to travel). In some areas, competition may be limited by low population density, especially if willingness to travel is low;
- 'Inappropriate' provider exit due to tariffs being set below cost; and
- The potential for large incumbent providers to act anti-competitively to discourage competitors from entering markets.

B23. The regulatory system must be designed to mitigate these risks.

C. What are the underlying causes of the problem?

Benefits of Competition

Overview of key evidence sources

B24. Economic theory and quantitative research studies have a clear message that more competitive markets 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 are:

- Nickell (1996)¹³ finds that firms which face more competition have significantly greater productivity growth than those facing more muted competition. The difference between the 80th and 20th percentile is 4% points.
- A study of transition economies (Djankov and Murrell, 2002)¹⁴ finds that the degree of competition has a significant impact on economic performance.
- Ahn (2002)¹⁵ 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”.

B25. 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. 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)¹⁶ 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 Haskell¹⁷ 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).

B26. 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”.

Benefits of action to support competitive markets

B27. 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 ant-competitive practices by firms and more generally,

¹³ Nickell, S. Competition and Corporate Performance. Journal of Political Economy, 1996. Volume 104

¹⁴ Djankov S and Murrell P, (2002). Enterprise Restructuring in transition: a quantitative survey. Journal of Economic Literature, 40(3), 739-92

¹⁵ Ahn, S. (2002). Competition, innovation and productivity growth: a review of theory and evidence, Economics Department Working Papers No 37, OECD

¹⁶ Choice and Competition in Public Services: A Guide for Policy Makers. March 2010

¹⁷ Matthew Barnes and Jonathan Haskell: Productivity, Competition and Downsizing. www.hm-treasury.gov.uk/d/254.pdf

providing a policy framework that enables competition to flourish. 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. Its most recent impact assessment report sets out the 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.

B28. A recent DTi study¹⁸ 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.

B29. Of the six case studies, three relate to removal of anti-competitive practices by firms, and three to deregulation/liberalisation¹⁹:

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

B30. 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.

Competitive Tendering

B31. Not all public services are appropriate for choice-based competition because of scale and/or scope economies. For such services, public authorities have looked to competitive tendering as a way of introducing competitive disciplines into public service provision (e.g. refuse collection services and public transport – so called ‘competition for the market’).

¹⁸ DTI Economics Paper Number 9, The Benefits From Competition: Some Illustrative UK Cases

¹⁹ Removal of government imposed restrictions that limited the scope for free competition.

- B32. There is international evidence to suggest that the use of competitive tendering of central and local government services can yield considerable cost savings²⁰. The potential for cost savings varies across services and efficiency gains can be reduced by the costs of contracting and monitoring, and it is important to understand the likely magnitude of these costs when considering 'competition for the market'.
- B33. Competitive tendering has been used for some time in transport service provision, with bus services probably being the most widespread example. In 1990, the World Bank concluded that competitive tendering for the provision of bus services offers a possible compromise between full deregulation and the provision of services by a large public or private monopoly²¹. The report found that experience of bus service deregulation in a variety of countries has demonstrated that cost savings of between 20% and 30% are usually achieved, with about one fifth of the saving required to fund system regulation activities. It appears that the social costs that may occur with deregulation - such as over-provision in popular transport corridors and the loss of financially unviable but socially beneficial services - have largely been avoided by careful commissioning.
- B34. Refuse collection services is another area where competitive tendering has been employed and there is strong evidence from a number of countries that significant cost reductions are achievable. For example, a study by Domberger of local authority refuse collection services in England is typical in that it found that costs were about 20% lower in areas where services had been tendered, compared to those where they had not. The estimates take into account the different characteristics of areas where tendering has and has not been employed and the research also found no evidence of lower quality in areas with tendered services. The study also concludes that efficiency improvement is just as great where the tender is awarded to the existing in-house provider as to a new private sector external provider. This finding is consistent with the economic literature that stresses the importance of competition in inducing enterprises to act efficiently.
- B35. A later study by the IFS²² looked at the impact of Compulsory Competitive Tendering²³ for local authority refuse services in England. This found cost savings of a similar magnitude to the earlier Domberger study and no evidence of reduced quality.
- B36. For both these examples, it is likely that the significant benefits are in part due to the ease of specifying the service to be operated – for example for buses, so many buses per hour at different times of day, a specified route and number of stops, and so on. Moreover, in both cases, it is relatively easy to monitor contractor performance and to transfer assets to a new operator if performance is unsatisfactory. This will be the case for some health services, but by no means all. This highlights the importance of the health service reforms being underpinned by an information strategy to improve monitoring of outcomes.

Market Structure and the Case for Regulation

Overview

- B37. The economic case for government intervention in markets is that markets sometimes fail and in such cases, efficient outcomes cannot be achieved without some form of intervention. Market failures include:
- Externalities. An externality occurs when the consumption or production of an economic agent impacts on the utility of other agents, but in deciding on the level of consumption or

²⁰ See Domberger and Jensen, 1997, for a review of evidence. Oxford Review Economic Policy 1997; 13:67-78.

²¹ Competitive Tendering for Public Bus Services. Richard Scurfield. World Bank 1990.

²² The Impact of Compulsory Competitive Tendering on Refuse Collection Services, Stefan Szymanski, 1996.

²³ From 1988, under the Compulsory Competitive Tendering rules, local authorities were required to issue competitive tenders for a wide range of local services.

production, the agent does not take into account this impact. So for example, when we consume healthcare, we consider our personal costs and expected benefit, but not the benefits that may accrue to the wider population (e.g. if we are immunised, we reduce the risk of disease for others).

- Natural Monopoly. Economies of scale and or scope mean that production by a single provider is the most cost effective solution. For example, transmission of electricity is better provided by a single national grid than competing providers, due to the cost of duplicating expensive network assets. Left unregulated, monopoly providers will abuse their market power by charging prices that generate profits above a reasonable level.
- Imperfect information and uncertainty. An important market failure in health markets, where individuals lack perfect knowledge of their health condition and the treatment needed.

B38. Government intervention in markets has also often been justified on the grounds of equity and national security.

B39. Historically, government intervention in markets has often taken the form of ownership of natural monopoly (and often non-natural monopoly) assets – the government effectively becomes the producer. For example, in the UK, until the late 1980s, the government owned the entire electricity infrastructure. In 1990, the system was restructured (generation, transmission and distribution assets were allocated to separate companies) and privatised. Monopoly elements of the system (transmission and distribution) are subject to independent regulation, which prevents abuse of monopoly power and also ensures the long-term sustainability of the system. The generation and the supply of electricity are now competitive markets, albeit subject to regulation regarding company conduct.

The English Health Sector

Introduction

B40. The health sector in England is characterised by a high degree of government intervention. The government or its agencies have acted as insurer, commissioner and provider of services. Healthcare is free at the point of use and patients do not pay directly for health services. This is very different from the model in *some* countries, where individuals arrange their own health insurance and receive their care from privately owned hospitals.

B41. Over time, as in other sectors of the economy, there has been a drive to introduce competitive disciplines into the market for NHS services. In recent years, patient choice has been introduced into parts of the health service - so that there is 'competition in the market'. One rationale for introducing patient choice is a belief 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) – i.e. competitive disciplines are introduced into choice-based services. The White Paper signals (subject to consultation) an acceleration of the extension of choice into other health service areas such as community services and mental health services. There has also been an increasing expectation that for services where patient choice has not been introduced, commissioners should look to contract for services via competitive tenders (competition for the market), rather than issuing contracts non-competitively to incumbent providers.

B42. Choice is an enabler of improved service quality as it introduces some of the incentives that exist in a private market. However, the incentives under patient choice are not the same as under free competition, since rapid entry and exit by providers is not possible under current arrangements – competition on the supply-side is between existing providers (who have a high degree of market power in their local area) and there is no or limited potential for new entry and also limited threat

of forced market exit²⁴. A limited range of viable providers on the supply side has also hampered efforts to increase efficiency via competitive tendering. Introduction of Foundation Trust Status, coupled with a degree of 'earned autonomy', was designed to begin to remedy weaknesses on the supply-side.

Evidence on impact of pro-competition reforms

- B43. A recent report by Civitas²⁵ provides a succinct summary of many of the issues. The report 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".
- B44. 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.
- B45. 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".
- B46. 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."
 - "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."
- B47. 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".
- B48. 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 'level playing field'. For example, during the level 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.
- B49. 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:

²⁴ Although institution managers may be forced to 'exit the market' and if this is the case, the incentives for better performance are stronger.

²⁵ Refusing Treatment: The NHS and Market Based Reform

- 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.

B50. 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”.

Fair Playing Field

- B51. NHS services are provided by a range of provider types, including 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’.
- B52. 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.
- B53. It should be noted that the existence of distortions would not affect competitive neutrality and efficiency if distortions balance out across provider types or if prices differ to neutralise competitive (dis)advantages.
- B54. 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.
- B55. A recent study of fair playing field distortions²⁶ was able to quantify the impact of some of the distortions identified. The majority of the quantifiable distortions work in favour of NHS organisations; tax, capital and pensions distortions result in a private sector acute provider facing costs about £14 higher for every £100 of cost relative to an NHS acute provider. 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).
- B56. 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 we suspect 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.
- B57. 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.

²⁶ KPMG Fair Playing Field Report, 2009, economic analysis commissioned by Department of Health.

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>Pensions</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>Labour Terms and Conditions</p> <p>Non-NHS providers can offer greater flexibility in their terms and conditions than the NHS, which can be a benefit in attracting staff from the NHS.</p> <p>As the NHS is the largest employer of health professionals in the UK, it effectively sets the benchmark for staff remuneration. Non-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>
<p>Cost of Capital</p> <p>There are a number of distortions here:</p> <p>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>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>PFI guarantee. State under-writing of PFI schemes means long-term private capital projects are cheaper than on fully commercial terms.</p> <p>NHS capital constraints. Although NHS providers have access to capital at interest rates below market rates, they are subject to capital rationing.</p>	<p>YES £4 (refers to distortion a) High</p>
<p>Cultural behaviours</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 NHS bias within commissioners, 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 High</p>
<p>Tariff Bundling and ‘Missing’ Tariffs</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 Medium</p>
<p>Cross-subsidy in tariffs</p> <p>Large multi-product hospitals must take emergency admissions 24/7, which is perceived to be systematically underfunded, 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 accept all elective referrals regardless of cost/complexity whereas private providers can have referral criteria, choosing who they treat.</p> <p>For both these distortions, non-NHS providers benefit because they do not offer</p>	<p>No High</p>

emergency admittance or take especially complex patients – but tariffs are based on NHS average costs, which include these higher cost cases.	
Corporation Tax Private sector providers and social enterprises are disadvantaged by being subject to corporation tax, reducing their returns. NHS providers and charities are exempt.	Yes £2 Medium
VAT 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 reliefs 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.	Yes £1 Low

Conclusions

B58. The evidence indicates the need for a more transparent, independent and open system of regulation of the NHS market to facilitate provider competition, shift the balance of power to commissioners and promote competition between autonomous providers. It also indicates that ideally, this regulatory system should be free of ministerial influence, to ensure that political imperative does not stifle the development of a market structure more conducive to competition.

B59. Evidence from the sources referred to above suggests that the following are needed:

- Increased autonomy for NHS providers so that they can respond more flexibly to patient needs and compete for business with other healthcare providers
- Strong policing of anti-competitive practices to restrain the market power of large incumbent providers and to give private and voluntary providers more opportunities to enter the market
- Improved mechanisms for calculating efficient prices to avoid predatory pricing and cross-subsidy
- A better understanding of how costs vary as a result of provider type and action to make the playing field fairer
- A failure regime that allows organisations to fail, whilst ensuring that patients continue to have access to essential services during the transition to a new provider (possibly a restructured existing provider)
- A regulatory regime that upholds the principal of universal coverage, with provision based on need and free at the point of use.

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)

B60. The functions of economic regulation are currently spread between several organisations. DH has lead responsibility for determining tariffs for health services, setting the overall competition policy (Principles and Rules for Cooperation and Competition – PRCC), and for setting the framework governing provider failure and service continuity. PCTs are responsible for supporting competition and have an important practical role in ensuring service continuity when providers fail. The Cooperation and Competition Panel advises Secretary of State and Monitor on competition issues (including mergers) although it has no statutory powers. Monitor regulates Foundation Trusts.

B61. The Do Nothing Option involves maintaining regulatory responsibilities where they currently lie without any change to the scope of regulation. This is the benchmark against which Option 2 is assessed.

Full range of options considered

B62. The evidence presented above leads us to conclude that a revised regulatory framework for the health sector is needed to free Foundation Trusts from central control and better facilitate provider entry and exit to the market for NHS services by removing the barriers discussed above. There is also evidence that points to potential benefits from removing regulation of the health sector from ministerial control in order to provide greater long term certainty for providers and commissioners as to the 'rules of the game'.

B63. This leads us to consider a policy option based on an independent regulator being established and a revised regulatory framework being implemented.

Option 2: Independent Economic Regulator and Revised Regulatory Framework

B64. For Option 2, Monitor is expanded to take on new duties as an independent economic regulator with responsibility for a revised regulatory framework that applies to all providers. The new regulatory framework is designed to address the structural problems in the market that stifle innovation and responsiveness to patients, as discussed previously – it will be transparent and will better support patient choice and freedom of entry.

B65. The principal strands of reform of the regulatory framework are discussed below.

- Enhanced autonomy for NHS providers in a regulated market
- Price setting
- Promoting competition with a fairer playing field
- Continuity of services

B66. To implement the regulatory framework, the regulator will have powers to issue an economic licence to providers and a joint licensing arrangement with CQC will be implemented. This is discussed in a separate section below.

NHS providers – enhanced autonomy

B67. The Government intention is that all NHS providers will be Foundation Trusts (FTs) which are not subject to direction by the Secretary of State. 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.

B68. In most cases, the proposed changes call for a transfer of powers, responsibilities and/or constraints. For example, the power of Monitor to approve changes to an FT's constitution would be replaced by the need for any such changes to be approved by the FT's governors and directors. Even the lifting of statutory borrowing limits does not mean that lending will be without constraint - lenders will continue to want to assure themselves of the creditworthiness of a borrower and existing creditors will continue to want to ensure the security of their investment. Monitor's current restrictions on the sale of FTs' 'protected' assets will be replaced by any restrictions the economic regulator puts in place on property associated with the delivery of designated services.

B69. 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

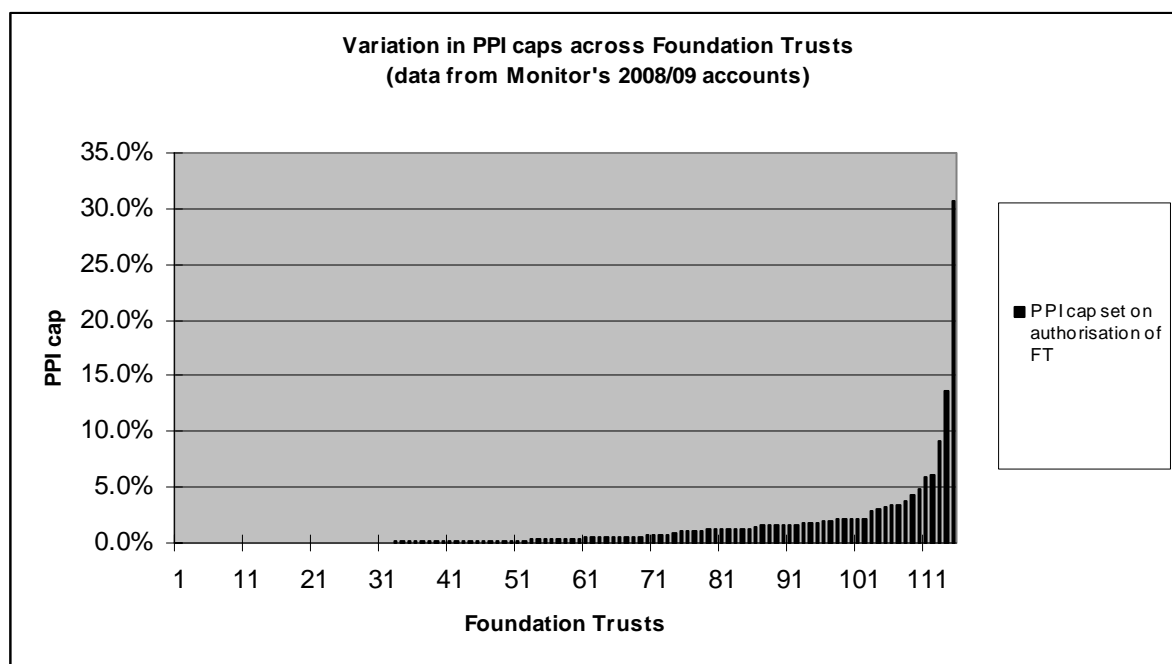
costs) within the system (whether that be to different organisations or from a national to a local level).

B70. In giving organisations greater autonomy and making the playing field more fair in the provision of NHS care, the proposed changes will contribute to the more dynamic and competitive social market for healthcare described in paragraphs B17-B36 of this Annex. Changes to remove the private patient income cap, the prudential borrowing code, arrangements for organisational changes, FT governance and the repeal of NHS trust legislation are discussed below. Administrative changes with insignificant impact are not considered here, for example renaming the “board” of governors as the “council” of governors to avoid confusion with the board of directors or allowing the regulator rather than the Secretary of State to operate the failure regime for FTs in transition until it is replaced by arrangements for the end-state failure regime).

B71. The main proposed changes are as follows:

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

B72. FTs are currently subject to a cap on income derived from private charges whereby income from non-NHS activity is capped at the 2002/03 level as a percentage of total income, resulting in arbitrary and variable levels of PPI caps across FTs, as demonstrated in the graph below.



B73. 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. In addition, the perverse consequences acting on FTs through the application of the PPI cap, such as: the inability in practice of an internationally respected organisation such as Great Ormond Street Hospital (on becoming an FT) to expand the services it can offer for the benefit of patients and more generally, for the NHS to exploit the power of its brand abroad; and resisting the decommissioning of unnecessary/inefficient NHS services simply to avoid breaching the cap, would be removed.

B74. Removing the cap would help to release the creativity and innovation of FTs to meet the challenges ahead where competition and choice will be the drivers for improving services and increasing productivity. 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.

