Health and Social Care Bill 2011

Coordinating document for the Impact Assessments and Equality Impact Assessments

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This document is the Impact Assessment (IA), incorporating the Equality Impact Assessment (EIA), for the Health and Social Care Bill.

Introduction, overview and coordination

1. This document, and its Annexes, is the IA of the Health and Social Care Bill. It assesses the benefits, costs and risks of implementing the policies proposed in the NHS White Paper *Equity and Excellence: Liberating the NHS*[i] that require primary legislation.

2. The proposals set out in the White Paper move the NHS towards a system that puts patients first, where there is a greater focus on outcomes, and professionals and providers have the freedom to innovate and respond to patient needs and aspirations. This is supported by greater accountability to the public and strengthened regulation.

3. The White Paper proposals are interlinked and mutually reinforcing. Some require legislation, and are reflected in the provisions of the Bill. Others, notably giving patients greater say, choice and control, the information revolution, and the NHS outcomes framework, have close ties to the policies that require legislation but do not themselves require provisions in the Bill.

4. This IA specifically analyses the effects of the policies in the White Paper that require legislation, as well as additional policies that require legislation. It also draws links to the other policies proposed in the White Paper, in order to give a more complete picture of the changes to the system, why the Government is seeking to bring about these changes, and how they fit together.

5. This is a final stage IA. It has been informed by the consultations on specific policies[ii] and the White Paper and by the Government's response to the consultation, *Liberating the NHS: Legislative framework and next steps*[iii]. It also links to the more recent consultation documents on *Greater choice and control*[iv] and *An Information Revolution*[v]. It is structured as a single document with six individual IAs, incorporating EIAs, annexed to it. The rest of the coordinating document is structured as follows:

I	Description of the current system;
II	Description of the new system, and links between the policies;
III	Benefits of the changes;
IV	Costs and cost-savings of the changes to the structure of the system;
V	Weighing of costs and benefits;
VI	Equality Impact Assessment and action plan;
VII	Transition risks; and
VIII	Post-implementation review
IX	How the IAs and EIAs link to the legislation

6. The Annexes are:

Annex A	Commissioning for patients (GP consortia and the NHS Commissioning Board)
Annex B	Regulating providers (increasing provider freedoms, economic regulation and joint licensing of providers between the economic regulator and the Care Quality Commission)
Annex C	Local democratic legitimacy (including the establishment of local health and wellbeing boards)
Annex D	HealthWatch
Annex E	Public Bodies (proposals from the Arm's-Length Body Review[vi] that require legislation, and the abolition of the Office of the Health Professions Adjudicator[vii])
Annex F	Public Health Service

7. Given the size of the IA and EIA for the Bill, and to make it easier for readers to find the relevant parts, this is split into three documents:

   (i) **The coordinating document**: this is this document, which gives an overview of the proposed changes to the system and a summary of the benefits and costs. It also gives the high-level EIA, including action plan.
   (ii) **The Impact Assessments**: this document is the 6 IAs, split into Annexes A-F as set out in paragraph 6.
   (iii) **The Equality Impact Assessments**: this document is the 6 EIAs, split into Annexes A-F as set out in paragraph 6. These documents cross-refer to the IAs. There is also an additional Annex which gives a summary of the evidence base.

8. There follows a contents page, which covers all three documents. Section IX explains how the IAs and EIAs correspond to the Health and Social Care Bill.

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I Description of the current system

9. As the White Paper said, at its best, the NHS is world class. The people who work in the NHS are among the most talented in the world, and some of the most dedicated public servants in the country. Other countries seek to learn from the UK's comprehensive system of general practice, and its role providing continuity of care and coordination. The NHS has an increasingly strong focus on evidence-based medicine, supported by internationally respected clinical researchers with funding from the National Institute for Health Research, and the National Institute for Health and Clinical Excellence (NICE). Other countries admire NHS delivery of immunisation programmes. Our patient participation levels in cancer research are the highest in the world.[viii]

10. However, compared to other countries, the NHS has achieved relatively poor outcomes in some areas. For example, rates of mortality amenable to healthcare,[ix] rates of mortality for some respiratory diseases and some cancers,[x] and some measures of stroke[xi] have been amongst the worst in the developed world.[xii] In part, this is due to differences in underlying risk factors, which is why public health needs more focus. Nevertheless, international evidence also shows the NHS has much further to go on managing care more effectively. For example, the NHS has high rates of acute complications of diabetes and avoidable asthma admissions;[xiii] the incidence of MRSA infection has been worse than the European average;[xiv] and venous thromboembolism causes 25,000 avoidable deaths each year.[xv]

11. The NHS also scores relatively poorly on being responsive to the patients it serves. It lacks a genuinely patient-centred approach, and too often, patients are expected to fit around services, rather than services around patients. Healthcare outcomes are personal to each of us. The outcomes each person experiences reflect the quality of our interaction with the professionals that serve us.[xvi] But, compared to other sectors, healthcare systems are in their infancy in putting the experience of the user first, and have barely started to realise the potential of patients as joint providers of their own care and recovery. While progress has been made in making the NHS patient-led, this has been relatively limited.[xvii]

12. This is compounded by a democratic deficit within the NHS. Local communities have very little input into decisions about the priorities of the local health economy, and many people lack a strong collective voice. While Local Involvement Networks (LINks) and the Joint Strategic Needs Assessments (JSNAs) have helped to link health organisations more closely to their local areas, this could go further. This is already happening in some places[xviii], but it is not systematic and the current structure of the health system does not serve to promote it.

13. Alongside this, commissioning decisions are often made at a level that is removed from patients, with limited input from them or the healthcare professionals that know them best. Services are therefore not truly tailored to their needs and aspirations, nor is there always effective coordination between

different health services, and between health and social care. This can in turn lead to fragmented care, poorer outcomes and lower levels of patient satisfaction.[xix] Primary care professionals coordinate much of the care that people receive, and yet they are not primarily responsible for the commissioning of services. Changing this will help to ensure that patients receive the right treatment for them.

14. Providers also have little incentive at present to respond to patient wishes, or to increase the quality of their services, partly because the current system does not promote efficiency or quality to their fullest potential. For example, people have some choice around provider for elective treatment, but this is limited in scope, has not expanded as far as it could, and, at present, is a relatively low-powered incentive for providers to change their behaviour. That is partly because of the lack of systematic information about the quality of providers that can be used by clinicians, patients and the public. Combined with choice being relatively limited, this means that most providers can be confident that the number of patients they treat during a year, and hence their income, will not be strongly correlated with the quality of the services they provide. There are therefore limited financial incentives to ensure they are offering high quality services that meet patients' preferences.[xx]

15. All of the problems described here represent structural challenges associated with the current system, that mean that care is not as good, or as efficient, as it could be. Alongside this, the next few years present a funding challenge. In order to free up resources for frontline services, the NHS and the Department of Health must therefore look through the entire system to see where functions could be done more efficiently, or could be removed entirely. There are a number of parts to this, covering the functions of the Department of Health, Strategic Health Authorities (SHAs), Primary Care Trusts (PCTs) and Arm's-Length Bodies (ALBs).[xxi]

16. The Government has committed to reducing the costs of administrative spending by one-third. The reforms proposed within with White Paper act as the mechanism for achieving these reductions.

17. The information above is a brief summary of some of the challenges that currently exist within the system – more information about these, and how the proposed policy changes aim to overcome them, is included within the individual Annexes.

II Description of the new system, and links between the policies

18. The White Paper set out a vision for the NHS that aims to rectify the problems outlined above and within the individual Annexes. These policies extend and expand what is already in the system, so that the NHS:

    - is genuinely centred on patients and carers;
    - achieves quality and outcomes that are among the best in the world;

- refuses to tolerate unsafe and substandard care;
- eliminates discrimination and reduces inequalities in care;
- puts clinicians in the driving seat and sets hospitals and providers free to innovate, with stronger incentives to adopt best practice;
- is more transparent, with clearer accountabilities for quality and results;
- gives citizens a greater say in how the NHS is run;
- is less insular and fragmented, and works much better across boundaries, including with local authorities and between hospitals and practices;
- is more efficient and dynamic, with a radically smaller national, regional and local bureaucracy; and
- is put on a more stable and sustainable footing, free from frequent and arbitrary political meddling.

19. The policies proposed in the White Paper and the Bill will put patients at the heart of the NHS, giving patients, carers and the public a stronger collective voice, greater choice and control, and more involvement in decisions about their care, supported by an information revolution that aims to transform how information is provided. They will bring about a greater focus on improving outcomes, so that the NHS focus on what matters most to patients: high quality care. They will also empower clinicians, free providers and professionals from bureaucracy and central control and make NHS services more accountable to patients and communities. Removing unnecessary layers of bureaucracy will simplify the existing structure of the NHS, driving efficiency in the short-term and helping to ensure that the NHS is both sustainable and self-improving in the longer-term.

20. Patients and the public often want more choice and involvement in decisions about their care, and there is evidence to suggest that giving patients more control over decisions about their care can both improve health outcomes and satisfaction with services, and reduce costs.[xxii] For this to work effectively, patients will need access to high quality, accessible information and appropriate advice and support. *Liberating the NHS: the legislative framework and next steps* and the consultations on *An Information Revolution* and *Greater choice and control* set out proposals for how shared decision-making, extending choice and control and the information revolution could come together to give the patient more input into decisions about their care. While these policies do not require legislation and are subject to ongoing consultations, they are integral to the proposed reforms.

21. These policies recognise that the knowledge of the individual can be invaluable when making decisions about the care that the person receives. The healthcare professional may well know about a person's health condition, but patients know more about themselves and their preferences. Putting individuals at the heart of the decision-making process, and providing them with the information about the choices that are available to them, is therefore aimed at improving health outcomes, raising levels of satisfaction with services and potentially also reducing costs.

22. This is already happening to an extent, with choice of provider already being available. As discussed above, however, there is considerable scope to extend choice further, with the aim of giving people more control about their care and increasing incentives in the system for providers to respond through providing services that people want, that benefit them and that are high quality.

