

Health and Social Care Bill 2011

*Coordinating document for the Impact
Assessments and Equality Analysis*

Coordinating document for Impact Assessments and Equality Analysis for the Health and Social Care Bill

This document is the Impact Assessment (IA), incorporating the Equality Analysis (EA), for the Health and Social Care Bill as introduced in the House of Lords. This is an update to the versions of the IAs and EAs that were published in January 2011, when the Bill was initially introduced into the House of Commons.

Introduction, overview and coordination

1. This document, and its Annexes, 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 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. It also reflects the changes that the Government has made to its proposals following the recent listening exercise and the report of the NHS Future Forumⁱⁱ.
5. This is a final stage IA. It has been informed by the consultations on specific policiesⁱⁱⁱ and the White Paper and by the Government's response to the consultation, *Liberating the NHS: Legislative framework and next steps*^{iv}, as well as by the NHS Future Forum report and the Government's response. It also links to the more recent consultation documents on *Greater choice and control*^v and *An Information Revolution*^{vi}. It is structured as a single document with six individual IAs, incorporating EAs, in annexes. The rest of the coordinating document is structured as follows:

- I Description of the current system
- II The financial case for change
- III Description of the new system, and links between the policies
- IV Changes as a result of Parliamentary scrutiny and the NHS Future Forum
- V Benefits of the changes

- VI Costs and cost-savings of the changes to the structure of the system
- VII Comparison of costs and benefits
- VIII Equality Analysis and action plan
- IX Transition risks
- X Managing the finances in transition
- XI Post-implementation review

6. The Annexes are:

- Annex A Commissioning for patients (clinical commissioning groups and the NHS Commissioning Board)
- Annex B Provider regulation
- 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^{vii} that require legislation, and the abolition of the Office of the Health Professions Adjudicator^{viii})
- Annex F Public Health Service
- Annex G Evidence base for the Equality Analysis
- Annex H Relationship and read-across to the Bill

7. The table below summarises the main changes in figures from the January impact assessment, including brief explanations of the reasons. More information is included to explain these figures within the main document, and within the Appendix to this document that compares all of the sets of figures in more detail.

Summary table – main differences in figures

	January	Now	Explanation
Total costs of transition (best estimates)	£1.4bn	£1.2bn - £1.3bn	Reduced redundancy costs
Long-term annual savings (from 2014/15 onwards)	£1.7bn per year	£1.5bn per year	Reduced estimate of administration spending in 2010/11 (the baseline year)
Long-term annual admin spending (2014/15 onwards)	£3.4bn	£3.0bn	Two-thirds of 2010/11 admin spending
Gross savings over the transition (2010/11 – 2014/15)	£5.2bn	£4.5bn	Gross savings changes: reduced admin baseline (£600m) and smoother trajectory for achieving savings (£100m). Net savings changes: as above, plus reduced transition costs
Net savings over the transition (2010/11 – 2014/15)	£3.8bn	£3.2bn - £3.3bn	

8. Given the size of the IA and EA for the Bill, and to make it easier for readers to find the relevant parts, this is split into three documents:
 - a. **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 EA, including action plan.
 - b. **The Impact Assessments:** this document is the 6 IAs, split into Annexes A-F as set out in paragraph 6.
 - c. **The Equality Analysis:** this document is the 6 EAs, 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.
9. There follows a contents page, which covers all three documents. Section XII explains how the IAs and EAs correspond to the Health and Social Care Bill.

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Equality Analysis

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I Description of the current system

10. 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.^{ix}
11. However, compared to other countries, the NHS has achieved relatively poor outcomes in some areas. For example, rates of mortality amenable to healthcare^x, rates of mortality for some respiratory diseases and some cancers^{xi}, and some measures of stroke^{xii} have been amongst the worst in the developed world^{xiii}. 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^{xiv}; the incidence of MRSA infection has been worse than the European average^{xv}; and venous thromboembolism causes 25,000 avoidable deaths each year^{xvi}.
12. 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.^{xvii} 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.^{xviii}
13. 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 have helped to link health organisations more closely to their local areas, this could go further. This is already happening in some places^{xix}, but it is not systematic and the current structure of the health system does not serve to promote it.
14. 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.^{xx} 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. Promoting greater integration will help to join up services for people, which is likely to improve outcomes.

15. Providers also have little incentive at present to respond to patients' 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.^{xxi}
16. 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 The financial case for change

17. 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 major funding challenge. The increase in resources available to frontline health services will, in the absence of modernisation, be more than offset by increasing demand for health care, and it is likely that this will become increasingly unsustainable. The proposed modernisation of the NHS aims to strengthen existing incentives in the system for more effective and more efficient care, to help meet the future funding challenge.
18. NHS funding will rise by £12.5bn over the next four years. However, the demand for services and the costs of providing them will grow more rapidly, meaning that the NHS needs to deliver up to £20bn of efficiency improvements to re-invest in meeting those demands and improving the quality of services.
19. These demand pressures are likely to continue over the medium-term and are attributable to several factors:
 - Demographic pressures – people both living longer generally, and living longer with long-term conditions;

- Medical advances and new technology – commentators in the US have estimated that approximately half of the growth in health spending is due to technological change, which tends to both lower thresholds for treatment and increase the capacity for more intensive interventions (though it is difficult to disentangle this effect from rising patient expectations); and
 - Rising expectations of what the NHS should do – backed up by international evidence that as people get richer, they tend to spend a greater proportion of their income on health and care.^{xxii}
20. All of this is good news for the country – people are living longer, and there is increasing scope to keep people alive through advances in medical technology and the public expectation that this should happen. Nevertheless, this means that the pressure on the NHS budget is increasing and illustrates clearly the need to make efficiency savings through the Quality, Innovation, Productivity and Prevention (QIPP) challenge, reinforced through the proposed modernisation.
21. To help address this, the Government has committed to reducing the costs of administrative spending by one-third, 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).^{xxiii} The reforms proposed within the White Paper act as the mechanism for achieving these reductions.

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

22. 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 build, in an evolutionary way, on 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 interference.

23. 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.
24. 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.^{xxiv} 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 modernisation.
25. 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.
26. This is already happening to an extent, with choice of provider already being available for patients referred by their GP. 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 of high quality.
27. Alongside this, there will be a cultural shift throughout the NHS away from performance management against process 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.

28. Supporting the intention to make care more patient-centred and outcomes-focused, the Bill will give clinical commissioning groups responsibility for commissioning most NHS services, supported by and accountable to a new, autonomous 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.
29. It would not make sense for clinical commissioning groups to commission all NHS services.^{xxv} Therefore, the 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 clinical commissioning groups to perform their commissioning functions, through things such as quality assurance and the drawing up of standard contracts. The Board will also hold them to account for the quality outcomes they achieve and for financial performance, and will only authorise clinical commissioning groups to take on responsibility for commissioning budgets when they are ready and willing to do so. More detail about the reasons for moving commissioning functions to clinical commissioning groups and for the introduction of the Board is included in Annex A.
30. Devolving responsibility to clinical commissioning groups 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 clinical commissioning groups, 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 clinical commissioning policies.
31. 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^{xxvi}, to bring together local councillors with 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 clinical commissioning groups, 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 delegate functions to health and wellbeing boards as they see fit.