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

- B75. 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, as it is for other types of organisations, with the new regulatory system containing strong incentives for financial discipline.
- B76. 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 (new DH loans, the historic taxpayer investment, or commercial debt) will constrain borrowing beyond levels that would present an unacceptable risk to the existing lenders – including the taxpayer. Any conditions applied by the new, operationally-independent DH banking function, acting as guardian of taxpayer investment, will be consistent with those applied by any commercial lender. They would only be triggered under exceptional circumstances and would not interfere with the operational freedom of Foundation Trusts. This should free FTs to invest in innovation and develop services more flexibly whilst being exposed to commercial rigour on lending.
- B77. 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. Rather than indirectly protecting taxpayers' interest in FTs (in the form of either loans made by the Foundation Trust Financing Facility or Public Dividend Capital) through the setting of borrowing limits, the public's investment will be more directly protected through conditions relating to the public debt or PDC itself. It will therefore be up to FTs (through their governance structures) and the market for commercial loans to determine the level of borrowing appropriate to each FT (providing none of the borrowing conditions are broken).
- B78. It is likely that it will take a few years for a commercial market to develop for lending to Foundation Trusts; for this initial period, the Department will need to continue to provide loans to meet ongoing capital requirements. Any new DH loans 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 making loans, terms and conditions applied to loans and actions on default. In addition, the Secretary of State powers to provide financing in a form other than as loans will be removed. This will ensure that all financing to FTs provided on behalf of the taxpayer can only be in the form of loans on commercial principles and subject to proper due diligence.

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

- B79. 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 also not currently possible. Monitor is currently responsible for authorising mergers of FTs. Critics say that 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.

- B80. 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, there are plans to explicitly designate Foundation Trusts as subject to the OFT controls. 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.
- B81. However, as for other providers, FT mergers, acquisitions and separations will not go unchecked. Providers will need to satisfy commissioners that designated services will continue to be available, creditors will have an interest in such major transactions to protect their investment and the economic regulator may be interested if designated services are affected.

Strengthening the governance of FTs.

- B82. 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.
- B83. 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 or complaints 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.
- B84. FTs would 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.
- B85. 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 (4,000²⁷) 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 3,000²⁸) there could be a one-off cost of approximately £7m ((4,000 + 3,000)* £1,000).

²⁷ 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)

²⁸ 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)

B86. 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 ($1/5^{\text{th}} * 7,000 = 1,400$) are replaced resulting in a yearly cost of approximately £1.4m²⁹. 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).

B87. 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)).

Repeal of NHS trust and FT authorisation legislation and powers to de-authorise FTs

B88. The above sections describe the proposals for how FTs will be given more autonomy to enable them to better respond to patient and commissioners' preferences and innovate like other providers. No FT has yet been returned to NHS trust status through de-authorisation, making it subject to direction by the Secretary of State. No impact is anticipated as the transitional failure regime would be amended to operate for FTs without the need for de-authorisation.

B89. A commitment to extend FT status to all NHS providers has long been established government policy. However, the Health and Social Care Bill would set a date by which all legislation relating to NHS Trusts will be repealed (April 2014) so that beyond this date all statutory NHS providers will be Foundation Trusts (except in exceptional circumstances and on a purely transitional basis for trusts under franchised management contracts). Beyond this date, Monitor would not have powers to authorise more FTs. It would only be possible to change this date by affirmative resolution.

B90. If all NHS providers have become FTs by April 2014, the setting of the date in legislation clearly has no impact. However, if setting a clear deadline contributes to enabling all NHS providers to become FTs earlier than would otherwise have been the case, any associated benefits could be brought forward. However, in bringing forward the date, the costs to some organisations of meeting the standards required may be higher than would otherwise have been the case. This risk is discussed further in the 'Risks and assumptions' section below.

Expected Benefits

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

Measures	Intermediate Outcomes	Expected Benefits
Removal of PPI caps FTs have new powers similar to those other providers have, with Monitor no longer operating existing constraints (eg constitution changes & mergers, removal of PBC)	More flexibility to respond to patient needs More autonomous and innovative providers	Better and more efficient organisations and services for patients FTs can grow income through developing private patient revenue streams

Regulating Prices for Patient Choice Services and Natural Monopoly Services

B92. Under Payment by Results (PBR), DH is currently responsible for setting efficient prices for a subset of NHS-funded services, in order to promote fair competition and drive productivity. These

²⁹ This would be an over estimate in early years before all NHS trusts become FTs.

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.

- B93. At a high level, the price setting process requires:
- Development of currencies (e.g. HRGs)
 - Pricing structure and rules – e.g. best practice tariffs
 - Setting the price level to apply for currencies in each year
- B94. For many health services, prices are negotiated locally between commissioners and providers.
- B95. Price-setting is enormously important for system efficiency. The currencies that payment is based on can have a big impact on provider behaviour – for example, one of the criticisms of an activity based system with prices for acute services only, is that it tends to incentivise care in an acute setting rather than alternative settings. The actual prices in place for currencies have an important influence on hospital finances and incentives to undertake different activities.
- B96. 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. It is also however, the custodian of NHS assets (hospitals) and historically has been required to guarantee continuity of service from providers when it is uneconomic or inefficient for that provider to continue service provision. The revised failure regime below removes the potential for DH to do this.
- B97. Why then transfer price setting responsibility to an independent regulator? DH clearly has a strong incentive to use prices to drive efficiency, and with the risk of it picking up the bill for financial failure of NHS providers removed, this incentive would be all the stronger. The option of moving price-setting responsibility to an independent regulator was favoured because:
- Even if DH is free from the risk of guaranteeing service continuity, the price setting regime may still be subject to changing political fortunes and there would not be long-term transparency in the aims of price-setting. This could stifle new entry and expansion by providers and efforts to establish a fair playing field.
 - 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 new entry.
- B98. The White Paper includes proposals for the extension of choice to more NHS services and a consultation is currently underway. Where choice is to be extended, administered prices will be required, so that money follows the patient. The decision as to which services are to be opened to choice will in future rest with the NHS Commissioning Board, although the regulator will need to influence this decision as it will be well placed to advise on the potential for provider entry and benefits of competition to particular service areas. It would then be the regulator'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.
- B99. 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 Commission Board will lead on what it will pay for (in terms of bundles of services etc.). This, however, has an implication for competition so Monitor needs to be able to influence that process. Monitor will set prices to drive efficiency and competition, but the prices set will have a significant impact on the NHS Commissioning Board's role of overseeing NHS finances.

- B100. As well as setting prices for services under the national tariff, the regulator should have powers to decide where to introduce price caps (a limit on the increase in price for a bundle of services), rather than fixed prices. It will also set the overarching framework governing local price setting (for health services commissioned by GPs and public health and adult social care services commissioned by local authorities).
- B101. Some health services have natural monopoly characteristics. Where services are best provided by a local or regional monopolist, competitive tendering may well be appropriate (as there may be a viable provider base, which is prepared to expand beyond their existing areas). For some natural monopoly services, particularly those that are national in nature, there may be only one viable supplier (e.g. a centre of excellence for a rare disease). The regulator will need to set national prices for these services.
- B102. The criteria for setting national tariffs will be developed by the regulator in consultation with the NHS Commissioning Board. These criteria should include setting tariffs to cover the reasonable cost of providing a service (and to ensure that unavoidable costs associated with delivering services with adequate access for patients in high-cost or remote locations are accurately taken into account), and over time, to generate efficiency savings by incentivising providers to move to adopt best practice. In accordance with one of Monitor's primary duties to promote competition it should have the freedom to set prices that enable competition and new entry, whilst having regard for equity and the overall budget constraint.
- B103. The regulator will have the power to supplement prices applicable to designated services in specific localities where an uplift is needed to ensure continued provision. A robust process and adequate resourcing of the regulator, so that it has an in-depth understanding of provider costs, will be needed to guard against the risk of a large number of providers applying for uplifts for their designated services.

Expected Benefits

B104. 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 the new economic regulator	Price-setting is free from political influence and there is increased regulatory certainty. New entrants are more likely to enter the market The regulator develops into a centre of expertise on price setting, developing strong technical skills.	Prices are increasingly reflective of efficient cost and currencies (developed jointly with the NHS Commissioning Board) are pro-competitive. Economic efficiency is improved

Promoting Competition

- B105. Currently, this function is carried out across a number of organisations. DH has responsibility for setting competition policy on a national level. PCTs have responsibility for competition issues locally and they are able to refer issues to SHAs, who can in turn refer to the Cooperation and Competition Panel (CCP). The CCP advises Secretary of State and Monitor on local and national competition issues, but has no decision-making power.
- B106. To further promote competition and address the structural barriers to effective competition discussed earlier, it is proposed that the independent regulator will become the sole body responsible for the promotion of competition in the health sector (including tertiary, secondary

and primary care services). One of its primary duties will be to promote competition where appropriate and it will have powers to impose remedies and sanctions to address restrictions on competition through licence conditions and concurrent powers with the Office of Fair Trading (OFT) to enforce key aspects of competition law.

B107. It will be able to:

- Impose general licence conditions to prevent anti-competitive behaviour / facilitate development of competition. For example, rules to prevent misleading advertising.
- Impose special licence conditions on individual providers to promote competition. For example, where an incumbent provider has significant market power, require the incumbent to grant access to its services to other providers (e.g. operating theatres, diagnostic scanning) at predetermined prices.
- Investigate anti-competitive conduct under Competition Act 1998 (for all publicly and privately funded healthcare and adult social care). It will have powers to enforce competition law and impose sanctions and remedies in relation to providers of health or adult social care services irrespective of whether they are required to hold a licence.
- 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)
- Monitor would have the power to regulate mergers where 'designated services' are involved. The broader regulatory regime would regulate mergers to maintain sufficient competition in the public interest.
- Regulate purchasers of healthcare services. There will be regulations on procurement and prohibitions on anti-competitive conduct. This is designed to ensure there is competition for the market whenever possible and improve the allocation of resources through competitive tendering.
- Investigate complaints about commissioners – for example, where a commissioner has failed to put a service out to competitive tender or has unfairly favoured an incumbent provider.

B108. The regulator will also be tasked with publishing advice to Government and NHS Board on barriers to competition / fair playing field, based on in-depth analysis, and to propose / implement recommended solutions. For example:

- Once the net distortion facing different provider types is better understood, the tariff methodology could be developed in such a way as to move towards a fairer playing field by setting different prices for different providers in order to recognise different levels of implicit subsidies. (Note that to avoid compromising the fair playing field from a commissioner perspective, these charges need not be reflected in the charges faced by commissioners of care).
- Working with the NHS Commissioning Board, the Regulator will have scope to devise currencies that better reflect the costs of provision to different patients, thus reducing distortions resulting from case-mix differences.
- Implement remedies in the event that it upholds complaints by providers and potential providers (new entrants) that commissioners are unfairly favouring incumbents (the NHS Commissioning Board will also have responsibility to ensure best value commissioning by GP Consortia).

B109. 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 will 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
Licence conditions Investigate anti-competitive conduct Market studies Regulate mergers where these involve 'ALS' Investigate complaints re: commissioners Fair playing field analysis and advice	Increasingly transparent pro-competition regulatory regime Move towards fair playing field Increasing clarity over time on acceptability of different types of mergers, joint ventures etc	Optimal organisation of providers, with providers more able to restructure and collaborate to focus on areas of comparative strength Entry and exit Improvement in technical efficiency

Supporting Service Continuity

- B110. Difficulties faced by commissioners in terminating poor provision from incumbents, because of fear of causing provider bankruptcy, political pressure, and service continuity practicalities, has been identified as an important barrier to greater competitive intensity.
- B111. Currently, DH has lead responsibility for ensuring service continuity in the event of provider financial failure, with Monitor having a key role with regard to Foundation Trusts. The failure regime established by the Health Act 2009 remains subject to some weaknesses: the process is not completely independent; it applies only to NHS and Foundation Trusts; and funds to maintain essential services during provider restructuring are provided directly by the taxpayer.
- B112. For competition to work effectively, less effective providers must be able to contract or exit the market entirely; historically, local and political objections have constrained the contraction of poorer providers. International experience³⁰ confirms that the state finds it politically hard to step away from underwriting deficits and to allow hospitals to fail. This presents a strong case for regulatory independence and freedom from political interference.
- B113. To address these weaknesses, it is proposed that an insolvency-based regime is introduced (see box 2), with special administration arrangements for all providers of designated services, and transition funding during provider restructuring is provided by a risk-pool funded from commissioner (indirectly through a higher price for a designated service) and provider contributions.
- B114. The taxpayer will be protected from political pressure to rescue providers – public funds will not be used to support unviable providers in the long-term and there will be no public liability for the commercial debts of failed providers. The exception to this will be where there are existing government guarantees of commercial loans provided as part of PFI schemes. Should a PFI funded facility become unsustainable, the taxpayer would be liable for the debt repayment. There are currently £6 billion of PFI assets in the health sector. Most of these assets are new facilities and it is unlikely that they would have no market value in the event of provider failure.

³⁰ 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.

Box 2: Proposed Changes to Provider Failure Regime

Under the proposed new approach, the independent economic regulator will issue guidance to help commissioners (in consultation with providers and the local population) classify services to be protected in the event of provider failure as 'designated services'. In classifying services subject to additional regulation, commissioners and providers will take into account the consequential additional costs incurred to fund the risk pool. Monitor will then set conditions in provider licences to protect service continuity. The purpose of defining designated services is to identify where it would be reasonable and proportionate for the regulator to impose additional regulation to support commissioners in maintaining access to essential public services. It will be for the regulator to set out the criteria for defining these services. The criteria are likely to focus on identifying where a provider is the only provider or one of very few providers of services in a local area. The justification for additional regulation in these circumstances is the need to maintain patient safety in the absence of alternative providers.

If providers of designated services were subject to normal administration arrangements, there is a real risk that such services would cease and patients would suffer. The purpose of administration is broadly to generate the best possible financial outcome for creditors, and involves assessing possible solutions ranging from rescue of the entity as a going concern to cessation of trading and sale of realisable assets (e.g. property, vehicles etc). Protecting continuity of services for patients would not be part of the decision criteria.

In certain areas of the economy, for example the water, transport and energy sectors, special administration arrangements have been put in place to ensure the continued supply of key services where a provider becomes insolvent and to protect the long-term future of publicly valuable assets. The special administration regime will work as in other sectors, providing an alternative to ordinary insolvency procedures. It will build upon aspects of the unsustainable provider regime in the Health Act 2009, without some of the bureaucracy and ability for political interference. In the event of provider insolvency, the regulator will have 14 days to trigger special administration to protect designated services, before the start of any other insolvency process.

In these cases, a special administrator will be appointed with responsibility for securing the continued provision of designated services. The administrator will be required to develop plans to ensure the continuity of those services. Possible outcomes include transfer, rescue or tendering for alternative provision. The administrator will have a strong incentive to reach a solution quickly, as poor performance in this regard will damage their chances of future appointments.

The regulator will be responsible for establishing funding arrangements to finance the continued provision of designated services during the administration process. It is likely that it will initially do this by establishing a 'funding risk pool', raised from an additional tariff paid by commissioners for designated services. The regulator will be responsible for determining an appropriate approach to risk assessment. The risk of political intervention in the failure regime is removed by shifting to a risk-pool based regime.

B115. A periodic review of the failure regime will be required, but Monitor will not actually be administering the regime. It will be responsible for making the application to the High Court to appoint a special administrator. If accepted, the Court would appoint the Special Administrator, which will be a qualified insolvency practitioner. The administrator will have a strong incentive to reach a solution quickly, as poor performance in this regard will damage their chances of future appointments. Monitor will appoint and make an annual payment to the risk pool administrator (financial institution) to manage the risk-pool fund.

Expected benefits

Measures	Intermediate Outcomes	Expected Benefits
Independent, rules-based failure regime with special administration arrangements	Better management of providers as clear that provider failure will result in restructuring or closure, as poor quality providers cannot be inappropriately supported by public funds. Providers more likely to take action early to remedy structural weaknesses (e.g. restructure operations)	New entry and expansion by more efficient, high quality providers
Protected services		Improved allocative and technical efficiency
Risk pool to fund transition when providers fail	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	

Joint Licensing Regime

- B116. Monitor will be responsible for the economic regulation of the health sector. It will have powers to set general and special licence conditions for providers. This licensing regime is a tool to implement the new regulatory framework – it does not produce benefits in itself.
- B117. Monitor will license providers of publicly funded care in order to deliver its regulatory functions in its three core areas of responsibility: promoting competition, price regulation and supporting continuity of essential services. The licence conditions could include: requirements to report information on costs, quality and volumes so that it can set prices effectively (information to be collected by the Health and Social Care Information Centre); rules to protect patient choice such as rules to facilitate patient switching or ensure that choice is offered at particular points along a patient pathway; conditions to restrict the sale of some assets and requirements to protect continuity of essential services such as to pre-notify the regulator of plans to stop providing services.
- B118. As now, the Care Quality Commission will act as quality inspectorate across health and social care. CQC provides independent assurance of the safety and quality of care across public, independent and voluntary providers. Registration is the cornerstone of CQC's current regulatory role. Under the Health and Social Care Act 2008, all providers of specified types of health care and adult social care ('regulated activities') are required to register with the Care Quality Commission. Providing a regulated activity without being registered is an offence.
- B119. This follows the model adopted in other regulated sectors such as water. Separation of economic and quality regulation means that the natural tension between the two aspects of regulation (higher quality tends to cost more) is dealt with in a transparent manner.
- B120. CQC and Monitor will be jointly responsible for administering an integrated and streamlined registration and licensing regime, in order to minimise regulatory burden on providers. The overall licence would be issued jointly by CQC and Monitor. The quality and economic licences would be separate subsections of this joint licence. CQC and Monitor will need to develop streamlined procedures for working together effectively, including efficient administrative processes.
- B121. If Monitor decides to revoke/suspend the economic element of the licence, the CQC element of the licence is still valid. This is because Monitor may cancel its licence for a variety of reasons. There could be a situation where Monitor cancels a provider's licence because it ceases to provide NHS funded services, but the provider might still be providing private services perfectly

adequately, and would therefore retain its quality licence. However, if CQC revoke the quality element of the licence, the entire joint licence is immediately invalid.

B122. There is a private sector impact from the introduction of the joint licensing regime, as the proposals mean that private sector providers will need to be licensed by both CQC (as at present) and by Monitor (which will be an additional burden). However, this is accompanied by private sector providers being given more opportunities to apply for NHS contracts, which means that if they think that it is worth their while, they can apply for a licence to provide NHS services. This will be an increase in regulation on the private sector, though one that is optional from the provider's perspective (private sector providers not providing NHS services will be unaffected) as well as being one that gives providers greater potential for benefit. This will be designed to minimise any additional burden.

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:

B123. The mechanism by which efficiency of delivery of health services will be improved is via greater competitive intensity to provide NHS services resulting in increased supply-side flexibility, with providers being much more proactive in restructuring their operations, expanding into new services, and redesigning their service offers to meet patient needs.

B124. Under the revised regulatory regime, all providers will be:

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

B125. This should ensure a much more vibrant supply side, with providers expanding services in some areas and ceasing to supply services in others – allowing more efficient providers to take their place.

B126. We do not expect large-scale provider failure, especially amongst larger providers. These providers will have a strong incentive to restructure prior to facing financial difficulties and to exit service areas where they are relatively inefficient. What we would expect is for the provider of specific services to change more regularly and for individual provider's service mix to change more quickly, expanding in areas of relative strength and contracting in areas of relative weakness. If provider management is failing to drive through such change, strengthened governance arrangements should enable them to be replaced by a team able to implement the necessary change.

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

Costs

B127. 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.