23. Alongside this, there will be a cultural shift throughout the NHS away from performance management against targets and towards a focus on delivering better outcomes for people. The first step to achieving this is the introduction of the NHS Outcomes Framework. This sets out the outcomes for which the Secretary of State for Health is accountable to Parliament, and the NHS Commissioning Board is accountable to the Secretary of State. It will help to drive improved outcomes and will also increase transparency within the NHS. The framework, together with the information revolution, would mean that commissioners, patients and the public would have better information about the quality of services delivered by individual providers.

24. Supporting the intention to make care more patient-centred and outcomes-focused, the Bill will give the GP consortia responsibility for commissioning most NHS services, supported by and accountable to a new independent NHS Commissioning Board. This will mean that decisions are made closer to the patient so the person's input is more likely to be influential, helping to ensure more integrated care. It will also mean that there is greater alignment between clinical decision-making and the financial consequences of those decisions.

25. It would not make sense for GP consortia to commission all NHS services.[xxiii] Therefore, the independent NHS Commissioning Board will have some commissioning responsibilities, such as primary medical services, dentistry, community pharmacy, primary ophthalmic services, and specialist services. The creation of the Board will also support GP consortia to perform their commissioning functions, through things such as quality assurance and the drawing up of standard contracts. It will also hold consortia to account for the quality outcomes they achieve and for financial performance. More detail about the reasons for moving commissioning functions to GP consortia and for the introduction of the Board is included in Annex A.

26. Devolving responsibility to GP consortia builds on existing arrangements for practice-based commissioning (PBC), with expanded roles and responsibilities for clinicians, stronger incentives and clear accountability. Combined with greater choice and control for patients and carers, commissioning through GP consortia supported by the NHS Commissioning Board is more likely to deliver the potential benefits, in terms of improved outcomes and efficiency, than the current system. Annex A discusses some of the effects of PBC and considers earlier GP commissioning policies.

27. The White Paper proposed that local authorities would lead on improving the strategic coordination of commissioning across NHS, social care, related children's and public health services. The Health and Social Care Bill requires the

creation of a health and wellbeing board in each upper tier local authority[xxiv], to bring together the key NHS, public health and social care leaders in each local authority area to work in partnership. Health and wellbeing boards will lead on joint strategic needs assessments, develop a joint health and wellbeing strategy for the area, represent the views of local people and support local voice, and promote joined-up commissioning. A statutory duty is being placed on GP consortia, local authorities and the NHS Commissioning Board to have regard to both the JSNA and joint health and wellbeing strategy in discharging their commissioning functions. Local authorities can give health and wellbeing boards additional functions as they see fit.

28. These new arrangements create a powerful new role for the local authority, and increase the local democratic legitimacy of NHS commissioning decisions. In addition, the Bill will establish local HealthWatch organisations to give communities a stronger voice. Local HealthWatch will ensure that the views of patients, carers and the public are represented to commissioners and provide local intelligence to HealthWatch England, an independent consumer champion within the Care Quality Commission (CQC). Local authorities will be under a duty to arrange with local HealthWatch to provide advocacy, advice and information to support people to complain and help people to make choices about health and care services.

29. The White Paper set out the Government's plans to free NHS providers from central control and put in place effective quality and economic regulation. This will mean that providers are free to innovate, respond to patients' choices and drive sustainable improvements in quality and efficiency. The Government will support all NHS trusts to become foundation trusts, and will remove some of the restrictions on that prevent them from achieving the levels of innovation and responsiveness originally envisaged for them. This will be accompanied by an expansion of best-practice tariffs, which will help to raise efficiency of services.[xxv]

30. Alongside greater freedom to improve services, there will be a consistent framework of regulation across all types of provider. Monitor's role will be expanded to become an economic regulator, safeguarding patients and the public by regulating prices, licensing providers, promoting competition and supporting service continuity within a framework set by the Department of Health but free from day-to-day political interference. The Care Quality Commission will also be strengthened in its role of licensing providers against essential levels of safety and quality. More detail about the additional freedoms for providers and how providers will be regulated is provided in Annex B.

31. As with moving commissioning to GP consortia, increasing the freedom of providers builds on the current system. Offering providers the option of becoming Foundation Trusts was intended to encourage them to become more responsive to the wishes and preferences of commissioners and patients. This has not been as effective as it could be, because commissioners and patients have not had a system in which they can express their preferences and because Foundation

Trusts have had restrictions on what they can do. The Bill will change both of these.

32. Increased autonomy for commissioners and providers is accompanied by a reduction in the Secretary of State's powers to intervene in the system. The proposals increase the incentives on both commissioners and providers, by giving patients more choice and more transparent and comparable information about service quality. If, however, there is still the possibility of the Secretary of State intervening, then there is not genuine freedom within the system and there remains the possibility of short-term political issues taking over from decisions being made in the longer-term interests of the NHS. This would blunt whatever incentives are introduced into the system through the expansion of choice, shifting commissioning functions to GP consortia and reducing restrictions on providers. Therefore, the powers of the Secretary of State to intervene will be constrained and made more transparent, while retaining overall political accountability to Parliament. This is picked up throughout the individual Annexes where it is most appropriate to be included.

33. The changes to commissioning outlined above have clear implications for PCTs and SHAs. Most of the functions that they currently perform will be transferring to GP consortia, local authorities and the NHS Commissioning Board. PCTs and SHAs will therefore be abolished – the projected costs and cost-savings of doing this are illustrated in section IV below.

34. There will also be a structural reorganisation of the ALBs, following the ALB Review. Some of the proposed changes are included in provisions of the Health and Social Care Bill. Annex E gives details about the changes that the Bill aims to bring about and why, and the projected benefits and costs associated with them.

35. The increase in resources available to frontline health services will, in the absence of reform, be more than offset by increasing demand for health care, and it is likely that this will become increasingly unsustainable as the population ages and demand for health care increases further. The proposed revised structure of the NHS also strengthens existing incentives in the system for more effective and more efficient care, to help meet the future funding challenge.

36. There will also be a rebalancing of the system towards prevention. This means an increased focus on public health, and the proposals are outlined in the Public Health White Paper *Healthy Lives, Healthy People: Our strategy for public health in England*. Annex F gives details of the proposed changes, and also links across to the IAs for the Public Health White Paper.

III Benefits of the changes

37. This section summarises the potential benefits of the changes proposed within the White Paper where they are difficult to attribute to any one particular policy. This is both across the policies proposed within the Bill, as well as those that are linked to it such as the extension of choice policy and the information revolution.

38. Where there are benefits that are specific to any of the Annexes, they are included there. A number of the Annexes do not include quantified information about the benefits or costs of the changes, even where sources are cited. This is because either the information that is available is not very robust and could therefore be misleading to include, or because the figures that could be included are not solely attributable to the changes that are not considered within that particular Annex.

39. A report from McKinsey[xxvi] quotes a figure of £13bn - £20bn of potential savings. Much of this potential saving identified is attributable to the proposed changes in provision, but some of the changes identified will only be possible as a result of changes in commissioning, some as a result of liberalising providers and so on. It is likely that changes in provision would need to be accompanied by changes in commissioning to deliver these potential savings. It is also important to note that this is only an opportunity for saving.

40. This gives an indication, however preliminary, about the potential benefits, and industry studies have consistently shown that firms subject to greater competitive intensity are more productive than those in less competitive environments. While the methodology used can be challenged, for example in not taking into account unavoidable factors that are not to do with the quality of NHS services within an area, it is useful in illustrating the possible scale of potential savings.

41. Alongside this, there are health benefits that also accrue to the White Paper. The changes proposed within the Bill are likely to improve health outcomes for patients as they receive services that are more appropriate to them and are of a higher quality. As with the potential cost savings outlined above, it is difficult to estimate a quantified health gain resulting from the changes proposed, and so the Annexes mainly focus on the mechanism for achieving these health gains rather than the size of them.

IV Costs and cost-savings of the changes to the structure of the system

42. As with the benefits section discussed above, this section summarises the costs and cost-savings of the structural changes outlined within *Equity and Excellence* and legislated for within the Health and Social Care Bill that are not easily attributable to any one particular policy. This section includes the abolition of PCTs and SHAs and the moving of responsibility for commissioning functions to GP consortia, local authorities and the NHS Commissioning Board. The proposed changes to ALBs[xxvii] are also included here.

A Cost-savings resulting from the reduction in administrative spending

43. There will be a reduction of one-third in administrative spending across Whitehall, which is assumed to cover the functions of the Department of Health, SHAs, PCTs and ALBs that are not directly frontline services.[xxviii] The Government has committed to making these savings, and the policies outlined within the White

Paper and legislated for within the Health and Social Care Bill are the proposed means of delivering the reduction in administrative spending.

44. The one-third real reduction in administrative spending is equivalent to a 26.8% nominal[xxix] reduction in total resources for the management of the system. Table 1, below, illustrates the current spending in SHAs, PCTs, ALBs, and the Department of Health and NHS leadership, which is not directly frontline spending. The table also includes the figure for the total reduction in administrative spending.

Table 1: Baseline administrative spending in 2010/11, and one-third reduction

	Baseline spend (£m)	**One-third reduction in baseline by 2014-15[xxx] (£m)**
SHAs	353	
PCTs	3,588[xxxi]	
ALBs	522	
NHS Leadership plus DH[xxxii]	612	
Total	**5,075**	**1,692**

45. The introduction of the reductions in administrative spending are staggered between the next financial year and 2014/15. Table 2, below, illustrates the proposed trajectory, and the cost-savings that correspond to this each year. All figures given are in 2010/11 prices, and are not discounted.

Table 2: cost saving from the reduction in administrative spending, 2010/11 – 2014/15

All figures below are in £m and are at 2010/11 prices					
Year	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**
Administrative running costs at 2010/11 level	5,075	5,075	5,075	5,075	5,075
Real administrative running costs	5,075	4,414	3,837	3,471	3,383
Saving per annum	**0**	**661**	**1,238**	**1,604**	**1,692**[xxxiii]

46. This table illustrates the cost-savings associated with the reduction in resources for administration, and reaches the one-third real reduction in administrative spending by 2014/15. The gross savings attributable to the reduction in administrative spending from 2010/11 to 2014/15 are £5.2bn. If this is extended through to 2019/20 (to match the timeline used within the Annexes), this gives a total saving of £13.7bn (£11.4bn when discounted). The annual saving is £1.7bn.

