

TOP LINE Q&A FOR THE DEPARTMENT OF HEALTH

GENERAL

Too much, too fast

Yes the reforms are bold but these are not new ideas for the NHS. Building on the best of what already exists - for example GPs working in practice based commissioning consortia, Foundation Trusts, choice of provider, payment by results for hospital services.

We are completing the reforms set out by the previous government and will ensure thorough implementation.

Yes we are removing management layers, because we don't want a system where Whitehall and regions are telling front line services what to do. Instead we are putting power in the hands of patients and professionals.

Yes there are risks in managing the transition. The NHS Chief Executive has set out the framework for implementation with clear plans to manage this, with, for example, shadow running.

Implementation will be bottom-up. Where GP consortia are ready, they will be able to take on greater responsibility before 2013.

Yes it will take time for the changes to become fully embedded. Programme is for the long-term not quick fixes.

Why change - Commonwealth Fund says the NHS is one of the best health care systems in the world

We need to improve outcomes - for example OECD data shows some of our outcomes such as for stroke and cancer care are poor.

We need to improve responsiveness to patients, so that services are designed around them, not patients having to fit around services.

We need to improve efficiency and deliver better value for the taxpayer.

We want to free up professionals and patients to focus on these things rather than what politicians tell them to do.

You said no more top down restructuring

We are building on existing structures. For example our plans for GP consortia build on existing practice-based commissioning arrangements and clusters. Plans for economic regulation build on Monitor, the regulator of foundation trusts. Many of the functions of the NHS Commissioning Board

already exist within the Department of Health; we are carving these out and slimming them down.

What we are doing is stripping out avoidable layers of management.

Devolving power to professionals and patients means we can remove SHAs and PCTs.

We have always been clear we want to have GP commissioning and our plans are the logical extension of that.

Implementation will be bottom-up.

No consultation on biggest reorganisation of the NHS in 60 years.

This White Paper provides clear leadership and purpose for the NHS.

We are providing clear leadership and purpose for the NHS.

By publishing our framework so quickly, we are now able to engage fully with external partners on the detail of how best to implement changes and we are launching a number of specific consultation documents.

Political meddling with the NHS - when you said you wanted to stop that

Our goal is clear - to remove politicians from day to day decisions and micromanagement; to empower professionals and patients.

But that's not how the current system works. So we have to change it. We are using our powers in order to devolve them.

Wrong time to shake up NHS when you need to deliver £20bn savings

These changes are part and parcel of our plans to drive efficiency in the short-term.

And they will help ensure that the NHS is financially sustainable in future.

They will help increase efficiency and financial control. For example, GP commissioning will give greater control and responsibility to the professionals whose decisions commit most NHS spend.

They will also cut out management costs as we move from a system run by Whitehall and regional management to one based on patient choice, clinical commissioning, and quality and economic regulation.

Wrong to protect the NHS budget

The Government is fully committed to the NHS, its values and principles. It will not make the sick pay the price of the deficit.

Right to protect NHS funding. But even with protection, still need to make major efficiencies simply to keep up with new demand and technologies. Planning on £20bn.

The quid pro quo of protection is reform so that we get better outcomes and a more responsive service for patients, and better value for the taxpayer.

Part of that reform is stripping out management layers so that resources can go to frontline services.

Treasury concerns

If HMT weren't 100% behind these plans, we wouldn't be launching the White Paper.

Contrary to the coalition agreement on PCTs & elections

The White Paper is based on the Coalition Agreement.

Yes there are some changes. The greater role for local authorities will strengthen local democratic legitimacy. Combined with our commitments to GP commissioning, they will enable us to end PCTs, thus supporting our commitment to cut costs of bureaucracy.

Will these changes require legislation? And if so when will this be introduced?

Chapter 6 of the White Paper sets out the aspects of the proposals which will require primary legislation. The Queen's Speech included a Health Bill in this Parliamentary session.

What is your timing on implementing reforms?

The White Paper sets out a proposed timetable for our reforms. Obviously where the reforms require legislation, this will be subject to Parliamentary approval. We expect the majority of the reforms to come into effect in 2012.

You have not properly assessed the likely impact of the policies within the White Paper.

The Department is committed to assessing the likely benefits, costs and risks associated with the White Paper. We've published an analytical strategy document outlining how this will be done.

