

NHS Autonomy and Accountability

Proposals for legislation

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Foreword

Improving the NHS is the Conservative Party's number one priority. We want the NHS to succeed today and in the future, and believe that this requires an end to the pointless upheavals, politically-motivated cuts, increased bureaucracy and greater centralisation that have taken place under Labour. That is why we have brought forward this NHS Autonomy and Accountability White Paper.

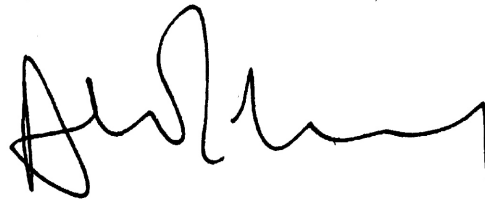
Building on existing foundations, this White Paper provides the structural and legislative blueprint which is needed to secure the long-term stability of, and bring success to, our NHS. It will give NHS professionals the greatest opportunity to exercise their professional judgement and expertise (in which the public have already put their faith), whilst improving the accountability of the NHS to patients.

Our aim is proceed from this White Paper to an NHS Autonomy and Accountability Bill in the next Parliamentary Session. This will enable the NHS to be responsive to professional expertise, competitiveness, and patient choice and voice.

If the Government supports these proposals, the NHS will do better in this Parliament and even better in the next.



Rt Hon David Cameron MP
Leader of the Conservative Party



Andrew Lansley CBE MP
Shadow Secretary of State for Health

Introduction

The NHS is the Conservative Party's number one priority. We share Britain's pride in the values which underpin it and we are confident about its future. We have made an unambiguous commitment to provide the NHS with the funding it needs to deliver European standards of health care to all, free at the point of use, and according to need and not ability to pay.¹

The unprecedented commitment from the taxpayer to the NHS in recent years underlines our collective desire to ensure NHS staff have the resources and equipment they need to deliver the highest quality of care to each and every patient. However, over this same period in which NHS resources have been increasing at record levels, opportunities to deliver commensurate gains in quality have been lost through a combination of falling productivity, excessive bureaucracy and lamentable leadership and management by Ministers.

We are determined to recover these lost opportunities in order to deliver tangible improvements in health outcomes for all.

Under David Cameron's leadership, the Conservative Party has set the agenda on the NHS. We have highlighted the risks to patient care engendered by the NHS financial crisis. We have cautioned against closures of NHS services which are not based on clinical evidence. We have warned of the impending threat to local facilities as a result of the European Working Time Directive. In each case, we have suggested solutions to tackle the problems. We have been able to do this successfully because we have reached out to the staff of our NHS, the patients they care for, and the public, and listened to their hopes for – and experiences of – our NHS.

In January 2006, we rejected any system of funding the NHS through any means other than general taxation. We committed ourselves to an NHS delivering comprehensive, universal standards of care to all who need it, and we ruled out sanctioning the use of public money to enable people to opt out of it.²

In October 2006, soon after Labour's ninth reorganisation of the NHS since 1997, we ruled out any more such pointless organisational upheavals which have done so much damage to the NHS. We pledged to re-engage and re-empower health professionals.

Box 1: Work with the Public Services Improvement Policy Group

The recent health report by the Conservative Party's Public Services Improvement Policy Group has provided us with a wealth of evidence and proposals from which we will develop further the policies of the next Conservative Government.

We share the principles underlying the Policy Group's report and – as evidenced by this White Paper – we are already working to deliver the ideas we share into workable proposals. We hope these proposals will not just help us to inform future policy, but also fill the current policy vacuum in the Department of Health.

This White Paper responds to several of the Policy Group's proposals. Separately, we have already initiated formal consultations on public health (Conservative Party, Public Health: Our Priority, 16 March 2007) and patient and public engagement (Conservative Party, HealthWatch: a consultation, 26 October 2006) – both of which have generated supportive and constructive responses.

The importance of a stronger framework for the delivery of Government-wide public health objectives can hardly be overstated. Well-being, the reduction of health inequalities, the improvement of health outcomes, and the sustainability of the NHS itself all depend on the achievement of far greater success in public health than has been seen over the last decade.

Our public health consultation, based on a Secretary of State-led focus on public health action, a public health service separate from the NHS, financed by flexible budgets, supported by advice from a strengthened Chief Medical Officer's Department, and led locally by Directors of Public Health, is designed to offer such a framework. We will now go on to assess in greater detail how we can move from a structural focus on these objectives to practical action.

Following the Policy Group's recommendations, we intend to conduct further work on the structure of primary care commissioning and the future for NHS dentistry.

¹ In his speech to the 2006 Conservative Party conference, David Cameron said that, 'we will always support the NHS with the funding that it needs.'

² David Cameron, Speech to the King's Fund, 4 January 2006

In January 2007, we pledged to end the top-down, centralised, target-driven culture which has so frustrated the work of front-line clinicians in our NHS. We are confident that those front-line clinicians are best placed to judge the clinical needs of patients; we are convinced that they do not need arbitrary targets to do it. We have since initiated extensive consultation on a framework of devolved performance management based on measuring the actual outcomes patients experience as a result of their treatment – as opposed to targets focused only on narrow processes.³

The Labour administration's obsession with top-down process targets is characteristic of their persistent, centralising approach to the delivery of NHS care. Despite promising to 'shift the balance of power' to the front-line six years ago⁴, Labour continue to seek to intervene in the day-to-day decisions of the NHS – and when the public seek to hold Ministers to account for major service reconfigurations, the Government absolves itself from all responsibility and claims that the decisions are made locally.

The NHS of today therefore lacks both autonomy and accountability. That is why in October 2006 David Cameron and Andrew Lansley pledged to bring forward proposals to legislate for greater NHS autonomy, to end political interference in the day-to-day decisions about patient services, and to enhance the accountability of the NHS to both patients and members of the public.⁵

This White Paper sets out proposals for legislation – subject to consultation over the next three months, during which work will be undertaken to prepare the legislation needed to give effect to these proposals. Subject to the responses we receive, we will present a Bill to Parliament early in the next Session. We will invite Gordon Brown to support it – as a basis for a long-term, sustainable consensus on the legislative constitution for the NHS – and we look forward to working to make the proposals a reality.

We believe the proposals contained in this White Paper will reverse the sense of confusion, upheaval and lack of direction which has done so much to damage and demoralise the NHS in recent years.

³ Conservative Party, Outcomes, not targets, 22 January 2007

⁴ Department of Health, Shifting the balance of power in the NHS, July 2001

⁵ The Daily Telegraph, 'We'll stop ministers meddling with the NHS, says Cameron', 8 February 2006

Executive Summary

1. The National Health Service (NHS) needs to be freed from day-to-day interference by politicians. It must be responsive to the needs and choices of patients.

This requires the full re-engagement of health professionals. We know that NHS staff will grasp the opportunity provided by genuine freedom from interference, and respond positively to the incentives of competition.

However, we recognise that – at the same time – the NHS must be made genuinely accountable both to patients (as consumers of health services), and to the democratic voice of the public.

2. This White Paper proposes legislation which, while minimising organisational upheaval, would give the NHS the coherent, sustainable, pro-competitive, and accountable structure which will provide the process of NHS reform with a direction and purpose which has been lacking until now.
3. We invite comments on these legislative proposals prior to their introduction in the next Parliamentary Session.

We call on the Labour Government to support these proposals, which will deliver the coherent framework for policy which has been lacking since the introduction of the NHS Plan.⁶

4. The NHS Autonomy and Accountability Bill will:

- Give statutory backing to the ten NHS core principles which were agreed in the NHS Plan (chapter 1).
- Provide enhanced inspection powers for Local Involvement Networks (LINKs) and make them independent of local authorities (chapter 2).
- Establish HealthWatch as a national consumer voice on behalf of patients (chapter 2).
- Require Primary Care Trusts (PCTs) to produce an annual Health Improvement Plan (HIMP) to govern service planning and contracts with healthcare suppliers, in consultation with their local authorities⁷ and LINKs (chapter 2).
- Extend patient choice and underpin it with an information strategy to empower both patients and commissioners (chapter 2).

- Establish an NHS Board, independent of day-to-day interference by Ministers, and responsible for: the commissioning of NHS services; the allocation of NHS resources; and the delivery of objectives to improve outcomes for patients, as agreed with the Secretary of State (chapter 4).
- Give primary care commissioners the responsibility for the majority of the NHS budget, together with the freedom to commission the majority NHS of services as they see fit (chapter 4).
- Extend the freedoms of NHS Foundation Trusts (chapter 5).

- Establish independent regulation of healthcare sector suppliers (chapter 5).
- Empower Monitor as an economic regulator and the Healthcare Commission as a quality inspectorate, together creating a pro-competitive ‘social market’ for the delivery of effective, high-quality healthcare to NHS patients (chapter 5).

5. This White Paper also:

- Sets out the development of the NHS tariff under payment by results (chapter 3).
- Proposes a statutory basis for the National Institute for Health and Clinical Excellence (NICE) (chapter 4).
- Invites comments on a sector strategy for the delivery of workforce planning, education and training in the healthcare sector (chapter 6).