32. 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 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.
33. The White Paper set out the Government's plans to free NHS providers from central control and put in place effective 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.^{xxvii}
34. 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 protect and promote the interests of patients and the public by regulating prices, licensing providers, tackling abuses and restrictions that act against patients' interests, 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.
35. As with moving commissioning functions to clinical commissioning groups, 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 aims to address both of these barriers.
36. Increased autonomy for commissioners and providers is accompanied by a reduction in the Secretary of State's powers to intervene in day-to-day operational decisions. 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 in operational management, 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 clinical commissioning groups and reducing restrictions on providers. Therefore, the powers of the Secretary of State to intervene will be constrained and made more transparent. The Secretary of State will, however, remain responsible for the strategic direction of the health service, for example through setting the mandate for the NHS Commissioning Board, and he can also intervene in the event of significant failure. His overall accountability to Parliament for the delivery of these strategic objectives will be strengthened, for example he will be under a specific duty to ensure that the national level bodies are carrying out their functions effectively, and he must report annually to Parliament on the performance of the health service. The powers of Secretary of State are picked up throughout the individual Annexes where relevant and appropriate.

37. 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 clinical commissioning groups, 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 VI below.
38. 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.
39. 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.

IV Changes as a result of Parliamentary scrutiny and the NHS Future Forum

40. Since the Bill was originally introduced in January 2011, there have been changes made to it as a result of both Commons Committee and as a result of the NHS Future Forum report. Among the key changes set out in the Government response to the Future Forum report are that^{xxviii}:
 - GP consortia will now be called “clinical commissioning groups”, and will have governing bodies with at least one nurse, one specialist doctor and lay members;
 - where a clinical commissioning group is ready and willing, it will take on commissioning responsibility from April 2013; if it is not ready by that date, the local arms of the NHS Commissioning Board will commission on its behalf;

- commissioners will be supported by clinical networks and clinical senates, both hosted by the NHS Commissioning Board;
- there will be clearer duties across the system to involve patients, the public and carers;
- foundation trusts will have public board meetings;
- health and wellbeing boards will have a stronger role in local councils;
- Monitor's core duty will be to protect and promote the interests of patients – not to promote competition as if it were an end in itself;
- there will be further safeguards against price competition, cherry picking and privatisation;
- there will be stronger duties on commissioners to promote, and Monitor to support, care that is integrated around the needs of users; and
- Public Health England will be established as an Executive Agency rather than a core part of the Department of Health.

41. These changes serve to strengthen the potential benefits hypothesised within the January impact assessments. The changes to the commissioning proposals will help to ensure that commissioning decisions are both quality-assured and made in the best interests of patients. Similarly, the clearer duties around patient, public and carer involvement will help to ensure that both commissioners and providers act in the best interests of patients. Finally, the changes to the Bill around the role of Monitor will ensure that competition works in the interests of patients and is only used when it is anticipated to benefit patients through improved care.
42. These changes, while significant, do not result in major alterations to the narrative of the analysis within this document and within the Annexes. There are still significant financial benefits around the reduction in administrative spending across the non-frontline elements of the system by one-third, and patient benefits around improved commissioning and more responsive provision of services. The changes serve to increase the likelihood of these benefits being achieved, and, in some cases, to mitigate risks that may have come about. The effects of the changes on costs and benefits are discussed in paragraphs 44-60.
43. The changes also help to mitigate some of the potential risks of the modernisation, and therefore the timetable for change has altered. This includes keeping SHAs running until the 1st April 2013 and delaying the full introduction of the NHS Commissioning Board, to help to manage the transition. This will increase the likelihood of delivering the benefits successfully. However, the revised timetable will delay some of the administrative savings, as is discussed in more detail below. It will not, however, alter the one-third reduction in administrative spending from 2014/15 onwards.

V Benefits of the changes

44. 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.

45. 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, while it indicates positive effects, is not felt to be sufficiently 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 considered within that particular Annex.
46. A report from McKinsey^{xxix} 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 some associated with other changes proposed by the Bill. This emphasises the need to consider the policies proposed in the Bill as a whole, though it is important to note that this is only an opportunity for saving.
47. 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. There are two caveats to this. Firstly, competition is not an end in itself, so Monitor's role is to promote and protect patient interests, by promoting value for money and quality in the provision of services, rather than a duty to "promote" competition proactively. Monitor will have powers to tackle abuses and restrictions on competition that act against patients' interests. Secondly, the methodology used in the McKinsey report 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. Nevertheless, the report is useful in illustrating the possible scale of potential savings.
48. 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.

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

49. 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

clinical commissioning groups, local authorities and the NHS Commissioning Board. The proposed changes to ALBs^{xxx} are also included here.

A Cost-savings resulting from the reduction in administrative spending

50. 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.^{xxxi} 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, while also improving system performance on health outcomes and efficiency.
51. The one-third real reduction in administrative spending is equivalent to a 25.8% nominal^{xxxii} 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^{xxxiii} (£m)
SHAs	456	
PCTs	2,749 ^{xxxiv}	
ALBs	577	
NHS Leadership plus DH ^{xxxv}	512	
Contingency ^{xxxvi}	206	
Total	4,500	1,500

52. The administrative baseline has been re-calculated as £4.5bn rather than the £5.1bn estimated in the January version of the impact assessment. This means that the size of the one-third reduction by 2014/15 is also re-calculated as £1.5bn rather than £1.7bn. More information is included in the Appendix about why the figures have changed since the January document. While this does reduce the annual saving, it does also mean that less money is being spent on administration across the system than was originally envisaged. This also means that future administrative spending will be lower than previously estimated, and more of the money for the NHS will be spent on frontline care.
53. The reductions in administrative spending are staggered between the next financial year and 2014/15, when the one-third reduction in administrative spending is fully achieved. 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

	2010/11	2011/12	2012/13	2013/14	2014/15	Reduction
Admin spend at 2010/11 level	4,500	4,500	4,500	4,500	4,500	
Projected admin spend	4,260	3,857	3,613	3,281	3,000	33.3%
Saving per annum	240	643	887	1,219	1,500^{xxxvii}	33.3%

54. 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 baseline against which cost-savings are estimated is £4,500m. The actual administrative spending in 2010/11 was £4,260m, which is as a result of PCTs beginning to reduce staff numbers earlier than anticipated in preparation for the proposed changes. A more detailed explanation of this is included within the Appendix.
55. The gross savings attributable to the reduction in administrative spending from 2010/11 to 2014/15 are therefore £4.5bn. If this is extended through to 2019/20 (to match the timeline used within the Annexes), this gives a total saving of £12.0bn (£10.0bn when discounted). The annual saving from 2014/15 onwards is £1.5bn. More information is given in the Appendix about how and why this has changed since the January version.
56. As set out in the Appendix to this document, the original trajectory for making administrative savings was relatively front-loaded, with three-quarters of the savings assumed to be made by 2012/13. The revised trajectory spreads the savings more evenly over the period to 2014/15. This has the result of delaying some of the savings: the total amount saved during the period until 2014/15 is reduced by an estimated £706m, from £5,195m to £4,489m.
57. There are two reasons for the revised cost-savings figures:
- i) The reduction in the baseline reduces the scope for overall savings by approximately £600m – this is based on a calculation of the old trajectory applied to the new baseline, as set out in the Appendix; and
 - ii) A small part is as a direct result of the Government's changes announced in response to the Future Forum, in particular the decision to keep SHAs running until April 2013 – this is estimated to cost approximately £100m, as set out in the Appendix.
58. It is important to note that the end-point remains the same: by 2014/15, there will have been a reduction of one-third in the administrative spending across the system. There is only a slight delay in how quickly this is achieved.