PRIVATISATION, MARKETS AND COMPETITION

Privatisation

WP true to NHS principles and values. Care free, based on need and not ability to pay.

Foundation trusts will not be privatised but they will be given more freedom to innovate and respond to patients.

There will be more competition, operating in patients' and taxpayers' interests. Private and voluntary sector providers have always made a vital contribution to delivering NHS services and we want this to continue.

Our governing principle is that 'any willing provider' that meets NHS standards and tariffs should be able to compete on a fair playing field, and that patients should be able to choose their 'preferred provider'.

Are Foundation trusts going off -balance sheet?

Our aim is better quality care. Giving provider greater freedoms will help with that.

The previous administration wanted FTs off the balance sheet. Whether our freedoms mean that now happens is a matter for the independent Office of National Statistics. And if the consequence of greater freedom is off-balance sheet then we favour that approach.

It would not mean FTs are privatised; they would be more like universities, with a clear social purpose and a public sector ethos.

You are driven by market ideology not evidence

No - our goal is not more competition for its own sake, it is better quality care - better outcomes and more responsive services.

Patient choice, payment by results and competition all have an important role to play in contributing to those goals. As do changes such as clinically led commissioning and national standards developed by NICE, based on clinical evidence .

People don't want choice just better local services

Choice is a key mechanism for improving the quality and responsiveness of services. The evidence shows that patients want it and providers respond to it.

Opening up healthcare to any willing provider will reward services which are responsive to patients' needs and who perform best in delivering high quality services and improved outcomes.

We need more integration of services, not fragmentation

Competition and cooperation isn't an either/or. We need more integrated services as well as more competition.

Changes such as individual budgets and clinical commissioning will help integrate services around the needs of individuals.

And local authorities will have a key new role in helping to join up services across the NHS, social care and public health.

What if hospitals become bankrupt and fail?

Our main responsibility as a Government is to improve results for patients - better quality of care and more responsive services; and ensure value for the taxpayer.

Payment will be for results. Patients will choose and GP consortia will commission. Hospitals will have stronger incentives to improve. We will make NHS funding much more transparent.

The previous administration promised to introduce a failure regime for hospitals. We will finish that work so that we get the right incentives in the NHS; so that patients don't receive poor quality, poor value services.

Commissioners and the economic regulator will be able to protect essential services.

GP COMMISSIONING

Why do we need GP commissioning?

GP commissioning will move responsibility for making decisions closer to patients, to the point with whom patients have the most contact. It means the design of local services will be clinically led, and bring together responsibility for clinical decisions and for the financial consequences of those decisions.

General practice is uniquely placed to do this, on behalf of patients on their lists. All GPs "commission" care now for individual patients by referring patients or prescribing medicines. They already commit NHS resources, and they know what their patients want, so it makes sense for them to have more control and responsibility for organising NHS services and resources.

GP commissioning plans unworkably radical

Our plans build on years of involvement of GPs in commissioning.

The previous administration introduced practice based commissioning over 5 years ago, and some consortia are doing an excellent job. But many GPs have been frustrated by not having clear responsibility and control. A flawed policy framework has confused their responsibilities with those of PCTs, and failed to transfer real freedom and responsibility to GP practices. We are now giving them that, learning from the past, and offer a clear way forward for GP consortia.

We are entering into talks with the profession about how we implement this change. A consultation document on the detail will be issued shortly.

Implementation will be driven bottom-up, with GP consortia taking on their new responsibilities when they are ready to do so, with early adopters promoting best practice.

What if GPs don't want to commission?

The principles are clear - all practices will need to be part of a consortium. Some GPs are enthusiastic but not all will choose to play a leading role in commissioning consortia, and our plans are based on that idea - that's why it's commissioning by consortia rather than individual practices.

GP consortia will be held to account by the NHS Commissioning Board for the resources they use and the outcomes they achieve. It will be for the consortia to decide what help they need in managing their budget.

Are you planning on paying GPs even more?

We will be discussing with the BMA and other NHS partners the changes necessary to empower GPs to achieve improved outcomes for their patients.

We are committed to payment by results right across the public sector; and we're also committed to making major efficiency savings. GPs are not going to be exempted from either of these two principles.

How and by whom will GP commissioners be held accountable?