B Redundancy costs resulting from the reforms

47. Paragraphs 43-46 illustrate the cost-savings associated with the reduction in administrative spending. To achieve the reductions outlined above, some staff who are currently employed by PCTs, SHAs, ALBs and NHS Leadership plus DH will be made redundant.

48. The White Paper recognised this. It made clear that the reforms amounted to a major delayering, which will cause significant disruption and loss of jobs, and incur transitional costs even as the management costs of the NHS are being reduced. The White Paper emphasised that the reforms would have one-off costs, and that the Government would ensure that these were affordable within the requirements of the wider Spending Review, while ensuring funding was focused on frontline patient care. As the Annexes demonstrate, the reforms will help to ensure that the NHS can deliver quality care efficiently in the longer term.

49. Based on internal modelling, to achieve a one-third real reduction in administrative spending, approximately 30% will no longer be employed across the organisations in Table 1. This is broken down as per Table 3, below:

Table 3: Redundancy costs and numbers resulting from the changes to the structure of the system

	Baseline staff[xxxiv]	**Total redundancy costs**[xxxv] **(£m)**	**Total redundancy numbers**[xxxvi]	**Wastage numbers**	**Total reduction percentage**[xxxvii]
SHAs	3,100	59	800	200	30%
PCTs	50,400	541	12,500	2,800	30%
ALBs	4,700	58	1,100	300	29%
NHS Leadership plus DH	6,000	114	1,400	300	29%
Total	**64,200**	**772**	**15,800**	**3,600**	**30%**

50. This gives the number of staff who are anticipated to be made redundant and the cost associated with this. This is the likely minimum, and depending upon the staff that GP consortia and the NHS Commissioning Board wish to employ, this could be higher. Therefore, the table below illustrates a range of 50% - 70% of staff transferring from PCTs and SHAs to the new structures, with 60% being taken as a midpoint of this range.

Table 4: range of costs depending on the proportion of PCT and SHA staff that transfer to the new system architecture[xxxviii]

Proportions of staff transferring to new system architecture	**Additional redundancy numbers**[xxxix]	**Total redundancy costs (£m)**
70%	0	772
65%	2,400	892
60%	5,100	1,024
55%	7,800	1,156
50%	10,400	1,288

51. As discussed above, a plausible range of proportions of staff made to no longer be employed is between 30% and 50%, with 40% being taken as the best

estimate at this stage (as the midpoint of this range). This therefore gives a total staff reduction figure of 24,500, which comprises 20,900 predicted redundancies and 3,600 staff leaving through natural wastage. The predicted redundancy cost from the proposed restructuring is £1.0bn.

C Non-redundancy costs resulting from the reforms

52. Besides any redundancy costs, there will also be some other one-off transitional costs as a result of abolishing or reconstituting organisations. These include costs around IT and property, for example.

53. The proposed changes mean that the current 151 PCTs and 10 SHAs will be abolished, and GP consortia and the NHS Commissioning Board will be created, together with health and wellbeing boards and new public health responsibilities in local authorities. The exact number of GP consortia cannot be determined at this stage, because this will be a matter for local discretion – the size and shape of consortia is likely to vary across the country in line with local circumstances. Meanwhile, the ALB sector will be restructured, with some of the ALBs changing their status.[xl]

54. The following table estimates the non-redundancy costs:

Table 5: Non-redundancy costs associated with the changes proposed within the Health and Social Care Bill

All figures below are in £m and are at 2010/11 prices		
Sector	**2010/11 Baseline Running Cost**	**Non-redundancy transition costs**
Abolition of PCTs	3,588	323
Abolition of SHAs	353	26.6
ALBs[xli], of which:	522[xlii]	
- Monitor (Annex B)	*16.5*	*12[xliii]*
- ALBs (Annex E)	*217 - 221*	*7.8*
- HPA and other bodies (Annex F)	*Partially included[xliv]*	*Not included*
DH and NHS leadership to Commissioning Board & New DH	612	8.6
Total	**5,075**	**377**

55. The non-redundancy costs are partially based on a report undertaken by the National Audit Office (NAO), called *Re-organising Central Government*[xlv]. This report estimates a transition cost of £12.5m per re-organisation, 70% of which are IT and accommodation. For the purposes of this reorganisation, the baseline transition figure for each organisation has been assumed to be lower, at £8.6m.[xlvi] The table above also contains assumptions about the number of reorganisations.[xlvii] This therefore gives a total estimated cost of £377m that results from the transition from the current structures to the new system architecture.

D Summary of costs and benefits from the structural changes

56. The total cost that is therefore assumed to be attributable to the changes in the system architecture is £1.4bn. This cost is assumed to be incurred predominantly in 2011/12 and 2012/13, when SHAs and PCTs are abolished and when GP consortia take on commissioning functions and the NHS Commissioning Board is set up.

V Weighing of costs and benefits

57. Some of the costs that are discussed in section IV are included within the individual Annexes, as and where this is felt to be possible to do. This section summarises the total costs of the reforms, including those identified within the individual Annexes and those from above, and weighs them against the benefits. All figures given are totals (both transition and ongoing costs) over 10 years, all figures are discounted at 3.5% per annum, and all figures quoted below are financial costs rather than opportunity costs[xlviii]. More detail on each section is available in the Annexes.

Table 6: costs and benefits from 2010/11 to 2019/20, summarised across all Annexes

All figures below are in £m, at 2010/11 prices and are discounted at 3.5% per annum		
Annex	**Benefits**	**Costs**
A – Commissioning	Subset of structural changes	Subset of structural changes
B – Provision	Not presented	545
C – Local Democratic Legitimacy	Not presented	Not presented
D – HealthWatch	70	50
E – Department of Health's Public Bodies	377	76
F – Public Health	Not presented	Not presented
Structural changes	11,373	1,331
Total	**11,820**	**2,002**

58. The figures displayed are financial costs, not including opportunity cost. The totals presented in the table above are those where there is felt to be sufficiently robust evidence to give a stated figure in the summary sheets of the IAs. The benefits figures include the cost-savings outlined in part A of section IV above. The benefits figures do not include the health benefits associated with the proposed changes. While the Annexes discuss why it is felt that there will be health gains resulting from the proposed changes, it is difficult or impossible at this stage to estimate with any degree of confidence the size of these gains.

VI Equality Impact Assessment and action plan

Introduction

59. The Coalition Government's programme for the NHS was published in the Department of Health's (DH) NHS White Paper *Equity and Excellence: Liberating the NHS*[1]. It was accompanied by four consultation papers, which were: *Transparency in Outcomes – a framework for the NHS*; *Commissioning for Patients; Local democratic legitimacy in health;* and *Regulating healthcare providers*, together with the report of the arm's-length bodies (ALBs) review. The consultations have now closed, and the Government has published its response and further detail about how the changes will be implemented in *Liberating the NHS: Legislative framework and next steps*.

60. The NHS White Paper set out a vision of patients at the heart of an NHS that focuses on what matters most to them: high quality care, not narrow processes. Providers and professionals would be free from unnecessary bureaucracy and central control and more directly accountable to patients and the public.

61. The changes proposed in the NHS White Paper and developed in *Legislative framework and next steps* are rooted in the Government's intention to put patients first, to achieve outcomes that are amongst the best in the world, and to empower clinicians to innovate and take decisions based on their clinical judgement. A patient-led NHS is one that involves all patients and their carers in the development of services that meet their needs and take account of their choices, lifestyles, backgrounds and characteristics. The title, *Equity and Excellence*, reflects the importance the Government places on the principle of fairness and its role as a cornerstone of the new direction.

62. In taking account of all patients' needs and aspirations, services will need to change to address current inequalities and insensitivities, some of which are described and evidenced in Chapter 5 of *Equity and Excellence: Legislative framework and next steps*. This will require an understanding of and genuine dialogue with patients, carers and the public so that their needs are properly understood and addressed. Chapter 6 of *Equity and Excellence: Liberating the NHS* stated that "the Department of Health will carry out a series of consultation activities with: patients, their representative groups and the public; NHS staff, their representative and professional bodies; local government; and the voluntary, social enterprise and independent sectors". The information gathered at these events has been used to inform the response to the consultation.

63. This Equality Impact Assessment (EIA) is a full assessment of the equality impact of the Health and Social Care Bill, except in relation to the Office of the Health

[1] Published 12 July 2010, and available at http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/DH_122624

Professions Adjudicator[2], which takes forward the reforms requiring primary legislation.

Purpose of the Equality Impact Assessment

64. The purpose of assessing the equality impact of the Health and Social Care Bill is to consider the effect of its provisions on patients and the public generally, and on staff. The impacts identified, together with the recommended actions, will inform the implementation of the White Paper vision, with the aim of:

    - enabling all patients to participate equally in a patient-centred system;
    - ensuring changes to the system preserve existing good equality and diversity practice and exploit opportunities for improving equitable rights-based provision; and
    - ensuring the workforce impacts of the system change are applied equitably across all staff groups.

65. The changes in these provisions will affect NHS patients and service users, and all those providing services for NHS patients and employing staff to provide such services. Service provision and employment are both areas in which the ban on discrimination in the Equality Act 2010 applies. Some of the provisions in the Bill give effect to policies that will also have an impact on staff currently employed in existing or new bodies. The three organisations concerned (the Department of Health, the NHS and ALBs) are developing Human Resources frameworks based on common principles to ensure that staff whose employment is affected by the system reconfiguration are treated fairly and equitably. These principles, which will inform and determine the frameworks' individual content, will be agreed with Trade Unions. The composition of the initial frameworks is subject to consultation with Trade Unions as will be any revisions to the frameworks.

66. One of the principles, equality, recognises the importance of a diverse workforce and will help to ensure that no employee receives less favourable treatment on the grounds of age, disability, gender re-assignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, gender or sexual orientation, or on the grounds of trade union membership.