59. As discussed above, the changes made to the Bill as a result of the Future Forum report mitigate some of the risks associated with the modernisation. While these changes are estimated to reduce the cost-savings by approximately £100m, they will also serve to increase the likelihood of achieving the benefits around improved patient care that are identified in the Annexes. This is through strengthening the changes to commissioning and ensuring that the changes to providers are in the best interests of patients.
60. The funding for the new organisations that are involved in the commissioning process, such as clinical networks and clinical senates will be included within the administrative spending for each year that is set out in Table 2, and will be hosted by the NHS Commissioning Board.

B Redundancy costs resulting from the reforms

61. Paragraphs 50-60 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.
62. 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.
63. In the January impact assessment, it was estimated that there would need to be a minimum reduction of 30% of staff across SHAs, PCTs, ALBs and DH plus NHS Leadership. It was assumed that the reductions in administrative spending would be equivalent across all organisations, as this allowed the prediction of an overall figure for the redundancy costs. The figures around redundancies and redundancy payments were based on this simplified modelling, to achieve a one-third real reduction in administrative spending. In addition to this, the document expressed a range between 30% and 50% of PCT and SHA staff being made redundant, with the midpoint of 40% being taken as the best estimate.
64. There is now more information available about the redundancies that have already been incurred and the associated costs, as well as greater certainty about the staff numbers in post. More information about the differences, and the reasons for them, are included in the Appendix. The following Table, 3a), gives redundancy costs incurred in 2010 and staff numbers as of April 2011.

Table 3a): Current staff numbers and redundancy costs incurred so far^{xxxviii}

	Staff (April 2011)	Redundancy costs incurred 2010/11 (£m)
SHAs	3,800	3
PCTs	34,500	142
ALBs	5,800	29
NHS Leadership plus DH	4,200	21
Total	48,300	195

65. The health system made £195m of redundancy payments in 2010/11. This is compared to a total of £7m across PCTs and SHAs in 2009/10^{xxxix}, so we can assume that the vast majority of the redundancy payments included in table 3a were in anticipation of the modernisation. For simplicity, it is assumed that all of the £195m is attributable to the modernisation.
66. This means that in 2010/11, the NHS went further and faster with reductions in staff numbers than was anticipated and discussed within the January impact assessment. This has had two effects: firstly, the administrative spending for 2010/11 is lower than was anticipated, which explains the £240m saving compared to the baseline set out in Table 2; secondly, it means that the NHS has already incurred more of the costs associated with the modernisation than was expected.
67. The next table displays the predicted redundancies and redundancy costs from April 2011 onwards, which follow on from the reductions in administrative spending set out in Table 2:

Table 3b): Predicted redundancy costs and numbers from April 2011 onwards

	Future expected redundancy numbers^{xi}	Predicted wastage numbers	Future expected redundancy cost (£m)^{xii}	Total future reduction in staff (%)^{xiii}
SHAs	600	400	51	27%
PCTs	7,900	3,500	343	33%
ALBs	200	600	11	15%
NHS Leadership plus DH	400	500	32	21%
Total	9,100	5,000	437	29%

68. This table shows estimated redundancy numbers and costs from April 2011 onwards, and how this is broken down over existing organisations. The numbers in Table 3b are a theoretical minimum, based on the new organisations employing all of their staff from existing organisations. Further reductions in staff numbers will be made through natural wastage. The difference in the predicted future staff reductions across different organisations is based on high-level modelling of what skills staff in the new organisations might require.

69. Adding this to the £195m redundancy costs incurred in 2010/11 gives a total redundancy cost of £632m. This is again a theoretical minimum total cost. There are likely to be extra redundancy costs because of:

- Friction – skill and geography mismatches between the staff available and those required in the new organisations; and
- Flexibility – future organisations may decide to employ staff that are not employed in the current system.

70. This uncertainty is most relevant for the numbers relating to SHAs and PCTs. Table 4a, below, shows what happens to the overall redundancy costs depending on the proportion of existing SHA and PCT staff that transfer to the new organisations. The minimum proportions are taken from Table 3b, and the total redundancy cost figures include the £195m already incurred in 2010/11.

Table 4a): range of costs depending on the proportion of PCT and SHA staff that transfer to the new organisations

Proportions of staff transferring to new organisations		Redundancy numbers ^{xliii}		Redundancy costs (£m) ^{xliiv}	
PCTs	SHAs	Extra	Total	Extra	Total
67%	73%	0	9,100	0	632
62%	68%	1,900	11,000	89	721
57%	63%	3,800	12,900	179	810
52%	58%	5,800	14,900	268	900
47%	53%	7,700	16,800	357	989

71. Table 4a gives the range of both the total redundancies and the total redundancy cost, depending on the proportion of existing SHA and PCT staff that transfer to the new organisations. The proportions of staff from ALBs and NHS Leadership plus DH are not assumed to change. This means that the overall range of redundancy numbers from the April 2011 baseline onwards are 9,100 to 16,800^{xliv}. The range for the redundancy costs, including those incurred in 2010/11 (as set out in Table 3a), is £632m to £989m. Using a best estimate of 57% of existing PCT and 63% of existing SHA staff transferring to the new organisations, the estimated redundancies are 12,900 and the estimated redundancy cost is £810m. Using figures of 57% and 63%, which are felt to be at the midpoint of the realistic ranges, allows for the new organisations to have flexibility in who they employ and how they perform their functions. Table 4b gives a breakdown of this across different sectors, along with the assumed ranges per sector – this again includes the 2010/11 redundancy costs figures:

Table 4b): Predicted range of total redundancy costs

<i>All figures are in £millions, and are in 2010/11 prices</i>			
	Minimum redundancy cost	Most likely redundancy cost	Maximum redundancy cost
SHAs	54	84	114
PCTs	485	634	782
ALBs	40	40	40
NHS Leadership plus DH	53	53	53
Total	632	810	989

C Non-redundancy costs resulting from the reforms

72. 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.
73. The proposed changes mean that the current 151 PCTs and 10 SHAs will be abolished, and clinical commissioning groups 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 commissioning groups cannot be determined at this stage, because this will be a matter for local discretion – the size and shape of clinical commissioning groups are 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.^{xlvi}
74. 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

<i>£millions, 2010/11 prices</i>			
Sector	2010/11 Baseline running cost	Non-redundancy transition costs	Estates costs
Abolition of PCTs	2,749	257	These costs are included as a total due to interdependency between the sectors
Abolition of SHAs	456	6.3	
ALBs ^{xlvii} , of which:	577 ^{xlviii}		
- Monitor (Annex B)	16.5	12 ^{xlix}	
- ALBs (Annex E)	223 - 227	8.5	
- HPA and other bodies (Annex F)	<i>Partially included^l</i>	<i>Not included</i>	
DH and NHS leadership to Commissioning Board & New DH	512	5	
Contingency	206		

Total	4,500	289	80-200
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75. The non-redundancy costs are partially based on a report undertaken by the National Audit Office (NAO), called *Re-organising Central Government*^{li}. This report estimates a transition cost of £12.5m per re-organisation. For the purposes of this reorganisation, the baseline transition figure for each organisation has been assumed to be lower, at £8.6m. This is based on specific one-off costs and circumstances^{lii}. The table above also contains assumptions about the number of reorganisations.^{liii} This therefore gives a total estimated cost of £369 - £489m that results from the transition from the current structures to the new system architecture. The wide range for estates costs is due to continuing uncertainty over the exact number and location of some new organisations. The aim, however, is to utilise as much of the existing estate as possible and keep reconfiguration costs to a minimum. More information about how this will be achieved is set out in section X.
76. As with the January impact assessment, this document does not include central IT costs for reasons of commercial confidentiality.