6. The proposals in this paper implement a number of the recommendations made by our Improving Public Services Policy Group.

They will give coherence to Labour’s contradictory reforms, and give the NHS and the staff who work in it a clear sense of the direction of reform.

The proposals will provide the NHS with the long-term institutional structure necessary to complement our other policies, which are designed to prioritise public health and to

⁶ Department of Health, NHS Plan, July 2000; available here: http://www.dh.gov.uk/prod_consum_dh/idcplg?ldcService=GET_FILE&dID=23612&Rendition=Web
⁷ Throughout this White Paper, ‘local authority’ means a local authority with a social services department (i.e. a county, unitary, metropolitan or London borough local authority).

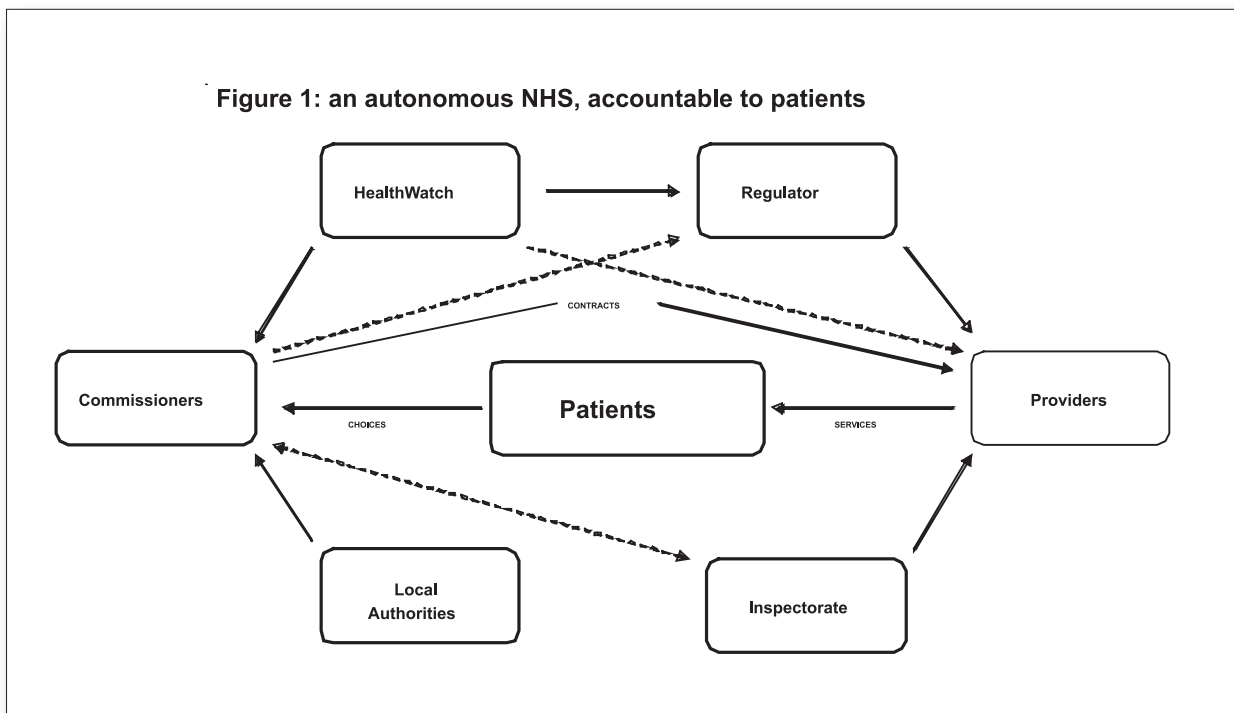
focus on clinical outcomes for patients instead of process-orientated top-down targets.

The NHS over the last decade benefited from unprecedented resources, yet has experienced declining productivity, escalating costs, excessive bureaucracy and the alienation of professionals.

We are determined to re-engage these professionals in the delivery of health care, to drive productivity improvements, and to enable leaders and managers in the NHS to respond to patients rather than bureaucratic requirements.

We will reverse the fragmentation of, and lack of accountability in, NHS services, and secure for NHS patients a healthcare service at least the equal of other leading European health services – and we will do so whilst remaining true to the founding principles of the NHS.

Together, the proposals in this White Paper set out a framework for an autonomous NHS, accountable to patients. Its structure is summarised in Figure 1, below.



1. The values of our NHS

1.1 This White Paper sets out a vision for the NHS which would give it greater autonomy in meeting the needs of patients.

It sets out a vision in which the providers of healthcare deliver care according to evidence-based standards, determined by clinicians and experts at both national and local level.

It sets out a vision in which these providers of healthcare are rewarded on the basis of how well they treat their patients, and not on their adherence to centrally-imposed, process-driven targets.

1.2 The proposals in this White Paper will set the NHS free to deliver the best possible care to patients.

They involve setting both commissioners and providers free to innovate and develop NHS services in response to the wishes of patients and members of the public.

1.3 In this environment of local autonomy and accountability, and scope for innovation, it is imperative that each commissioner and each provider holds true to the founding principles of the NHS in co-operating with one another.

1.4 Although the current legislation governing the NHS requires the Secretary of State to provide a comprehensive health service, it does not express the principles on which the NHS was founded apart from placing restrictions on patient charges and requiring that health services are provided effectively, efficiently, and economically.⁸

1.5 This White Paper sets out our proposals for legislation which will provide greater statutory definition for the various NHS bodies, bring clarity to the NHS's regulatory regime, and set out clearly for the first time the duties, responsibilities and functions of the organisations providing NHS care to patients.

1.6 We believe there is a crucial need for this legislation to ensure that all bodies and organisations providing NHS care would have to have regard to these principles of the NHS in caring for patients.

This will reflect the continuing commitment of Parliament and

the public to the principles of the NHS.

It will ensure that any attempt to deviate from them would require primary legislation – exposing it to both Parliamentary and public scrutiny.

1.7 Seven years ago, the NHS Plan set out ten NHS core principles which were endorsed by 25 organisations representing both NHS staff associations and patient groups.⁹

Though many of the NHS Plan's original policies have now largely been ignored or superseded¹⁰, we are of the view that the NHS core principles it contains are timeless; that they inspire NHS staff; and that they are shared by the vast majority of patients and members of the public.

The next Conservative Government will incorporate the following principles in legislation.

Box 2: NHS core principles

1. The NHS will provide a universal service for all based on clinical need, not ability to pay.
2. The NHS will provide a comprehensive range of services.
3. The NHS will shape its services around the needs and preferences of individual patients, their families and their carers.
4. The NHS will respond to different needs of different populations.
5. The NHS will work continuously to improve quality services and to minimise errors.
6. The NHS will support and value its staff.
7. Public funds for healthcare will be devoted solely to NHS patients.
8. The NHS will work together with others to ensure a seamless service for patients.
9. The NHS will help keep people healthy and work to reduce health inequalities.
10. The NHS will respect the confidentiality of individual patients and provide open access to information about services, treatment and performance.

⁸ Office of Public Sector Information, National Health Service Act 2006, 2006; available at: <http://www.opsi.gov.uk/acts/acts2006/20060028.htm>

⁹ The core principles (in box 2) are available here: <http://www.nhs.uk/England/AboutTheNhs/CorePrinciples.cmsx>.

¹⁰ For example, two of the Government's flagship policies, Payment by Results and Practice-Based Commissioning, are not even referred to in the NHS Plan.

Department of Health, NHS Plan, July 2000; available here:

http://www.dh.gov.uk/prod_consum_dh/idcplg?IdcService=GET_FILE&dID=23612&Rendition=Web

1.8 We regret that Labour are currently in the process of revising these core principles,¹¹ and we are particularly concerned that in the list of Labour's revised principles, the following principle has been omitted:

Public funds for healthcare will be devoted solely to NHS patients.

We are of the view that omitting this principle from legislation would allow the use of NHS funds to cross-subsidise private healthcare, and we reject this.

1.9 We will incorporate the ten NHS core principles contained in the NHS Plan in legislation, as they appear in the NHS Plan.

¹¹ Department of Health, Consultation on NHS core principles, 11 December 2006; available here: http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_064732

2. Accountability

2.1 The NHS suffers from a democratic deficit and a lack of accountability to patients and members of the public.

Current problems

2.2 The lack of accountability in part derives from the NHS Act, which gives the Secretary of State immense discretion in determining the way in which the NHS operates, and allows great scope for ministerial interference in NHS services without reference to either patients, members of the public, or NHS staff.

2.3 Cases of ministerial interference include, for example:

- **The tariff.** The Secretary of State has responsibility for setting the national price list for procedures - the ‘tariff’ – delivered in NHS hospitals. This allows scope for manipulation of the tariff in order to meet policy objectives: the tariff, for example, was raised on average by 1.5 per cent in 2006-07 as compared to 2005-06¹², and by 2.5 per cent in 2007-08¹³ – despite inflation in the hospital sector currently running at 5.3 per cent per year.¹⁴

Whilst this is a brutal way to control costs, it is ultimately unsustainable because it inevitably leads to the reduction of services. The only way in which costs can be controlled in the long run is by driving efficiency improvements in services delivered by the hospital sector.