B128. 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 economic regulator

Function	Steady State FTE Estimate (from 2015/16)
Board	6
Economic Regulation	385
Regulatory Strategy	36
Legal	25
Corporate	44
Total	496

B129. The estimated number of FTE staff is 496. Application of pay rate assumptions results in a staff cost estimate of £42m, which implies an average pay rate of £84k (including on-costs).

B130. The total estimated operating cost of the economic regulator in 2015/16 (steady state) is £72m per annum. The major single cost item is £42m for permanent staff. Other significant cost categories are as follows:

- Spend on consultancy services of £12m per annum
- Non-pay costs relating to permanent staff of £6m per annum
- Legal fees of £4m per annum
- Premia for recruiting outsourced staff of £4m per annum
- Premises cost of £3m per annum

B131. Projected steady state (2015/16) cost per FTE for Monitor of £144k is comparable with costs in the major UK economic regulators. Note the other regulator figures below are 2009/10 outturns, whereas the Monitor estimate is for 2015/16. Inflating these outturn figures for earnings growth and inflation to 2015/16 would add c15-20% to costs. OFCOM and FSA are the most relevant comparators, as like the health regulator, they are responsible for economic regulation of highly complex and diverse sectors.

Table B3: Comparison with other regulators

Regulator	Sector	FTE Staff	£k per FTE (9/10)
OFWAT	Water	226	83
OFGEM	Energy	403	127
OFCOM	Comms. and media	865	141
FSA	Financial Services	2952	143

B132. There are costs associated with the special administration regime. Some initial modelling work has been undertaken to establish the likely size of the risk pool and the annual payments into the pool, which providers will be subject to. The estimated size of the pool required is sensitive to the number of designated services (and its corresponding cost of provision) and the failure rate of these services.

B133. Assuming all services are designated, the maximum cost, results in an estimated annual cash call on the risk pool of £53m per provider failure. At the other extreme, assuming that only life critical services are designated, the estimated annual cash call per provider failure is £17m. A central estimate of £22m was estimated by using a combination of these two methodologies.

B134. There are some additional costs related to provider failure. These fall into two categories:

1. The legal and administration costs associated with failure.
2. The dislocation harms. These are the costs associated with underutilisation of resources during transition and the impact it has on patients from a lower quality of care.

B135. The consultation-stage 'Impact Assessment of Regime for Unsustainable NHS Providers' (2009)³¹ estimated these costs. The administration and legal costs were estimated at £1.1m per incident. The additional dislocation costs per incident were modelled as 1.5% of average trust turnover, which is £2.82m per failure.

B136. This gives an estimate of average cost per failure of £26m, estimated as £22m (central estimate of risk pool funding) plus £1m (legal and admin costs) plus £3m (additional dislocation costs).

Benefits

B137. There is strong evidence from industry studies that greater competitive intensity impacts positively on productivity (as set out above – e.g. Nickell). Moreover, in 2009, a report by McKinsey, estimated that the NHS in England could achieve recurrent annual efficiency gains of £13-20bn within 3-5 years³².

B138. Greater competitive intensity has the potential to drive innovation in the system and release significant efficiency savings and only a small annual improvement is needed to cover the annual cost of regulation in the new system.

B139. Given the size of the healthcare sector, there is potential for a new provider system to deliver significant savings in the health sector. As an illustrative example, a 1% reduction in unit costs in the acute sector would lead to a £468m saving to the health system. This figure is based on the £46.8bn received in income from activities by NHS Trusts and Foundation Trusts in 2008/09. Even if this only included activity covered by the current Payments by Results system, a 1% reduction in price levels would lead to a £260m saving for the system. The freeing of providers, along with the changes in the structure of commissioning, mean that these savings are more likely to be delivered than under the current system. Given that this is at the very lowest end of the estimated potential benefits, it is clear that the potential gains resulting from the changes, through lower unit costs, easily justify the costs incurred.

H. SUMMARY AND WEIGHING OF OPTIONS

B140. The Do Nothing option leaves NHS providers constrained in their ability to respond to patient wishes and does not address the barriers to entry and exit discussed above. Potential efficiencies from more innovative and responsive providers and more intense competition between providers would be lost. Whilst it is not possible to quantify the benefits that will accrue from provider freedoms and 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 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.

³¹ Available at:

http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Consultations/Liveconsultations/DH_087835.

³² The report is accessible on the DH website at

http://www.dh.gov.uk/en/FreedomOfInformation/Freedomofinformationpublicationschemefeedback/FOIreleases/DH_116520

Risks and assumptions

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

- B141. 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.
- B142. 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

- B143. 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.

Rigorous competition fails to develop as planned

- B144. The aim is to develop a dynamic regulated market where providers compete vigorously for patients and revenues, based on the quality and efficiency of their services. There is a risk that vigorous competition between providers takes longer than expected to develop. There are a number of reasons why this might happen. For example, commissioners might fail to seize opportunities to harness competition where appropriate, incumbent providers might prevent new providers entering their markets; or patients might fail to seize new opportunities to choose between providers based on the quality of their services.
- B145. The reform proposals include a number of regulatory mechanisms to minimise this risk. These include: proposals for new regulation to ensure that commissioners use competition where appropriate; scope for Monitor to impose licensing regulation such as access regimes or other obligations to prevent incumbent providers excluding competitors unfairly; and a new information strategy to provide patients with better information so that they can make informed choices between providers.
- B146. Alternatively, there is a risk that competition develops but fails to deliver the intended benefits. The aim is to harness competition to drive improvements in quality and reductions in providers' costs. However, there is a risk that competition develops in ways that fail to deliver these benefits. For example, providers might compete purely on the basis, of costs, leading to a deterioration in the quality of services. Alternatively, patients might struggle to make informed decisions regarding which providers offer the best quality of services.
- B147. Again, the reform proposals include a number of mechanisms to minimise this risk. Monitor will be able to impose regulation to ensure that providers compete on the right measures, such as

using price regulation and ensuring competition on quality for some services. The information revolution will help patients to make informed decisions between providers. The CQC will also have a stronger role in ensuring that all providers meet essential levels of quality and safety.

Establishment of Monitor leads to disproportionate regulatory burdens

B148. 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. 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.

The proposals for competition jeopardise access to essential services

B149. In the new regulated market, providers will succeed or fail based on their ability to offer high quality, efficient services. Successful providers will be able to expand as they attract new patients to their services or win new contracts. However, some providers will struggle to attract patients to their services or win contracts. These providers will need to restructure their services and those who are unable to improve the quality and efficiency of their services may fail. There is a risk that this could lead to inequalities in access to services or disruption to the continuity of essential services. The Government's proposals will give Monitor substantial powers to protect access to essential services where they are "designated services". These include the ability to require providers to continue delivering particular services for local populations, the power to require providers to contribute to a risk pool so that funds are available to protect the continuity of these services; and the power to appoint a special administrator (rather than reliance on normal insolvency arrangements), with the aim of ensuring continued provision of essential services.

B150. The risk of indefinite expensive provision, funded from the risk pool, needs to be mitigated by obligating the Administrator to quickly find an efficient solution, eg by working with commissioners to invite tenders from possible substitute providers in order to find the most cost-efficient substitute. Administrators will have a strong incentive to do this, since failure to do so will result in serious damage to their reputation and a loss of future work.

Repeal of NHS Trust legislation

B151. In enshrining in legislation a date by which remaining NHS Trusts will have to become FTs, there is a risk that organisations that currently do not meet FT authorisation criteria will be forced to incur higher costs than would otherwise be expected over a longer timeframe. However, it has long been the intention that all services should be provided from within Foundation Trusts and with the deadline being in 2014, NHS trusts have some time to prepare. If it proves to be necessary for some organisations to exit the market to ensure essential services are sustainable, the adapted unsustainable provider regime and the new provider failure regime (described in section D) will provide mechanisms by which provider failure can be appropriately managed, with minimal impact on the continuity of service offered to NHS patients. If necessary, the Secretary of State could seek Parliamentary approval to change the date.

Protecting taxpayer investment in FTs

B152. Whilst there is a strong case for giving FTs greater freedoms to borrow, since DH, on behalf of Government, holds the substantial investment in FTs in the form of Public Dividend Capital (PDC), it is important that this investment is properly managed. The section under 'Removal of the Prudential Borrowing Code (PBC) and limiting future financial assistance' earlier in this Impact Assessment explains how risks would be managed in a proportionate way without statutory controls – the new operationally independent banking function of DH would manage public lending to FTs more transparently in future.

PPI cap

B153. 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.

B154. 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.

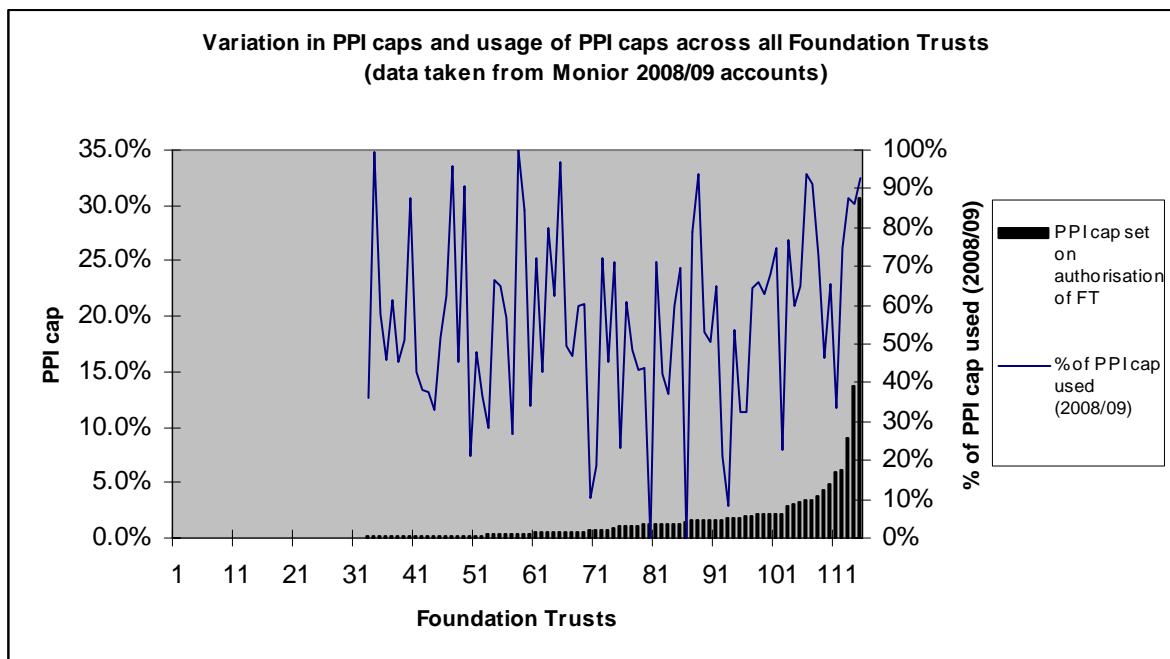
B155. If the former, then NHS patients may derive benefit if the new or enhanced facilities are shared between private and NHS patients.

B156. 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 Willing 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 2008/09 accounts indicates that during that year most FTs operated at a level significantly below their PPI cap³³ – see the chart below. The chart also demonstrates

³³ 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.

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. 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



- 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 it is envisaged that separate accounting will continue to 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>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.</p>
<p>Review objective: [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>Review approach and rationale: [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>Baseline: [The current (baseline) position against which the change introduced by the legislation can be measured]</p>
<p>Success criteria: [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>Monitoring information arrangements: [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>Reasons for not planning a PIR: [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 Economic 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 economic 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.

Title: Increasing Local Democratic Legitimacy in Health Lead department or agency: Department of Health Other departments or agencies:	Impact Assessment (IA)
	IA No: 6032
	Date: 30/11/2010
	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; involve elected representatives and local HealthWatch; and 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.

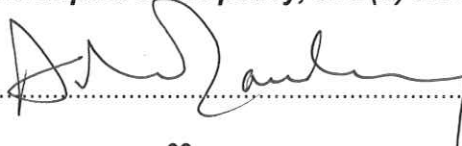
What policy options have been considered, including any "alternatives to regulation". Please justify the preferred option below.

- 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 LA 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:  Date: 18/11/11

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 increase running costs are considered. The health and wellbeing boards are outlined through a statutory framework. It is assumed that no staff will transfer to the health and wellbeing board as it is 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 preferences. 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?	01/01/2010				
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 ₂ equivalent change in greenhouse gas emissions? (Million tonnes CO ₂ 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
Statutory equality duties ³⁴ <u>Statutory Equality Duties Impact Test guidance</u>	Yes	EIA 55
Economic impacts		
Competition <u>Competition Assessment Impact Test guidance</u>	No	
Small firms <u>Small Firms Impact Test guidance</u>	No	
Environmental impacts		
Greenhouse gas assessment <u>Greenhouse Gas Assessment Impact Test guidance</u>	No	
Wider environmental issues <u>Wider Environmental Issues Impact Test guidance</u>	No	
Social impacts		
Health and well-being <u>Health and Well-being Impact Test guidance</u>	Yes	Throughout
Human rights <u>Human Rights Impact Test guidance</u>	No	
Justice system <u>Justice Impact Test guidance</u>	No	
Rural proofing <u>Rural Proofing Impact Test guidance</u>	No	
Sustainable development <u>Sustainable Development Impact Test guidance</u>	No	

³⁴ 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
1	Health and Social Care Bill 2011
2	“The White Paper” – <i>Equity & Excellence: Liberating the NHS</i> http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353
3	‘Liberating the NHS: Increasing democratic legitimacy in health’, 2010, http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_117586
4	<i>Liberating the NHS: Legislative framework and next steps</i>
5	‘An information revolution: A consultation on proposals’, 2010, http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_120080
6	‘Liberating the NHS: Greater choice and control. A consultation on proposals,’ 2010, http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_119651

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 costs
- v. Assessment of benefits
- vi. Risks

i. Problem under consideration

- C1. As the White Paper *Equity & Excellence: Liberating the NHS* said, at its best, the NHS is world class³⁵. However, compared to other countries, the NHS still achieves relatively poor outcomes. This is in part due to differences in underlying risk factors. However, as these risk factors will naturally differ at local level, local input, engagement and leadership will be required to better meet these different challenges.
- C2. Poor outcomes within the NHS are inherent in the design of the current system. The White Paper therefore, proposed structural reforms, including increasing local democratic legitimacy, to provide a greater alignment of incentives and objectives to overcome the following problems.

Problem 1: The current systems are a barrier to high quality, efficient services

- C3. The NHS scores relatively poorly on being responsive to the patients it serves³⁶. It lacks a genuinely patient-centred approach in which services are designed around individual needs, lifestyles and aspirations. This means that rather than basing services the NHS delivers around the patient, the patient often has to fit around the services the NHS delivers.
- C4. Organisations within the current health system do not have strong incentives to respond to patient wishes. This is especially true of commissioners. In the current system, the lines of accountability to patients, and the means to hear patient voices, are weak. Patients have a limited impact on decisions made by PCTs. In future, GP consortia will have far stronger incentives to respond to patients through patient choice of GP (and GP practice choice of consortium) and, as mentioned in the White Paper, the Government intends to extend the current offer of patient choice³⁷. This expansion of patient choice is to be supported by the NHS information revolution³⁸, 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.

³⁵ See http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

³⁶ *Equity & Excellence: Liberating the NHS*, page 8. See:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

³⁷ *Equity & Excellence: Liberating the NHS*, page 17. See:

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

³⁸ 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

- C5. 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. The coordination between different health services is often less developed or insufficient, and, in particular, the links between health and social care are often poor³⁹. This often leads to fragmented care, poorer outcomes and lower levels of patient satisfaction. Increasing local democratic legitimacy aims to counter this poor coordination by providing strong input from the public and patients to encourage commissioners and providers to develop the services that best meet their needs and preferences.
- C6. The problems above refer to challenges associated with improving the quality of the current system, that is, 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 patchy. To ensure a coherent structure, legislation is needed to ensure a common, yet flexible, approach across England.

Problem 2: Lack of local Democratic Legitimacy

- C7. The current line of democratic accountability for health services 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. Equally, the King's Fund (2008)⁴⁰ noted 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 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."
- C8. This lack of democratic legitimacy creates a systemic 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 a deficit of democratic legitimacy in NHS commissioning.

ii. Rationale for Intervention

- C9. 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 on 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.
- C10. To meet these aims the problems highlighted above need to be confronted. The underlying problem is of the limited incentives to health professionals to provide coordinated services.

³⁹ 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*.

⁴⁰ King's Fund report: Should PCTs be made more locally accountable?', [2008].

Patient choice for instance provides incentives to professionals only at an individual level rather than for a geographical area. Hence, incentives have to be created via the ballot box filling a gap that currently exists in the system, as detailed in the 'problem under consideration' section.

C11. The White Paper therefore proposed to strengthen partnership working across health and local authorities, underpinned by local democracy. To do this local authorities will have greater responsibility in four areas:

- leading joint strategic needs assessments (JSNA) and developing the joint health and wellbeing strategy, to ensure coherent and co-ordinated commissioning strategies;
- supporting local voice, and the exercise of patient choice;
- promoting joined up commissioning of local NHS services, social care and health improvement; and
- leading on local health improvement and prevention activity.

C12. There is the potential to align the incentives of the healthcare system to the incentives of the patients and the public, those who receive the healthcare the PCTs and local authorities currently influence. This could be done through the proposals outlined above, underpinning current systems with local democratic legitimacy. Doing this would create the opportunity for more responsive services that better meet the needs of patients, creating the increased opportunity for improved patient outcomes.

iii. Description of proposal and implementation options considered

C13. To enhance their role in health, the Government originally proposed that local authorities be given the following functions:

- to assess the needs of the local population and lead the statutory 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
- to undertake a scrutiny role in relation to major service redesign.

C14. 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.

C15. The initial consultation⁴¹ *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 prescribed form called the health and wellbeing board. Respondents were strongly supportive of the proposal to have statutory health and wellbeing boards in each local authority, with requirements of participation, and a statutory framework with, clearly established set of high level functions.

C16. The Government therefore proposes the creation of statutory health and wellbeing boards, which would bring the NHS, public health and social care commissioners together with elected representatives and local HealthWatch representing patients and the public. 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

⁴¹ See http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_117586

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. 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 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.

- C17. 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*⁴².

Implementation options considered

Option 1:

- C18. 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:

- C19. The following option is compared to the 'do nothing' option in this impact assessment. The legislation option is to implement proposals around increasing local democratic legitimacy in health⁴³. 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.

- C20. 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 one set of structural duties and powers. However, 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. However, 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.

- C21. At their core, the proposals for health and wellbeing boards stipulate the board's functions and the minimum membership of the boards. There is scope within the framework for individual local authorities to go further and delegate other local authority functions and add members to meet and respond to local needs. The intention for the design is that it will create the opportunity for health and wellbeing boards to impact sufficiently upon the current local health and social care landscape and the incentives in the system 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.