D Summary of costs and benefits from the structural changes

77. The total cost that is therefore assumed to be attributable to the changes in the system architecture is £1,001m – £1,478m, which equates to future costs of £806m to £1,283m. This is the full range, from the estimated best case to the estimated worst case. These costs, beyond the £195m already spent on redundancy, are assumed to be incurred predominantly in 2011/12 and 2012/13, when SHAs and PCTs are abolished, and the NHS Commissioning Board and clinical commissioning groups are set up.
78. The cost range based on the most likely estimate of redundancy costs, which means that 57% of PCT and 63% of SHA staff who were in post in April 2011 transfer to the new organisations, is £1,179m to £1,299m. This includes the £195m already spent.

VII Comparison of costs and benefits

79. Some of the costs that are discussed in section VI are included within the individual Annexes, as and where this is felt to be possible to do. Some of these, such as those within Annex B (Provision) and Annex E (Department of Health's Public Bodies) are a subset of the costs and cost-savings discussed within this document. The modernisation is estimated to cost between £1,179m and £1,299m in total. This is compared to a total predicted saving over the 10-year period of £11,989m. These figures are financial costs rather than opportunity costs^{liv}, are in 2010/11 prices, and are not discounted.

VIII Equality Analysis and action plan

Introduction

80. 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*^{iv}. 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. Following the consultations, the Government published its response and further detail about how the changes would be implemented in *Liberating the NHS: Legislative framework and next steps*.
81. 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.
82. The changes proposed in the NHS White Paper, and developed through *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.
83. 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.
84. During spring 2011, the Government took advantage of a natural break in the legislative process to pause, listen and reflect on its programme for the NHS. The NHS Future Forum, a group of 45 senior professionals from across health and social care, including equality and patient representatives, was established to help drive an intensive eight-week period of engagement. In their report they confirmed that there is considerable support for the principles of the reforms. But they also said that some of the ways in which we were putting those principles into practice could be improved. The Government accepted all of their key recommendations and reflected this, where necessary, in amendments to the Health and Social Care Bill, for example to:

- Make it clear that competition would not be pursued as an end in itself, only where it was in the best interests of patients, and create additional safeguards to this end;
- Ensure that a range of clinicians are involved in commissioning;
- Strengthen duties of organisations across the system with regard to patient, carer and public involvement; and
- Ensure that Local HealthWatch is representative of local people and those who use services.

The Health and Social Care Bill has also been amended to change references to “commissioning consortia” to “clinical commissioning groups”. This EA will therefore refer to CCGs, except in the case of direct quotations.

85. This Equality Analysis is a full assessment of the equality impact of the Health and Social Care Bill, except in relation to the Office of the Health Professions Adjudicator^{vi}, which takes forward the reforms requiring primary legislation. It has been revised and updated to reflect the changes which have been made to the Bill during its passage through the House of Commons. The main changes from the previous Equality Impact Assessment can be found at paragraphs 84, 95-96, 106-110, 115, 126, 129-133 and in the action plan.

Purpose of the Equality Analysis (EA)

86. 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.

87. 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 Department of Health has issued a DH HR Framework and an arms length bodies HR Framework. The NHS has issued Regional HR Frameworks. All the Frameworks are based on shared common principles to ensure that staff whose employment is affected by the system reconfiguration are treated fairly and equitably. These principles, which have informed and determined the individual content of these frameworks, were developed in partnership with Trade Unions as has the content of the frameworks. In relation to the overall transition, a national HR Transition

Framework has been issued. Its intention is to provide consistency during the transition as well as encouraging best HR practice throughout and provides generic guidance covering the employment and HR processes throughout the transition. This framework is underpinned by the same principles as the HR frameworks and its content was developed in partnership with Trade Unions.

88. 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.

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

- Age
- Disability
- Gender reassignment
- Pregnancy and maternity
- Race or ethnicity
- Religion or belief
- Sex
- Sexual orientation
- Socio-economic status

90. The Department has chosen to include all the relevant protected characteristics covered by the Equality Act 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; for example the prohibition on age discrimination in services will be implemented from April 2012. Our consideration of these characteristics takes into account that the Department expects these measures to be in force when these provisions come into effect.

91. 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.

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

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

- Annex A Commissioning for patients (clinical commissioning groups and the NHS Commissioning Board)
- Annex B Regulating providers (increasing provider freedoms, Monitor and joint licensing of providers between Monitor 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

94. This EA has now been revised and updated to reflect the changes which have been made to the Bill during its passage through the House of Commons.

95. Separate EAs and EIAs have been produced for other aspects of the NHS White Paper:

- an EIA 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*.
- an initial EIA on patient choice was published alongside the consultation document *Greater choice and control*^{lvii}.
- on 18 August 2011, we published an initial list of equality opportunities and concerns alongside a summary of responses we received to the Information Revolution consultation. We plan to issue a further, more detailed, equality analysis alongside the Information Strategy, following the further work of the NHS Future Forum which is looking at information as one of its four main themes.

96. Although a separate EIA was also carried out on the Public Health White Paper published on 30 November 2010^{lviii}, 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

97. The individual EAs 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

98. 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. 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.

99. The individual EAs 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 EA.

The Equality Act 2010 and Powers of the Secretary of State

100. The Equality Act 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, while the single public sector equality duty came into force in April 2011^{lix}.

101. 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.

102. This general duty is underpinned by specific duties, to help public bodies meet the general duty. These are set out in *The Equality Act 2010 (Specific Duties) Regulations 2011*.^{lx}

103. 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 clinical commissioning groups (CCGs), 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

104. 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:

- 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 2010. 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 2010.
- 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).

105. 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.”*

106. In addition, during the listening exercise on the Health and Social Care Bill:

- over 6,700 people attended listening events with members of the NHS Future Forum,
- 3,000 comments were posted on the website, and
- over 25,000 people emailed the Future Forum.

107. Ensuring that equality was properly considered was a priority for the Listening Exercise. The NHS Future Forum membership included equality and patient representatives. The Listening Exercise also held five specific equality events in May 2011:

- NHS Equality and Diversity Council – NHS Equality Leaders
- Race Equality Foundation Equality Event (Liverpool) – Patients, Service Users.
- BME Event organised by the Afiya Trust.
- Race Equality Foundation Equality Event (Croydon) - Patients, Service Users.
- Equality Listening Event – DH Equality Stakeholders.

108. The key themes at these events tended to mirror those raised in the original assessment of equality for the White Paper. For example, the equality agenda should not be forgotten during the NHS reforms and that the reforms could represent an opportunity to further equality. The reforms could allow for the increased involvement in delivery of services by community groups and that greater diversity of providers could better meet the needs of diverse communities. The events also raised specific issues relating to the protected characteristics, and related issues such as the potential benefits of specialist commissioning of gender identity services for Trans patients.