The tariff should, therefore, be set independently of Ministers.

- **NHS funding.** The Secretary of State determines whatever results of the NHS funding formula he or she wants to see. This allowed the Secretary of State, in November 1998, to demand that a key objective of the NHS funding formula should be, ‘to contribute to the reduction in avoidable health inequalities’.¹⁵

Although the objective is admirable, it has had the effect of creating a mismatch between the supply of NHS resources

and the demands on the service – a situation which has led to what the Department of Health admits is a ‘moderate correlation’ between NHS deficits and the funding formula.¹⁶

NHS resources should only be allocated to areas in order to ensure equal access to healthcare for all. To avoid incentives to manipulate the funding formula, it should be set independently of Ministers.

2.4 No NHS organisation has genuine autonomy from the Ministerial interference described above. All of them are ultimately accountable to the Secretary of State.

*Even Monitor¹⁷ – the regulator of NHS Foundation Trusts – must:*¹⁸

‘...exercise its functions in a manner consistent with the performance by the Secretary of State of his duties.’

Note the way in which this requires Monitor to be consistent with the way in which the Secretary of State ‘performs’ his or her duties: this means that if the Secretary of State chooses to perform these duties differently, then so must Monitor.

2.5 We believe that accountability in the NHS should not rest with the Secretary of State to the extent it does now.

2.6 We believe that the NHS itself should be more accountable to both individual patients and to patients’ collective interests.

We also believe that NHS services need to be accountable to members of the public in their locality.

2.7 We have considered the possibility of placing NHS budgets in the hands of local authorities, as a means by which democratic accountability can be brought into the provision of local NHS services.

However, we are of the view that the commissioning of local

12 Department of Health, The NHS Operating Framework for 2006-07, 22 February 2006; available here: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4130756

13 Department of Health, 2007-08 tariff uplift, December 2006; available here: http://www.dh.gov.uk/prod_consum_dh/idcplg?ldcService=GET_FILE&dID=135883&Rendition=Web

14 Office of National Statistics, Consumer Price Indices: May 2007, 12 June 2007; available at: <http://www.statistics.gov.uk/pdfdir/cpi0607.pdf>

15 Department of Health, Resource Allocation: Weighted Capitation Formula, 27 May 2005; available here: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4112067.pdf

16 Department of Health, Explaining NHS deficits, 20 February 2007

17 Monitor’s statutory name is the Independent Regulator of NHS Foundation Trusts.

18 Section 32, Office of Public Sector Information, National Health Service Act 2006, 2006; available at: <http://www.opsi.gov.uk/acts/acts2006/20060028.htm>

NHS services requires a unique mix of professional input, national standards and local priority-setting.

We are also of the view that the demands on the NHS budget, together with the priority attached to NHS services by members of the public, would overwhelm the budgets for other services provided by local authorities.

We believe that placing NHS commissioning budgets in the hands of local authorities is unsustainable, and we reject it.

2.8 The remainder of this chapter spells out the special means by which we propose NHS services will become genuinely accountable to patients and members of the public.

Patient voice at a local level

2.9 All patients need to have easy access to an NHS watchdog with a powerful, national brand and a strong, local presence.

2.10 Labour have failed to provide this:

- Community Health Councils (CHCs) – which had originally been established in 1974 – were abolished on 1 December 2003¹⁹, after almost 30 years’ existence. The expertise they built up in helping patients was lost.
- The longevity of CHCs contrasts with the brevity of their successor bodies: Patients’ Forums. Patients’ Forums were established in December 2003²⁰ and are set to be abolished by the end of this year.²¹
- Labour are currently progressing legislation through Parliament which will establish Local Involvement Networks (LINKs) in the place of Patients’ Forums.²²

These changes have delivered three different mechanisms for patients and members of the public to engage and involve themselves in the development of NHS services in less than four years.

2.11 In contrast, we are of the view that mechanisms for

engaging patients in their health services need to endure, so that brand awareness increases over time and to ensure that the experience of those who operate these mechanisms is retained.

In keeping with our commitment to avoid organisation upheaval, we will not abolish LINKs.

2.12 We will use LINKs, when established, as the foundation of our policies for patient and public involvement in health at a local level.

2.13 However, we are of the view that LINKs – as currently planned – are too weak and will have too few powers to command the confidence of patients and members of the public. Therefore, we believe that:

- LINKs should be made independent of local authorities. Our plans to enhance the accountability of NHS services to local authorities are outlined below.

LINKs should be given additional powers of inspection, and the ability to act as advocates for patients who complain about NHS services.

Patient voice at a national level

2.14 We recognise that there are occasions on which patients also need national representation – particularly when concerns about NHS services occur as a result of policy determined nationally.²³

2.15 In December 2005, an independent review of the NHS’s regulatory framework – ordered by the Department of Health – concluded that:²⁴

‘...the importance of consumers/patients in the values of Health Service reform is frequently expressed but not always so effectively mobilised. *Establishing representative national and regional fora to contribute a reasoned collective consumer*

19 Hansard, 24 October 2005, Col. 170WA; available at: <http://www.publications.parliament.uk/pa/cm200506/cmhansrd/vo051024/text/51024w43.htm>

20 Ibid.

21 Department of Health, A stronger local voice, 13 July 2006; available at:

http://www.dh.gov.uk/prod_consum_dh/idcplg?ldcService=GET_FILE&dID=20130&Rendition=Web

22 Local Government and Public Involvement in Health Bill, introduced 13 December 2006; available at:

http://www.publications.parliament.uk/pa/cm200607/cmbills/016/en/index_016.htm

23 Concerns over the provision of NHS-funded continuing care, for example, account for more than half of the complaints made to the Health Service Ombudsman.

Parliamentary and Health Service Ombudsman, Making a difference, 2006; available at:

http://www.ombudsman.org.uk/pdfs/ar_06.pdf

24 David Currie (Chairman of the Department of Health’s Wider Review of Regulation), Letter to Patricia Hewitt, 18 January 2006

perspective to the process of reform could well improve both the efficacy and legitimacy of that reform.'

We share this conclusion.

We will establish a national consumer voice for patients: HealthWatch.

2.16 HealthWatch will provide support to patients at a national level and leadership to LINKs at a local level. It will also incorporate the functions of the Independent Complaints Advisory Body.

2.17 HealthWatch will have statutory rights to be consulted:

- Over guidelines issued nationally concerning the care NHS patients should receive ('commissioning guidelines').
- Over decisions which affect how NHS care is provided in an area. It will also be able to make representations to the NHS Board in relation to the planning of NHS services, such as where an Accident and Emergency Department closure is proposed.

Public engagement through local authorities

2.18 Strategies to engage members of the public in the delivery of NHS care overlap with - but are distinct from - mechanisms to ensure patients have 'voice' in the care they receive.

2.19 Mechanisms for patient voice are concerned, by necessity, with the care which only patients receive. However, members of the public also quite rightly have an interest in the NHS services in their locality: at some point in their lives, after all, everyone will need the NHS.

2.20 Therefore, mechanisms for public engagement need to be representative not only in reaching out to those who rely on NHS care, or those who have a particular interest in NHS services, but also to those who are not necessarily as directly interested in the delivery of health care.

Mechanisms for public engagement also need to have the capacity to plan the prospective provision and delivery of NHS care.

2.21 We are of the view, therefore, that local authorities are best placed to engage members of the public in the delivery of local NHS services.

2.22 NHS accountability to local authorities exists at present through embryonic Local Area Agreements, through the ability to create 'Care Trusts' providing both NHS services and local authority social services, and through local authority Overview and Scrutiny Committees which have powers to refer NHS reconfigurations to the Secretary of State.

2.23 We believe all these mechanisms can be enhanced.

- Local Area Agreements between local authorities and PCTs should explicitly define local priorities for NHS services, desired outcomes for patients, and the steps public bodies will take to improve the general health of the population.
- The creation of Care Trusts should be encouraged where appropriate, since they help to avoid the unnecessary duplication of staffing and services.
- Local authority Overview and Scrutiny Committees should be given greater powers and scope to investigate and report on NHS services.

2.24 In addition, we believe that local authorities – where appropriate – should jointly commission health and social care services. This can be achieved either through pooling budgets at the organisational level, or by giving individual service users 'individual budgets' with which they can commission health and social care services themselves.

2.25 The use of 'individual budgets' will particularly help those living with long-term conditions: a common criticism of existing NHS and social care services is that the care provided to the estimated 17.5 million people in England living with long-term conditions is 'done unto' them – despite that fact that they often know more about their own condition than clinicians.

In allowing those living with long-term conditions to exercise greater choice and voice in the care they receive, the widespread use of individual budgets will help to provide genuine accountability in NHS and social care services to those living with long-term conditions.