- C22. 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. The 'do nothing' option above is consistent with the 'do nothing' options from the other IAs annexed in this document. Furthermore, 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, for the proposals for statutory

⁴² http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/DH_122624

⁴³ As detailed in the content on the face of the Health and Social Care Bill 2010 and the response to the White Paper consultation

requirements on local authorities to perform certain roles and functions through a health and wellbeing board link, in economic benefit terms, to the proposals for changing the commissioning landscape in healthcare.

iv. Assessment of benefits

C23. The model below captures the possible effects of creating health and wellbeing boards.

Cost and benefit model for Health & Wellbeing Boards

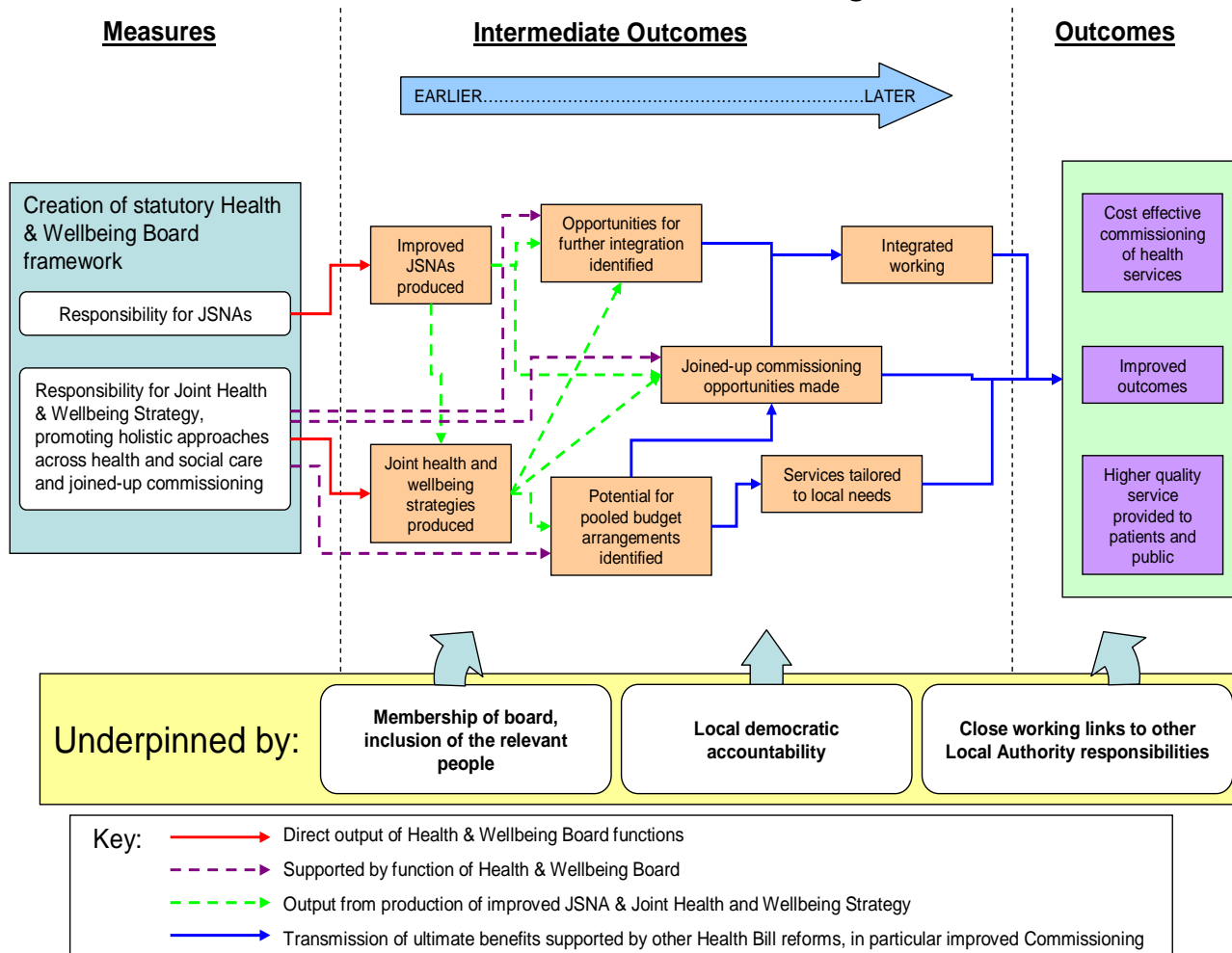


Figure 1: Cost and benefit model for Health and Wellbeing Boards

C24. 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 JSNAs; and
- responsibility for Joint Health and Wellbeing Strategies.

C25. 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.

C26. As mentioned above, the policy proposed to increase local democratic legitimacy is closely linked to the other policies proposed in the White Paper and outlined in this wider Impact Assessment. 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 Impact Assessment' and 'Public Health Service Impact Assessment' (see Annexes A 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.

- C27. As a result, this impact assessment does not provide monetised figures for its benefits. However, see paragraphs 42 and 43, which show that the value of a minimal improvement in health status (0.2% increase) is greater than £50million for an average PCT. The direct benefits of the health and wellbeing board are through the improved JSNA and joint health and wellbeing strategy process, which cannot be accurately estimated. 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, creating 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 GP consortia and the establishment of Public Health England.
- C28. This impact assessment examines the different underpinning characteristics of the health and wellbeing board proposals explaining why they will improve the performance of their functions.

Membership of the boards

- C29. The proposals for health and wellbeing boards includes a minimum membership for the boards⁴⁴. 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)⁴⁵ 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 impact⁴⁶.
- C30. 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.

Local democratic legitimacy

- C31. The second underpinning aspect of the proposals for health and wellbeing boards is ensuring legitimacy through local democratic involvement. This is 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 design characteristic provides the incentives for the health and wellbeing board to be truly representative of the health needs of people who it is responsible for, bringing together clinical and commissioning expertise, alongside elected and

⁴⁴ See paragraphs 5.11 to 5.15 of *Liberating the NHS: Legislative framework and next steps*

⁴⁵ Ham, C, 2009i; 'Only connect: policy options for integrating health and social care', The Nuffield Trust.

⁴⁶ 'Joint Strategic Needs Assessment North West Regional Review', *North West Public Health Observatory*, June 2009.

patient representatives. These incentives, through the ballot box, 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.

- C32. The ‘median voter theorem’⁴⁷ 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 differ⁴⁸, and so the decision made by central government may not be representative of the different median voters in different local areas. 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.
- C33. 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 that do not necessarily cover all services that are provided. For example, the incentives provided through increased local democratic legitimacy would allow patients and the public to impact upon services and service provision that is not currently covered by patient choice.
- C34. The King’s Fund report, ‘Should Primary Care Trusts be made more locally accountable?’⁴⁹ 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.
- C35. However, local democratic involvement needs to be balanced with clarity around the lines of accountability between consortia, 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 would 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.

Links with other local authority responsibilities

- C36. Furthermore, as health and wellbeing boards will be a committee of the local authority there is the increased possibility of 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,

⁴⁷ 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.

⁴⁸ 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).

⁴⁹ Thorlby R, Lewis R and Dixon, J; 2008, ‘Should Primary Care Trusts be made more locally accountable?’, King’s Fund

- 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.

C37. 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.

C38. There is therefore the opportunity for the health and wellbeing boards to work closely with colleagues in local authorities who work on the areas listed above to see the overall picture and take a holistic view of both local needs and local services. This increases the possibility of encouraging decisions that lead to improved outcomes for local people across the different protected equality characteristics. ‘Tackling Health Inequalities’ (2003)⁵⁰ 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.

C39. There are examples of health and wellbeing boards currently in existence. In particular, Birmingham Health and Wellbeing partnership has had success in a number of areas. For example, increased life expectancy (above the national average), the development of a social risk assessment tool developed and piloted across the city and maternity service linkages between children’s centres and two local PCTs⁵¹. 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

C40. Health and wellbeing boards will increase local involvement in developing JSNAs and joint health and wellbeing strategies. In particular, community involvement and engagement would be supported and has the opportunity to be improved. Improved community engagement can make the needs assessment more representative which in turn creates the opportunity to improve how the needs of the community are met.

C41. Three further details will further strengthen the tailoring of services a local area by allowing the health and wellbeing board to consider how commissioning plans can meet local need, backed up by the JSNA. These are “Health Act” flexibilities⁵², allowing health and wellbeing boards to look at the totality of resources in their local area, and the proposed joint health and wellbeing strategy⁵³. 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

⁵⁰ Dept. of Health (2003) *Tackling Health Inequalities: A Programme for Action*. Report Cm6374. Dept. of Health, London.

⁵¹ See: <http://www.bhwp.nhs.uk/Apps/Content/HTML/ViewContent.aspx?id=29>

⁵² See paras 5.28 – 5.31 in *Liberating the NHS: Legislative framework and next steps*

⁵³ See paras 5.21 – 5.27 in *Liberating the NHS: Legislative framework and next steps*

Commissioning Board to have regard to both the JSNA and joint health and wellbeing strategy in discharging their commissioning functions.

C42. JSNAs were initially introduced as part of the *Commissioning framework for health and wellbeing*⁵⁴ in 2007. The impact assessment of the framework⁵⁵ 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 caveats⁵⁶) 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

Source: *Regulatory Impact Assessment: Commissioning Framework for Health and Wellbeing* page 15

C43. 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 QALY⁵⁷ per year. The benefits are scaled by the degree to which this increase can be attributed to the implemented JSNA. As mentioned in the Commissioning 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 originally introduced and so are the potential benefits from improved commissioning that an improved needs assessment process can incentivise.

C44. The national Children and Adolescent Mental Health Services (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.”⁵⁸ Undertaking the JSNA in the context of local democratic involvement is a step towards this.

C45. The Association of Public Health Observatories, and its constituent regional Public Health Observatories published various regional reviews of the JSNA process which included recommendations to improve the process⁵⁹. 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 impact⁶⁰. The proposals for functions and the underpinnings of health and wellbeing

⁵⁴ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072604

⁵⁵ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_072612

⁵⁶ 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 for further discussion.

⁵⁷ QALY – Quality Adjusted Life Year. Standardised measure of health status. Monetised currently at being worth £30,000 per annum.

⁵⁸ ‘Children and young people in mind: the final report of the National CAMHS Review’ November 2008

⁵⁹ See <http://www.apho.org.uk/resource/aphosearch.aspx>

⁶⁰ ‘Joint Strategic Needs Assessment North West Regional Review’, *North West Public Health Observatory*, June 2009.

boards, as highlighted in figure 1, aim to cater for these recommendations, creating the opportunity for improved JSNA processes for all equality groups.

C46. 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).

C47. 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.

C48. 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, through better engagement from patients and the public, from locally elected representatives and local HealthWatch, could help flag the needs of the local population, including groups who aren't 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 into increased commissioning outcomes for patients that are more reflective of their requirements. Having health and wellbeing boards at this local level in local authorities also mitigates the possible risk of potentially diverse GP consortia not working together on the strategic needs of a local population.

C49. 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'⁶¹. 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.

⁶¹ '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>

- C50. 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 progress⁶² 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.)
- C51. These examples show how the current JSNA process creates improved tailoring of services to meet local needs. An improved, more informed JSNA and joint health and wellbeing strategy, which involves the relevant partners across a local area, sits within a local authority, 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.
- C52. 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.
- C53. 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 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 circumstances⁶³.
- C54. 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.

⁶² IDeA, 2009, ‘JSNA – Progress so Far’, see: <http://www.idea.gov.uk/idk/core/page.do?pagelId=9616134>

⁶³ See Ham, C, 2009; ‘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.

- C55. 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).⁶⁴ 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.
- C56. The Department of Health's '*Evidence Base for Integrated Care*' (2006)⁶⁵ 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.
- C57. Furthermore, Enthoven and Tollen (2004)⁶⁶ 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.
- C58. 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 used⁶⁷ 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."⁶⁸ 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.

⁶⁴ Taken from the '*Turning Point Connected Care Report*', 2010. See: <http://www.turning-point.co.uk/commissionerszone/centreofexcellence/Documents/Benefitsrealisation2010.pdf>

⁶⁵ See: http://www.dhcarenetworks.org.uk/library/Resources/ICN/ICN_advice/The_evidence_base_for_Integrated_care.pdf

⁶⁶ Enthoven, A.C., & Tollen, L.A. (Eds.) (2004), '*Towards a 21st Century Health System*', Jossey Bass : San Francisco.

⁶⁷ 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.

⁶⁸ Audit Commission (2009i), '*Working better together: managing local strategic partnerships*', see: <http://www.audit-commission.gov.uk/nationalstudies/localgov/workingbettertogether/pages/workingbettertogether.aspx>

v. Assessment of costs

C59. This section summarises the costs associated with the establishment and running of health and wellbeing boards.

Implementation costs

C60. The implementation costs of health and wellbeing boards have been assessed in the same way as those of the other White Paper reforms.

C61. 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 cut waste and transform productivity, simplifying the architecture of the health and care system. PCTs will be replaced by GP consortia, 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 delaying these changes will incur transitional costs from the disruption and loss of jobs.

C62. This is the case for all the policies presented in this wider Impact Assessment. These 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,"⁶⁹ and are covered in greater detail in the overarching Impact Assessment.

C63. 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.

C64. 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 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 aspects⁷⁰. 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 GP consortia, where they can input to the JSNA, joint health and wellbeing strategy and opportunities for more integrated working through GP consortia's representation on the health and wellbeing board. The costs associated with these transfers is covered in the commissioning impact assessment (see annex A of the coordinating document).

C65. 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

⁶⁹ National Audit Office, 2010, 'Re-organising central government', see: http://www.nao.org.uk/publications/0910/reorganising_government.aspx

⁷⁰ Based upon DH contact with JSNA teams in local authorities.

Health in local authorities. The costs associated with these transfers is covered in the Public Health Service impact assessment (see annex F, beginning on page 146).

Running costs

- C66. 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.
- C67. 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 in Birmingham, have operated and delivered successes without additional funding⁷¹. 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.
- C68. 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 creates the potential 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 budgets⁷², 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.
- C69. 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, 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

- C70. Health and wellbeing boards have the potential to realise further opportunities in integrated working, joint commissioning and 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.
- C71. It is the conclusion of this impact assessment that health and wellbeing boards will be net beneficial; their benefits will outweigh their costs. Whilst the benefits described above cannot be

⁷¹ See: <http://www.bhwp.nhs.uk/Apps/Content/HTML/ViewContent.aspx?id=29>

⁷² Including GP consortia allocations and the public health ring-fenced budget, if applicable to the nature of the health and wellbeing board's proposed expanded role

monetised, they reinforce the potential for 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.

C72. As a recent report by the Audit Commission (2009ii) highlights, 'central government could do more to support joint working'⁷³. The proposals for health and wellbeing boards represent an opportunity for this to occur.

vi. Risks

C73. This section outlines the potential risks in implementing the proposed health and wellbeing boards that may affect the assessment of the costs and benefits.

C74. 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. For more info, please refer to *Liberating the NHS: Legislative framework and next steps*.

C75. 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 business⁷⁴.

C76. 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 were hung. 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 consortia, to protect them from interference in commissioning decisions at both a local and national level. To ensure their autonomy, both board and consortia 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.

C77. 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 arises given the tendency for not everyone to vote⁷⁵. However, the potential for the limited 'reach' into the all sections of the community is mitigated by the membership that the boards have. The locally elected representatives are not the sole representatives on the health and wellbeing board. The inclusion of representatives from local HealthWatch and GP consortia as well as the potential to include representatives from other local authority responsibility areas looking at 'general health determinants' reduces the risk that limited 'reach' to the voting public becomes a possible detrimental effect.

⁷³ 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>

⁷⁴ Thorlby R, Lewis R and Dixon, J; 2008, 'Should Primary Care Trusts be made more locally accountable?', King's

Fund
⁷⁵ *ibid.*

- C78. There is 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 features 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.
- C79. 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. Also, as mentioned in the costs section (see paragraphs C66-C69) 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.
- C80. 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 GP Consortia 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 GP consortia and local authorities entering into new arrangements. This will reduce the transition risk on patient outcomes.
- C81. 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 Impact Assessment action plan.

Annex C1: 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

Title: HealthWatch Lead department or agency: Department of Health Other departments or agencies:	Impact Assessment (IA)
	IA No: 6033
	Date: 30/11/2010
	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 end user. This situation can lead to user 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 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, people using health and social care services.

Creating a Healthwatch system is the preferred option as it will strengthen existing functions for patient voice (Local Involvement Networks) and complaints advocacy (Independent Complaints Advocacy Service) by bringing them together and making better routes for patients to shape care and access health related complaints advocacy services.

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 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 SELECT SIGNATORY:  Date: 18/1/11

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: -150.8	High: 210.9	Best Estimate: 30.1

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	9.8	2	14.8	128.7
High	11.0		15.8	138.2
Best Estimate	11.0		15.8	138.2

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	-1.4	-12.6
High	0		40.8	349.1
Best Estimate	0		19.7	168.2

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 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 D95-D120. 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):			In scope of	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?	01/04/2012				
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 ₂ equivalent change in greenhouse gas emissions? (Million tonnes CO ₂ 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

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
Statutory equality duties ⁷⁶ Statutory Equality Duties Impact Test guidance	Yes	EIA 68
Economic impacts		
Competition Competition Assessment Impact Test guidance	No	n/a
Small firms Small Firms Impact Test guidance	No	n/a
Environmental impacts		
Greenhouse gas assessment Greenhouse Gas Assessment Impact Test guidance	No	n/a
Wider environmental issues Wider Environmental Issues Impact Test guidance	No	n/a
Social impacts		
Health and well-being Health and Well-being Impact Test guidance	Yes	Throughout
Human rights Human Rights Impact Test guidance	Yes	In EIA
Justice system Justice Impact Test guidance	No	n/a
Rural proofing Rural Proofing Impact Test guidance	Yes	EIA 72
Sustainable development Sustainable Development Impact Test guidance	No	n/a

⁷⁶ 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 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
- 3 Consultation “Liberating the NHS: Increasing democratic legitimacy in health” –
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

+ Add another row

Evidence Base

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

	Y ₀	Y ₁	Y ₂	Y ₃	Y ₄	Y ₅	Y ₆	Y ₇	Y ₈	Y ₉
Total Transition costs	3.4	7.7	0	0	0	0	0	0	0	0
Total Annual recurring cost	0.0	15.6	16.8	18.0	18.0	18.0	18.0	18.0	18.0	18.0
Total annual costs	3.4	23.3	16.8	18.0	18.0	18.0	18.0	18.0	18.0	18.0
Total Transition benefits	0	0	0	0	0	0	0	0	0	0
Total Annual recurring benefits	2.0	6.3	13.4	19.6	23.7	25.9	26.7	26.7	26.4	26.0
Total annual benefits	2.0	6.3	13.4	19.6	23.7	25.9	26.7	26.7	26.4	26.0

One In One Out

From 1st September 2010 all INs (new regulation) that impacts the private sector and civil society organisations (formerly known as 3rd 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, as they are regulations on local authorities.