The NHS Commissioning Board will hold consortia to account for the outcomes they achieve and the NHS resources used to achieve those results. The consortia would then hold their constituent practices to account.

Too much power for GPs - what about other professions?

Primary care professionals coordinate all the services that patients receive – they are best placed to ensure they get the best care, whilst involving all other professionals who are part of any pathway of care.

The consortia will involve a range of disciplines and professions, such as nurse led-general practices. This is about bringing together responsibility for clinical decisions with the financial consequences of those decisions.

GPs have a terrible record in diagnosing complex conditions (cancer, rheumatoid arthritis etc.) - what makes you think they will be able to commission services for them?

GPs are already responsible for making decisions about the use of NHS resources – for example through hospital referrals. These reforms are about bringing together responsibility for funding decisions with the outcomes they achieve.

GP consortia will be able to make decisions on what aspects of commissioning they wish to take on board themselves, and which aspects they want to buy-in outside support for. They will have access to expert support if they feel they need it, and the NHS Commissioning board will provide expert commissioning guidelines to further support them.

Who will provide the support needed as GPs build capacity and capability required to deliver effective commissioning?

The new arrangements will provide more effective, clinically led commissioning, by decentralising responsibility. GP consortia will want support but we will not prescribe exactly how that support is provided; there is a range of support available for commissioning, including PCT teams, local authorities and independent commissioning support organisations.

GP fund-holding was deemed a failure, how will GP commissioning succeed?

These plans are not GP fund-holding or practice based commissioning but learn the lessons of the past.

GP commissioners will operate in a different NHS environment to that of the GP fund-holding era. Critics of GP fund-holding pinpoint high transaction costs as a major weakness of the scheme. There are now standard prices and requirements for common hospital procedures, so that GP commissioners will be able to focus on designing the best packages of care for patients rather than getting bogged down in detailed contract negotiations. GPs also now have access to much richer information on the comparative quality of healthcare services to inform commissioning decisions.

RECONFIGURATIONS

Why should GPs decide local hospital reconfigurations?

Local service change should be clinically led. GPs are a key part of local clinical communities and act as the agents of patients across the breadth of their care needs. So it is entirely logical for GPs to have a say in hospital changes. This is about GPs working with the local communities and having confidence in, and supporting, reconfiguration proposals.

NHS organisations leading any reconfigurations will need to hold a dialogue with and work alongside their local GP commissioners and the public. This is about ensuring proposals are locally led, drive up quality and improve outcomes for patients.

Will service reconfigurations end?

We have already stopped top-down closures of A&E and maternity wards. We have also set tough new standards that all new reconfiguration proposals will need to meet including:

- support from GP commissioners;
- strengthening public, patient and local authority engagement;
- a clinical evidence base;
- developing and supporting patient choice.

STAFF

How many redundancies are you expecting as a result of the White Paper?

We know that in the current climate it is inevitable that there will be reductions in the size of the workforce – this would be the case even if we did not bring forward any reforms. These reforms are about trying to make sure that we reduce unnecessary management and administrative functions, to protect the jobs of nurses and doctors wherever possible.

How much unemployment among doctors, nurses and other clinical staff is the government willing to tolerate?

Even with the protection afforded to the NHS unprecedented levels of efficiency savings are needed. This means that it will employ fewer staff by the end of the Parliament, albeit rebalanced towards clinical staffing and front-line support. This is a hard truth that any responsible Government has to face.

Wasting money on system change at a time when nurses are going to have their pay frozen?

We recognise that there will be short term costs involved in making these changes. But we can't afford the layers of bureaucracy that the NHS has been carrying. We cannot afford to wait - we need to make this change now to put the system on a sustainable footing.

How can the NHS continue to attract / retain good managers or leaders with a pay freeze?

Pay restraint is essential right across the public sector, and the NHS is not exempt from that – everybody has to accept the position that we find ourselves in. Will Hutton's Fair Pay Review will publish its findings in due course.

But the NHS is in a relatively privileged position. Every penny we save in efficiencies, we can reinvest in frontline services.

Will NHS pay and conditions be consistent with wider public sector pay policy?

The NHS will still need to contribute fully to wage restraint. Last year's uplifts included 0% for consultant doctors, senior managers, GPs and dentists, showing a realistic understanding of the need for restraint.