67. In carrying out this assessment, the Department has considered the following dimensions:

    - Age
    - Disability
    - Gender reassignment
    - Pregnancy and maternity

[2] This EIA does not address the proposed abolition of the Office of the Health Professions Adjudicator. A separate Impact Assessment and Equality Impact Assessment is available at http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_122293

- Race or ethnicity
- Religion or belief
- Sex
- Sexual orientation
- Socio-economic status

68. The Department has chosen to include all the relevant protected characteristics covered by the Equality Act 2010 in accordance with good practice guidance from the Equalities and Human Rights Commission (EHRC). Not all the provisions of the Equality Act are yet in force; some, such as the prohibition on age discrimination in services and public functions are still under consideration, and the public sector equality duty is due to commence in April 2011. Our consideration of these characteristics takes into account that the Department expects these measures to be in force when these provisions come into effect.

69. The Department recognises that marriage and civil partnership is a protected characteristic in relation to employment. Where there are workforce issues within particular policy areas the potential impact of those policies is considered on people in all the protected groups. The Department does not consider that people will be at a particular disadvantage because of their marital or civil partnership status as a result of changes to their employment. It is felt that consideration of impact relating to other protected characteristics and action proposed to be taken to mitigate any adverse impact for them will be enough to ensure equitable treatment for people to whom marriage or civil partnership status would apply.

70. Socio-economic status is not one of the protected characteristics that must be covered in the public sector equality duty and therefore in the EIA, but has been included for completeness of impact on current health inequalities.

71. The initial EIA published alongside the NHS White Paper identified the need to pay due regard to equality impact assessment in future related policy developments in public health and social care reform. This document is the full EIA and covers the areas of the NHS White Paper which rely on primary legislation in the forthcoming Health and Social Care Bill, namely:

Annex A	Commissioning for patients (GP consortia and the NHS Commissioning Board)
Annex B	Regulating providers (increasing provider freedoms, economic regulation and joint licensing of providers between the economic regulator and the Care Quality Commission)
Annex C	Local democratic legitimacy (including the establishment of local health and wellbeing boards)
Annex D	HealthWatch
Annex E	Public Bodies (proposals from the Arm's-Length Body Review that require legislation, and the abolition of the Office of the Health Professions Adjudicator)
Annex F	Public Health Service

72. Separate IAs and EIAs will be produced for other aspects of the NHS White Paper, and an IA for the NHS Outcomes Framework was published in December, alongside the Government's response to consultation on *Transparency in Outcomes - a framework for the NHS*.

73. Two important aspects of the NHS White Paper, concerning patient choice and an information revolution, are currently under consultation in *Greater choice and control*[3], and '*An Information Revolution*'[4]. An initial EIA was published alongside *Greater choice and control*. The implementation of these policies will be informed by the responses to those consultations, which end in January 2011.

74. Although an EIA was also carried out for the Public Health White Paper published on 30 November 2010[5], this document contains an assessment of the legislation in the Health and Social Care Bill required to set up Public Health England. This includes the transfer of responsibilities for public health (including the Director of Public Health and associated staff) to local authorities, and the abolition of the Health Protection Agency and transfer of its functions and workforce to the Secretary of State.

Evidence and Stakeholder Feedback

75. The individual EIAs rely on evidence and stakeholder feedback to:

- provide supporting evidence where actual or potential impacts on equality were identified
- assist with developing proposals for mitigating potential negative impacts
- demonstrate how proposed reforms can advance equality of opportunity, where possible

76. The evidence used has been both qualitative and quantitative, and includes research papers, evaluation reports, census data, patient and public surveys, guidance, independent inquiries, health outcomes data and NHS workforce data, as well as stakeholder feedback. This intelligence was obtained from a range of organisations and sectors. Community intelligence from third sector organisations working with seldom-heard groups was particularly valuable where official data and research was limited. Disaggregated data were obtained where possible, to enable assessment of impact by protected characteristic.

77. The individual EIAs contain evidence and stakeholder views specific to each policy. In addition, cross-cutting evidence on access of health services and health outcomes by protected group has been summarised in Annex G of the EIA.

[3] http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_119651
[4] http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_120080
[5] http://www.dh.gov.uk/en/Publichealth/Healthyliveshealthypeople/index.htm

The Equality Act 2010 and Powers of the Secretary of State

78. The Equality Act 2010 aims to simplify, harmonise and strengthen equality law, replacing nine major pieces of legislation and around 100 other instruments with a single Act. It received Royal Assent on 8 April 2010. The main provisions in the Act came into force in October 2010 and the single public sector equality duty will come into force in April 2011[6].

79. The single public sector equality duty covers race, disability, and gender (existing duties), plus age, sexual orientation, religion or belief, pregnancy and maternity, and gender reassignment. These dimensions are collectively referred to as the protected characteristics. All public bodies, including those changed or set up through these provisions, must have due regard to the need to:

    - eliminate unlawful discrimination, harassment, and victimisation;
    - advance equality of opportunity; and
    - foster good relations between those who share a relevant protected characteristic and those who do not.

80. This general duty is underpinned by specific duties, to help public bodies meet the general duty. The Government has recently undertaken a public consultation on the specific duties.[7]

81. The Equality Act 2010 will ensure that all public bodies within the health service, including the NHS and the public health service, are obliged to comply with principles of equality. This will include those bodies established under the Bill, such as GP consortia, and those whose functions are changed, such as some of the arm's-length bodies (CQC, NICE and Monitor). These duties also apply to private providers as far as they are providing NHS services, on the basis that the provision of services for the purposes of the health service is a function of a public nature. This can be brought about by measures such as the inclusion of contractual terms relating to equality in contracts with such organisations, where this is considered necessary.

Consultation responses and stakeholder feedback

82. The Government received over 6000 responses to the consultations on the NHS White Paper and the associated documents, which ran from July to October 2010. The Government also heard the views of key partners during stakeholder engagement events over the summer, including:

[6] From April 2012, the ban on age discrimination in provision of goods, facilities, services and public functions will be implemented.
[7] This is available at http://www.equalities.gov.uk/pdf/402461_GEO_EqualityAct2010ThePublicSectorEqualityDuty_acc.pdf.

- Listening events held at regional level in each SHA and through Regional Voices, seeking dialogue with staff, services users, local government, health managers, equalities organisations, and independent and voluntary sector bodies. Over 1000 people attended these events, representing over 440 organisations
- A special listening event for a wide range of organisations on 30 September. This included 25 equalities organisations who contributed on behalf of their members and networks
- Strategic Partner events with the Equality and Human Rights Commission on 5 October
- Discussions on the NHS White Paper and its themes at regular meetings with DH Corporate Partners (including major partners in health and local government), the Social Partnership Forum (including NHS management and trades union partners, which set up a sub-committee for further work on these themes), and the Equality and Diversity Council (DH and NHS equalities partners).

83. Responses to the NHS White Paper consultations highlighted how the proposals set out in the NHS White Paper present significant opportunities to embed equality and human rights in the commissioning and delivery of health services. The Race Equality Foundation, for example, "*recognises and welcomes the commitment to equality in Equity and Excellence: Liberating the NHS. The document provides a detailed view of a new emerging NHS landscape that uses the language of universal values of equality and diversity and which are also backed up by those values being legally embedded within the proposed new structures and bodies that will be at the centre of the NHS.*"

84. *Liberating the NHS: Legislative framework and next steps* considers the responses received in detail, and these responses have informed the drafting of the individual EIAs. Below is a snapshot of responses addressing the equalities impact of the reforms.

Putting patients first

85. The NHS White Paper proposed putting patients and the public at the heart of the NHS, empowered to take control of their health and care through shared decision-making and greater choice of not only where they are treated, but also the treatment that they receive and who provides it. An information revolution would support patients to take charge of their health and care, and shape services. These proposals are being consulted on, and an initial EIA was published alongside *Greater choice and control*[8].

86. Respondents broadly welcomed the Government's commitment to putting patients and the public first. Stonewall, for example, commented that "*proposals for a stronger patient voice and increased patient involvement in the health and care services they receive are important to reducing discrimination for LGB*

[8] http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_119651

people. [...] Case studies have shown that regular engagement with LGB people can better shape services that are tailored to need. This engagement of LGB people will make the NHS more responsive to LGB need and potentially improve value for money through staff awareness (tackling perceptions and training), innovation (LGB health forums or online consultations for example) and, targeting resources where they are needed".

87. Respondents particularly called for action to ensure that vulnerable communities have a voice through HealthWatch; Advocacy Partners Speaking Up, for example, stressed that "*there must be strenuous efforts to ensure that these bodies genuinely represent their communities, including those groups who are currently often overlooked and who may suffer from health inequalities*."

88. HealthWatch will give patients and the public a real input into decision making about the shape of health and care services, both nationally and within local communities. As the local consumer champion for health, Local HealthWatch will support patients to make choices and raise concerns about their health and care services. This support is particularly critical for seldom-heard communities, who have felt unable to engage with statutory services.

Improving healthcare outcomes

89. The NHS White Paper proposed shifting focus to outcomes, not process targets, with the aim of reducing mortality and morbidity, increasing safety, and improving patient experience and outcomes for all.

90. Respondents generally welcomed the increased focus on outcomes. Mencap, for example, "*welcomed the creation of the NHS Outcomes Framework and believes that it can play a valuable role in tackling existing health inequalities for patients with a learning disability, particularly those with the most complex profound and multiple learning disabilities, who still experience some of the worst health outcomes across England*".

91. There was also support for patient reported outcome measures (PROMs), especially if these feed into quality standards and commissioning regime for providers. The British Homeopathic Association, for example, "*applaud the efforts of the new government to not focus on targets without quality, emphasising the importance of listening to patients by judging evidence not only by randomised controlled trials but through PROMs which provides a far better measure of the patient's own experience and value to their health of an intervention or treatment regime*". A number of respondents called for carers to input into PROMs, both in their own right and on behalf of the person they support, with the British Specialist Nutrition Association, for example, noting that this will be particularly important "*where patients may have a condition such as dementia and be unable to report on their own experience but where their carer could provide a proxy*".

92. However, there was some concern that loss of targets could disadvantage those who had benefitted from them, such as cancer sufferers and older people;

Samaritans, for example, highlighted the benefits some targets have had for people at risk of suicide.