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. 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 independent scrutiny. And, Local Involvement Networks (LINks) have delivered £120 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 D68-D76 for details).
- D5. 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).
 - For support for choice, from the data from 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.
- D6. 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 don't 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.
- D7. 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.

Rationale for intervention

- D8. Without an independent 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.
- D9. 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.
- D10. The evidence base below gives more details on these claims.

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

- D11. **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.
- D12. 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, a major voice in identifying concerns and ensuring action is taken
- D13. HealthWatch England will provide national leadership and support to Local HealthWatch organisations. Its will be able to advise the Secretary of State for Health, the proposed NHS Commissioning Board, local authorities and regulators, including CQC itself. This will be underpinned by statute.
- D14. HealthWatch England will have to be consulted about any new commissioning guidelines developed for our health and social care services. Thus, they will be able to influence national strategy, policy and operations, as well as the registration and regulation of services.
- D15. **Local HealthWatch organisations** will be the local consumer champion across health and social care; they will have a role in 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. 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
- D16. The White Paper proposes giving Local HealthWatch additional functions and funding, for providing complaints advocacy services and for supporting individuals to exercise choice.
- D17. 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.

- D18. **Local authorities** will fund local HealthWatch organisations and contract for their services. They will have an important responsibility holding Local HealthWatch 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 the contract and enter into a new contract.
- D19. Each local authority will have to establish a health and wellbeing board covering 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.
- D20. 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.
- D21. **GP consortia** will have a duty of public and patient involvement, and will need to engage patients and the public in their neighbourhoods in all stages of commissioning. Through its exercise of functions, Local HealthWatch will provide evidence about local communities and their needs and aspirations. GP Consortia 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

- D22. Options considered were making HealthWatch England
- a standalone organisation,
 - part of the NHS commissioning board,
 - a statutory committee of the Care Quality Commission.
- D23. 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 more quickly, so that it can provide support and leadership Local HealthWatch as it develops.
- D24. The main risk for setting up Healthwatch as a statutory committee of CQC is that it would not be formally independent of the NHS and social care system. To address this, we will need to ensure that HealthWatch has a clear identity within CQC with clear and transparent processes for ensuring patient views count.

2. Role of HealthWatch England

- D25. 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

- D26. Following consultation, HealthWatch England will be set up as a 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 and will also sit on CQC's Board.
- D27. We will engage with CQC, LINKs and the voluntary sector 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. We anticipate that the Committee will include appointed and representative members.
- D28. CQC will 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

- D29. Options considered were to
- Use a host/volunteer relationship as exists for LINKs;
 - Create Organisational entities "HealthWatch <place>"
- D30. 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. The type of organisation will be for local determination. As an organisation in its own right, the role of hosts will need to change and 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 the changing role of hosts.

4. Routes for funding local HealthWatch

- D31. 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.
- D32. Many responses to the consultation supported direct funding for Local HealthWatch. Fewer, but more persuasive arguments were made for local funding as the role of Local HealthWatch organisations will be to shape and influence local services. As such, it will be preferable for them to be part of the Local Authority funding envelope.

5. Accountabilities of local HealthWatch

- D33. 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
- D34. Following consultation, and based on the importance of locality, local HealthWatch organisations 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 complaints advocacy

D35. Options considered were

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

D36. There were strong opinions about this and it is proposed that local authorities will commission NHS advocacy services which are delivered through Local HealthWatch organisations or another provider. This will continue to meet high standards for advocacy.

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

D37. 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 PALS functions into local HealthWatch

D38. Feedback on this was less than expected, though with the development of GP Consortia, 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

D39. Options considered were to

- To include HealthWatch on local Authority Health and Wellbeing Boards
- Omit Local HealthWatch on Boards

D40. 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

D41. This section summarises the estimated costs associated with the establishment and running of national and local HealthWatch.

HealthWatch: total funding

D42. Total funding for 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/£7m/£7.5m in these years.

Local HealthWatch: Existing Funding

D43. It is our intention to redirect funding for the following activities to local authorities from 2012/13:

- *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. From 2012/13, the funding will be transferred to local authorities to commission complaints advocacy which will be delivered through local HealthWatch;
- *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), the average cost of a PCT PALS service (uprated to 2009-10 costs) is £169,000. However, the report also states that time spent dealing with functions other than providing advice on choice is around 35% of staff time. Assuming that staff costs account for 70% total, this suggests that existing spend by PCTs is about £127k per PCT.

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 from local HealthWatch 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 and complaints*: we expect that patient demand for help to make choices and complaints 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 increase of 2.5% annual increase above the existing spend.

HealthWatch England: New funding

D44. 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.

D45. 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

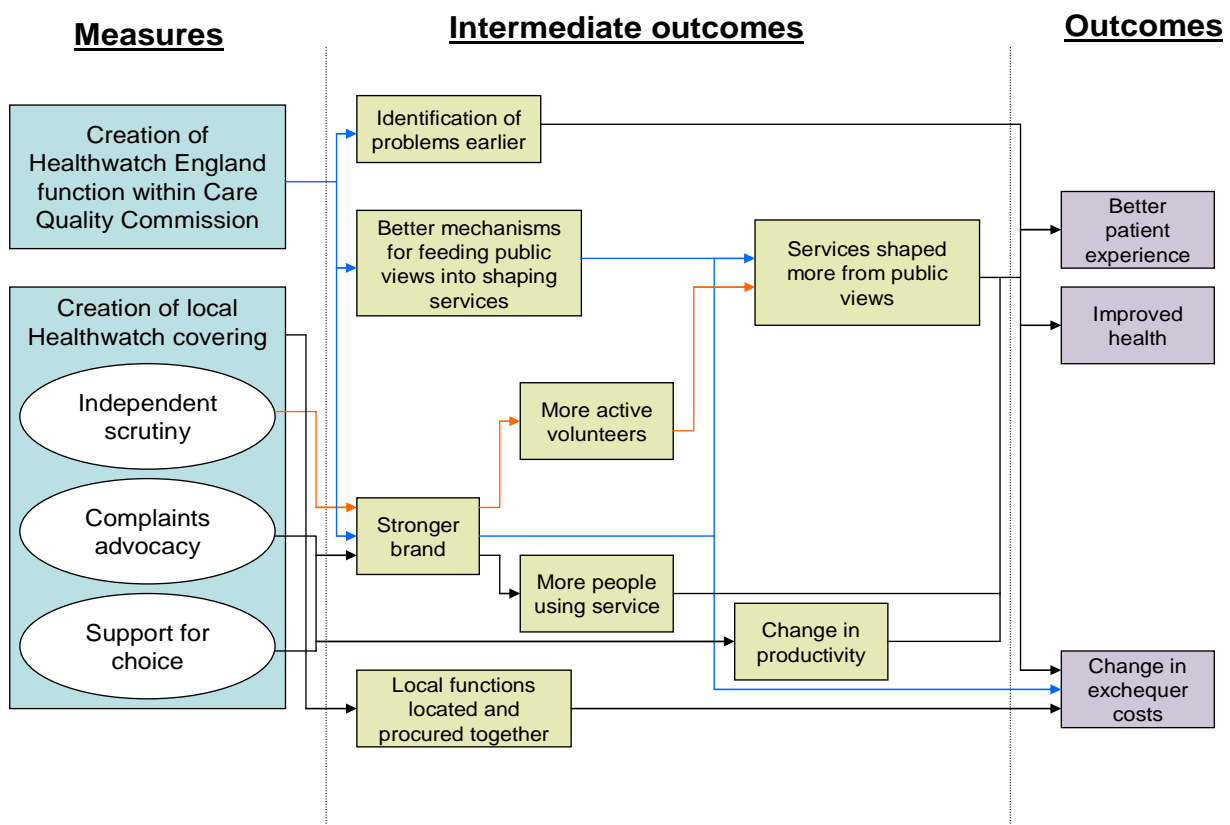
£m	2011/12	2012/13	2013/14	2014/15
Existing HealthWatch funding				
LINKs	28.1	28.1	28.1	28.1
Independent Complaints Advocacy Service	11.7	11.7	11.7	11.7
PALs expenditure in PCTs	19.3	19.3	19.3	19.3
TOTAL	59.1	59.1	59.1	59.1
Additional SR funding				
Lost economies of scale	0	2.5	2.5	2.5
Increased demand 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
TOTAL	1.4	9.7	7	7.5
Total transition costs	1.4	3.2	0	0
Total ongoing costs	59.1	65.6	66.1	66.6
Total funding for HealthWatch	60.5	68.8	66.1	66.6

D46. The additional SR 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 86 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 86 for a further explanation of why an opportunity cost multiplier is used.

Assessment of benefits

D47. The model below captures the possible effects of introducing HealthWatch.

Cost and benefit model for Healthwatch



D48. 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 independent scrutiny role.
- (3) More people involved in independent 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

D49. 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;

- D50. 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 independent 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.
- D51. 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 will be able to recommend that CQC review, creating an additional safeguard in the system. It can also provide a way to potentially share information 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.
- D52. 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.
- D53. 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 of this guidance.
- D54. In addition, the Parliamentary and Health Service Ombudsman provides 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 Healthwatch will mean more people using complaints advocacy services, demanding support for choice and volunteering to help in independent scrutiny role.

- D55. 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 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.
- D56. Of particular relevance is the consultation around widening the scope of choices available to people about their healthcare services. This is likely to increase the demand for support for choice services. The impact assessment for the choice consultation and the consultation on changes to GP practice boundaries give more details.
- D57. 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 HealthWatch, it is the closest example.

- D58. Most people who volunteer do so by being directly asked to (source: Citizenship survey, plus see equality impact assessment below). 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).
- D59. The risk here is that the people who would benefit from 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 target those who will benefit most.
- (3) [More people involved in independent scrutiny leads to services better shaped by the public.](#)
- D60. 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.
- D61. What the analysis of the LINKs reports revealed was that there was only one issue on which 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](#)
- D62. 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.
- D63. 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 to 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.
- D64. 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 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.”
- D65. 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.

- D66. 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.
- D67. Given LINKs have been established for two years, 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

- D68. 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.
- D69. 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 2009-10⁷⁷. This is a fall of 1,764. A parliamentary enquiry estimated the cost of a day of delayed discharge as £144 in 2001-02⁷⁸. 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

- D70. 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.
- D71. 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)⁷⁹. 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.
- D72. There may also be reductions in delayed discharge or readmissions, though information wasn't available about these aspects to quantify the savings.

Case study 3: Blackburn with Darwen LINK

- D73. They picked up a problem with hospital signage leading to "did not attends" & potential health problems in emergencies. They arranged a public meeting, attended the Overview & Scrutiny Committee and conducted further research inc. 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.

⁷⁷ Source: Vital Signs Monitoring Return (VSMR) data, Department of Health

⁷⁸ <http://www.parliament.the-stationery-office.co.uk/pa/cm200102/cmselect/cmhealth/617/61704.htm#n22>

⁷⁹ Quarterly Activity Statistics, Department of Health

D74. 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%)⁸⁰. 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.

D75. There may be other savings or improvements associated with this change that are not quantified.

Calculation of total benefit and return on investment

D76. The average benefit across quantified examples is £271,000 per year. From the LINKs annual reports 2009-10, there were 443 LINK inspired service changes. Assuming these quantified changes were representative of all 443, the total benefit delivered through this part of LINKs activity is £120 million.

D77. Given spend on LINKs was £24.7 million in 2009-10, this suggests a net benefit of £95 million, a return on investment of £3.90 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 86).

D78. 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

D79. Part of the role of HealthWatch could be to promote these conditions.

D80. The calculation of benefit stemming from the independent scrutiny role of local HealthWatch assumes that the difference in local HealthWatch is those organisations currently inspiring low levels of change will improve at a faster rate than under the current system of LINKs. Our assumption is that organisations inspiring fewer than three changes per year will increase

- Under the do nothing scenario, 40% of 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 25%, as LINKs contracts would be re-tendered in that year)
- under the low benefit scenario, 40% of 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 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%)

D81. 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).

⁸⁰ Quarterly Activity Statistics, Department of Health

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

- D82. 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.
- D83. 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](#)

- D84. Support for choice is about improving the information people have to make health related decisions. Quality of information or advice 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.
- D85. Quality of information seems to be driven by the level of trust people have in the source, with over 75% of advice from friends and colleagues being seen as good, compared to just over 50% of advice 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.
- D86. 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)).
- D87. 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 aren't 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.
- D88. The average cost per query of £42 for information for choice services. 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 specifically market the service people who are most likely to gain.
- D89. 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](#)

- D90. 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 D5 above.

- D91. 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 independent scrutiny.
- D92. 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.
- D93. This suggests there is significant scope to improve productivity and efficiency of HealthWatch compared to existing functions. In particular, we can:
- Set common organisational forms for local HealthWatch, which will be achieved by setting it up as a corporate body;
 - Develop staff competencies and discuss with HealthWatch England how training can be made available for HealthWatch employees and volunteers; and
 - Develop performance/efficiency indicators for complaints advocacy to facilitate performance management
- D94. There is clearly a need to have a degree of independence for the scrutiny function of HealthWatch, 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.

E. Risks

- D95. 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.](#)
- D96. 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.
- D97. 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 independent scrutiny role.
- D98. 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).

D99. 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)

D100. This suggests that reductions in funding would directly impact upon what local HealthWatch delivers, though other means of ensuring good value are equally as important.

D101. This is being mitigated against by providing a legal obligation for local authorities to make arrangements for provision of the functions of local HealthWatch, continuing some of existing legal obligations. Further mitigations against this risk are currently being considered.

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

D102. 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.

D103. 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 sharing intelligence from local communities and mean greater levels of variation.

D104. 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.

D105. The Health and Social Care Bill would result in a duty on Local Authorities to fund local HealthWatch. This may be perceived as a conflict of interest, given the role of local HealthWatch in relation to scrutiny. Local Authorities can do fund this either through a host organisation or, if there is no host, directly. It is likely that Local Authorities may choose to continue current arrangements, which is funding through host organisations, and this will keep local HealthWatch more independent. However, this will be dependent on the performance of their host organisations and if they are suitable for rolling forward with local HealthWatch.

(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

D106. 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 will work with stakeholders involved in the functions of HealthWatch to produce an agreed transition plan. This will be published by the end of March 2011.

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

D107. 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 2009-10, there was a three fold increase in membership and the level of activity was between seven and sixteen times greater than the year before.

- D108. 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 hosts become effective quickly.
- D109. 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.](#)
- D110. This stems from the fact that we are setting up roles in feeding into official channels (in CQC, NHS Commissioning Board) and having to be seen to be independent.
- D111. 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.](#)
- D112. HealthWatch England will have the power to recommend CQC reviews emerging concerns from intelligence gathered by local HealthWatches 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.
- D113. 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.
- D114. There needs to be a similar published agreement on roles within CQC between HealthWatch England and other parts of CQC.
- (8) [People who would benefit from HealthWatch the most are crowded out](#)
- D115. 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 HealthWatch markets their services in a way to target those who will benefit most.
- (9) [There is potential for duplication or conflicting working between local HealthWatches.](#)
- D116. There will be times where commissioners or 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) [GP consortia may not have the capacity to respond effectively to reports from local Healthwatch](#)
- D117. 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 GP consortia. There are likely to be many cases where multiple GP commissioners are significant contractors of the same service provider.
- D118. The Bill allows local HealthWatch to pass on views and make reports to healthcare providers, though need to consider the implications with CQC to avoid duplication.

(11) There is potential duplication/conflict between local HealthWatch and the formal health and care sector

- D119. 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, there may be different organisations in the same areas looking into the same issue.
- D120. It is important to have ways of sharing intelligence locally on what service users value, suggest a building relationships competency for HealthWatch staff and think through further how we can ensure the incentives are in place 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>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];</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>Review objective: [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>Review approach and rationale: [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>Baseline: [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 & Liaison Services that preceded Healthwatch</p>
<p>Success criteria: [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>Monitoring information arrangements: [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>Reasons for not planning a PIR: [If there is no plan to do a PIR please provide reasons here]</p> <p>N/A</p>

<p>Title: The Department of Health's Public Bodies Impact Assessment</p> <p>Lead department or agency: Department of Health</p> <p>Other departments or agencies: _____</p>	<p>Impact Assessment (IA)</p> <p>IA No: 6034</p> <p>Date: 22/11/2010</p> <p>Stage: Final</p> <p>Source of intervention: Domestic</p> <p>Type of measure: Primary legislation</p>
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Summary: Intervention and Options

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

The Government is committed to reducing central bureaucracy and shifting power from national organisations to the frontline, patients and the public. Changes being made to the wider health system have offered opportunities to review the DH's Arm's Length Body sector, to ensure it is 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 OHPA, please see 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

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).

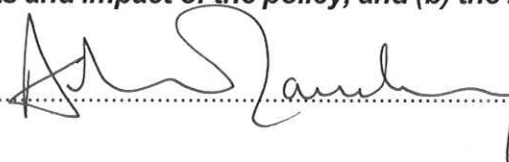
Option 2: Pursue the proposals set out in "Liberating the NHS: Report of the arm's length bodies review" and no longer proceed with the creation of OHPA (for the full outline of OHPA proposals please see http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_122293)

This is the preferred option because it will satisfy the policy objectives – specifically, it will bring about efficiencies and alignment with other changes to the health sector.

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:  Date: 18/1/11

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: 687.1	High: 783.9	Best Estimate: 735.5

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	44.1	7.8	107.4

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

Transition costs to DH of implementation: Relocation of staff, establishing staff on new HR/IT systems, redundancy payments, and early exit of estate costs, mainly based on cost figures from ALBs. Costs on government budgets are multiplied by 2.4 to reflect opportunity costs and are included in the estimates above. Annual costs: to private doctors, professional registrants and the GMC following changes to the CQC, CHRE, GSCC and OHPA. Costs divided by ALB/OHPA in Tables 3a and 3b.

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

Indirect costs of organisational change (loss of stakeholder assurance, disenchanting workforce) are considered but not quantified.

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	24.0	92.8	794.5
High	38.4	102.8	891.3
Best Estimate	31.2	97.8	842.9

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

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'

Impact of social care guidance by NICE expected to be positive but currently unknown. Introduction of voluntary registers by CHRE will impact on those who decide to register; patients/public will 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. Where the detail for new policies has not been fully determined, it has not been possible to complete a full analysis. Risk that other parts of the health system may not be established in the way that DH has envisaged.