109. The Future Forum workstream reports highlighted the ways in which the arrangements set out in the Health and Social Care Bill could be used to tackle inequalities. In his Summary Report the chair of the Future Forum, Professor Steve Field, noted that *“The Government’s focus on inclusion health and reducing health inequalities has also been warmly welcomed. The duties the Bill already places on the Secretary of State, the NHS Commissioning Board and clinical commissioning groups will all need translating into practical action through the mandate, the outcomes frameworks for the NHS, public health and social care, commissioning plans and other system levers in order to reduce health inequalities and improve the health of the most vulnerable.”*

110. The responses to both the original consultations and the listening exercise have informed the drafting of the individual EAs. Below is a snapshot of responses addressing the equalities impact of the reforms.

Putting patients first

111. 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. An initial EIA was published alongside *Greater choice and control*^{ixi}.

112. 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 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"*.
113. 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."*
114. 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.
115. Following the listening exercise, the Department of Health introduced amendments to the Health and Social Care Bill designed to ensure that Local HealthWatch is representative of local people and those who use services. It also introduced amendments to require commissioners and providers to have regard to the findings of Local HealthWatch. Taken together these requirements strengthen the role of Local HealthWatch in reducing inequalities between difference groups by requiring that Local HealthWatch makes efforts to represent the views of the whole of the local population and that commissioners and providers take proper account of the messages delivered to them through Local HealthWatch.

Improving healthcare outcomes

116. 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.
117. 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"*.

118. 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*”.
119. 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.
120. 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.
121. Promoting excellence and equality is one of the seven principles underpinning the development of all the 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

122. The NHS White Paper proposed giving clinical commissioning groups 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.
123. Respondents were concerned that clinical commissioning groups 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.

124. Many respondents stressed the importance of clinical commissioning groups 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 clinical commissioning groups should reflect their diverse local communities.

125. Clinical commissioning groups 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.

126. In addition, following the listening exercise, Government has amended the Health and Social Care Bill to:

- ensure that a range of clinicians are involved in commissioning; and
- strengthen the duties of organisations across the system with regard to patient, carer and public involvement

Increasing local democratic legitimacy

127. 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 wellbeing 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.

128. 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

129. The NHS White Paper set out a number of policies designed to bring about higher quality services that are more responsive to patient needs and more efficient. It included the Government's aim to increase the extent to which patients have choice about which provider delivers their healthcare.
130. If there is to be more choice, there will need to be more providers in the system. This in turn means that there needs to be effective market regulation, to ensure that increased competition operates in the best interests of patients. In particular, safeguards are needed to ensure that competition operates on the basis of quality, not price. There needs to be a transparent system of fixed prices, which removes the potential for providers to "cherry pick" and deliver only those elements of a service that are most profitable or to deliver the service only to those patients who are less costly to treat. The Government wants to ensure that existing NHS providers can compete on fair terms with independent and third sector providers, to ensure that patients have the best possible choice of qualified providers.
131. This supplier 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.
132. 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*".

133. Following the Introduction of the Health and Social Care Bill, there was considerable debate about the Government's initial proposals for choice and competition. As part of the Listening Exercise, the NHS Future Forum produced a report and recommendations on "Choice and Competition". In the light of this, amendments were made to the Bill during Commons re-committal to create additional safeguards in relation to the operation of competition and make it clear that competition would not be pursued as an end in itself, only where it was in the best interests of patients.

An integrated public health service

134. 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*. 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."*
135. 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"*.
136. The publication of *'Healthy Lives, Healthy People'* launched a consultation process on elements of the public health service. A summary of consultation responses on equality issues was published on 29th July 2011 as part of *'Healthy Lives, Healthy People - Summary of responses to the consultations on our strategy for public health in England'*. This accompanied the public health strategy document *'Healthy lives, healthy people: update and way forward'*^{xii}, which was published on 14th July 2011.

Streamlining public bodies

137. 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*^{xiii} 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 "of *'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.

138. 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

139. 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 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

140. Each individual EA includes a table of impacts which analyses the impact – positive, neutral or negative – of each main policy. 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

141. 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 EA are embedded into the policy making process throughout DH.

142. 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.

143. This action plan reflects the individual policy EAs and highlights key actions for both DH and the wider health and care system. 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

144. 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.
- As part of the forthcoming Information Strategy, develop a consistent approach to the collection of equalities data in line with forthcoming guidance on public sector equalities duties.

- Ensure that future research on CCGs includes an analysis of the approaches taken to reduce health inequalities and advance equality.
- Work with health and wellbeing board early implementers and CCG pathfinders to consider and share the lessons on how their work can contribute to reducing inequalities and promoting equality.
- Seek to ensure that the final guidance that may be published by the NHS Commissioning Board on the form and content of CCG proposed constitutions is available to patients and the public, and clearly explains the provision CCGs may wish to make to guard against conflicts of interest.
- Ensure that the mandate for the NHS Commissioning Board sets out clear expectations on equality.

Actions for NHS organisations and health and wellbeing boards:

- Consider developing appropriate equality training and support for prospective CCGs, linking it clearly to their role as commissioners. [NHS Commissioning Board] and prospective CCGs to consider their development needs in this area and how these will be met [CCGs].
- Where possible, align the 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.^{lxiv} [NHS Commissioning Board]
- 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 [CCGs]
- Consider practical ways of supporting local third sector advocacy groups working with marginalised or seldom heard communities. [Local HealthWatch, working with health & wellbeing boards]
- Monitor NHS workforce statistics throughout the transition period in order to highlight and mitigate any negative impacts on NHS staff from protected groups. [Initially Primary Care Trusts & Strategic Health Authorities; later NHS Commissioning Board & CCGs]
- Work with local partners, including Local HealthWatch and advocacy groups, to promote choice among protected groups and disadvantaged communities. [CCGs]
- Work with local partners, including Local HealthWatch and advocacy groups, to identify ways of providing more integrated delivery of health and social care. [CCGs]

Provision

Competition and market regulation

- The Government has provided (clause 76 of the Bill) for the Competition Commission to conduct a review every seven years of competition and regulation in public healthcare services. It will be responsible for considering whether the healthcare market is functioning effectively in delivering services to patients, including those with protected characteristics. Whilst the Commission will not have a specific equality remit, vulnerable groups could be considered in some instances. Where the Competition Commission finds that an issue it has considered could have effects adverse to the public interest, it will be required to include in its report recommendations to the Secretary of State, Monitor and the NHS Commissioning Board and they will be required to respond to those recommendations.
- In addition, Monitor will be required to report annually on how it is exercising its functions. There are powers in the Bill for the Secretary of State to require additional information from Monitor.

Transition to the new policy

- Until the new policy is finalised and implemented, the regulatory functions outlined in the consultation document and this assessment will continue to be undertaken by the organisations currently responsible. This will safeguard the continuity of the system and of services to patients and allow an effective transition to be planned.