In the future, all providers will have power to set pay, as foundation trusts already do. But experience suggests that most providers will use nationally-negotiated workforce contracts and tariff price set by Monitor will creating stronger incentives for efficiency in providers without micromanaging them.

What does this mean for pensions for NHS staff?

Pending any action arising from the work of the Commission on public sector pensions, the Government intends that foundation trusts will remain as employing authorities for the purposes of the NHS Pension Scheme, able to participate fully in the Scheme.

What does this mean for NHS pay?

As per the budget, in the short-term pay will be frozen for two years for those earning more than £21,000, with Pay Review Bodies being asked to make a recommendation for those earning below this threshold.

In the longer term, employers will be responsible for leading pay negotiations within a transparent regulatory framework. Those who are best placed to know the needs of local populations will be trusted to determine their own pay structures. In practice, we expect many providers will continue to use national terms and conditions as the basis for local decisions.

What does this mean for the future of Pay Review Bodies?

We will explore a range of options for making appropriate arrangements for setting pay. To date the Pay Review Bodies have provided valuable advice to inform the national pay framework.

FINANCE

What will the White Paper cost?

Until the consultations are over, and we are clearer on the design of the system, we can't put exact figures on it. But we will need to live within the funding that DH will be awarded in the next Spending Review.

Why make such major changes in the current financial climate?

The financial climate is a reason to accelerate reform, rather than not reform at all. The reforms will create a long-term sustainable NHS through

- cutting bureaucracy and duplication;
- delivering real autonomy for providers matched by transparency and accountability within a regulated system; and
- creating stronger incentives for quality and efficiency.

If managerial numbers are to be cut by a third, how will efficiency improvements be delivered without distracting clinical staff from frontline responsibilities?

Cutting bureaucracy, for example around performance managing process targets, will free up clinicians to focus on what matters most - improving outcomes for patients. The quantity of managers should not be confused with the quality of management.

How much are current management costs? How much will be saved?

Management costs in PCTs and SHAs have increased by over £1 billion since 2002/03, with over £220 million of the increase taking place during 2009/10.

Management costs now stand at £1.85 billion and it is our intention that during 2010/11, we will remove all the management costs that have been additionally incurred during 2009/10, to get back to the level of 2008/09.

In subsequent years, we will go beyond that, with a further £350 million reduction in 2011/12. The overall reduction in management costs by 2013/14 will be £850 million – a 46% reduction on 2009/10 costs.

How will financial risk be managed in relation to autonomous providers?

The current regime is not free from financial risk, and the system is unsustainable.

Our reforms will create a coherent regulated system with better incentives for financial control and efficiency.

Every provider delivering an essential service will, as a condition of their licence with Monitor, contribute to a risk pool. This risk pool will be used to ensure that services are kept running if a provider becomes insolvent.

LOCAL DEMOCRATIC LEGITIMACY

Why renege on the coalition commitment to introduce elections to PCT boards?

The Government is committed to ensuring that there is a strong local voice for patients through democratic representation in healthcare.

The Coalition Programme proposed directly elected individuals on the PCT board as a mechanism for doing this.

However, because of the proposed transfer of commissioning functions to the NHS Commissioning Board and GP consortia, the Government has concluded that PCTs should be abolished.

Instead, we propose an enhanced role for elected local councillors and local authorities, as a more effective way to boost local democratic engagement. These are practical plans that give stronger effect to the intentions for local democratisation in health.

NHS spending has been protected, but will it now become responsible for activities previously financed by cash-strapped local authorities?

Health spending will increase in real terms each year. And we have no current plans to transfer local authority responsibilities to NHS organisations. The health improvement funding allocated to local authorities will be ring-fenced and need to demonstrate improvements in population health outcomes.

How much money will be transferred to local authorities? What will it be used for?

The local ring-fenced budget will be based on current identifiable expenditure by the NHS and the Department of Health on local health improvement activity.

Its distribution will be based on need, using a new "Health Premium", which will also include a means of rewarding good performance, in terms of improved health outcomes.

Why can local authorities not become responsible for primary care?

National accountability for the health service is critical. It currently receives nearly £100bn through national taxation, and it is right that it is held to

account for the stewardship of these finances and outcomes through Parliament. Transferring commissioning to GP consortia will ensure that commissioning decisions are underpinned by clinical insight and knowledge of local healthcare needs.