Public engagement in NHS services

2.26 PCTs already have powers to publish an annual Health Improvement Plan (HIMP), which sets the framework for the local commissioning and contracting of services.

2.27 We will require all PCTs to produce such plans, and require each PCT's coterminous local authority to be consulted on their development. Both of these requirements will be enshrined in legislation.

2.28 In those cases where agreement between local authorities and PCTs cannot be reached, disputes will be resolved in the first instance by the relevant Strategic Health Authority (SHA), with a right of appeal to the NHS Board (see chapter 3 for details on the NHS Board).

If the HIMP involves a major service reconfiguration, the Independent Reconfiguration Panel will be consulted as necessary.

Patient choice

2.29 The mechanisms outlined above relate to the formal, organisational processes through which the NHS can be made accountable to patients and members of the public.

2.30 However, we also believe that the NHS can and should be accountable at the level of each and every individual patient.

We remain committed, therefore, to the concept of patient choice as a means through which a patient-centred service is created, and through which the standards and quality of health care services are raised.

2.31 However, we recognise that patient choice needs to be supported by comprehensive information relating to the provision and delivery of NHS services.

Though simply allowing patients to choose where they are treated will drive improvements in the information provided to them – for example, hospitals will unilaterally seek to highlight to prospective patients why they should be chosen over other

hospitals – we recognise that this process may not go far enough, fast enough.

2.32 We also recognise that the standard of information actually available to patients about the care they receive at present is lamentable. Though the quantity of data collected by the Department of Health is vast – it demands from all NHS organisations in England each year a total of almost 250,000 data returns²⁵ - its relevance to patients is limited.

The Picker Institute has also confirmed that the availability of useful information to NHS patients in the UK is relatively poor.²⁶

2.33 Therefore, we will contract the NHS Information Centre to secure public access to high-quality information relating to the standards of care they may expect from providers.

This information will include:

- Standardised mortality rates and morbidity data, adjusted as far as possible for the complexity of the procedures undertaken.
- Waiting times.
- Patient satisfaction survey data.
- Self-reported outcomes by patients.
- Data on the prevalence of healthcare-acquired infections.

2.34 We are confident that the provision of high-quality information will help make each provider of NHS care truly accountable to patients, and drive large gains in the standards of care provided by them.

²⁵ Conservative Party analysis of: Hansard, 12 June 2007, Col. 999WA; and Hansard, 16 May 2007, Col. 792WA.

²⁶ Picker Institute, Engaging patients in their healthcare – how is the UK doing relative to other countries, 24 April 2006

3. Payment by Results

3.1 Patient choice needs to be supported by a powerful system which offers rewards to the best providers.

We believe that the best way this can be achieved is by allowing money to follow the patient to the provider of their choice.

3.2 Allowing money to follow the patient in this way rewards popular and efficient providers and offers incentives to poor providers to improve productivity and raise the standards of patient care they deliver.

3.3 This principle underpinned the last Conservative Government's 'internal market' reforms of the NHS which drove the unprecedented rate of service improvement in the early 1990s. It was abandoned by the incoming Labour Government in December 1997, but returned as policy in 2002 and was progressively introduced from 2003-04 under the name of 'payment by results'.

3.4 The absence of such a market-based mechanism between 1997 and 2003, and the loss in efficiency which resulted, is an important factor in explaining the NHS's declining productivity in recent years:

- 1.2 million more people would be getting hospital treatment if Labour after coming to power had kept up the rate of increase in hospital treatments achieved by the NHS under the internal market.²⁷
- If Labour had reduced the length of time patients had to stay in hospital since 1997 at the same rate as the Conservatives did before 1997, the NHS would have the equivalent of over 10,000 extra beds.²⁸

3.5 Since 2003, the value of NHS activity covered by payment by results has increased markedly: it now stands at some £22 billion.²⁹

Under it, hospitals are reimbursed for delivering any given procedure at an average price for the range of case-mixes and clinical interventions associated with it. The full list of prices is known as the 'tariff'.

3.6 **We support the concept of payment by results.** However,

we recognise that there are ways in which it can be improved.

Primary care commissioning

3.7 As it currently operates, payment by results creates powerful incentives for providers to increase activity, but it has not been introduced alongside similarly powerful mechanisms for commissioners to manage the activity levels which they have to pay for.

3.8 The result is an unbalanced market, in which equilibrium exists at a point where hospitals are delivering an inefficiently high level of procedures.

3.9 This imbalance can be solved by creating demand management mechanisms.

The GP fundholding model in the 1990s allowed GPs to manage patients in the community and avoid unnecessary hospital admissions as they saw fit, rather than be bound by the contracts negotiated by NHS managers in Health Authorities which tended to entrench historical [and inefficient] activity patterns, and which restricted scope for innovative care.

3.10 We support the return of powerful, clinician-led commissioning in primary care – like that engendered by GP fundholding in the 1990s.

Service-level economics

3.11 All markets require information, yet the information which is needed to support payment by results is deficient.

3.12 Service-level data collection is so poor in many NHS providers that – even with the transparency engendered by payment by results – NHS hospitals have little idea which of their activities are profitable under the tariff, and which are loss-making.

3.13 Without adequate service-level information, each price listed in the tariff necessarily groups many different 'case-

²⁷ Figures drawn from analysis of figures in Hansard, 21 June 2004, Col. 1281WA; Hansard, 25 February 2005, Col. 904WA; and Department of Health, Hospital Episodes Statistics, 13 December 2006

²⁸ Figures drawn from analysis of figures in Hansard, 18 October 2006, Col. 1325WA; and Department of Health, Hospital Episodes Statistics, 13 December 2006

²⁹ Department of Health, Departmental Report 2007, 18 May 2007

mixes' and clinical interventions together under a single price.

This means there is considerable potential for astute providers to 'cherry-pick' routine, high-volume procedures, leading to a situation where low-volume, high-cost cases will eventually not be undertaken because they are not profitable.

3.14 Imperfect information results in market failure, so a much greater emphasis on service-level economics is required.

Our proposed regulatory framework will ensure that providers of NHS care manage their services in a way which encourages the collection and use of information.

Varying the tariff

3.15 At present, the tariff is too rigid a pricing mechanism.

Although setting prices at average cost will help to make those providers who currently deliver procedures at above-average cost more efficient, it can have perverse effects on those providers who can deliver procedures at a below-average cost.

In the long run, without change, the result of a tariff which lists prices at average cost is that each and every provider's cost structure will gravitate towards the average cost.

Therefore, we believe that the tariff should increasingly be set on the basis of the costs delivered by the more efficient providers – and that providers should also be entitled to offer discounts to it.

3.16 However, we recognise that allowing providers to offer discounts to the tariff is difficult at present because of the paucity of comprehensive, service-level information about the costs they incur.

Therefore, we will seek to permit discounts to the tariff only after the existing framework for delivering payment by results becomes redundant in 2008.

Price-setting

3.17 As mentioned in chapter two, the tariff is ultimately set by

Ministers and is therefore open to political manipulation.

3.18 The tariff should not be manipulated in this way, but should be based on the costs providers incur in delivering treatments: divorcing the prices which the providers of NHS care are paid for treating a patient from the actual costs incurred in providing the treatment is obviously unsustainable.

3.19 We believe that the tariff should be set on the basis of the actual costs incurred in providing treatment. To remove the possibility of Ministerial manipulation, the responsibility for setting the tariff should pass to an independent body (see chapter five).

4. Autonomy in commissioning

The purchaser-provider split

4.1 Allowing money to follow the patient to the provider of their choice – as under payment by results – will help to drive improvements in the responsiveness of services to patients.

However, it does not address the mechanism through which providers operate, and what services they provide.

The process by which this is achieved is ‘commissioning’, or what used to be called ‘purchasing’: negotiating contracts and contract values; stipulating the services which should be provided; and setting out long-term plans for the development of NHS service provision.

4.2 The effectiveness of commissioning is pivotal to the success or failure of NHS services, and we are of the view that commissioning is at its most effective when clearly split from the provision of NHS services. We believe that the split between commissioners purchasing health care, and providers delivering it, remains an essential check and balance, ensuring that the NHS responds not to the vested interests of healthcare providers, but to the interests of patients.

4.3 Though Labour have not abandoned the split between purchasers and providers introduced by the last Conservative Government in 1990, it has muddied the distinction between them by combining the two functions in PCTs.³⁰

The lack of effective commissioning since the creation of PCTs in 2002 in part explains the failure of the NHS to use its increased resources to deliver corresponding healthcare gains.