93. Respondents such as the NHS Confederation also called for an integrated outcomes framework across health, social care and public health. This was discussed in *Liberating the NHS: Legislative Framework and next steps*, which outlined how the three outcomes frameworks for NHS, public health and adult social care formed part of a single integrated vision for better health and care outcomes.

94. Promoting excellence and equality is one of the seven principles underpinning the development of all the proposed outcomes frameworks. As far as possible, outcomes measures will be chosen so that they can be measured by different equalities characteristics and by local area.

Commissioning for patients

95. The NHS White Paper proposed giving GP consortia responsibility for commissioning the majority of NHS services, supported by and accountable to an independent NHS Commissioning Board. Clinical commissioning shifts responsibility for buying NHS-funded care to the clinicians who know patients best, ensuring that patients' needs and aspirations shape the future development of NHS services.

96. Respondents were concerned that GP consortia might not have the right skills and expertise for commissioning NHS services – in particular, that they might lack knowledge or awareness of specific groups, communities or conditions. The Race Equality Foundation, for example, said that there was "*fear that GP's are not adequately equipped to fill dual responsibilities of Individual Patient Care and gaining knowledge around the health needs of the local community, specifically those of marginalised communities and many black and minority ethnic communities. This process will entail an in depth engagement with those communities on both a social level and an understanding of the existing workable programmes that are ongoing*". However, Yorkshire and Humber Learning Disability Commissioners felt that, in relation to learning disability needs in particular, "*If GPs have good advice, development and commissioning guidance, there could be the opportunity to improve their understanding of the needs of this population to offer greater personalisation and coordination of the care of people with learning disability, but this would need considerable skill and knowledge development*". Others pointed out that GP commissioning needed to be seen alongside the new role for local authorities (discussed below), and that NHS commissioners could draw on councils' extensive knowledge of and relationships with local communities.

97. Many respondents stressed the importance of consortia engaging with their communities. The Health and Social Care Forum said that "*GP consortia need to be fully involved with the local area they are involved with. For example, this will again involve a robust partnership between the public, private and Voluntary,*

Community and Faith (VCF) sector and will provide consistency in terms of existing services available and intelligence on the area. Through partnership it is more likely that we are able to reduce health inequalities and aim to prevent the gap from widening". Moreover, respondents such as the SHA Equalities and Inclusion Leads felt that consortia should reflect their diverse local communities.

98. GP consortia and the NHS Commissioning Board will be under duties in relation to patient and the public involvement and partnership arrangements with local authorities, which can further strengthen and improve the ability of the NHS to embed equity through their commissioning plans and decisions, in order to improve outcomes.

Increasing local democratic legitimacy

99. The NHS White Paper set out how the Department would strengthen local democratic legitimacy in health, with new functions for local authorities and the creation of health and well being boards to join up the commissioning of local NHS services, social care and health improvement. The leadership role of local authorities in producing the Joint Strategic Needs Assessment (JSNA) will be an important lever in identifying and tackling health inequalities experienced by protected groups. Together with their strategic partners, health and wellbeing boards will also be able to plan activity across health and social care to improve the wellbeing of their communities.

100. There was broad support from respondents for the creation of health and wellbeing boards. NHS Bedfordshire, for example, "*support the creation of health and wellbeing boards with clear and sufficient legal powers to provide local leadership and a strategic framework for coordination of health improvement and addressing health inequalities in local areas, based on local health needs identified by the JSNA*". Walsall Council and PCT said that "*Closer joint working between the council and colleagues in primary care and public health is welcomed and will facilitate the efficient use of resources and expertise to improve health and reduce health inequalities*" while CLIC Sargent felt that health and wellbeing boards will have "*an important role to play in driving integration. This is particularly important in terms of services for children and young people*".

Regulating healthcare providers

101. The NHS White Paper proposed giving providers greater freedom to innovate and respond to patients, underpinned by strong quality and economic regulation. Enabling greater and fairer competition to develop, within an appropriate regulatory framework, will encourage supplier diversity. This diversity can give commissioners the opportunity to engage third sector providers and social enterprises that can provide services more tailored to the needs of specific groups and communities. Greater competition can also drive greater efficiency and higher quality.

102. As discussed in *Liberating the NHS: Legislative framework and next steps*, although many respondents had concerns that competition might undermine equity, many social enterprise and voluntary providers were supportive of proposals that would enable them to enter new markets and provide better and more tailored services to particular groups. The charity Turning Point, for example, "*support the principles of any willing provider and advocate strongly for the role of social enterprises and civil society organisations in not only supporting statutory organisations but in directly providing alternative solutions*." Respondents such as the Terrence Higgins Trust and the Third Sector Assembly Health and Social Care Network also stressed the need to ensure a genuinely level playing field to ensure that smaller organisations with unique knowledge of local minorities can compete. In the words of the East Midlands SHA Public and Voluntary sector, "*there needs to be a level playing field between the big providers of health services and the small providers in the voluntary and community sector*".

An integrated public health service

103. The NHS White Paper set out the Government's proposals for the creation of a new integrated public health service, Public Health England, to spread and support innovation and help provide disease control and protection. Further detail is given in the public health White Paper, *Healthy Lives, Healthy People*, which was published on 30 November. This was broadly welcomed by many consultation respondents. Leicester City Directors of Public Health said *"The transfer of health improvement functions to local authorities will provide opportunities to strengthen the work already undertaken by local authorities to improve the wider social and economic determinants of health and to promote healthy living... The proposal to create a new national public health service is welcome and will provide an opportunity to improve the co-ordination of actions to protect the health of the population."*

104. The Public Health Commissioning Network commented: *"We also welcome the emphasis in the White Paper and the accompanying consultation documents on increasing transparency in decision-making and health service data; reducing fragmentation across the NHS; and increasing productivity. In devising the structure and functions of the PHS, we would encourage the authors of the Public Health White Paper to be bold and innovative, integrating into PHS a formal but voluntary network for sharing knowledge, experience and intelligence between PHS and local authority employees throughout the country, based on the structure of (and the learning from) the Public Health Commissioning Network".*

105. Consultations on the detailed implementation of Public Health England,[9] and on the outcomes framework and relevant indicators for the public health system,[10] are ongoing and will close on 8 March 2011 and 9 February 2011 respectively.

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9 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121941

Streamlining public bodies

106. A focus on outcomes demands a shifting of power and resources from national organisations to the frontline, patients and the public. The report of the ALB review *Liberating the NHS: Report of the arm's length bodies review*[11] sets out how the Department will simplify the national landscape by reducing the number of ALBs and removing duplication and inefficient use of resources, to ensure effective and affordable delivery of these functions. Whilst some respondents welcomed the Government's commitment to efficiency through a more streamlined ALBs sector, others were concerned that it could mean the loss of roles that are important for the promotion of equality. Kirklees PCT, for example, noted that the principles "o*f 'simplifying a national landscape, removing duplication and better aligning the arms length body sector with the rest of health and social care system'*" are "*unarguable in general*" but stressed the importance that the work of the Alcohol Education and Research Council and the National Treatment Agency for Substance Misuse can have in relation to health inequalities.

107. The White Paper described the Government's proposals to abolish SHAs and PCTs. Some respondents were concerned that this would mean a loss of expertise in dealing with particular groups. Bradford District Learning Disability Partnership, for example, expressed concern that, "*With the proposed demise of a regional architecture [… people with learning disabilities] will lose their advocates*". However, others recognised that the existing management structures would have faced very considerable reductions even without the White Paper reforms, and that a priority was to focus resources on front-line services.

Concerns specific to identified communities or protected characteristics

108. Consultation respondents also raised concerns in relation to particular communities or protected characteristics, including the following:

- Respondents such as Hampshire Partnership NHS Foundation Trust and the British Red Cross highlighted that those without fixed addresses, such as Roma, gypsies and travellers, asylum seekers and refugees, had difficulty in accessing services and their needs were often different and unknown, so were not provided for.
- Some people with learning disabilities, older people and people whose first language was not English could not always access and/or use computer-based information and would therefore find it hard to participate in choice and decision-making. The South Ribble Older Peoples' Forum, for example, were concerned that an "*emphasis on on-line services will mean that many*

[10] http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_122962
[11] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_118053.pdf

vulnerable older people are disadvantaged as they frequently do not have access to these services".

- LGB and trans people and those of different religious faiths and cultures would have additional needs to be taken into account in determining what are good healthcare outcomes and when interpreting PROMs data. As one individual said, "*one person's definition of good is different to another's. Some people particularly the elderly or vulnerable groups or their carers may be reluctant to be critical of services that they will have to access in the future*".

Impact

109. Each individual EIA includes a table of impacts which analyses the impact – positive, neutral or negative – of each main policy set out in *Legislation and next steps* on each equality strand. The tables include proposed action to mitigate any adverse impact or to strengthen positive impacts to ensure that the Government's intention of putting patients at the forefront of their healthcare services becomes a reality.

Action Plan

110. The framework for action agreed between the Equality and Human Rights Commission and DH provides DH with the opportunity to demonstrate that the planned actions emerging from this EIA are embedded into the policy making process throughout DH.

111. Key to this is DH's commitment to integrate the action plan into current and future business plans and improve data collection and analysis to inform policy making. As part of the policy development process, DH will engage with external stakeholders on issues in relation to the protected characteristics. DH will monitor and evaluate progress on equality performance concerns and will take appropriate action where identified to deliver improved health outcomes for these groups.

112. This action plan reflects the individual policy EIAs and highlights key actions for both DH and the wider health and care system. The individual EIAs highlight the areas of the Department that are responsible for the action plans. Key to these actions are:

    - Involvement and engagement of stakeholders in the process both at a local and national level
    - Embedding of equalities and human rights legislation into future organisations and commissioning
    - Improvement in data collection and analysis

113. The following section summarises the action plan outlined in each of the individual Annexes.

Commissioning for patients

Actions for DH

- Consider the effect of (a) areas of high deprivation and poor health outcomes, and (b) impacts on health outcomes due to third party improvements in the determinants of health in implementing the proposal for payments in respect of performance.
- Ensure that the forthcoming longitudinal research project on the impacts of GP consortia commissioning strategies includes an analysis of the impacts on protected groups and approaches taken to reduce health inequalities and promote equality.
- Work with health and wellbeing board early implementers and GP consortia pathfinders to consider and share the lessons on how the work of these organisations can contribute to reducing inequalities and promoting equality.
- Ensure that the final guidance for establishing GP consortia is available to patients and the public, and clearly explains the arrangements for guarding against conflicts of interest.