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 Yes	Measure classified as IN
Costs: 2.3	Benefits: 0.6	Net: 1.7		

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 ₂ equivalent change in greenhouse gas emissions? (Million tonnes CO ₂ 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 <£0.01	< 20 <£0.01	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
Statutory equality duties ⁸¹ Statutory Equality Duties Impact Test guidance	Yes	EIA 92
Economic impacts		
Competition Competition Assessment Impact Test guidance	Yes	139
Small firms Small Firms Impact Test guidance	Yes	140
Environmental impacts		
Greenhouse gas assessment Greenhouse Gas Assessment Impact Test guidance	Yes	142
Wider environmental issues Wider Environmental Issues Impact Test guidance	No	142
Social impacts		
Health and well-being Health and Well-being Impact Test guidance	Yes	141
Human rights Human Rights Impact Test guidance	No	142
Justice system Justice Impact Test guidance	No	142
Rural proofing Rural Proofing Impact Test guidance	No	142
Sustainable development Sustainable Development Impact Test guidance	No	142

⁸¹ 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

- 5 DEFRA (2002) “Developing DEFRA: A report on the merger for people who lead and manage change”
- 6 DH (2010) “Equity and Excellence: Liberating the NHS”
- 7 DH (2010) “Liberating the NHS: Report of the arm’s length body review”
- 8 Annual Reports and Accounts from Arm’s Length Bodies

+ Add another row

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

	Y ₀	Y ₁	Y ₂	Y ₃	Y ₄	Y ₅	Y ₆	Y ₇	Y ₈	Y ₉
Total Transition costs	6.8	37.0	0.3	0	0	0	0	0	0	0
Total Annual recurring cost	0	0.6	5.5	10.3	10.3	10.3	10.3	10.3	10.3	10.3
Total annual costs	6.8	37.7	5.8	10.3	10.3	10.3	10.3	10.3	10.3	10.3
Total Transition benefits	0	31.2	0	0	0	0	0	0	0	0
Total Annual recurring benefits	0	8.8	116.0	121.9	121.9	121.9	121.9	121.9	121.9	121.9
Total annual benefits	0	40.0	116.0	121.9	121.9	121.9	121.9	121.9	121.9	121.9
Business transition costs	0	0	0	0	0	0	0	0	0	0
Business annual recurring costs	0	0	0.5	3.3	3.3	3.3	3.3	3.3	3.3	3.3
Business annual costs	0	0	0.5	3.3	3.3	3.3	3.3	3.3	3.3	3.3
Business transition benefits	0	0	0	0	0	0	0	0	0	0
Business annual recurring benefits	0	0	0	0.8	0.8	0.8	0.8	0.8	0.8	0.8
Business total annual benefits	0	0	0	0.8	0.8	0.8	0.8	0.8	0.8	0.8

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

Changes to the Department of Health Public Bodies

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. 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. As 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, costs and benefits for the proposal to no longer proceed with the Office of the Health Professions Adjudicator (OHPA) are covered in our calculations in Tables 3a, 3b, 3c and 4 from paragraph E109. A more thorough analysis of this proposal is covered in a separate impact assessment⁸², and it is not otherwise discussed below.
- E3. The Review's intention was to create an ALB sector that achieves better outcomes, is more responsive to patient's needs, has 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.
- E4. This IA is structured as follows:
- A description of the current landscape is discussed from page 110;
 - The problem under consideration is discussed from page 113 ;
 - A description of the sectors and groups affected is discussed from page 113;
 - The methodology used is discussed from page 114;
 - The policy objectives and intended effects are discussed from page 115;
 - Option one and its associated costs and benefits is discussed from page 115;
 - The costs and benefits of our preferred Option 2, split into each ALB/public body are discussed from page 118;
 - The Post Implementation Review plan is discussed in Annex E1 from page 134 ;
 - A description of current ALBs with figures for headcount and administrative funding is at Annex E2 from page 135 ;
 - An assessment of the impacts of these proposals on equality begins on page EIA 92;
 - Specific impact tests including impacts on competition, small firms, health and greenhouse gas admissions is at Annex E3 on page 139;
 - Detail of our assumptions and sources used to inform some of our cost and benefit estimates is at Annex E4 from page 143; and
 - A discussion of the methodology and approaches used is at Annex E5 from page 144.

Current Landscape

- E5. 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)

⁸²

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 range 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.

- E6. This network of ALBs has been created at national level, but at “arm’s length” from DH 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.
- E7. Table 1 also 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, although this will differ for each individual ALB depending on the different policies and legislation involved. This impact assessment and equality impact assessment only covers those changes set out below that are included within this Health and Social Care Bill.

#	ALB Name	Acronym	Review Proposal
1	Alcohol Education and Research Council	AERC	Abolish as an ALB and remove from the sector, while seeking to maximise the opportunities for effective cross-government policy to reduce the harm from alcohol misuse.
2	Appointments Commission	AC	Abolish as an ALB in view of the substantial reduction in the number of appointments required. Move remaining appointments to the DH. Secretary of State and Privy Council will in future, retain powers of appointment.
3	Care Quality Commission	CQC	Retain as quality inspectorate across health and social care, operating a joint licensing regime with Monitor. Host organisation for Healthwatch England. Current responsibility of assessing NHS commissioning moves to the NHS Commissioning Board. May receive functions from other organisations, e.g. HTA and HFEA. Will receive functions from NIGB.
4	Council for Healthcare Regulatory Excellence	CHRE	Remove from the sector. Make a self-funding body by charging a levy on regulators. Extend role to set standards for and quality assure voluntary registers.
5	General Social Care Council	GSCC	Abolish and transfer 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	Retain , in principle. Abolish the IC as a SpHA but establish a new body in primary legislation to take on similar functions. National repository for data collection across health care, public health and adult social care. Clearer focus on data collection, with a close working relationship with the NHS Commissioning Board. Has own powers to collect data for bodies other than NHS Commissioning Board and Secretary of State, and a duty to minimise the burden of data collection. Has powers to receive confidential patient information.

7	Health Protection Agency	HPA	Abolish 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	Abolish as an ALB and transfer functions to other regulators by the end of the current Parliament. In the meantime, DH will examine the practicalities (and legal implications) of how to divide the functions between a potential new research regulator ⁸³ , the CQC and the IC.
9	Human Tissue Authority	HTA	Abolish as an ALB and transfer functions to other regulators by the end of the current Parliament. In the meantime, DH will examine the practicalities (and legal implications) of how to divide the functions between a potential new research regulator ⁸⁴ , the CQC and the IC.
10	Medicines and Healthcare products Regulatory Agency	MHRA	Retain , with the expectation that it will undertake its regulatory duties in the most cost effective way.
11	Monitor	Monitor	Retain and make an economic regulator, operating a joint licensing regime with CQC.
12	National Institute for Health and Clinical Excellence	NICE	Retain , in principle. Abolish the SpHA and establish a body corporate to take on similar functions. Expand scope to include social care standards.
13	National Patient Safety Agency	NPSA	Abolish as an ALB. Safety functions retained and transferred to the NHS Commissioning Board. Explore transfer of National Research Ethics Service (NRES) functions to single research regulator ⁸⁵ . National Clinical Assessment Service (NCAS) to become self-funding over the next two to three years.
14	National Treatment Agency for Substance Misuse	NTA	Abolish 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	Retain , and commission an in-depth review of opportunities to make more commercially effective. Transfer Bio-Products Laboratory out of NHS BT into a DH owned company.
16	NHS Business Services Authority	NHS BSA	Retain in short term, and commission commercial review to identify potential for increased commercial opportunities, including potential to remove functions from the ALB sector.
17	NHS Institute for Innovation and Improvement	NHS I ³	Remove from ALB sector. Move functions that will support the NHS Commissioning Board in leading for quality improvement to the Board. Review the potential for its remaining functions to be delivered through alternative commercial delivery models.
18	NHS Litigation Authority	NHS LA	Retain , and commission an industry review to identify potential opportunities for greater commercial involvement.

⁸³ DH (2010): *Liberating the NHS: Report of the arm's length bodies review*, p18

⁸⁴ DH (2010): *Liberating the NHS: Report of the arm's length bodies review*, p18

⁸⁵ DH (2010): *Liberating the NHS: Report of the arm's length bodies review*, p18

What is the problem under consideration?

E8. The Government is committed to reducing central bureaucracy and shifting power from national organisations to the frontline, patients and the public. Changes being made to the wider health system offered the opportunity to take a fresh look at the Department's ALB sector, to ensure it is fit-for-purpose as the system around it evolves. 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

E9. 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 impact assessment.

ALBs

E10. 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 E27.

Providers

E11. ALBs work in connection with a variety of health and social care providers, and their work has an impact on the day to day workings of providers. 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

E12. 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:

- the streamlining of some guidance (integrating some social care guidance into NICE); and
- exploiting the benefits of a voluntary regulatory system (through CHRE's new role in accrediting voluntary registers).

Department of Health

E13. 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 may be responsible for managing any residual public appointments following the abolition of the AC. These impacts are covered in greater detail for each ALB from paragraph E31.

Other Government Departments (OGDs)

E14. 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.

Devolved Administrations (DAs)

E15. 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.

E16. 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 the ALBs' 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

E17. Patients, service users and the public are affected by ALBs both indirectly through the valuable services they provide to the NHS, DH, and social care, and directly through, for instance, the guidance and publications they issue and the assurance they provide by regulating health and social care services and the individuals that provide them. The removal of some functions from the ALB sector may have a negative effect on society in the form of a loss of welfare. However, this might be counter balanced by improvements elsewhere, which come as a result of cash releasing savings.

E18. Where functions are simply being delivered by an alternative means, it is assumed that no value will be lost. In these instances, DH expects functions to be delivered more efficiently, thereby creating a positive effect on patients through cash releasing savings that can be reinvested into frontline services. Therefore, of the changes covered in this impact assessment, patients, services users and the public will be affected by:

- improved services following the streamlining of guidance to integrate health and social care, through changes to NICE (indirect effect);
- less bureaucratic processes around supervised community treatment, through changes to CQC (direct effect); 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

E19. 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 in detail the functions of ALBs to find ways to rationalise and simplify

the landscape. In addition, test criteria have been applied, to ensure that only functions which need to be in the ALB sector remain in the ALB sector. Each of these elements has guided our thinking behind the ALB proposals set out in Option 2. A more detailed explanation of our methodology can be found in Annex 6.

E20. As set out in the Review report, the functions of some ALBs are still in need of further research and reviews to determine their most appropriate future. This is explained further from paragraph E27.

Objectives and intended effects of the ALB Review

E21. There are four main objectives of the ALB Review. These are set out below along with their intended effects.

- **A streamlined sector:** Fewer ALBs will mean fewer central organisations for frontline staff to have to deal with, and less resource tied up in administrative overheads associated with individual bodies, for example, boards, governance, and business support functions such as finance, HR, and IT. Clarity of the scope of organisations will reduce mission creep and overlap of functions.
- **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 than the sum of their individual activities.
- **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.
- **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.

ALB Options assessment

E22. 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, financial basis as remit 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, drives up efficiency and value for money through removing duplication, and takes advantage of commercial opportunities to improve function delivery and service.

E23. 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

E24. 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 2009/10⁸⁶.

⁸⁶ DH finance data, baseline revenue funding

- E25. Option 1 is the baseline that Option 2 is costed against. Because this policy fits in with the wider health reforms, it is not straightforward for us to identify a baseline from which to measure our preferred policy. Hence, our interpretation of the baseline is one such that:
- There are no changes to the structure of the NHS; and
 - All ALBs continue to exist with the same remit and the same grant in aid as that in 2009/10.
- E26. With the proposed system architecture changes, leaving the ALB sector alone would create a confusion of roles. For example: both the NHS III 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. 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

- E27. 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 E80 the impact of the changes to the 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 professionals and workers in the UK and social care workers in England. 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 E49-E65;
 - 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 E66-E76;
 - AC, AERC, NPSA and NHS III 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 NHS III. The analysis of the impact of these proposals is considered in paragraphs E77-79 and E83-108. The changes to the remaining functions of the NPSA and NHS III will be covered in secondary legislation in due course, with associated impact assessments and equality impact assessments;
 - 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. The analysis of these proposals will be covered outside the Health and Social Care Bill, and will be covered in separate impact assessments and equality impact assessments 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 (page 146);
 - 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). However, the Bill includes a ‘*saving provision*’, which maintains JCVI as a statutory body under the provisions of the NHS (Standing Advisory Committee) Order 1981. The intention is that when discussions with the Welsh Assembly Government have concluded on the future of JCVI, the 1981 Order will be revoked. The Secretary of State then 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 the same functions. The JCVI chair and members are expected to become members of the new Departmental Expert Committee when that is established. Therefore, we expect any impact of this change to be minimal. As a result, it is not appropriate to do 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.

E28. Therefore, the proposals and associated impacts that will be discussed in this impact assessment are summarised in Table 2 below.

Table 2: Summary of proposals covered in this Impact assessment	
1	Expand the role of NICE to cover adult social care
2	Focus the CQC as an effective quality inspectorate
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 in England 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 natural repository of data
8	Abolish AC
9	Abolish the NPSA and transfer the Patient Safety Division to the NHS Commissioning Board
10	Transfer relevant functions from the NHS III to the NHS Commissioning Board

E29. Overall, these proposals will simplify the national landscape, reduce duplication and bureaucracy, and better align the ALB sector with the rest of the health and social care system. In addition, the Department expects this option to substantially reduce the costs of the sector by driving up efficiency and value for money.

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 and 3b at paragraph E109.

Raising Standards

National Institute for Health and Clinical Excellence (NICE)

- 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 is seen as key to supporting the work of the NHS Commissioning Board in developing quality standards along each part of the patient pathway, and outcome indicators for each step. To do this, NICE intends to rapidly expand its existing work programme to create a broad library of standards for all the main pathways of care. The quality standards will therefore extend across the range of care pathways. The Health and Social Care Bill will contain provisions to put NICE in primary legislation, and extending its remit to 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."⁸⁷ Hence, expanding the remit of NICE to cover social care would allow a consistent approach across health and social care, tap into NICE expertise on quality standards and exploit economies of scale.
- E33. NICE's future activities in respect of social care are not yet exactly defined, so it is not possible to definitively estimate the cost impacts of the proposals. 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 £10,000.
- E34. The function of issuing guidance in respect of social care is currently partly provided by the Social Care Institute for Excellence (SCIE). The general process NICE will follow in developing guidance is likely to be comparable to the activities of SCIE though there may be differences in the scope and output of their work. Such differences could lead to additional efficiencies and benefits.
- E35. 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 but it is not known precisely how much will transfer over. NICE may choose to contract out work to SCIE. However, such arrangements would have to come from the additional money NICE receives. Hence, since money will be transferred from SCIE to NICE, the net cost impact on the Exchequer will be zero. It is not fully clear at present whether this will happen or what the magnitude of any change in funding would be. Our best estimate at this stage is that there is no change in funds and the net cost is zero. NICE also receive funding of approximately £1m from OGDs and DAs⁸⁸. DH does not anticipate any additional cost pressures on these bodies from this proposal.
- E36. There will be impacts on SCIE following the removal of this funding. There could be impacts on staff and on the priorities of the organisation. It is not fully clear what these impacts will be, and

⁸⁷ 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>

⁸⁸ Source: NICE Annual Report and Accounts 2009-10

SCIE intends to identify the best ways to adapt to these changes. It is not appropriate to predict in advance how SCIE will change and hence quantification of costs and benefits on SCIE are not possible.

- E37. Providing such guidance is expected to improve the ability of social care organisations to allocate their budgets to the services which provide the greatest benefit to their recipients. The degree to which its guidance will beneficially influence budget allocation is not yet known. 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 £16bn⁸⁹. Hence even a very small change in the way that social care funds are allocated following NICE guidance could deliver significant benefits.

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 in turn below. The Health and Social Care Bill will also cover 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 Health and Social Care Bill, and hence it would not be appropriate to include here.
- E39. To remove duplication in the sector, the ALB Review proposed transferring periodic reviews of NHS Bodies, which has previously been undertaken by the CQC, to the NHS Commissioning Board. The CQC will continue to conduct periodic reviews of adult social care and retain its responsibilities under the Mental Health Act 1983. 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 no current resource within CQC to deliver this function. This policy does not place any additional costs on the CQC.
- E41. There are no direct benefits on the CQC from the removal of this function. CQC has reallocated funds that were previously allocated towards Periodic Reviews of NHS Bodies, so there is no reduction in GIA for the CQC as a result of this policy. There are likely to be significant impacts for the NHS Commissioning Board and patients, though these are included in the commissioning impact assessment supporting the Health and Social Care Bill.
- E42. 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 three main impacts of this policy: impact on CQC resources; impact on SOAD employment and the impact on the mental health sector.

⁸⁹ Source: Information Centre's "Personal Social Services Expenditure and Unit Costs", 2008-9

- E43. There are approximately 15,000 requests for SOAD visits each year in England, around 2,700 of which relate to SCTs patients who are thought to be consenting to the treatment in question⁹⁰. Assuming current levels of requests in the future, the amendments made by the Bill will mean that CQC will have these fewer requests to process. 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, estimated at around £0.6m. 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 Wales⁹¹ have been added. Hence there will be a small benefit to the Healthcare Inspectorate Wales⁹², assuming they have the same cost basis as the CQC.
- E44. There will be an impact on SOADs themselves as, compared to the option of doing nothing, there will be fewer visits to be made. While above this is represented as a benefit to CQC, it is also a cost on SOADs themselves. It follows that the payments foregone as a result will be approximately £0.6m. 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. 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. While the level of burden is not reduced, the frequency would be cut by approximately 18%, 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. There is a risk that this policy could have a detrimental impact on safeguarding patients, in that less treatment will now have to be approved by a SOAD. However, this risk is thought to be 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 being continued to prevent serious suffering by the patient).

National Information Governance Board (NIGB)

- E46. 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 on the grounds of removing duplication, improving efficiency and bringing 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.
- E47. 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 these changes will be cost minimal. It is possible that staff may transfer from the NIGB to the CQC or other organisations. If this were to happen, transfer by Transfer of Undertakings (Protection of Employment) (TUPE) would be

⁹⁰ Figures provided by DH sponsor teams and CQC policy leads.

⁹¹ 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

⁹² The responsibility of SOAD services is formally given to Welsh Ministers, but in practice it is delegated to the Healthcare Inspectorate Wales.

made. However, it is not fully clear how many staff will transfer over and hence cost estimates are not possible.

- E48. The main benefit of bringing NIGB into CQC is removing duplication elsewhere in the system. 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. In the absence of more complete information, a cost saving of £0 - £1m is estimated, with a best estimate (mid-point) of £0.5m. 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 cost savings. This benefit is unquantified, but would be captured in the benefit estimate above.

Council for Healthcare Regulatory Excellence (CHRE)

- E49. 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.
- E50. The levy will be compulsory. This is required to prevent any actual or perceived compromise of CHRE's independence from the regulators, which 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.
- E51. 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).
- E52. For illustration, it is assumed that CHRE's annual chargeable costs will be in the region of £2.75m⁹³ per year⁹⁴. 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 every three years.
- E53. The regulators will be free to choose whether to pass on the cost of the levy to their registrants, or absorb them. 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 around £2 per year⁹⁵. Registrant's 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.
- E54. If the Department assumes that the levy is passed on in full to registrants, and that all registrants pay a marginal rate of income tax of either 20% or 40%, then the cost to the exchequer would be

⁹³ The level of CHRE's funding from the DH and the DAs in 2009/10

⁹⁴ 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.