4.4 In July 2005 Sir Nigel Crisp, the then Chief Executive of the NHS, published *Commissioning a Patient-led NHS* which called on PCTs to become commissioning-only organisations and to divest themselves of their provider functions.³¹

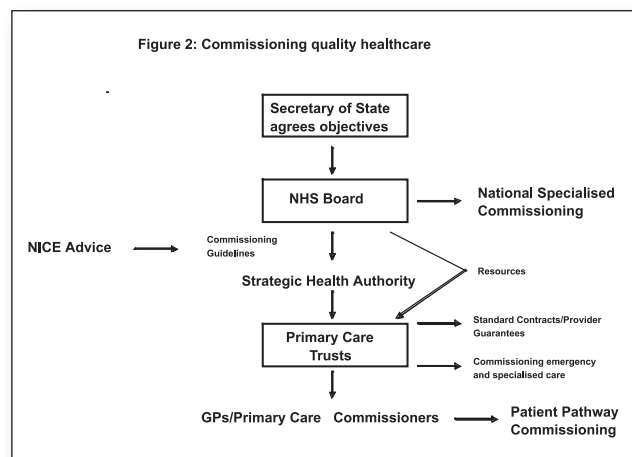
Regrettably, this plan was effectively undermined three months later when Ministers decided that PCTs could, in fact, remain as providers.³²

4.5 We will separate the purchasers of NHS care from its providers.

Commissioning quality healthcare

4.6 We will ensure that the NHS has a commissioning structure fit for purpose: a structure focused on patients; innovative and effective in its procurement of a patient pathway; and an effective promoter of competition between providers of NHS care.

4.7 Given our commitment to avoid organisational upheaval, this commissioning structure will be based on existing structures outlined in Figure 2.



Clinician-led commissioning in primary care

4.8 This White Paper has already set out, in chapter two, our support for clinician-led commissioning in primary care, as a means through which demands on the NHS can best be managed.

We believe it has other merits beyond this.

Clinician-led commissioning in primary care combines the decision-taking responsibility for where and how patients are

³⁰ Department of Health, *Shifting the balance of power in the NHS*, July 2001

³¹ Department of Health, *Commissioning a patient-led NHS*, 28 July 2005; available at: http://www.dh.gov.uk/prod_consum_dh/idcplg?ldcService=GET_FILE&dID=20618&Rendition=Web

³² Hansard, 25 October 2005, Cols. 152

treated with the finances which are necessary to support it.

In aligning these two tasks:

- The clinician's voice, on behalf of their patient, is strengthened because the clinician is responsible for the resources needed to support his or her judgement.
- If a clinician is engaged in inappropriate or inefficient referral practices, they will be able to identify and address them easily. This will help drive efficiency improvements in the NHS.

4.9 In addition, commissioning requires an understanding of the current and future epidemiology of an area – i.e. the burden of disease which exists there. Clinicians in primary care are those best placed to assess and anticipate an area's burden of disease.

4.10 Clinician-led commissioning in primary care is the best tool, therefore, to develop the effective use of procurement and contract processes so that they secure delivery of services that best meet the needs of an area's population.

4.11 The Government, in introducing Practice-Based Commissioning (PBC), has recognised the value of this approach.

However, although PBC is clearly derived from the successful aspects of the last Conservative Government's policy of GP fundholding – and, in particular, total purchasing pilots (through which GPs controlled most of the NHS budget for their patients) – PBC is not making fast enough progress in transferring day-to-day commissioning responsibilities to front-line primary care clinicians.

4.12 We believe that PBC needs to be strengthened. We will ensure that legislation enables primary care commissioners to hold real – as opposed to hypothetical – budgets, to hold and vary contracts with healthcare providers³³, and to reinvest savings on behalf of their patients.

³³ However, to safeguard the integrity of the purchaser-provider split primary care commissioners will not be able to negotiate contracts with providers in which they have direct or connected interests (for example, to commission services from a pharmacy which is situated in the clinicians' own practice); they will be able to utilise contracts negotiated by the PCT.

The NHS Board

4.13 Patients want to know that high quality services are available to them, and that they have access to a high and equitable standard of care wherever they live in the country.

This must, therefore, also be the concern of commissioners.

4.14 Commissioners are currently performance-managed by the Department of Health. We believe that this has been a failure.

As a result of political interference in the NHS, commissioners are at present focused on narrow, process-based targets – such as the speed at which patients receive their first treatment.

We have already pledged to remove these process targets, which distort clinical priorities, and replace them with a new focus on the actual outcomes for patients.

4.15 To ensure that political interference does not result in the distortion of clinical priorities and the denial of autonomy to front-line NHS clinicians, we will establish an autonomous NHS Board to oversee the commissioning of NHS services.

Box 3: Targets

'The downsides of targets are several.

'One is that you get perverse outcomes - people focus on one target at the expense of others and actually that damages the services and that's happened, for example, in the health service.

'A second problem is that people cheat - resources get marshalled behind a particular target; people find ways of meeting that target although actually perhaps not facing up to the things that are driving it.

'But perhaps the biggest problem of targets is that they deny autonomy to frontline managers.'

Matthew Taylor, Former Head of No.10 Policy Unit and adviser to Tony Blair, 15 July 2002

4.16 The NHS Board will be established on a statutory basis, and its members will be appointed by Ministers on the basis of recommendations made by the Appointments Commission.

The Board will have both executive and non-executive members, and include clinical, financial and commissioning directors.

The Board will report to a Chief Executive and a non-executive Chairman.

4.17 The NHS Board's statutory duties will be to:

- Secure comprehensive health services.
- Deliver improvements in the physical and mental health of the population.
- Deliver improvements in the diagnosis and treatment of illness.

These are duties consistent with those of the Secretary of State. Legislation will require that the duties of the Secretary of State in relation to providing NHS services are undertaken through the NHS Board.

4.18 The Secretary of State will agree with the NHS Board a set of objectives based on improvements in measurable health outcomes (rather than processes) over a given period

of time, and consistent with the level of resources for the NHS determined by Ministers and voted by Parliament.

Our overall, long-term objective will be to achieve in this country standards of healthcare which match the best in Europe.

4.19 The NHS Board will reflect the highest standards of corporate governance and transparency.

Its Chairman and Chief Executive will be accountable for its statutory responsibilities to Ministers, whilst the NHS Board itself will be required to report to Parliament.

4.20 Like all other NHS bodies, the NHS board will also be bound by the values of the NHS listed in chapter one.

4.21 The Board's specific functions will include:

- Setting commissioning guidelines on the basis of advice issued by the National Institute for Health and Clinical Excellence (NICE).
- Setting of standards for commissioning in the NHS, taking into account the available resources.
- Performance-managing commissioners at a local level, through SHAs and PCTs.
- Developing national framework contracts for primary

Box 4: Outcomes, not targets

Cancer is a key public and NHS priority.

As a result of the Department of Health's Cancer Plan, resources have been made available to raise the quality of cancer care provided by the NHS. However, although the Plan encompasses all aspects of cancer care, it focuses the NHS on specific process-based targets: for example, the achievement of a maximum two-week urgent GP referral target for breast cancer patients, or a 31-day waiting time target for the period between diagnosis and first treatment.

Such targets have caused major

distortions. Many cancer cases are not the subject of an urgent GP referral, and patients have in some cases suffered consequent delays in outpatient consultations after being routinely referred. In addition, the Royal College of Radiologists reported in February 2006 that waiting time for therapeutic radiotherapy, which is generally a 'follow-up' treatment rather than a first treatment, have lengthened since Labour came to power.

We have already announced our intention to measure progress in cancer services by measuring the actual

outcomes for patients, such as five-year survival rates, rather than the length of time they must wait for one aspect of their treatment.

Measuring outcomes would reflect better the overall quality of care patients receive and would not distort service planning to the same extent that process targets have done. The use of measures of outcomes, such as five-year survival rates, also underlines just how far we have to go in order to raise the standards of our cancer care to the levels routinely achieved by our European neighbours.

medical services, primary dental services and community pharmacy services, with the aim of maximising the ability of primary care commissioners to secure holistic care on behalf of their patients.

- Commissioning very low-volume, high-cost (i.e. specialist) services.³⁴
- Resolving disputes over HIMPs in those circumstances where the plan cannot be agreed between the PCT and its local authority, and if the dispute has not already been resolved successfully by the relevant SHA.

Box 5: the role of NICE

- NICE will be put on a statutory basis, with a responsibility to provide advice to commissioners and providers. It will be subject to legislative requirements relating to the level of engagement with clinicians and the public which it must demonstrate in coming to its decisions.
- It will operate through service-level agreements with the NHS Board, the Department of Health, and national and international healthcare providers.
- NICE will specifically support the NHS Board by providing evidence-based commissioning guidelines in order to drive the development of effective commissioning on a consistent and uniform basis across the country. In compiling their own commissioning guidelines, the NHS Board will depend on advice from NICE.
- NICE will continue to conduct appraisals of new drugs and technologies to encourage the adoption of the most clinically- and cost-effective treatments, taking into account wider societal costs where appropriate.
- NICE will also conduct evaluations of public health services and interventions on behalf of the Chief Medical Officer and the Secretary of State.
- We recognise that more consistent care needs to be delivered to those living with long-term conditions. NICE will also be charged with identifying the evidence base for, and the clinical consensus on the commissioning of, care for people living at home with long-term conditions – and will be tasked with developing commissioning guidelines accordingly.