PUBLIC HEALTH AND SOCIAL CARE

Plans for public health?

Improving public health is a key priority and the Secretary of State for Health will take personal responsibility for leading and driving a cross government approach to this agenda.

The coalition government will create a new public health service led by the Department of Health, with ring-fenced public health funding which will be weighted towards the most disadvantaged areas through payment of a health premium.

Local Authorities will hold the local health improvement budgets and will be tasked with improving the health of their residents. They will work closely with the NHS, voluntary organisations and local business to deliver this. And they will be paid according to the outcomes they achieve.

The plans for the new public health service will be published in due course, and will be followed by consultation on the detail of the public health ring fence and the outcome measures to be adopted.

Wrong to protect public health funding

It's essential we invest in prevention to ensure long-term affordability of the NHS.

We are determined to build a much stronger focus on public health.

In the past public health budgets have been cut as part of NHS efficiencies - a ring fence will stop that.

How does social care fit?

The NHS will focus on improving the outcomes for NHS treatment. Where appropriate this will be through working in partnership with social care. This will be supported through commissioning guidelines and quality standards incorporating appropriate joint working.

The different parts of the health and care system will also be brought together by overarching strategies.

The commission on long-term care will help inform our future plans.

Why protect NHS spend but cut money for social care

We are facing new challenges in the NHS and new demand as a result of an ageing population.

That's why we're protecting the NHS budget, and pushing the resources to where they're needed most – the frontline.

The Commission on Long-Term Care, outlined in the Coalition Programme, will inform our thinking on the long-term funding of social care.

How will the NHS take account of policy priorities elsewhere in government?

The mandate for the NHS Board, including the outcomes framework, will fit with the spending review and form part of government's contract with the taxpayer.

The outcomes frameworks for the NHS, public health and social care will take account of other policies where they interact. For example, the NHS outcomes framework will be focussed on the treatment the NHS provides to patients, and will take account of policies which impact on healthcare outcomes.

OTHER

What will happen to Strategic Health Authorities?

The NHS Commissioning Board will combine functions of the Department and SHAs, in a much more streamlined way.

Subject to Parliament, the NHS Commissioning Board will become fully operational from April 2012, removing the need for SHAs. The Board will decide on its own organisational arrangements.

In the meantime, SHAs will continue to have a vital role in delivering financial control and performance, and driving improvements in quality and productivity.

What will happen to Primary Care Trusts?

A number of PCTs have made important progress in developing commissioning experience which we will look to capitalise on during the transition period. GP consortia will take over much of their commissioning functions and local authorities will take over responsibility for health improvement functions. PCTs will cease to exist from 2013, in the light of the successful establishment of GP consortia, but will have an important task in the coming years in supporting practices to prepare for these new arrangements.

NHS Commissioning Board is biggest quango of the lot.

The functions the Board will carry out currently sit in the Department of Health, and our proposals will ensure that they are set free from day top day political interference.

We will be publishing a review of ALBs shortly, setting out our proposals to reduce ALBs by a third.

Why an economic regulator?

Effective economic regulation will ensure every pound of taxpayers' money invested in the NHS achieves maximum value.

We propose to develop the role of Monitor so that it becomes an economic regulator with responsibility for ensuring patients have access to essential services; that money invested in the NHS achieves maximum value and that competition operates effectively in the public interest.

How does expanding the capacity of Monitor fit with reducing bureaucracy?

As economic regulator, Monitor would need to take on significant new functions for promoting competition, price setting and licensing providers. The extra resources this requires will be freed up by large administrative reductions elsewhere.

How will Government improve standards

Our vision is for an NHS where providers are autonomous and accountable to local commissioners and the patients they serve, rather than being subject to bureaucratic controls. There will be proper regulation to provide appropriate safeguards to protect patients' and taxpayers' interests:

- we will strengthen the role of the Care Quality Commission so that it becomes an effective quality inspectorate; and
- develop the role of Monitor into an economic regulator that will oversee aspects of access, competition and price-setting in the NHS and social care.

How will CQC be able to compare the quality of NHS hospitals if there are no targets?

Setting the priorities of the local NHS through top down process targets distorts clinical priorities. Abolishing unjustified process targets will free clinicians to focus on the outcomes that really matter.