Joint Licensing Regime

- Monitor will be required to have due regard to the need to advance equality as part of its responsibilities as a public body. Currently, NHS contracts between providers and commissioners explicitly recognise the obligation of providers to provide services to all. The obligation may:
 - Remain within the contract between providers and commissioners.
 - Remain in the contract and be included in the licensing agreement.
 - Be removed from the contract and rely on legislation.
- The question remains whether Monitor should have special powers to revoke or cancel a licence if equality standards in provision are not met. The CQC has responsibility for ensuring that equality issues are upheld by providers, so it may be the case that Monitor will not need to duplicate these powers, though, as a public body it does have a responsibility to pass on information pertinent to another regulator's functions. The option will be chosen on the basis that it best advances equality within the system.

- An improved method of data collection via licensing commitments, alongside current data collections, may provide evidence in the future to assess equality impacts. As part of the licence agreement (with CQC and/or Monitor), providers could be required to record participation information (e.g. % of healthcare used, by whom) by the protected characteristics covered by the public sector equality duty, in order to reveal any issues around inequitable access to services and outcomes. If equality of access is not being achieved, providers could be required to take action to address any inequalities.

Pricing Regulation

- It is within Monitor's remit to devise a pricing methodology, to be consulted upon and agreed with the NHS Commissioning Board. Although it will be a decision for Monitor, it is possible that prices may be set to 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 clinical commissioning groups, to compensate providers who operate in more deprived areas for providing a better service to patients in these areas. This would only be a mitigating factor if the different costs associated with patients in deprived areas was included as part of Monitor's methodology.

FTs: Governance

- We are discussing with stakeholders how FT governance can be strengthened through explicit training and support, particularly during the transition, including how governors can best help the organisation discharge its equality and diversity duties. This is the case both for the governors of existing FTs and for the new governors that will be needed in NHS Trusts that achieve FT status.

General

- Given that we were unable to find any specific evidence relating to religion or belief, pregnancy and maternity, or sexual orientation, it is important that the Department, the Commissioning Board and the others involved keep under review what actions can be taken in order to increase the evidence base in the future.

Local democratic legitimacy in health

- The Government is also establishing a group of early implementer councils to work through with NHS commissioners and local communities some key issues around implementation of the proposals. These will include 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 a wide range of services.

Specifically, we plan to set up learning sets to develop and disseminate learning on a number of key themes including; public health (including health inequalities), service improvement, public engagement (linked to the HealthWatch pathfinders) and JSNA/JHWS. All of these will include consideration of equality issues.

- The JSNA/JHWS guidance will be co-produced with partners including the Local Government Group (LGG) and will include a particular focus on equality issues.

HealthWatch

- To discover the extent to which the establishment of HealthWatch will provide people from all protected characteristics 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.
- The Department of Health will do further work with and support stakeholders to shape HealthWatch England and local HealthWatch. This will include addressing how local HealthWatch can engage more with groups such as children and those living in rural communities. It will also include an equalities and diversity task and finish group that is likely to co-produce, with our stakeholders, a transition document to further advance equality of opportunity.

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, EAs 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 EAs 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

- The Department of Health will:
 - pay due regard to the three aims of the public sector equality duty as set out in the Equality Act 2010 during policy formulation and decision making;
 - incorporate any relevant actions arising from our equality analyses into the Department's equality objectives; and
 - ensure that the Public Health Service Outcomes framework properly highlights inequalities.

IX Transition risks

145. As outlined in the Annexes, there are some risks associated with the introduction of these policies, and those included have been informed by the responses to the consultations and by the report of the NHS Future Forum. 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.

146. Given the Spending Review settlement for health, there are clearly going to be funding challenges for the system 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 £1,179m - £1,299m costs being incurred in this Parliament 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.

147. 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 clinical commissioning groups 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.

148. 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 clinical commissioning groups starting to take over their commissioning functions. Following the report of the NHS Future Forum, this will only happen when the NHS Commissioning Board is satisfied that the clinical commissioning group is ready and willing to do so.
149. 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 clinical commissioning groups and health and wellbeing boards, 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.
150. It is very important to ensure that the timetable for the modernisation does not excessively destabilise the system and create unnecessary uncertainty. Conversely, delays in the timetable are likely to increase double-running costs^{lxv}, 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 clinical commissioning groups will also be delayed.
151. 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 is likely to be challenging regardless of the structure of the health system, and potentially even more so during a period of change with NHS staff more concerned for their jobs than by QIPP.
152. To help mitigate this risk, local QIPP and transition plans will be brought together, integrating actions to deliver reform and improved quality and productivity. While it may be possible to achieve the required QIPP savings within the old structure, the new structure offers additional opportunities to improve productivity further. 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 are more likely to be able to deliver efficiency savings than the current structures.

153. As stated in *Liberating the NHS: Legislative framework and next steps*, aligning the clinical and financial aspects of commissioning through clinical commissioning groups is a prerequisite of the QIPP agenda. It is staff working in GP practices, and other clinical staff, 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.
154. 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.

X Managing the finances in transition

155. To help ensure that costs do not exceed the figures set out above, the Department has introduced mechanisms to manage the financial risk of the transition. More detail about precisely how this will be done will be released in due course.
156. The Department is also refining procedures to monitor spend on a quarterly basis. This will allow control of costs, mitigation of the risks of excess spending and the ability intervene where necessary.

XI Post-implementation review

157. 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.
158. 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 clinical commissioning groups 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.

159. 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 clinical commissioning group 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.

160. 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 to intervene in day-to-day operational management will mean that there is significantly reduced potential for political interference within the system.
- Monitor will help to ensure that prices of NHS services are set to reflect true cost, and will have powers to tackle anti-competitive abuses and restrictions that act against the interests of patients.

161. 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.

162. 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.

163. At the heart of the transition is a pathfinder programme for emerging clinical commissioning groups. 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, early implementers are exploring the development of health and wellbeing boards in local authorities.

164. 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 where appropriate will take time to embed. Following consultation and the recommendations of the NHS Future Forum, the Government has therefore allowed for a longer and more structured transition period for completing the reforms to providers.

165. While 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 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 clinical commissioning groups. 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 the commissioning changes in more detail.

XII How the IAs and EAs link to the legislation

166. This section explains how the IAs and EAs 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.

167. Not all of the clauses within the Bill are explicitly covered within the IAs and EAs. 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 EAs to the Health and Social Care Bill

Part of Bill	Title	IA and EA 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	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 The NHS Future Forum report, and the Government response to it, are available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127443
- ⁱⁱⁱ 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>
- ^{iv} http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/DH_122624
- ^v 'Liberating the NHS: Greater choice and control: A consultation on proposals', see http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_119651
- ^{vi} 'An information revolution: A consultation on proposals', see http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_120080
- ^{vii} 'Liberating the NHS: Report of the arms-length bodies review', see http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117691
- ^{viii} 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/digitalassets/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/digitalassets/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/digitalassets/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.
- ^{ix} National Cancer Research Network, National Institute for Health Research, www.ncrn.org.uk
- ^x Nolte, E., McKee, C.M, *Measuring the Health of Nations: analysis of mortality amenable to healthcare*. BMJ 2003; 327:1129; (2003).
- ^{xi} EURO CARE-4, www.eurocare.it
- ^{xii} OECD *In-hospital case-fatality rates within 30 days after admission for ischemic stroke (2007)*
- ^{xiii} OECD, *Health at a Glance 2009*, (2009).
- ^{xiv} Ibid.
- ^{xv} European Antimicrobial Resistance Surveillance System (EARSS) incidence of MRSA per 100,000 patient days (2008).
- ^{xvi} House of Commons Health Committee. *The prevention of venous thromboembolism in hospitalised patients*. Second report of session 2004-5. (2007).
- ^{xvii} 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).