Actions for NHS organisations and health and wellbeing boards:

- Monitor NHS workforce statistics throughout the transition period in order to highlight and mitigate any negative impacts of the move from PCT commissioning to clinical commissioning on NHS staff from protected groups [Initially SHAs and PCTs; later NHS Commissioning Board and GP consortia].
- Align the emerging NHS Equality Delivery System with the existing Equality for Local Government Framework, to facilitate partnership working on equality and diversity and the development of joint equality outcomes where appropriate [NHS Commissioning Board].
- Support and utilise community development expertise within the third sector to build trust and develop links with local communities, in order to facilitate their involvement in shaping and influencing commissioning decisions [GP consortia].
- Work with local partners, including Local HealthWatch and advocacy groups, to promote choice among protected groups and disadvantaged communities [GP consortia].
- Support local advocacy groups working with marginalised or seldom heard communities [Local HealthWatch, working with health and wellbeing boards].

Provision

Involvement and Consultation

- DH will ensure, through provision in the Health and Social Care Bill and the development and implementation of its policy, that the introduction of Monitor as the economic regulator and the policy on providers of NHS

services comply fully with current equality legislation and the proposed public sector equality duty.

Joint Licensing Regime

- Monitor will be required to advance equality as part of its responsibilities under the Equality Act 2010 as a public body. Currently, NHS contracts between providers and commissioners explicitly recognise the obligation of providers to provide services to all. DH are currently considering whether the obligation will:
  (i) Remain within the contract between providers and commissioners.
  (ii) Remain in the contract and be included in the licensing agreement.
  (iii) Be removed from the contract, relying instead on legislation.

Pricing Regulation

- It will be within Monitor's remit to devise a pricing methodology for NHS-funded services, to be agreed through consultation with interested parties and with the agreement of the NHS Commissioning Board. While the methodology will be shaped by consultation, it is possible that Monitor could set prices that recognise the different costs associated with patients from more deprived areas. This would work alongside the recognition of deprivation in the funding formula to GPs and consortia, to fully compensate providers who operate in more deprived areas, to provide a better service to patients in these areas.

Regulator Subject to a Seven-Yearly Review from the Competition Commission

- The development of competition and regulation in public healthcare services will be subject to a seven-year review from the Competition Commission. The Competition Commission will be able to assess any aspects of the functioning and development of competition and regulation in the markets for public healthcare services, which could include consideration of equality issues. In some other regulated sectors, regulators have imposed conditions to ensure that more vulnerable customers are protected, for example, limiting charges payable by customers with pre-pay electricity meters (who tend to be low-income households), despite the higher billing costs of such arrangements. If equality is considered, it will help to improve the availability of evidence in this area in the future as well as providing insights into the potential improvements that can be made to the regulatory regime.

Giving Foundation Trusts more autonomy

- Foundation trusts will have flexibility to merge, acquire another foundation trust or NHS trust, or separate into two or more Foundation Trusts without the approval of Monitor. The Government recognises that organisational mergers could impact upon certain specialised services, with a risk that certain disadvantaged groups could be disproportionately affected. However, Foundation Trusts will be subject to merger controls to protect competition and Monitor could decide to place restrictions on organisational

changes in order to protect essential healthcare services that are safeguarded through additional regulation.

- Governance: DH has started to explore (and will implement accordingly) ways in which foundation trust governance can be strengthened through explicit training and support, particularly during the transition, including how governors can best discharge their equality and diversity duties. This is the case for both existing foundation trust governors, and those of current NHS trusts achieving FT status.

Local democratic legitimacy in health

- DH has commissioned the Joint Strategic Needs Assessment (JSNA) Development Programme in 2010/11 to refresh the 2007 DH JSNA guidance in light of the changes to how JSNAs will be produced in the future. DH will also work with Local Government Improvement and Delivery (LGID) and other partners to provide good practice support during the transition, including case studies and tools to assist with:
    (i) preparations for transfer of JSNA to health and wellbeing boards;
    (ii) wider statutory and community involvement;
    (iii) using JSNA to informing commissioning; and
    (iv) involving the JSNA process in scrutinising service provision.
- The Government is inviting local authorities to become early implementers, to establish a shared development agenda and explore key issues. This includes: how to use the health and wellbeing boards as a lever for greater integrated working through pooling and aligning budgets; how to work together with GPs over different geographies with a focus on local population needs; and how health and wellbeing boards can work effectively with children's services.

HealthWatch

- To discover the extent to which the establishment of HealthWatch will provide people from all equality strands a stronger patient and public voice and effective support to make choices and complaints, DH will need to fill gaps in evidence, particularly on people in civil partnerships and married people, people having undergone gender reassignment and people of different sexual orientations.
- DH will further consider the NHS White Paper consultation responses and, together with stakeholders, use this information to shape HealthWatch and local HealthWatch as these are being set up. This will include addressing how local HealthWatch can engage more with groups such as children and those living in rural communities.

The Department of Health's public bodies

- DH will work with its arm's-length bodies (ALBs) to help them to achieve robust transitional plans and will ensure that they fully consider equality and

human rights issues during this process. In particular, DH will set timescales for ALBs and bodies receiving ALB functions to agree implementation plans that cover transfer of function, process, staff and where appropriate funding and assets. These plans should reflect an understanding of the impact on groups of service users and staff with different protected characteristics, and should demonstrate how adverse impacts will be mitigated.

- In addition, ALBs have already undertaken, or will carry out, EIAs to consider the impact of the changes to the ALB landscape on age and socio-economic disadvantage. They will also give due regard to human rights legislation. Key to the above will be the need for DH to:
    (i) Collect feedback from key staff and stakeholder consultation events to ensure that staff are being consulted in a way that is equitable and appropriate;
    (ii) Find out when ALBs will be producing their EIAs and equality schemes; and
    (iii) Collect business data through the Health and Social Care Information Centre and feedback from patients, user groups and other affected groups in the population to monitor and evaluate the effect of the changes as they are implemented.

Public Health elements of the Health and Social Care Bill

114. This EIA is concerned with the legal framework relating to the Public Health Service. Development of some of the detailed implementation of this service is at an earlier stage and there are gaps in the evidence base. DH has already taken some action to address this, by including questions relating to equality and human rights issues in the consultations on the implementation of Public Health England, and on the outcomes framework and relevant indicators for the public health system. These consultations are ongoing and will close on 8 March 2011. Further, DH will:

- Publish a full EIA on the Public Health Service after the close of the consultation on the Public Health Service White paper;
- Involve stakeholders in policy development between the publication of the Public Health White Paper and the publication of the EIA;
- Encourage Directors of Public Health to take into account the recommendations outlined in the Race for Health and Shared Intelligence on JSNA practice in relation to race equality; and
- Ensure that the Public Health Service Outcomes Framework properly highlights inequalities.

VII Transition risks

115. As outlined in the Annexes, there are risks associated with the introduction of these policies, and those included have been informed by the responses to the consultations. The Annexes themselves give a lot more detail about the risks of

the particular policies, though there were some areas that were repeatedly raised:

- The upfront costs associated with the transition;
- Loss of key personnel and skills;
- The pace of the changes and the scope for delay to increase double-running costs and cause a loss of coordination across organisations;
- The potential impact upon the Quality, Innovation, Productivity and Prevention (QIPP) programme; and
- The potential impact on patient care during the transition.

116. Given demographic trends and other pressures, there are clearly going to be funding challenges for the NHS over the next few years. The changes proposed within the White Paper and the Bill are the Department's proposed method for meeting these funding challenges. While there are significant upfront costs associated with the transition, with an estimated £1.4bn cost being incurred in 2011/12 and 2012/13 in changing to the new structures, Table 2 illustrates how quickly the savings accrue so that the upfront costs are offset by the end of 2012/13.

117. The pace of the changes was repeatedly raised within the responses to the consultation. Some respondents expressed that the changes were being implemented too quickly, and that they would result in NHS staff being preoccupied with their jobs and with the restructuring rather than with patient care. Conversely, other respondents thought that the changes were being implemented too slowly, and that once they have been announced then PCTs and GP consortia will begin responding immediately. If this is then not accompanied by an accelerated timetable, then there will be a longer transition period than is necessary, which could then result in a longer period of uncertainty for those affected by the transition.

118. Given these differing viewpoints, it is difficult to say beforehand what the "ideal" pace for these reforms would be, which, more importantly is likely to vary across the country depending on how developed PBC is within areas. The Government intends that PCTs will be abolished by the end of March 2013, with GP consortia taking over their commissioning functions. This is estimated at being longer than is probably necessary, and allows time for the shadow arrangements to fully explore issues and test solutions, as well as allowing the flexibility for areas to proceed at different speeds.

119. This is linked to the risk around losing key personnel and skills. The more uncertainty there is, and the longer that the changes take to implement, the more likely it is that the best quality staff will move elsewhere to different jobs. This requires local leadership to be able to manage this risk, with early identification of those staff and roles that would be desirable within the new system. Shadow arrangements, including pathfinder consortia, will help with the early identification of appropriate future staffing structures. These arrangements will also help to

ensure that key personnel and skills are retained, so that the new organisations will be able to secure the necessary capability by 2013.

120. Nevertheless, while the Government thinks that the pace of the changes is necessary, and that there is enough flexibility to allow for local differences, there remain risks associated with the speed of the changes. Any sort of delay within the timetable is likely to increase double-running costs[xlix], which represents a risk. Similarly, if some of the changes are delayed and others are not, then this also represents a risk to all of the potential benefits described within the Annexes. This becomes even more pronounced when considering the potential impact for a delay of interlinked policies. For example, if there is a delay in either the implementation of the information revolution, or of the expansion of choice policy, then it is likely that the realisation of the potential benefits of moving commissioning functions to GP consortia will also be delayed.

121. Given the current funding situation within the NHS, it is estimated that the QIPP programme will need to deliver savings of up to £20bn by 2014/15. This will present a significant challenge to the NHS regardless of the structure of the health system. Inevitably, during any period of significant financial challenge and change, there is a risk that staff may be concerned about their jobs, and potentially lose their focus on QIPP.