³⁴ A list of specialised services is available on the Department of Health website, here: <http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Specialisedservicesdefinition/index.htm>

4.22 The NHS Board will have further statutory duties complementary to those listed above:

- The promotion of patient choice and the information required to support it.
- The promotion of patient and public involvement in healthcare.
- The delivery of safe and high-quality health services.
- The delivery of efficient, effective and economical purchasing of health care services.

4.23 This White Paper has already outlined, in chapter two, the way in which Ministerial interference in the resource allocation process has resulted in a mismatch between the supply of NHS resources to an area and the demand which exists there.

We believe that vesting responsibility for allocating NHS resources in the NHS Board is the correct approach to avoid such Ministerial interference. We believe it strikes the right balance between ensuring that those who take the decisions relating to resource allocation are accountable to Ministers for it, whilst recognising the fact that determining resource allocation is a specialist task which should not be subject to political interference.

4.24 **Therefore, the NHS Board will be charged with the allocation of NHS resources so as to secure – as far as practicable – equal access to health services in all areas of the country.** In doing so, it will be instructed to take into account the relative burden of disease throughout England.

Strategic Health Authorities

4.25 **As part of our commitment to avoid organisational upheaval, we will retain England’s ten SHAs, which will report to the NHS Board.**

4.26 SHAs will be the NHS Board’s regional presence, and will help to performance-manage Primary Care Trusts in the delivery of the NHS Board’s commissioning objectives.

4.27 SHAs will be the first point at which disputes over HIMPs between PCTs and local authorities are settled.

Primary Care Trusts

4.28 PCTs will remain local commissioning bodies. Their functions will include:

- Preparation of the HIMP, agreed in consultation with the local LINK and the local authority.
- Negotiation of standard ‘off-the-shelf’ contracts with healthcare providers, which primary care commissioners can use on behalf of patients to minimise their administrative burden.
- Commissioning certain aspects of care, such as emergency care, in combination with the local consortia of primary care commissioners.
- Performance-managing GPs and primary care commissioners through the terms of nationally- and locally- determined contracts.

4.29 The PCT will be a partner in Local Area Agreements, as well as a partner to the local Director of Public Health.

4.30 PCTs will also remain, as now, the areas to which NHS resources are allocated, although almost all of these resources will be cascaded down by the PCT to its primary care commissioners.

Primary care commissioning

4.31 The centrepiece of the commissioning framework is the clinician commissioner working in primary care.

We envisage the vast majority of health care commissioning being undertaken through this process of primary care commissioning.

4.32 The majority of primary care commissioners will be GP practices. However, they may also be:

- Multi-disciplinary practices.
- Alternative contractors, if they are able to demonstrate to the PCT that they can provide the necessary combination of primary medical services and commissioning skills to deliver the highest standards of care for NHS patients.

4.33 The budgets of primary care commissioners for

commissioning NHS services will be derived from two sources:

- An allocation from the primary care commissioner’s PCT, largely calculated by the PCT on the basis of a weighted capitation formula determined by the NHS Board.
- Fees for services provided in relation to health promotion and preventative work, funded through the Local Director of Public Health.

4.34 The salaries of primary care commissioners will be derived from three sources:

- A simple capitation-based payment, based on how many people are registered with the primary care practice.
- Fees for any ‘enhanced services’ delivered locally and which the primary care commissioner delivers, such as out-of-hours care and weekend GP practice openings.
- Payment for performance, based on the delivery of outcomes determined in a Quality and Outcomes Framework which, though simplified, will incorporate a much greater emphasis on actual outcomes for patients, including patient self-reported outcomes.

4.35 We will ensure that primary care commissioners respond to the needs and wishes of their patients through the mechanisms of patient choice:

- Patients will be entitled to exercise choice in elective care, in community provision where possible, and in respect of treatment options where appropriate – provided that the options are cost- and clinically- effective. The choices of patients over where and how they are treated will in turn influence commissioning decisions.
- Patients will be entitled to choose their GP or other primary medical service provider – and hence will also decide the commissioner of their care. Contestability in primary care commissioning will form an increasing element of patient choice, and differing approaches to commissioning will drive differentiation in the services provided. This will allow patients to have increasingly tailored care on the NHS.

4.36 We recognise that tensions – or even contradictions – between this system of primary-care commissioning on the one hand, and national standards on the other, are inevitable.

It is vital that both aspects are transparent and clear. At the

national level, national standards will be clear where the evidence makes certain aspects of care imperative, and where other aspects of care are discretionary or developmental. The commissioning clinician will have the balancing responsibility, and will remain accountable for his or her decision through:

- **His or her professional regulatory body.**
- **The system of performance management in commissioning overseen by PCTs, SHAs and the NHS Board outlined in this chapter, above.**
- **The system of patient and public involvement in health, as outlined in chapter two.**

5. Autonomy in delivery

Setting providers free

5.1 Over the last decade, rising levels of administrative interference and centrally imposed costs, allied to a lack of competition between providers in the delivery of healthcare, has meant that productivity in the NHS has been falling by up to 1.3 per cent a year.³⁵

5.2 Our proposals for NHS autonomy will set healthcare providers free to concentrate on satisfying the needs of patients and the associated contractual requirements of NHS commissioners.

5.3 In order to secure increased capacity, rising productivity and responsiveness in healthcare services, we will offer significant new freedoms to NHS providers.

5.4 **We will encourage every NHS Trust to become a self-governing NHS Foundation Trust.** This will apply to Trusts delivering both hospital services and community services.

We will encourage them to secure public, patient and staff membership of the Trust as an important source of direct engagement for the public in NHS provision.

We will minimise barriers restricting the ability of NHS Foundation Trusts to invest and expand. Subject to the application of competition rules and meeting the needs of NHS commissioners, we will permit NHS Foundation Trusts to integrate primary, secondary and even specialist services, so that they can develop integrated patient services to offer to commissioners.

To maximise the freedoms of NHS Foundation Trusts, we will lift the restrictions on borrowing secured against their assets and remove the prohibitions in the NHS Act³⁶ which restrict their capacity to secure private income.

5.5 **Alongside NHS Foundation Trusts, which are public benefit corporations, we will enable any willing provider, who is able to meet NHS standards within NHS tariffs, to offer services to NHS commissioners.**

The services they provide will continue to be NHS services, free to NHS patients and provided on the basis of need, not ability to pay. Autonomous providers – voluntary and private – will be required to subscribe to NHS core principles (as well as NHS contracts determined by commissioners) when providing NHS services.

5.6 Liberating the supply of health care will help to bring about effective competition in the delivery of health care services to NHS patients, including between both NHS and independent sector providers. It will stimulate new capacity and drive productivity improvements in a market designed to deliver a social purpose: a ‘social market’.

We recognise, however, that opening up the supply side also entails risks and rewards. It is essential, therefore, that a key public service like healthcare benefits from a strong and independent regulatory structure.

A robust regulatory framework

5.7 Regulation by Ministers and the Department of Health has not succeeded, and will not do so.

Political risk coupled with constant organisational upheaval and confusion has frozen out major new investment and innovation.

We therefore propose that the ‘social market’ in healthcare be subject to a new regulatory structure. In line with our commitment to minimise organisational upheaval, we shall develop this regulatory structure from existing regulatory institutions.

Box 6: Minimising bureaucracy

The burden of bureaucracy on our NHS is clear to see: official workforce statistics show that, since Labour came to power, the number of managers in our NHS has increased at well over two-and-a-half times the rate of increase in the number of nurses.

This White Paper contains proposals for a new regulatory structure to govern the social market, which will minimise the bureaucratic burden on our NHS:

³⁵ Office of National Statistics, 26 February 2006
³⁶ Contained Section 44, Office of Public Sector Information, National Health Service Act 2006, 2006; available at: <http://www.opsi.gov.uk/acts/acts2006/20060028.htm>

Box 6: Minimising bureaucracy continued

- Our proposed quality inspector, modelled on the Healthcare Commission, will combine the current functions of the Healthcare Commission as well as those of the Commission for Social Care Inspection (CSCI). This means that there will be one regulator for both health and social care, as opposed to two – as now.
- At present, performance management of NHS providers is undertaken by Monitor (for NHS Foundation Trusts) and England's Strategic Health Authorities (for non-Foundation NHS Trusts). This involves much wasteful duplication. Under our proposed regulatory structure, all performance management of providers of NHS care will be undertaken by Monitor.

Other proposals will further minimise the bureaucratic burden on our NHS:

- We will develop and refine the Healthcare Commission's risk-based approach to quality inspection, so that no NHS body is subject to needless inspection.
- Though information will still need to be collected from providers of NHS care, this information will be of genuine value to patients, such as hospital mortality data. We can envisage the NHS Board deciding a large proportion of the Department of Health's 250,000 NHS data collections, which largely track arbitrary process targets, be discounted on the grounds that they do not help patient care.

5.8 There are two key regulatory functions:

- Economic regulation, which covers all aspects of the operation of the social market.
- Quality inspection, which ensures that the delivery of health care by all those within the social market is of a high standard.