^{xviii} “There is a need for significant progress to improve issues such as the 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).

^{xix} 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>.

^{xx} 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*.

^{xxi} *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%).

^{xxii} OECD (2010) Value for Money in Health Spending: How much is too much. Kings Fund (2006) Health Spending: How much is enough.

^{xxiii} 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

^{xxiv} 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/digitalassets/dh_098503.pdf (for personalised care planning)

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

^{xxv} These include some of the services where there could be a potential conflict of interest if the clinical commissioning groups responsible for commissioning them, such as those where the members of the clinical commissioning group 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.

^{xxvi} An upper-tier local authority is a county council.

^{xxvii} The areas of best-practice tariffs implemented so far are below average cost and will help to deliver higher-quality services.

^{xxviii} The Future Forum recommendations about developing the healthcare workforce are not dealt with in this document – more information about the anticipated impact will be published in due course.

^{xxix}

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

^{xxx} Any reference to ALBs within this document does not include OHPA

^{xxxi} 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 £577m

^{xxxii} 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.

^{xxxiii} 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.

^{xxxiv} This figure is for the PCT spending on commissioning, and does not include PCT provider costs.

^{xxxv} This includes Connecting for Health and the NHS Institute for Innovation and Improvement

^{xxxvi} As explained in a footnote within the main document, there is the inclusion of £206m contingency funding. This reflects prevailing uncertainty as this is the first time that PCT costs information has been split in this way, and so it is possible that there are costs that have been incorrectly classified. Therefore, at this time the contingency funding is included within the administrative spending baseline. If the figures stated above prove to be 100% correct, then the contingency funding will not be scored as a saving.

^{xxxvii} A figure of £1.9bn reduction in annual admin spend by 2014/15 was originally quoted as the annual saving from 2014/15 onwards. This was the equivalent of the £1.7bn from the January version of the document, but the £1.9bn was in 2014/15 prices rather than 2010/11 prices. The revised figure is £1.5bn in real terms – the Appendix explains exactly why this figure has changed..

^{xxxviii} These figures are from the NHS 2010-11 final accounts summarisation schedules. The £142m for PCTs and £3m for SHAs figures given are those for payments made by PCTs and SHAs to staff who were made redundant in 2010/11. There is also £78m for PCTs and £6m for SHAs for new redundancy provisions. This is for people who will be made redundant in 2011/12. However, as these people will have been in post as of April 2011, they will be included in the workforce figures in Table 3a, and therefore this cost is not included as the predictions of future redundancies are made based on the April 2011 figures.

^{xxxix} This is from the Termination Benefits in 2009/10 for PCTs (£6,825k) and SHAs (£266k) accounts, available at:

<http://www.official-documents.gov.uk/document/hc1011/hc04/0410/0410.pdf>

^{x1} The figure quoted in Annex E for redundancy costs to ALBs is £10.0m, 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.

^{xii} The costs and figures in this table are based on the following assumptions:

- There are differential redundancies across sectors;
- Redundancies are phased over more years, so more of the reduction in the workforce is achieved through wastage rather than redundancy. This is, however, counteracted by higher unit costs of redundancy as a result of increased pay pressures in the system;
- A one-third real reduction in running costs over 4 years for the whole non-provider administrative spend;
- The redundancy multipliers (the number of times their salary an individual can expect to receive if they are made redundant) are 1.5 for DH, SHAs and ALBs, and 1.2 for PCTs. These are based on the information available at this stage, including from the Electronic Staff Records database;
- 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 multiplier for DH, SHAs and ALBs to 1 and the PCT multiplier to 0.8 would reduce the redundancy costs by £154m.

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 £243m.

^{xiii} This percentage includes both the reduction in staff numbers from redundancy and those that occur from natural wastage.

^{xiii} The figures for redundancies and redundancy costs in this Table are from the April 2011 baseline. The extra redundancy numbers are those additional to the minimum set out in Table 3b) (8,900) and the total redundancy numbers are those set out in this Table added to those set out in Table 3b). The wastage numbers (5,100) are not assumed to increase, and so are not included.

^{xiv} The extra redundancy costs are those additional to the minimum set out in Table 3b), but in this case the total redundancy costs include both those set out in Table 3b) (£448m) as well as those already incurred in 2010/11 (£277m) as set out in Table 3a).

^{xiv} As discussed in the Appendix to this document, while it is possible to state what the redundancy costs incurred in 2010/11 were, it is not possible to say what the redundancy numbers were with any degree of confidence. Therefore, redundancy numbers are compared to the April 2011 baseline only.

^{xvi} 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.

^{xvii} 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.

^{xviii} This figure includes only the portion of the Arm's-Length Body Sector that is non-frontline and funded directly.

^{xix} 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.

ⁱ Some of the Grant In Aid funding that HPA receives is included within the £577m figure. This is the portion of HPA funding that is not for frontline services.

ⁱⁱ 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.

ⁱⁱⁱ 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
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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. As can be seen above, 62% of this figure (£5.3m) is assumed to be from IT and property costs.

The “property” element is then removed from this, as it goes into the estates costs in total, which gives a figure of £6.3m for reorganisation excluding estates – as for the transfer from SHAs to the NHS Commissioning Board, for example.

^{liii} 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	1.7 (= £257m in total)
Abolition of 10 SHAs	1	6.3
ALBs From 18 to 8	8	Variable – 20.5 total assumed attributable to the Bill
Reduction of NHS management within DH	1	5
Total	161	289

Estates costs are not included in the figures above, and are displayed separately in Table 5 of the coordinating document. 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 clinical commissioning group;
- 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.

^{liv} 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.

^{lv} Published 12 July 2010, and available at http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/DH_122624

^{lvi} This EA 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

^{lvii} http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_119651

^{lviii} <http://www.dh.gov.uk/en/Publichealth/Healthyliveshealthypeople/index.htm>

^{lix} From April 2012, the ban on age discrimination in provision of goods, facilities, services and public functions will be implemented.

^{lx} <http://www.legislation.gov.uk/ukdsi/2011/9780111512951>

^{lxi} http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_119651

^{lxii} http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_128838

^{lxiii}

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_118053.pdf

^{lxiv} EDS is designed to help NHS organisations meet their legal requirements under the Equality act and Human Rights Acts as well as helping NHS organisations to reduce health inequalities faced by disadvantaged and protected groups.

^{lxv} 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.

Appendix – differences in figures

1. This Appendix displays the differences between the figures that were stated in the coordinating document for the Health and Social Care Bill in January, and those within the revised document. It explains why these differences have come about. The purpose of it is to be entirely transparent about what changes to the Bill have results in changes to the projected costs and benefits, and to separate this from where figures have changed as a result of more information becoming available.
2. This Appendix therefore goes through each of the tables included within the coordinating document, highlighting what changes have been made since the January document and what these changes have come from. This is structured in the same way as the coordinating document, beginning firstly with the cost-savings associated with the changes, followed by the costs, which are in turn split into redundancy and non-redundancy costs.