122. The Department will also work to mitigate this risk. To increase the potential for further benefits and to give the NHS additional incentives and opportunities to improve the quality and productivity of the services its offers, local QIPP and transition plans will be brought together, integrating actions to deliver reform and improve quality and productivity. In practice, the reforms and QIPP will go hand-in-hand. This is because of the increased incentives in the system described above and within the individual Annexes, for effective and efficient care. Annex B outlines the scope of some of the potential savings within providers, and describes why the revised structures may be able to deliver further efficiency savings than the current structures.

123. As stated in *Liberating the NHS: Legislative framework and next steps*, aligning the clinical and financial aspects of commissioning through GP consortia is a prerequisite of the QIPP agenda, and active ownership of the QIPP agenda was an important criteria in the selection of GP consortia pathfinders. It is GPs, not PCTs, whose actions incur the majority of NHS expenditure, whether directly through prescribing and referring, or indirectly through the access they offer for urgent care and how well they help to prevent and manage long-term conditions. Alongside this, liberalising providers gives both the capability and the incentive for providers to respond to the changes in commissioning.

124. Similarly, given the structural changes, NHS staff may be less focused on patient care during the transition. As outlined within the costs section, some of this would be incurred anyway due to the reduction in the staff numbers associated with the reduction in administrative spending. However, those staff most affected are not those who are involved directly with patient care.

VIII Post-implementation review

125. The changes proposed in the Health and Social Care Bill, and in the White Paper in general, will:

- significantly increase transparency about the functions and objectives of all parts of the NHS;
- strengthen accountability to patients, the public and Parliament about the performance of the NHS and the quality of services;
- improve the feedback mechanisms, freedoms and incentives that enable patients, commissioners and providers to make better use of information to improve the quality and efficiency of services: for example, by exercising choice, or commissioning or providing services differently.

126. First, the reforms will improve transparency about functions and objectives. For example:

- The new NHS Outcomes Framework will set out the outcomes for which the NHS Commissioning Board will be held to account. In turn, the Board will develop a Commissioning Outcomes Framework to hold GP consortia to account for their contribution to improving outcomes.
- The Secretary of State will be required to publish a mandate, based on public consultation, setting objectives for the NHS Commissioning Board.
- The NHS Commissioning Board must produce and publish a business plan, specifying how it intends to achieve its objectives.
- At local level, health and wellbeing boards will be obliged to publish a joint strategic needs assessment and a joint health and wellbeing strategy, which local authority and NHS commissioners will be required to have regard to.

127. Second, accountability for performance will be significantly strengthened:

- The proposed information revolution aims to bring about improvements to information about health and care and how it is made available, backed by an enhanced role for the Health and Social Care Information Centre.
- The NHS Commissioning Board will be required to produce an annual report summarising its assessment of how it has performed its functions. This report is given to the Secretary of State, who must then lay it before Parliament.
- Each GP consortium must publish an annual report about how it has discharged its functions, including how it has improved the quality of its services over the year in question.
- The revised regulatory regime for providers, which includes the removal of some of the restrictions on providers as set out in Annex B, will be reviewed by the Competition Commission every 7 years, with the first review by 2019.

- Directors of Public Health must produce an annual report, published by the local authority, about the health of the local population.
- The Secretary of State must report annually on the overall performance of the health service, both public health and NHS.
- HealthWatch England must produce and publish an annual report, including its views on standards of provision of health and social care.

128. Third, there will be more effective feedback mechanisms, incentives and freedom for the system to respond and improve. For example:

    - The extension of choice policy will make it easier for patients (and clinicians) to opt for high-quality services. Coupled with the development of tariff pricing, so that money increasingly follows the patients, providers will need to respond to patient preferences or risk those patients going elsewhere.
    - There will be greater freedoms for NHS providers to respond to the wishes of patients and develop their organisations and services. High quality providers will be able to attract greater numbers of patients and expand, and there will be greater scope for innovative new providers to compete on a fair playing field.
    - A consistent regulatory regime will ensure that low-quality providers have clear incentives to improve their performance. Failing that, there are measures in place to deal with poor performance while safeguarding essential NHS services.
    - Local HealthWatch will ensure that the views of patients, carers and the public are represented to commissioners, while the local authority scrutiny role will be extended to cover all publicly funded healthcare.
    - The reduction in Secretary of State powers and duties will mean that there is significantly reduced potential for political interference within the system.
    - The economic regulator will help to ensure that prices of NHS services are set to reflect true cost, and that there is no anti-competitive behaviour.

129. Therefore, rather than a series of static changes that can be reviewed in isolation, the Bill and White Paper describe a set of mutually-reinforcing reforms that will create a more dynamic, responsive and self-improving NHS.

130. Until the new system is fully functional, it is important to ensure that there is the scope for policy refinement. Therefore, as outlined in section F of chapter 7 of *Liberating the NHS: Legislative framework and next steps*, there will be a phased transition programme over four years, which allows freedom for enthusiasts to make progress early, and gives time to plan, test and learn.

131. At the heart of the transition is a pathfinder programme for emerging GP consortia. These early adopters will be modelling the new system and exploring key issues to inform wider national rollout. The NHS Commissioning Board and the Department will be pulling together analysis of the lessons learnt for

publication. Similarly, there will be early implementers to explore the development of health and wellbeing boards in local authorities.

132. Alongside this, on the provider side it is important to make progress to ensure that providers are clinically and financially viable. Learning the lessons of other sectors is also very important – based on the experience within other sectors, full reform of the provider side and the introduction of greater competition will take time to embed. Following consultation, the Government has therefore allowed for a longer and more structured transition period for completing the reforms to providers.

133. In conclusion, because of the dynamic nature of the reforms and the phased approach to implementation, the Government does not believe that an overarching formal evaluation would be appropriate or necessary in this instance. However, in some cases there are particular risks and uncertainties that point towards a greater need for evaluation. For example, there are a number of implementation challenges and risks around moving commissioning responsibilities to GP consortia. Therefore, alongside the increased transparency within the system that will illustrate how well the reforms are meeting their objectives, greater accountability to make clear how well different organisations are performing, and the pathfinder programme to help refine policy direction as the reforms are introduced, there will be a specific evaluation project to examine this in more detail.

IX How the IAs and EIAs link to the legislation

134. This section explains how the IAs and EIAs correspond to the various chapters of the Health and Social Care Bill. This is to enable readers to navigate this document as easily as possible.

135. Not all of the clauses within the Bill are explicitly covered within the IAs and EIAs. This is because some of the clauses are to allow existing functions and powers to be able to transfer to the new system architecture. Where the clause is expected to result in a significant change, it is included.

Table 7: Read-across from the IAs and EIAs to the Health and Social Care Bill

Part of Bill	Title	IA and EIA in which it is covered
Part 1	The health service in England	Annex A; throughout
Part 2	Further provision about public health	Annex F
Part 3	Economic regulation of health and adult social care services	Annex B
Part 4	NHS Foundation trusts and NHS trusts	Annex B
Part 5	Public involvement and local government	Annex C; Annex D
Part 6	Primary care services	Annex A
Part 7	Regulation of health and social care workers	Annex E
Part 8	The National Institute for Health and Care Excellence	Annex E
Part 9	Health services and adult social care: information	Annex E
Part 10	Abolition of certain public bodies	Annex E
Part 11	Miscellaneous	Throughout
Part 12	Final provisions	Throughout

References

[i] '*Equity and excellence: Liberating the NHS*', http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

[ii] Individual consultations: 'Transparency in Outcomes – a framework for the NHS'; 'Local democratic legitimacy in health'; 'Commissioning for patients'; and 'Regulating healthcare providers'. http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/index.htm

[iii] http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/DH_122624

[iv] '*Liberating the NHS: Greater choice and control: A consultation on proposals*', see http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_119651

[v] '*An information revolution: A consultation on proposals*', see http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_120080

[vi] '*Liberating the NHS: Report of the arms-length bodies review*', see http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117691

[vii] The consultation for the proposed abolition of OHPA is available at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_118459.pdf, the response to the consultation is available at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_122297.pdf, and the final stage IA is available at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_122296.pdf. Annex E of this document includes the costs and benefits of that proposal in its calculation, but does not provide any further information. This is instead available at the links above.

[viii] National Cancer Research Network, National Institute for Health Research, www.ncrn.org.uk

[ix] Nolte, E., McKee, C.M, *Measuring the Health of Nations: analysis of mortality amenable to healthcare.* BMJ 2003; 327:1129; (2003).

[x] EUROCARE-4, www.eurocare.it

[xi] OECD *In-hospital case-fatality rates within 30 days after admission for ischemic stroke (2007)*

[xii] OECD, *Health at a Glance 2009,* (2009).

[xiii] Ibid.

[xiv] European Antimicrobial Resistance Surveillance System (EARSS) incidence of MRSA per 100,000 patient days (2008).

[xv] House of Commons Health Committee. *The prevention of venous thromboembolism in hospitalised patients*. Second report of session 2004-5. (2007).

[xvi] World Health Organisation defines a high performing health system as one that should be "responsive to people's needs and preferences, treating them with dignity and respect when they come into contact with the system", *The Tallinn Charter: Health Systems for Health and Wealth Draft Charter.* WHO, (2008).

[xvii] "There is a need for significant progress to improve issues such as he provision of information, noise in hospitals, and the engagement of patients in decisions about their care", Richards, N., and Coulter, A., *Is the NHS becoming more patient centred? Trends from the national surveys of patients in England 2002-2007,* Picker Institute (2007).

[xviii] For example, Birmingham Health and Wellbeing Partnership, http://www.bhwp.nhs.uk/ ; Camden Health and Wellbeing Board, http://www.camden.gov.uk/ccm/content/social-care-and-health/health-in-camden/local-health-partnership.en ; Nottingham Health and Wellbeing Partnership, http://www.nottinghamcity.gov.uk/onenottingham/index.aspx?articleid=5966 .