⁹⁵ 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.

between £0.55m and £1.1m. Since CHRE currently receives all of its chargeable costs as grant-in-aid, this yields a saving to the exchequer of between £1.65m and £2.20m⁹⁶. It is assumed that labour markets will have sufficient slack to bear an impact on pay of this scale without an effect on the quantity of labour supplied.

- E55. Depending on whether the cost is passed on to the registrants, any increase in registration fees would contribute to upward pressure on the public sector pay bill. However, since the increase in fees would be very small for each registrant, the effect on wages is likely to be negligible.
- E56. 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.
- E57. 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 needs to review 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, 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. Overall, as regulation improves under the oversight of CHRE, the number of referrals should continue to fall.
- E58. 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 which were not incurred by the GSCC (these costs are being reflected in assumptions about fee levels being made by the HPC).
- E59. Oversight of social work regulation by CHRE in England will lead to more effective regulation, improving the safety and quality of social work, and maintaining the confidence of the public, service users and employers.
- E60. 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. An assured system of voluntary registration would seek to enhance standards of professional and occupational competence and provide clear standards of expected conduct, but without the need for compulsory statutory regulation.
- E61. The Department proposes to expand CHRE's remit to enable it to set standards for and to quality assure systems of voluntary registration. It will be for CHRE to determine its quality assurance processes, but on the basis of discussions with CHRE, DH anticipate initial set-up costs of £100,000 in the first year, 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. DH expects CHRE to reach full cost recovery within three years.
- E62. 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.

⁹⁶ 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 = £2.20million. If all registrants pay a marginal rate of income tax of 40%, the cost to the exchequer would be 40% of £2.75 = £1.10million. Therefore, the saving in grant-in-aid would be £2.75million - £1.10million = £1.65million.

- E63. Accredited voluntary registration should lead to improved standards of education, proficiency and conduct, improved dissemination of good practice, robust processes to improve public safety, and will 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.
- E64. The Appointments Commission (AC) currently makes appointments on behalf of the Privy Council to the healthcare professions regulatory bodies. The costs of the appointment process are fully met by the regulatory bodies. The Department proposes that Privy Council will ask each of the regulatory bodies to manage their own recruitment process, in line with good practice guidance provided by the Privy Council. The regulators would be free to arrange with a third party to manage this process. The CHRE would establish a committee to 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.
- E65. 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.

General Social Care Council (GSCC)

- E66. 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. Our proposed reforms are intended to ensure that social workers 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.
- E67. 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 2009/10⁹⁷ the CHRE described the HPC as a 'well-organised, efficient and cost-effective regulator' which maintained a good performance as it assumed responsibility for further professions. 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.
- E68. It is estimated that the HPC will need approximately £0.3m in 2011/12 to prepare their systems and processes. It is expected that the HPC will be able to take on this function with some staff transferring over from the GSCC on protected terms of employment. However, it is possible that the HPC will require fewer staff to undertake its functions than the GSCC does as it will apply different approaches and support functions would not be duplicated. Through this, the public sector may incur redundancy payouts of up to £4.6m (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 of £6.9m⁹⁸.

⁹⁷ Performance Review Report 2009/10. Enhancing public protection through improved regulation, Council for Healthcare Regulatory Excellence, July 2010

⁹⁸ As of 31st March 2010 – GSCC Annual Report and Accounts 2009/10

- E69. The 83,464⁹⁹ social workers currently on the GSCC register pay £30 per year as registration fees. This is likely to increase in 2011/12 and DH estimates that fees will be around £76 when the regulation function is transferred to the HPC in 2012/13 and the grant in aid is removed. By this estimate, the total cost to social workers of the transfer would be £3.8m. A high proportion of social workers are employed in the public sector¹⁰⁰ and it will be the choice of public sector employers to decide whether to reflect the increase in registration costs to individuals in the terms and conditions of employees. For the purposes of this assessment, DH has assumed that the increased fee will be represented as a reduction in take-home pay by social workers of £46 rather than an increase in overall pay by £46, hence there will be minimal impacts on public sector finances.
- E70. The GSCC also delivers education support grants. This function will not be transferred to the HPC but will instead be transferred to a more appropriate body – final decisions on this have yet to be taken and hence it would not be appropriate to include in this impact assessment.
- E71. Indirect costs are also anticipated, in particular a dip in productivity while the changes are implemented. Monetising this is not straightforward but using the assumptions in Annex 5, this will have a cost estimate of £0.2m each year during the transition phase. A possible loss of stakeholder confidence pending the transfer and a drop in workforce morale can be expected, though these are not quantifiable.
- E72. Once the HPC takes over the regulation function, the regulation of social workers will be fully funded by their fees to the HPC. This means that the grant in aid that the Department currently makes available to the GSCC, estimated at between £21m and £25m for 2011/12, can be redeployed to front-line services, yielding additional benefits.
- E73. While this impact assessment focuses on two options – do nothing and the Government’s proposed course of action – during the ALB Review the Government assessed the possibility of the GSCC moving to a self-financing model, whereby the GSCC would remain as an independent body, but fully funded by fees from its registrants and with no Government subsidy. If the entire costs of the grant in aid currently made available to the GSCC were distributed amongst the 100,882 social workers and student social workers on the GSCC’s register equally¹⁰¹, then fees would have had to rise by a cost in the region of between £210 and £250 on top of the fees currently paid. If student social workers continued to pay a lower rate than social workers then the rise in costs to social workers would have been higher still. The Government therefore took the decision that this option would impose too high a burden on social workers. It was therefore discounted as being a viable option and is not explored further in this impact assessment.
- E74. Economic theory suggests that if a barrier to entry (e.g. registration fees) is raised then supply into the market (in this instance, for social workers) will fall. However, the Department believes that the effect of fees on the supply of social workers is unlikely to materialise. This is because the salary of social workers in England is not significantly different from other professions currently registered under the HPC. The bulk of professions under the HPC (for instance chiropodists, dietitians and physiotherapists) have salaries within Bands 5-7 of the NHS Agenda for Change Pay Bands¹⁰², between £21,000 and £40,000. This compares favourably with social workers, who have a median weekly wage of £555, or £29,000 per year¹⁰³. Hence the Department does not believe that an annual fee of £76 for social workers (an increase of £46 a year on current fees or less than £1 per week) will place a sufficiently high burden (in addition to the possibility that the GSCC may review their fee structure before their abolition).

⁹⁹ As at 31 March 2010 – GSCC Annual Report and Accounts 2009/10

¹⁰⁰ State of the adult social care workforce in England 2010. Skills for care. 2010

¹⁰¹ As at 31 March 2010 – GSCC Annual Report and Accounts

¹⁰² Source: <http://www.nhscareers.nhs.uk/details/Default.aspx?Id=766>

¹⁰³ State of the adult social care workforce in England, 2010. Skills for care 2010.

- E75. The Bill will include a power to enable the HPC to hold a voluntary register of social work students, as the GSCC currently does. Registration fees for the 17,418¹⁰⁴ registered social work students are currently set at £10 per year. However, final decisions about whether the HPC will register student social workers on a voluntary register, or deliver the responsibility of overseeing student social workers through other approaches, have yet to be taken.
- E76. 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 Principles¹⁰⁵ and should lead to better regulation and improved public safety. 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.

Public Welfare

Alcohol Education and Research Council (AERC)

- E77. The Review report proposed to abolish the AERC as an ALB and remove from the sector, as our current ALB sector governance arrangements are disproportionate to the size and scale of the organisation, and it does not satisfy the criteria to remain as an ALB. The existing Council intends to establish a separate charitable body to which all staff and the full Alcohol Education and Research Fund will be transferred to.
- E78. Provisions in the Health and Social Care Bill will enable the repeal of the 1981 Act, which created the AERC and remove references to AERC in other primary legislation.
- E79. The AERC receives no government funding and therefore the costs associated with this change will be minimal. However, 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 information on alcohol and its effect on health.

Information

Health and Social Care Information Centre (IC)

- E80. The review recommended the centralisation of data returns in the IC, leading to streamlining data collection functions across the healthcare sector in an attempt to remove inefficiencies and duplication in the system around data collection and dissemination. The review also recognised the Government's intention to establish the IC in primary legislation, in line with proposals to establish more autonomous NHS institutions under the reforms of the NHS. 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 will not attract any transitional costs as it does not require any transfer of staff or change in building location.
- E81. The IC will therefore become the national repository for data 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 make aggregate data available in a standard format for use by third parties, meeting the needs of a multiplicity of customers including the 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.

¹⁰⁴ As at 31 March 2010 – GSCC Annual Report and Accounts 2009/10

¹⁰⁵ Source: <http://www.bis.gov.uk/files/file22988.pdf>

E82. All of this is expected to reduce existing duplication and overlap in collections of data from multiple organisations as well as the overall cost of collection to the system. The IC will have an increased role in data collection and dissemination of quality assured data, but it will cease to provide and support certain analytical and presentation tools, which a market of information intermediaries is expected to pick up. The role of the IC is also covered in *Liberating the NHS: An Information Revolution*¹⁰⁶.

Public Appointments

Appointments Commission (AC)

- E83. 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.
- E84. There will however, be a residual cost associated with making remaining public appointments in DH and its national bodies. Of the approximately 2700 public appointments, of the order of 150 may continue into the future¹⁰⁷. 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. Analysis conducted earlier in the year 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.
- E85. Based on estimates of resources employed by other Departments to manage recruitment in-house, the costs are lower than when private recruitment consultants are used. Restrictions on the use of headhunters and advertising will result in a more efficient and streamlined appointments process undertaken in-house. DH is confident that this will be at a lower cost than both the private sector and the AC, and is in fact the reason that a number of government departments retain the function in-house currently. Other elements of the management of the wider public appointments function cannot be delegated to a private company, such as formally making the appointment, managing a personal performance appraisal, a suspension or the termination of an appointment.
- E86. 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, separate internal function to support Ministers in making any appointments that remain. The final costs of delivering this function will be partly dependent on systems, yet to be established by Cabinet Office, where Departments can draw on alternatives to more expensive advertising, to publicise posts and attract talent. However, the Department expects the costs to be lower than current average recruitment costs.
- E87. It is estimated that all of the AC's staff will need to be redeployed or made redundant at a total cost of £1.75m - £1.82m over a two-stage period¹⁰⁸. It is estimated that there will be a reduction in staffing levels of around half of staff by 1st April 2011, with remaining staff being made redundant or redeployed by 31st March 2012 – the current planned date for closure of the organisation.

¹⁰⁶ Published 18 October, 2010.

¹⁰⁷ Figures from DH sponsor teams

¹⁰⁸ These costs incorporate pension liabilities and were provided by the AC

- E88. 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 most public appointments are regulated by the Commissioner for Public Appointments and it is a requirement that appointments are made on merit. Departments must also comply with clear guidance with regard to how Ministers are engaged. As with other Government Departments (OGDs), DH intends to comply with these rules in the future.
- E89. The AC has offered fee-based services to 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. Economic theory suggests that this could decrease competition in the private sector, and cause prices charged to OGDs to rise. However, as there are now fewer public appointments overall, competition has increased and private sector companies are offering lower prices to attract the business of OGDs. Thus, this positively impacts on OGDs through lower costs and cash-releasing savings that can be reinvested to the frontline.
- E90. The abolition of the AC may have an impact on the costs of recruitment for FTs that have used the AC for public appointments. 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. 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.
- E91. 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 4. 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.
- E92. It is likely that the AC will experience fluctuations in productivity over the forthcoming 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.
- E93. By abolishing the AC, the Department will no longer be required to provide grant in aid. The Department estimates that this will release an annual cash releasing saving of around £3.56m. 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 unquantifiable.

Quality and Safety Improvement

- E94. Patient safety is synonymous with improving overall clinical excellence and sits at the heart of the quality agenda. Currently, functions associated with quality and safety improvement are distributed across a number of 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.
- E95. 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 NHS III should be brought together within the mainstream work of the NHS

Commissioning Board, to exploit the leverage that commissioning would provide in placing quality and safety at the heart of patient care.

National Patient Safety Agency (NPSA)

- E96. The ALB review report proposed the abolition of the NPSA, with 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 the future of the National Research Ethics Service (NRES) is dependent on the outcome of a report on a possible research regulator by Academy of Medical Sciences¹⁰⁹. The function relating to Confidential Enquiries would move into DH. Only the functions relating to the PSD will require primary legislation in the Health and Social Care Bill, so our analysis below considers only this aspect of policy. All other changes are expected to, or, in relation to the regulation and governance of health research¹¹⁰, may follow in secondary legislation and thus it is not appropriate to include in this impact assessment.
- E97. The work of the PSD relating to reporting and learning from serious patient safety incidents will move to the NHS Commissioning Board as a Patient Safety sub-committee of the Board. This is intended to happen by September 2011. The functions for which the sub-committee would be responsible (for overseeing or arranging) would include:
- Coordinating system-wide patient safety activity in the health service;
 - Improving the safety of NHS care by promoting a culture of reporting and learning from patient safety incidences including adverse events or near misses;
 - Devising, implementing and managing patient safety systems, or arranging for these, including providing for the existing national reporting and learning system (NRLS) and central alerting system (CAS), with a view to informing and disseminating learning;
 - Appraising and analysing information on reported adverse events and near misses, identifying patterns of practice or service provision that appear causally related to unexpected or serious adverse outcomes.
- E98. This will provide an opportunity to preserve the synergy between learning and operational practice that already exists in the system. If the NHS Commissioning Board is set up with outposts, the strategic thinking and leadership on safety could sit at Board level, while support for operational delivery could sit with the outposts.
- E99. 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 relocation costs. An analysis of assets shows there are likely to be costs of £275,000 incurred during the process of writing off and transferring fixed assets, such as IT. There would also be costs of up to £4.1m incurred from redundancies¹¹¹ over a two year period.
- E100. 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. Therefore, the future of this function will be subject to the outcome of *Liberating the NHS: An Information Revolution*¹¹².
- E101. By transferring the PSD function of the NPSA to the NHS Commissioning Board DH will save the current grant in aid spend on this function. Therefore, the Department estimates an annual saving

¹⁰⁹ *Liberating the NHS: Report of the arm's-length bodies review, p18*

¹¹⁰ *Liberating the NHS: Report of the arm's-length bodies review, p18*

¹¹¹ Redundancy figure estimates provided by NPSA

¹¹² Published 18 October, 2010.

of £17.8m. The costs of carrying out the PSD function in the NHS Commissioning Board will be considered in the Commissioning IA¹¹³.

- E102. The NPSA receives funding from Devolved Administrations (DAs). Where the PSD function is moving to the NHS Commissioning Board, the DAs may choose to continue to fund this and therefore experience no additional costs or benefits. Whether the DAs continue to fund this function or not, the Department expects the impact on DAs to be minimal.
- E103. 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.
- E104. There is a possible risk that bringing the PSD 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 staff to the NHS Commissioning Board will ensure that expertise in patient safety is retained and the commitments outlined above will ensure that the role of patient safety – and the importance that patients place on safety under NHS care – are maintained.

NHS Institute for Innovation and Improvement (NHS III)

- E105. The ALB Review document 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. It makes sense, therefore, that some of the functions NHS III currently undertakes relating to the leadership of quality improvement are transferred to the NHS Commissioning Board, for the sake of removing duplication in the sector.
- E106. Detailed cost estimates for moving staff to the NHS Commissioning Board are currently unknown. However, using the assumptions in Annex 5, it is estimated these 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 social enterprise under a contract to provide the leadership for commissioning improvement services directly to the Commissioning Board. It is possible there might be indirect costs from staff due to underperformance from changes. However, it is believed the changes will be small and negligible in cost terms.
- E107. The Review also proposed to abolish the NHS III 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. Therefore, it would not be appropriate to include in this impact assessment.
- E108. It is likely that the removal of NHS III from the ALB sector will generate sufficient benefits to justify the costs of this policy (since NHS III currently receives over £65m grant in aid). However, since this impact assessment covers only proposals requiring primary legislation and only those

¹¹³ Beginning on page 2 of this document.

impacting on NHS III, it is not possible to give a complete picture of the costs and benefits of the changes to NHS III.

Summary cost and benefit table for Option 2

- E109. Tables 3a, 3b and 3c summarise the monetised costs and benefits from each of the interventions outlined above. Table 3a is purely financial costs, and tables 3b and 3c are separated by impacts on the Exchequer and non-Exchequer respectively. As indicated at paragraph E2 above, it also includes OHPA. Where costs and benefits fall on the Exchequer (i.e. on public finances), the opportunity cost of these impacts is included, which is applied in table 3b. As these funds are 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. So, to get the total financial costs, the figures in tables 3a and 3c should be added together. The figures presented in the summary sheets are the aggregation of those in tables 3b and 3c.
- E110. In addition, the figures presented below may not fully match with the cost/benefit estimates identified above, especially in the case of annual estimates. This is because annual estimates are presented as an average over ten years, and as the base year for estimates is 2010/11, some costs may not be incurred for two or three years in the future¹¹⁴. 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 above.
- E111. The estimates in Tables 3a, 3b and 3c 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.

Table 3a: Monetised Costs and Benefits for Option 2 (Exchequer Impacts, excluding opportunity cost - i.e. financial cost)				
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	£0.57m
NIGB	£0	£0	£0	£0.4m
CHRE	£0.22m	£0.58m	£0	£1.9m
GSCC	£11.7m	£0	£0	£18.4m
AERC	£0	£0	£0	£0
AC	£1.78m	£0	£0	£3.0m
IC	£0	£0	£0	£0
NPSA	£4.4m	£0	£0	£14.2m
NHS III	£0.006m	£0	£0	£0
OHPA	£0	£0	£13m	£0
Total	£18.2m	£0.58m	£13m	£38.5m
<i>Of which Redundancy cost</i>	<i>£10.4m</i>			
<i>Of which non-redundancy cost</i>	<i>£7.8m</i>			

¹¹⁴ 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 3b: 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	£1.4m
NIGB	£0	£0	£0	£1.0m
CHRE	£0.5m	£1.4m	£0	£4.6m
GSCC	£28.2m	£0	£0	£44.2m
AERC	£0	£0	£0	£0
AC	£4.3m	£0	£0	£7.2m
IC	£0	£0	£0	£0
NPSA	£10.6m	£0	£0	£34.2m
NHS III	£0.01m	£0	£0	£0
OHPA	£0	£0	£31.2m	£0
Total	£43.6m	£1.4m	£31.2m	£92.5m
<i>Of which Redundancy cost</i>	<i>£25.0m</i>			
<i>Of which non-redundancy cost</i>	<i>£18.6m</i>			

Table 3c: 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	£0.6m	£0	£0
NIGB	£0	£0	£0	£0
CHRE	£0	£2.0m	£0	£0.6m
GSCC	£0.4m	£3.1m	£0	£0
AERC	£0	£0	£0	£0
AC	£0	£0	£0	£0
IC	£0	£0	£0	£0
NPSA	£0	£0	£0	£0
NHS III	£0	£0	£0	£0
OHPA	£0	£0.8m	£0	£4.8m
Total	£0.4m	£6.4m	£0	£5.4m

E112. Table 4 brings the overall figures together from Tables 3a and 3b to give 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.