5.9 It is Labour's view that these two functions can be combined in one body – 'OfCare'³⁷. We believe that this is inappropriate:

- An economic regulator needs to possess substantial powers to intervene in order to determine service reconfiguration and

the management of NHS Trusts, and to determine how service requirements must be met.

- A quality inspector needs to report openly and frankly on the quality of services provided.

It is quite clear there is a tension between the two: the need to drive efficiency from an economic point of view may conflict with the need to warn about the potential of declining standards of care from a quality perspective.

For example, the economic regulator may sanction the rationalisation of a Trust's estate from two sites to one. However, this may be detrimental from a quality perspective. If the two regulatory functions are combined, there is a risk that one side of the argument will be lost. Such intra-institutional conflicts of interest will make a regulatory regime in which economic regulation and quality inspection are combined unsustainable.

5.10 We therefore propose that the two functions remain separate:

- We will legislate to develop Monitor into an economic regulator.
- We will develop the role of the Healthcare Commission as a quality and value-for-money inspectorate.

³⁷ The Times, Yet another regulator to monitor care homes, 8 June 2007; available at: http://www.timesonline.co.uk/tol/life_and_style/health/article1901970.ece

Box 7: the role of the Healthcare Commission

The Healthcare Commission, which will be merged with the Commission for Social Care Inspection (CSCI), will have a statutory duty to undertake inspections of healthcare commissioners and suppliers.

Complementary to the statutory duties of other bodies, the Healthcare Commission will provide a multi-purpose inspectorate, with the functions of:

- Providing external audit and ensuring the propriety of public expenditure, as well as offering value-for-money audit and advice.
- Conducting safety inspections of providers, with powers of intervention in the event of service failure. This will be risk-based, so that those providers with a proven record of safety will be subjected to a lower level of inspection.
- Conducting quality inspection of providers, with powers to refer them to Monitor and to NHS commissioners if it finds breaches of licence or breaches of commissioning guidance. This will again be risk-based, so that those providers with a proven record of offering high quality services will be subjected to a lower level of inspection.
- Determining the common standards of information which may be made available to patients for the purposes of informing patient choice.
- Validating the information which providers submit to commissioners for the purposes of monitoring contract compliance, and which providers submit to Monitor for monitoring potential breaches of licence.
- Notifying Monitor in the event of a risk of service failure.

Box 8: the role of Monitor

Monitor will be given the statutory duty to be the economic regulator for the healthcare sector, and will have the following duties:

- Securing the provision of universal access to healthcare services.
- Promoting competition in healthcare services, wherever practicable.
- Promoting safety and quality in healthcare services.
- Promoting efficiency and economy in the provision of health services.
- Promoting research and development in health.
- Promoting the sufficient supply of skilled healthcare professionals.

Monitor will exercise the following key functions:

- Licensing healthcare providers (in the place of the Healthcare Commission licensing process), subject to a de minimis criteria which will include considerations of professional regulation. For example, each GP providing healthcare will not need to be licensed by Monitor, because they will already be bound by the professional regulation of the General Medical Council.
- Intervening in the event of market failure.
- Controlling market entry, including authorising the constitutions of NHS Foundation Trusts.
- Applying price controls and, in particular, determining the NHS tariff.
- Specifying the 'universal service obligations' and protected services which providers will have to deliver; stipulating licence conditions requiring that providers guarantee services to the NHS; and determining the levels of subsidy needed to maintain a 'provider of last resort' in the case of market failure.
- Exercising concurrent competition powers, such as how competition laws are applied to the healthcare sector.
- Promoting NHS Foundation Trust freedoms.
- Adhering to best regulatory practices.

Appointments to the Board of Monitor will be made by the Secretary of State on the advice of the Appointments Commission and those appointed would only be subject to removal within their terms of office on grounds of incapacity or misbehaviour.

A new framework for investment

5.11 The way in which NHS providers access capital for investment is too rigid and too inflexible for a healthcare sector in which NHS providers must compete on a level playing field with non-NHS providers.

5.12 For example, too few NHS Foundation Trusts are able to borrow and invest in their services through a route other than the Private Finance Initiative (PFI) format, which locks Trusts into binding 30-year contracts regardless of their income over the contract period.

We wish to see NHS Foundation Trusts free to structure their capital financing and projects in ways which best meet their needs, without the rigidities and costs associated with PFI.

NHS-sector providers should not be locked into rigid borrowing arrangements when their independent sector competitors can structure their borrowing as they wish.

5.13 This is not a rejection of private investment in NHS services: flexible public-private partnerships will continue to be a desirable way for Trusts to manage risk and secure efficient funding and management.

However, such partnerships will be strengthened if NHS Foundation Trusts can offer their own assets as security on loans, together with sound long-term business plans based on the stable framework of regulation outlined above.

5.14 The Department of Health and the Treasury currently offer financial guarantees to support PFI projects and can provide public dividend capital to NHS Trusts and NHS Foundation Trusts.

This is not consistent with the development of competition in healthcare, since NHS providers continue to have access to Treasury guarantees for their capital financing, whilst their independent sector competitors do not.

5.15 We are aware that the use of more market-based mechanisms for securing capital investment brings risks of financial failure.

Increased capital investment, in the absence of Treasury

guarantees, will entail risks to the assets necessary for the provision of essential NHS services.

We are therefore conducting an internal review to establish how the Secretary of State can in future support sufficient levels of capital investment without distorting competition, and how the legitimate interests of creditors can be recognised whilst at the same time ensuring NHS services can be maintained for patients.

This review will encompass how capital costs should be reflected in the tariff, as well as the extent to which NHS-sector providers should be able to access public dividend capital, capital grants and Treasury guarantees for their borrowing.

Box 9: Accountable healthcare

The proposals in this paper will substantially enhance the accountability of healthcare providers and the NHS.

Allied to the regulatory structure for health professionals (which is outside the scope of this White Paper), we are proposing the creation of a framework in which care is subject to contestability, where providers respond to the choices of patients, and where the rewards of NHS commissioners are tied to the outcomes they deliver for patients. In addition, the information which we will provide in order to support patient choice will empower patients directly.

In addition, formal mechanisms for accountability will empower patients and members of the public:

- Their democratically elected local authority will approve HIMPs and engage in joint commissioning arrangements with NHS bodies.
- Their local authority's Overview and Scrutiny Committee will investigate and report on service standards and design.
- They will be entitled to become members of NHS Foundation Trusts delivering both hospital and community services, and to take a direct interest in their local NHS organisations.
- LINKs (and HealthWatch) will allow them to be represented, as patients, in service planning and investigatory services, and in pursuing complaints.
- HealthWatch, nationally, will ensure that the voice of consumers plays a pivotal role in policy-making and decision-taking.

In relation to major service reconfigurations, PCTs will be required to take account of both local authority and HealthWatch views in the consultation process and, if necessary, accept referral of the issue to the NHS Board alongside the advice of the Independent Reconfiguration Panel. There will be a requirement to provide clear, clinical evidence supporting the case for change. Configuration of services will to a much larger extent than now respond to patient choice and local commissioning, rather than a priori structures, and without political interference from the centre.

The NHS Board and the two regulatory bodies will become more accountable for how they conduct their duties, and more transparent in conducting them. For example, the decisions made by the NHS Board over resource allocation will have to be demonstrably fair in allocating resources in relation to the prospective burden of disease: any failure to do so will result in inequitable access to NHS services.

Likewise, if commissioners depart from adherence to commissioning guidelines in ways which contradict the evidence base for them, they will have to demonstrate reasonable cause.

With clear checks and balances between commissioners and providers, and with the Secretary of State accountable to Parliament for the performance of the NHS Board against its objectives, there will be a clarity of function and responsibility which will drive accountability in NHS services. This will stand in stark contrast to the confusion and lack of responsiveness which exists at present.

6. Valuing staff

6.1 There are ways in which the principles of autonomy can be applied to the NHS's greatest asset: its staff.

Education and Skills

6.2 The workforce needed to deliver our objective of healthcare at European standards must be well-skilled and motivated.

Labour have demoralised the NHS workforce and in the last three financial years have sanctioned the raiding of education and training budgets to deal with deficits arising in the acute sector.

6.3 The Improving Public Services Policy Group has already announced proposals to re-engage with those involved in the delivery of our public services, and to build a new partnership with the professions.

6.4 Although this White Paper is concerned with proposals for legislation on the structures and processes of the NHS, we wish to make clear our intention to consult with health professionals and their employers, NHS Employers, the NHS Confederation and other stakeholders on our policies for building an NHS workforce fit for the future.

6.5 Workforce planning since Labour came to power has been appalling. The Department of Health has admitted that the central workforce targets it imposed on the NHS have contributed to the decline in productivity in recent years.³⁸

In addition, the recent failures of the Modernising Medical Careers (MMC) programme – including both the failure by the Department of Health to implement the principles agreed with the Royal Colleges, and the catastrophic security breach in the Medical Training Application Service (MTAS) – illustrate the adverse effects of excessive Department of Health control over medical education and training.

In the light of Sir John Tooke's on going review of MMC, we do not make detailed proposals here for the future of MMC. However, we do believe that the medical, nursing and other clinical professions should be given greater autonomy in determining their education, training and career paths.