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

[xx] *The Report on the National Patient Choice Survey* (2009) shows only 47% of patients being offered choice. This is confirmed by the King's Fund report *How Patients Choose and how providers respond* (2010), which showed that 49% of patients recall being offered choice. A more recent report by the King's Fund gives a more positive picture, with increasing proportions of patients choosing to travel beyond their local hospital. This would increase incentives on providers to ensure higher quality of treatment. More information is available here: http://www.kingsfund.org.uk/publications/patient_choice.html. While this does indicate challenges for the choice policy in general, the section entitled *'Are patients exercising choice?'*, beginning on page 59, talks about a higher proportion of patients attending their non-local hospital when they are offered choice (between 5% and 14%).

[xxi] The Review of Arm's-Length Bodies is available at '*Liberating the NHS: Report of the arms-length bodies review*', http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117691

[xxii] Personalised care planning and personal health budgets are two examples of policies already aimed at giving the individual more choice and control over decisions about their care. More information on the benefits and costs of both is available at the following links:

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_098503.pdf (for personalised care planning)

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_094799.pdf (for personal health budgets)

[xxiii] These includes some of the services where there could be a potential conflict of interest if the GP consortia is responsible for commissioning them, such as those where the members of the GP consortia could be the provider. This does not apply to all services, for example community health services. It also includes services where a higher population level is required for adequate budget-planning and risk mitigation.

[xxiv] An upper-tier local authority is a county council.

[xxv] The areas of best-practice tariffs implemented so far are below average cost and will help to deliver higher-quality services.

[xxvi]

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

[xxvii] Any reference to ALBs within this document does not include OHPA

[xxviii] Within this definition, some of the money that is allocated to ALBs is considered to be frontline service funding. Therefore, while overall ALB funding is £804m (as outlined in Annex E), funding that is assumed to fall into the definition of "admin" is £522m

[xxix] Real changes take into account inflation, while nominal changes do not. The nominal reduction in administrative spending is calculated using the GDP deflator, which is available on the Treasury website at http://www.hm-treasury.gov.uk/data_gdp_fig.htm.

[xxx] The figures in Table 1 are the real reduction in administrative spending that is required to deliver a one-third reduction in administrative spending by 2014/15. This table therefore uses 2010/11 prices, rather than uplifting them for inflation.

[xxxi] This figure is for the PCT spending on commissioning, and does not include PCT provider costs.

[xxxii] This includes Connecting for Health and the NHS Institute for Innovation and Improvement

[xxxiii] A figure of £1.9bn reduction in annual admin spend by 2014/15 has been quoted. This is the equivalent of the figure in the table above, but includes inflation and so is expressed in 2014/15 prices whereas the table above is in 2010/11 prices.

[xxxiv] All staff numbers in this table are rounded to the nearest 100.

[xxxv] The costs and figures in this table are based on the following assumptions – these are only assumptions used to be able to give an estimate of the likely redundancy costs, and should be taken as such, rather than being taken as what will happen or what has already been decided:

- All of the organisations affected have a one-third reduction in their baseline spend (An equivalent reduction in spend across the groups does not translate to an equivalent reduction in staff across the groups. This is because the proportion of spending on staff varies across the organisations);
- A one-third real reduction in running costs over 4 years for the whole non-provider administrative spend;
- The reduction in staff numbers is applied evenly over 2 years – 2011/12 and 2012/13;
- The redundancy multipliers (the number of times their salary an individual can expect to receive if they are made redundant) are 2.0 for DH and 1.5 for the NHS and ALBs – the figures here are towards the top end of the plausible range
- Redundancies are spread evenly throughout the wage structure, across all levels of employment; and
- Natural wastage (the proportion of staff that leaves of their own accord, for example through finding new jobs or through retirement) is 3% per annum.

The big drivers of cost in this table are the redundancy cost multiplier and the wastage assumption. The redundancy cost multiplier is at the top of the scale, making this a high-end estimate – this is because redundancy packages are more attractive to higher paid, longer serving staff. Also, older staff have some pension protection included in the redundancy package. Reducing the NHS and ALB multiplier to 1 and the DH multiplier to 1.3 would give redundancy costs of £361m for PCTs, £39m for SHAs, £38m for ALBs and £75m for DH, a total redundancy cost of £513m (a reduction of £259m).

The wastage assumption is derived from current levels of wastage, estimated at 6%, being halved by the prospect of redundancy packages being made available. The turnover of managers within the NHS is estimated to be around 12.5%. The working assumption within this document is that this is halved during an economic downturn as managers have transferable skills but have fewer opportunities. This is then halved again as fewer staff will choose to leave when there is the prospect of redundancy packages, which gives the assumption of 3% used here. For example, wastage fell by a half in 2006/7 when PCTs were being reorganised and redundancy was made available; doubling the wastage to 6% would reduce costs by £183m.

[xxxvi] The redundancy figures are illustrative in terms of the split across the groups of organisations, and are included to be transparent about the basis for the calculations. The figure quoted in Annex E for redundancy costs to ALBs is £10.4m, which is for those changes that are proposed within this Bill. More information is available in Annex E about where the other changes proposed by the ALB Review will be occurring.

[xxxvii] This percentage includes both the reduction in staff numbers from redundancy and those that occur from natural wastage.

[xxxviii] The figures for NHS Leadership and DH and for ALBs are not assumed to change within Table 4, and remain at 30% redundancy.

[xxxix] While reductions in staff numbers in Table 3 are split into redundancy and wastage, any additional staff reductions shown in Table 4 are done through redundancy only.

[xl] Of the ALB changes, 12 are covered within this Bill and IA. Monitor is covered in Annex B, along with the part of Care Quality Commission (CQC) that pertains to joint licensing. The changes to the National Institute for Health and Clinical Excellence (NICE), the National Information Governance Board (NIGB), the Council for Healthcare Regulatory Excellence (CHRE), the General Social Care Council (GSCC), the Alcohol Education and Research Council (AERC), the Health and Social Care Information Centre (IC), the Appointments Commission (AC), part of National Patient Safety Agency (NPSA), the NHS Institute for Innovation and Improvement (NHSIII) and the rest of the changes to CQC are covered in Annex E. The changes to the Health Protection Agency (HPA) are covered in Annex F.

[xli] Changes as proposed by the ALB Review. Only the changes that are being legislated for within this Bill are included in the Annexes, and within the costs section of this document. The figures quoted here assume that all of the reorganisations proposed within the ALB Review go ahead in that format, and that the HPA and other bodies transfer to the Public Health Service.

[xlii] This figure includes only the portion of the Arm's-Length Body Sector that is non-frontline and funded directly.

[xliii] This figure includes the £5m transition cost of the organisational change, as outlined in Annex B. Costs around introducing the risk-pool and supporting new FT governance arrangements are not included in this figure.

[xliv] Some of the Grant In Aid funding that HPA receives is included within the £522m figure. This is the portion of HPA funding that is not for frontline services.

[xlv] http://www.nao.org.uk/publications/0910/reorganising_government.aspx. This report quotes a figure of £15m per reorganisation, but this also includes redundancy costs which are discussed earlier.

[xlvi] A table outlining the breakdown of this figure and the assumptions for the estimated reduction in actual cost relative to the NAO report follows:

Table EN1: NAO Estimates of transition costs and DH Equivalents

Other Transition Costs	NAO Estimate	Possible DH Variant
Pay harmonisation	£1.8m	£0m
Staff other	£1.8m	£0.9m
IT	£3m	£3m
Property	£2.3m	£2.3m
Corporate functions	£2.1m	£1m
Indirect costs	£1m	£1m
Branding and communications	£0.64m	£0.3m
Total	**£12.5m**	**£8.6m**

The rationale for reducing the costs is that the proposed reorganisations will be undertaken under tighter financial conditions than those considered in the NAO report. The NAO report is also based upon large-scale reorganisations within central government, and so it is assumed that costs of reorganisation will be lower, as per the table above. The £8.6m figure in the above table is therefore taken as the default, unless better information exists.

The abolition of SHAs and the formation of an NHS Commissioning Board including some transfers of functions from DH is currently captured as two re-organisations at £8.6m each, plus £18m for the cost of downsizing the SHA estate (which currently costs £16m per annum and has long leases).

For the abolition of and transfer of functions from PCTs, the estimate of transition costs is £2.1m per PCT. More detail about the rationale for this is available in Annex A.

[xlvii] To make estimations about the overall non-redundancy costs associated with the restructuring, assumptions are needed about the total numbers of reorganisations. The numbers used are assumed because within the NAO report, a merger and a de-merger are described as one reorganisation. This means that the total non-redundancy costs assumed of the reorganisation are as follows:

Table EN2: Estimated number of reorganisations, and total non-redundancy costs of reorganisation

Sector	Number	Cost per reorganisation (£m)
Abolition of 151 PCTs	151	2.1
Abolition of 10 SHAs	1	26.6
ALBs From 18 to 8	8	Variable – 30.6 total assumed attributable to the Bill
Reduction of NHS management within DH	1	8.6[xlvii]
Total	**161**	**388**

The number of reorganisations assumed is based on the following:

- Abolition of SHAs assumed to be one reorganisation because the majority of SHA functions are transferring into one organisation (the NHS Commissioning Board);
- Abolition of PCTs assumed as 151 reorganisations, because the majority of PCT functions are assumed to transfer to GP consortia;
- 18 to 8 ALBs assumed as 8 reorganisations (This assumes that the changes go ahead as described within the ALB Review, and with HPA and other bodies transferring to the Public Health Service); and
- Reduction of NHS management within DH assumed to be one reorganisation (The IT costs included within this figure are £3m, as per Table EN1. There is, however, a significant range of IT costs within the NAO report, though this remains our best estimate at this stage. The final cost will vary depending on the number of people and the type of the transfer involved.

[xlviii] Financial costs and benefits rather than opportunity costs and benefits are used to be absolutely clear about the costs that are expected to be incurred and the benefits that are expected to accrue as a result of the changes, and to be clear about the scale of the costs associated with the transition. Therefore, costs and benefits are not multiplied by 2.4, as the figures quoted in some of the Annexes are.

[xlix] Where costs are incurred for both the old and the new system, as it is not realistic that one system can stop as the other starts. There will be an overlap here, and the longer this overlap is the higher the associated costs will be.