Table 4: Total Costs and Benefits for Option 2				
	Transition Costs	Average Annual Costs	Transition Benefits	Average Annual Benefits
Total	£44.1m	£7.8m	£31.2m	£97.8m
Present Discounted Value	£107.4m		£842.9m	
Net Present Value	£735.5m			

Key risks and sensitivities

- E113. 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 5.
- E114. 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 £735.5m.
- E115. 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 carefully consider the timeline for transfer of functions, so as not to coincide with other significant deliverables such as the CQC registration of primary care services.
- E116. 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 the move for NHS Trusts to become, or be part of, FTs, and this small number will be handled within Government.
- E117. 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

- E118. The impacts on the private sector outlined throughout this Impact Assessment would suggest this policy falls within the remit of the recently developed One In One Out framework. Regulatory burdens do not change significantly as a result of the policies outlined in this impact assessment in terms of form filling, background checks etc. Some areas will witness a reduction in the frequency of regulatory burden, in particular for mental health providers where the requirements for a SOAD request will see a reduction in the frequency of applications and preparation for visits. The main impact is twofold: from the abolition of the GSCC and the transfer of the role of the regulation of social workers in England to the Health Professions Council (HPC), and the changes to the way in which the CHRE is funded. This will lead to changes to fees for registrants currently regulated by GSCC and potential changes to fees for registrants of the professional regulators overseen by CHRE.

- E119. The Department has considered non-legislative approaches for delivering the objectives outlined in paragraph E21 (i.e. streamlining ALB sector, reducing duplication and central bureaucracy.) Such non-legislative approaches include voluntary regulation or self-regulation, and as far as it is feasible to do so, they have been included. Fundamentally, primary legislation will be needed to change the structure of the ALB landscape and therefore these objectives cannot be delivered without the need for primary legislation.
- E120. Where there are additional burdens placed on the private sector DH has attempted to quantify these as far as possible. Preliminary estimates for this burden are approximately £2.3m annually using Equivalent Annual Costing techniques. This is to be counterbalanced by benefits that the private sector would enjoy through these proposals, for instance through the expansion of NICE guidance and accredited voluntary registers. This has been provisionally quantified as around £0.6m annually, using the same Equivalent Annual Cost method. With this in mind, DH must consider the policies outlined in this impact assessment to comprise an IN in the One In One Out framework.

Administrative Burden

- E121. 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 E1: 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.

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: [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?]

Review approach and rationale: [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]

Baseline: [The current (baseline) position against which the change introduced by the legislation can be measured]

Success criteria: [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]

Monitoring information arrangements: [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]

Reasons for not planning a PIR: [If there is no plan to do a PIR please provide reasons here]

Annex E2: Description of the current ALBs

ALB	Function	Headcount (Month 12 Monitoring returns from ALBs, 2009/10)	DH funding (admin budget 2010/11 ¹¹⁵) £000	Is it covered in the Health and Social Care Bill?
National Institute for Health and Clinical Excellence (NICE)	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
Care Quality Commission (CQC)	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
Monitor	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.
Medicines and Healthcare products Regulatory Agency (MHRA)	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
Human Tissue Authority (HTA)	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	67	1,093	No

¹¹⁵ 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.

	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.			
Human Fertilisation and Embryology Authority (HFEA)	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
Council for Healthcare Regulatory Excellence (CHRE)	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"> • Quality assurance of professional regulation • Audit of fitness to practise cases • Reviewing fitness to practise decisions under Section 29 of the NHS Reform and Health Care Professions Act 2002 	19	1,876	Yes
General Social Care Council (GSCC)	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	21,000-25,000 ¹¹⁶	Yes
Alcohol Education and Research Council (AERC)	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
NHS Blood and Transplant (NHS BT)	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	5,568	n/a – no admin budget, all	No

¹¹⁶ Figures based on GSCC's forecast and subject to the approval of their business case.

	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.		frontline services.	
Health and Social Care Information Centre (IC)	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
Appointments Commission (AC)	The AC provides recruitment services and related functions (managing suspensions) at reasonable costs, provides value for money and has built up considerable NHS expertise.	62	3,564	Yes
National Patient Safety Agency (NPSA)	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 the transfer of the Patient Safety Division (PSD) to the NHS Commissioning Board, of which funding is 17,800
NHS Institute for Innovation and Improvement (NHS III)	The NHS III was established as a Special Health Authority under the National Health Service Act 2006 and is an arm's-length body sponsored by the Department of Health to act as the NHS' "in house improvement organisation". Its purpose is to support the NHS to transform healthcare for patients and the public by rapidly developing and spreading new ways of working, new technology and world-class leadership. It supports NHS organisations in analysing their current practices against best practice and implementing changes to achieve better results.	194	66,027	No – However, the transfer of the leadership function to the NHS Commissioning Board is covered.
NHS Litigation Authority (NHS LA)	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	147	3,948	No

	wholly, as a result of clinical negligence claims.			
NHS Business Services Authority (NHS BSA)	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 E3: Specific Impact Tests

Competition Assessment

E3.1. Using the checklist of impacts from the Office of Fair Trading website¹¹⁷ 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 have 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) has fluctuated recently 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 paying £30 a year as a registration fee. However, GSCC may review their fees before the transfer of functions is complete and this may mitigate some or all of the cost impact for social workers.

E3.5. The HPC deliver their regulatory function through a model financed by the 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, physiotherapists and paramedics and with nurses who are regulated by the Nursing and Midwifery Council. This compares favourably with the scenario whereby if GSCC were to operate solely under a full-cost recovery model the fees could be higher.

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. In addition, it is possible that some employers of social workers may choose to bear this fee increase rather than allow the social worker themselves to incur it. In these cases any detrimental competition aspects will have been mitigated.

E3.7. For the CHRE, the compulsory levy on the regulators is likely to 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.

¹¹⁷ Link: http://www.offt.gov.uk/shared_offt/reports/comp_policy/oft876.pdf

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 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 competitors¹¹⁸" where a small business is defined as a business with a headcount of less than 50. DH envisages impacts on small firms for the changes to the GSCC and CHRE.

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. As explained in the Competition Assessment, GSCC may review their fees before the transfer is complete and this may mitigate some or all of the cost impact for social workers.

E3.14. This would lead to an additional cost on registered social workers in England. However, of the 83,464 registered social workers the majority¹¹⁹ are employed by local authorities and agencies who will fall outside the definition of a "small business". Therefore, the level of impact on small firms will potentially be on a small proportion of the workforce estimated to cost up to £0.5m a year. This cost will fall on individuals, though this may lead to pressure on their employers. The increase of costs may have a comparatively disproportionate impact on smaller firms 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 firms 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.

E3.16. For the CHRE, the compulsory levy on the regulators is likely to result in a very small increase in the registration fee paid by registrants. This is very unlikely to have any effect on registered

¹¹⁸ Link: <http://www.bis.gov.uk/files/file49614.doc>

¹¹⁹ State of the adult social care workforce in England 2010. Skills for care. 2010

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 assessments¹²⁰ 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.

¹²⁰ Link: 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. After consideration of the questions using the guidance on the Ministry of Justice website DH does not believe this policy will have any impact on the justice system and hence a full Justice Impact Assessment is not required.

Rural Proofing Test

E3.27. 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

E3.28. 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 E4: Assumptions and sources used for cost and benefit estimations

E4.1. 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

E4.2. A range of different sources are used as the basis for transition costs.

1) Developing DEFRA report¹²¹: 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.

E4.3. *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

E4.4. 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 Government¹²² 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.

¹²¹ 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>

¹²² Source: http://www.instituteforgovernment.org.uk/pdfs/making_and_breaking_whitehall_departments.pdf, footnote 43

Annex E5: 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.

Title: Public health elements of the Health Bill Lead department or agency: Department of Health Other departments or agencies: Health Protection Agency	Impact Assessment (IA)
	IA No: 3023
	Date: 01/12/2010
	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. 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, improving the health of the poorest fastest, by establishing a public health service, Public Health England, 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
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 local authorities. The public health responsibilities of local NHS and roles and responsibilities of local authorities are set out in legislation and therefore transferring responsibilities will require legislation.

When will the policy be reviewed to establish its impact and the extent to which the policy objectives have been achieved?	See Annex A
Are there arrangements in place that will allow a systematic collection of monitoring information for future policy review?	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: 18/1/11

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]

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	[Redacted]		[Redacted]	[Redacted]
High	[Redacted]		[Redacted]	[Redacted]
Best Estimate	[Redacted]		[Redacted]	[Redacted]

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

Transition costs: Transfer of HPA staff to Department of Health [Redacted] Transfer of DsPH and some public health PCT staff to Local Authorities - [Redacted]
 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]

We have redacted figures which could compromise the commercial activity of the HPA or prejudice negotiations with staff prior to formal consultation.

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	Optional
High	Optional		Optional	Optional
Best Estimate				

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

NA

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

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.

Key assumptions/sensitivities/risks

Discount rate (%) 3.5%

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.
 Salaries of staff transferring into the Department will not rise at greater than the rate of inflation
 The value of HPA income generating function would not have risen faster than the rate of inflation
 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 DsPH and other PCT staff to Local Authority contracts is a key sensitivity.
 Key risks include the loss of the skilled and specialist workforce and the potential loss of HPA's income generating function.

Direct impact on business (Equivalent Annual) £m):			In scope of OIOO?	Measure classified as
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?	01/04/2012 for HPA 01/04/13 local				
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 ₂ equivalent change in greenhouse gas emissions? (Million tonnes CO ₂ equivalent)	Traded:		Non-traded:		
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:		Benefits:		
Annual cost (£m) per organisation (excl. Transition) (Constant Price)	Micro	< 20	Small	Medium	Large
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
Statutory equality duties ¹²³ Statutory Equality Duties Impact Test guidance	Yes	EIA 117
Economic impacts		
Competition Competition Assessment Impact Test guidance	No	
Small firms Small Firms Impact Test guidance	No	
Environmental impacts		
Greenhouse gas assessment Greenhouse Gas Assessment Impact Test guidance	No	
Wider environmental issues Wider Environmental Issues Impact Test guidance	No	
Social impacts		
Health and well-being Health and Well-being Impact Test guidance	Yes	162
Human rights Human Rights Impact Test guidance	No	
Justice system Justice Impact Test guidance	No	
Rural proofing Rural Proofing Impact Test guidance	No	163
Sustainable development Sustainable Development Impact Test guidance	No	

¹²³ 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
9	Equity and Excellence: liberating the NHS; July 2010
10	Health Profile for England 2009 (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_114561)
11	Marmot review 2010 (http://www.marmotreview.org/)
12	A Healthier Nation 2010 (http://www.conservative.com/News/News_stories/2010/01/A_Healthier_Nation.aspx)
13	National Audit Office report "Reorganising central government" (March 2010) (http://bit.ly/aymAGx)

+ Add another row

Annual profile of monetised costs and benefits* - (£m) constant prices – Redacted text marked by ■

	Y ₀	Y ₁	Y ₂	Y ₃	Y ₄	Y ₅	Y ₆	Y ₇	Y ₈	Y ₉
Total Transition costs (low)	■									
Total Transition costs (high)	■									
Total Annual recurring cost (low)	■	■	■	■	■	■	■	■	■	■
Total Annual recurring cost (high)	■	■	■	■	■	■	■	■	■	■
Total annual costs (low)	■	■	■	■	■	■	■	■	■	■
Total annual costs (high)	■	■	■	■	■	■	■	■	■	■
Total Transition benefits										
Total Annual recurring benefits										
Total annual benefits										
Business transition costs	■	■	■	■	■	■	■	■	■	■
Business annual recurring costs	■	■	■	■	■	■	■	■	■	■
Business annual costs	■	■	■	■	■	■	■	■	■	■
Business transition benefits	■	■	■	■	■	■	■	■	■	■
Business annual recurring benefits	■	■	■	■	■	■	■	■	■	■
Business total annual benefits	■	■	■	■	■	■	■	■	■	■

* 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 (Health and Social Care Bill). The Bill will set 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. 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

- F3. As a nation, we are living longer, healthier lives than ever before. However, we know that too many of us damage our health through the choices we make in living our lives and we know that we need to be ever-vigilant in protecting people from hazards to health (such as infectious diseases) where individuals cannot readily protect themselves.
- F4. 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 group within the general population), where public health experts contribute to scientific and technical expertise resulting in an intervention (usually implemented by NHS services) applied to the members of a group.
- F5. 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 or local communities 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.

Background - Current public health system

- F6. 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 (SoS) and various NHS bodies have a role within health improvement as part of the existing healthcare system. For example, 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 who smoke into these services, or to provide brief interventions themselves. 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.

F7. Public health interventions are different from other health interventions – generally they involve an assessment of the needs, patterns and demands influencing health improvement and protection requirements 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

F8. The overall policy of setting up Public Health England 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.

Rationale for Government intervention

F9. The current public health system has grown up piecemeal and as a result is fragmented, not making 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.

F10. 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, but 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, which 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.

F11. Although disestablishing the NTA and transferring its responsibilities to the SoS 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. However, we believe that this move would tackle the dependency problems of individuals and, together with services provided by local authorities, help to address the entire range of issues which users face. The full recovery of drug users back into society, housing and employment will provide significant benefits to all.

- F12. With respect to 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.
- F13. Public health expertise can 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.
- F14. 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; thus 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.
- F15. Last year a report from the King's Fund suggested that "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."¹²⁴
- F16. 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 of 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.
- F17. 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, improving the health of the poorest fastest.

Options for the structure, funding and functions of the public health service

- F18. 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;

¹²⁴ Boyce, T, Commissioning and behaviour change, Kicking Bad Habits final report, Kings Fund, 2008

- 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

F19. Each of these is considered in the impact assessments accompanying the public health White Paper, which are integral to this impact assessment.

Interventions in the Health and Social Care Bill

F20. 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

F21. 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 as efficiency savings from the public health system as less duplication and more effective use of corporate services can occur within a unified service.

F22. 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

F23. The Do Nothing option is not viable because:

- SHAs and PCTs will be abolished following the transfer of their functions, including 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; and
- maintaining the status quo is unlikely to meet the overall objective of effectively protecting and improving the health of the population, improving the health of the poorest, fastest.

Preferred policy option

F24. The preferred policy option is to use the Bill to:

- Disestablish the Health Protection Agency and transfer responsibilities to SoS
- Transfer responsibilities for health improvement, and the role of Director of Public Health from NHS PCTs to local authorities.

F25. 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.

- F26. The preferred option means the Health and Social Care Bill will set out the public health functions and duties that will be led in future by SoS through Public Health England, including appointing Directors of Public Health (DsPH) jointly with local authorities.
- F27. The Bill will set 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.
- F28. It should be noted that the establishment of Public Health England is far wider than the simple legislative changes. 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 SoS 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.
- F29. 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 SoS, 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 SoS needs a public health service that he is able to deploy flexibly as needs arise and change, without further potentially costly reorganisations. That realistically can only be delivered by a service, which is integrated within the Department.
- F30. 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

- F31. 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:
- F32. The recent volcanic ash incident 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.
- F33. 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, as stressed elsewhere, 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. In addition, use of research funding has meant that to comply with EU regulations projects have had to go out to competitive tender even if in reality HPA was the only credible bidder. This can introduce significant delays in getting the required work started. In one instance, the Department needed to know whether to continue piloting an intervention against a common infectious disease. A full academic level analysis was not required initially, and HPA had the capacity and expertise to take the work forward quickly. However, the need to treat this as a 'research project' required that the project go out to competitive tender. HPA provided a bid sufficient to meet the Department requirement, HPA but insufficient to meet the requirements of a full academic research proposal. The work eventually proceeded, but only after considerable delay.
- F35. Most importantly, 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 can fairly be described as patchy. Success is overly-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 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 scope for 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 sent.
- 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 advice¹²⁵. 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, *integration* of mechanisms to prioritise work and *coherence and cost-effectiveness* in information collection and management - e.g. collecting each given piece of information once and 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 of around 30% 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.

F42. It is arguable that 30% savings in non-front-line costs could be made in the bodies concerned without integration. This is potentially true. However, the purpose of integration is **not** simply to make savings, rather it is to develop a streamlined, integrated public health service which can

¹²⁵ 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 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.

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 these size would make it unsustainable, further strengthening 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 better integrate intelligence may enhance the ability of the service to deliver what is needed and what works best. For example, we know that 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). We believe that better alignment of information, analysis and intelligence, would put us in a better position to understand the most appropriate interventions and enable early intervention.

Benefits associated with better responsiveness

- 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 SoS 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, improving the health of the poorest, fastest. In the Department's view, a first step to achieving this is to draw together under the SoS, 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. 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.
- 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, e.g. modelling using different methods, to ensure robustness of conclusions. This was of great benefit, for example, 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 – e.g. setting up trading companies wholly-owned by Secretary of State.

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 as to 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 and Departmental colleagues and stakeholders involved in the design of the NHS commissioning board and supporting development of commissioning consortia 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 preferred option for the national structure is the highest cost option. 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 significantly improve public health outcomes, 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])
- 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 SoS that there are no barriers, legal or structural, that would prevent the continuation of current income-generating activities. However there are potential risks to the fixed costs which are funded by this income. Assuming that there are no barriers to income generation and Public Health England supports a risk-aware, responsive, cost-focussed approach which supports income generation, the overall net reduction in contribution to the fixed costs has been estimated at [REDACTED]. If there are some barriers to income generation, customer perception problems to contracting with a Government department and lack of drive for external income, the overall net reduction has been

estimated at [REDACTED] 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 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, 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 even without moving HPA into Public Health England this external income would remain the same at constant prices.
- 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 of around 30% in non-front-line 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.
- 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 Health Bill (expected 2011).

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 counteract 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.

Benefits

- F64. By moving the role of the Director of Public Health, we are seeking 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.
- F65. 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.
- F66. 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 (i.e. local authority/PCT) to plan service provision across the public health arena.
- F67. Local authorities are more likely than GP consortia 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 undertake some public health preventive activities, since they will see cost savings in other areas under their control
- F68. 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

- F69. **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.
- F70. **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.

- F71. **Fragmentation:** Local authorities and GP consortia 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.

Other impacts

Equality impact assessment

- F72. 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.
- F73. 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 a 30% reduction in light of cost reductions across the public sector (to apply to non-front-line 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.
- F74. 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.
- F75. A full screening for equality impacts, and an action plan, is published within the Equality Impact Assessment document for the Health and Social Care Bill

Health and Wellbeing impact test

- F76. 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, improving the health of the poorest fastest. 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

- F77. The policies on the development of the new public health system and health visitors are unlikely to have a significant impact on rural areas or people. 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. In formulating policies for public health interventions, it may be appropriate to consider further the needs of rural communities.

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>Basis of the review:</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>Review objective:</p> <p>The national public health service will be in place by April 2012. 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>Review approach and rationale:</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 the success of the transfer at an operational level.</p>
<p>Baseline:</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>Success criteria:</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>Monitoring information arrangements: 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>Reasons for not planning a PIR: N/A</p>