6.6 In particular, we believe that the lessons painfully learned in the MMC fiasco should be reflected in the Government's approach to Modernising Nursing Careers (MNC). MNC must command the support of nurses. It must also include professional responsibility for continuing professional development within the nursing profession.

Medical training to specialty status continues to take a much more structured form than does the professional progression within nursing, and we wish to see the latter developed.

6.7 We believe that the process of workforce training should be made more autonomous of the Department of Health.

We believe that the professions should take on greater responsibility for determining training, and that the role of the Department of Health in this process be minimised.

We are also of the view that those who employ health professionals – both NHS and independent sector – should themselves take on responsibility in relation to workforce planning, and accept the risk should they get it wrong.

The transfer of risk is a key element in this proposal: in taking on risk, providers are provided with incentives to avoid either a major over- or under- supply of health professionals, given the deadweight cost of educating and training beyond requirements if there is an oversupply, and the extra costs of meeting staff shortages if there is an undersupply.

6.8 The current Workforce and Development Confederations which provide education and training to NHS staff are NHS-only bodies, and their responsiveness to the needs of other, non-NHS employers is limited.

We see merit therefore in developing Skills for Health to become a fully-fledged sector skills organisation, with a responsibility to deliver healthcare training either in-house or through commissioned places. All large employers of health professionals will be required to provide training places, or contribute a levy which will train and develop healthcare staff. We particularly welcome views from interest parties on how we may develop this proposal.

³⁸ Department of Health, Explaining NHS deficits, 20 February 2007

NHS pay

6.9 Workforce development is not the only area in which the principles of autonomy can be applied to NHS staff.

Ministers also continue to exercise substantial control over pay levels and contractual arrangements for NHS staff.

6.10 The enhanced autonomy for both commissioners and providers set out in this White Paper will reduce the need for Ministers to exercise control over the negotiating mandate for NHS staff contracts.

We propose that these contracts be negotiated by NHS Employers and the NHS Board, and by those bodies who have negotiating rights on behalf of the relevant staff groups. Over time, we can expect these contracts to become collective negotiations for staff groups in the healthcare sector generally.

6.11 However, we recognise that these negotiations will need to continue to benefit from the advice of the Pay Review Bodies, which take into account not just recruitment and retention criteria, but also issues of affordability.

Because they will retain the role of determining overall resources, Ministers will continue to advise the Review Bodies on affordability – although it will be for NHS Employers and the NHS Board to advise on staffing and cost pressures.

6.12 We propose to retain the health-related Pay Review Bodies in the above framework for pay determination.

However, NHS bodies and other healthcare providers currently have the legal right to determine pay for their employees as they see fit: we do not anticipate changing this.

Information Technology

6.13 The NHS workforce needs up-to-date, robust and secure information technology to support it in delivering patient care. This is not currently being provided by the National Programme for Information Technology.

6.14 We have already announced our plans for a separate review into how the IT needs of the healthcare sector for interoperability, communication, patient record-keeping and research can be met.³⁹

³⁹ Hansard, 6 June 2007, Col. 263; available at: <http://www.publications.parliament.uk/pa/cm200607/cmhansrd/cm070606/debte xt/70606-0004.htm#07060669001570>

7. The role of the Secretary of State

7.1 This White Paper sets out our proposals for the autonomy of the commissioning functions of the NHS, and for an independent structure of regulation for the providers of health care to NHS patients.

7.2 This will inevitably mean a different role for Ministers in the future.

7.3 The future key functions of the Secretary of State are listed below. The list is not exhaustive.

- To provide leadership to the healthcare sector, and to the NHS in particular.
- To establish and, where necessary, update the legislative and regulatory framework.
- To determine within Government, and agree with the NHS Board, the overall level of resources for the NHS.
- To agree objectives for the NHS Board, particularly relating to the outcomes of patients after their treatment.
- To take direct responsibility for the delivery of the public health service, emergency preparedness planning, and the achievement of public health targets.
- To approve the scope of health services included in the comprehensive health service required by the NHS Act.
- To appoint members of the NHS Board and other NHS bodies, on the basis of recommendations made by the Appointments Commission.
- To exercise back-stop powers of intervention in circumstances in which the NHS Board fails to meet its statutory duties.
- To account to Parliament for both the NHS and the Government's public health service.
- To approve the objectives and funding of the NHS Research and Development programme.

Summary of recommendations

This White Paper's main recommendations are summarised below:

1. We will incorporate the ten NHS core principles contained in the NHS Plan in legislation, exactly as they appear in the NHS Plan.
 2. We believe that placing NHS commissioning budgets in the hands of local authorities is unsustainable, and we reject it.
 3. We will use Local Involvement Networks (LINKs), when established, as the foundation of our policies for patient and public involvement in health at a local level.
 4. We will establish a national consumer voice for patients: HealthWatch.
 5. We are of the view that local authorities are best placed to engage members of the public in the delivery of local NHS services.
 6. We will require all Primary Care Trusts (PCTs) to produce local Health Improvement Plans (HIMPs), and require each PCT's coterminous local authority to be consulted on their development. Both of these requirements will be enshrined in legislation.
 7. We remain committed to the concept of patient choice as a means through which a patient-centred service is created, and through which the standards and quality of health care services are raised.
 8. We will contract the NHS Information Centre to secure public access to high-quality information about the standards of care they may expect from providers.
 9. We support the concept of payment by results.
 10. We support the return of powerful, clinician-led commissioning in primary care – like that provided by GP fundholding in the 1990s.
 11. Our proposed regulatory framework will ensure that providers of NHS care manage their services in a way which encourages the collection and use of information.
 12. We believe that the national tariff should increasingly be set on the basis of the costs delivered by the more efficient providers.
 13. We will seek to permit providers to offer discounts on the tariff after the existing framework for delivering payment by results becomes redundant in 2008.
 14. We believe that the tariff should be set on the basis of the actual costs incurred in providing treatment. To remove the possibility of Ministerial manipulation, the responsibility for setting the tariff should pass to Monitor.
 15. We will separate the purchasers of NHS care from its providers.
 16. We believe that practice-based commissioning needs to be strengthened. We will ensure that legislation enables primary care commissioners to hold real – as opposed to hypothetical – budgets; to hold and vary contracts with healthcare providers; and to be able to reinvest savings on behalf of their patients.
 17. To ensure that political interference does not result in the distortion of clinical priorities and the denial of autonomy to frontline NHS clinicians, we will establish an autonomous NHS Board to oversee the commissioning of NHS services.
 18. The Secretary of State will agree with the NHS Board a set of objectives based on improvements in measurable health outcomes (rather than processes) over a given period of time, which is consistent with the level of resources for the NHS determined by Ministers and approved by Parliament. Our overall, long-term objective will be to achieve in this country standards of healthcare which match the best in Europe.
 19. The NHS Board will be charged with the allocation of NHS resources in order to achieve – as far as practicable – equal access to health services in all areas of the country.
 20. As part of our commitment to avoid organisational upheaval, we will retain England's ten Strategic Health Authorities, which will report to the NHS Board.
 21. PCTs will remain local commissioning bodies.
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22. We envisage the vast majority of health care commissioning being undertaken through this process of primary care commissioning.

23. We will encourage every NHS Trust to become a self-governing NHS Foundation Trust.

24. Alongside NHS Foundation Trusts, which are public benefit corporations, we will enable any willing provider, who is able to meet NHS standards within NHS tariffs, to offer services to NHS commissioners.

25. The 'social market' in healthcare should be subject to a regulatory structure. We will legislate to develop Monitor into an economic regulator. We will develop the role of the Healthcare Commission as a quality inspectorate.

26. NHS-sector providers should not be locked into rigid borrowing arrangements when their independent sector competitors can structure their borrowing as they wish.

27. We are conducting an internal review to establish how the Secretary of State can in future support sufficient levels of capital investment without distorting competition, and how the legitimate interests of creditors can be recognised whilst at the same time ensuring NHS services can be maintained for patients. This review will encompass how capital costs should be reflected in the tariff, as well as the extent to which NHS-sector providers should be able to access public dividend capital, capital grants and Treasury guarantees for their borrowing.

28. We believe that the process of workforce training should be made more autonomous of the Department of Health. In particular, we are of the view that those who employ health professionals – both NHS and independent sector – should themselves take on responsibility in relation to workforce planning, and accept the risk should they get it wrong.

29. We see merit in developing Skills for Health to become a fully fledged sector skills organisation, with a responsibility to deliver healthcare training in-house or through commissioned places. All large employers of health

professionals will be required to provide training places, or contribute a levy which will train and develop health care staff.

30. We propose that staff contracts be negotiated by NHS Employers and the NHS Board, and by those bodies who have negotiating rights on behalf of the relevant staff groups. Over time, we can expect these contracts to become collective negotiations for staff groups in the healthcare sector generally.

Comments are welcome on the proposals in this paper. Please send comments in hard copy or via email by 21 September 2007 to:

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