A Cost-savings resulting from the reduction in administrative spending

Table 1: Comparison of baseline administrative spending in 2010/11, and one-third reduction

<i>£millions, 2010/11 prices</i>	Baseline spend in January version (£m)	Baseline spend in latest version (£m)
SHAs	353	456
PCTs	3,588	2,749
ALBs	522	577
NHS Leadership plus DH	612	512
Contingency	0	206
Total	5,075	4,500
One-third reduction	1,692	1,500

3. The latest baseline figure is lower than was estimated within the previous version, as some of the individual figures have changed:
 - For SHAs, the baseline has been re-calculated to be £456m rather than £353m. This is mainly because some of the staff working on the administration of the Multi-Professional Education and Training (MPET) levy were originally captured as programme funding and therefore not included in the non-frontline administrative spending. These are now correctly classed as admin. Also, the SHA baseline in the January document was based on projections, but now there are actual reported figures available.
 - The PCT figure has been re-calculated to be £2,749m rather than £3,588m. The original figure was based on assumptions that split out PCT commissioning and providing figures. There is now more information available than there was when the original document was published,

allowing us to refine this estimate. This is from the first data collection that separately identified staff working in the commissioning arm of PCTs.

- For ALBs and NHS Leadership plus DH, the NHS Institute for Innovation and Improvement is now included in the ALB sector rather than the NHS Leadership section. The DH figure has also changed slightly as some of the Connecting for Health programme costs were incorrectly scored as administration.
 - As explained in a footnote within the main document, a contingency margin of £206m has been included in the baseline. This partly reflects some remaining uncertainty on the baseline administration costs of organisations other than PCTs (PCTs are dealt with below). It also allows a prudent margin against unforeseen cost pressures that might arise over the course of any financial year. Therefore, at this time the contingency margin is included within the administrative costs baseline. If the figures stated above prove to be 100% correct, then the contingency funding will not be scored as a saving.
4. This information is from financial data reporting the 2010/11 spend. This data was not available in January as the financial year was not complete so projections from 2009/10 spend data was used. Furthermore, the data collection was more sophisticated in 2010/11 as for the first time, it allowed splitting of PCT expenditure into its constituent parts of commissioning, which is included within the administrative baseline figure, and provision, which is not.
 5. The total of the 2010/11 baseline has been affected by a reduction of £240m in the administrative element - since, while £2,749m was provided for, only £2,409m was actually spent. This is because PCTs went further and faster than anticipated, and began reducing their staff numbers in anticipation of the proposed changes. As this is as a result of the White Paper and the legislation, this has been included within the baseline – so, £240m from PCT administrative spending is included within the savings, set out in table 2a below. The PCT baseline also includes £100m contingency, which is to allow for this being the first year of the information being split between PCT commissioning and provision: there may be some costs which have been attributed to the wrong expenditure category.
 6. The following tables explain what has changed in Table 2 in the coordinating document. Table 2a below replicates that which is included in the latest version, while Table 2b below is that which was included within the coordinating document in January:

Table 2a): Cost saving from the reduction in administrative spending, 2010/11 – 2014/15 (latest version)

<i>£millions, 2010/11 prices</i>					
Year	2010/11	2011/12	2012/13	2013/14	2014/15
Administrative running costs at 2010/11 level	4,500	4,500	4,500	4,500	4,500

Real administrative running costs	4,260	3,857	3,613	3,281	3,000
Saving per annum	240	643	887	1,219	1,500
Proportion of the final savings achieved by each year (i.e. speed of trajectory)	15%	43%	59%	81%	100%

Table 2b): Cost saving from the reduction in administrative spending, 2010/11 – 2014/15 (January version)

<i>£millions, 2010/11 prices</i>					
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
Proportion of the final savings achieved by each year (i.e. speed of trajectory)	0	39%	73%	95%	100%

7. As discussed above, the changes in the administrative baseline are as a result of more information now being available. This has reduced the annual saving by 2014/15 from £1.7bn to £1.5bn. The total savings over the 5 years from 2010/11 to 2014/15 have also fallen from £5,195m to £4,489m, a difference of £706m.
8. Part of this is because of the reduction in the administrative spending baseline. In addition, the trajectory has also been revised to spread the savings more evenly over the period to 2014/15, as discussed within paragraphs 50-60 in the coordinating document. In order to come up with a cost figure for the revised trajectory, the trajectory from table 2b above is applied to the baseline from table 2a. This is displayed in table 2c below, which gives the same proportionate reductions from year-to-year as are displayed in table 2b, but with the revised baseline:

Table 2c): Cost saving from the reduction in administrative spending, 2010/11 – 2014/15 (new baseline with old trajectory)

<i>£millions, 2010/11 prices</i>					
Year	2010/11	2011/12	2012/13	2013/14	2014/15
Administrative running costs at 2010/11 level	4,500	4,500	4,500	4,500	4,500
Real administrative running costs	4,500	3,914	3,402	3,078	3,000
Saving per annum	0	586	1,098	1,422	1,500
Proportion of the final savings achieved by each year (i.e. speed of trajectory)	0	39%	73%	95%	100%

9. Comparing the savings per annum of tables 2a and 2c gives us a total reduction in cost-saving resulting from the delay in the trajectory. This amounts to £117m. This means that the other £589m reduction in the cost-saving is a result of the re-calculation of the administrative spending baseline. It is unlikely that the estimates are completely accurate, given the uncertainty, so it will be safer to round the figures calculated to £600m as a result of the re-calculation of the administrative spending baseline, and £100m as a result of the delayed trajectory.

B Redundancy costs resulting from the reforms

10. The following tables discuss what has changed since the January document about redundancy numbers, and the costs associated with them. The first table, 3a, begins with the comparison between staff numbers:

Table 3a): Staff estimates in January document and from April 2011, and redundancy costs incurred so far

	Baseline staff (Original document)	Staff (As at April 2011)	Redundancy costs incurred 2010/11 (£m)
SHAs	3,100	3,800	3
PCTs	50,400	34,500	142
ALBs	4,700	5,800	29
NHS Leadership plus DH	6,000	4,200	21
Total	64,200	48,300	195

11. This table shows the differences in staff numbers. Those for the January document were based on estimates of people in post halfway through 2010/11, while those for April 2011 are based on DH data collection of staff employed at April 2011. They are therefore not directly comparable as they are at different times, but there are other explanations for the differences as well:
- as with the administrative spending for SHAs, some staff funded out of MPET were not previously classed as admin;
 - for PCTs, the figure is significantly lower. The January estimate was based on information that did not accurately break down PCT running costs or staff numbers between commissioning and provision functions. This means that assumptions were made, which have proved to be incorrect. This includes the assumption that commissioning and provision staff in PCTs received equivalent pay, whereas in fact the average wage was higher in the commissioner arm than the provider arm. The staff numbers are also lower due to some staff who are delivering public health functions being incorrectly classified as admin. Finally, the reduction in staff numbers in 2010/11 was much higher than anticipated. All of these factors serve to reduce the figure that was published in January.

- the figure for NHS Leadership plus DH is much lower as a result of major reductions in the numbers of programme funded workers and the voluntary exit scheme. In addition, the figures for Connecting for Health that are included in this are now based on staff numbers, rather than a budget divided by a unit cost.
- It is difficult to estimate what of the difference in the figures is a result of redundancies between the two measuring points and what is as a result of mis-estimation. Based on the redundancy costs incurred in 2010/11, it is possible to make an estimate of the number of staff who were made redundant in 2010/11: however, this will not be reliable as there is not enough information to be able to make assumptions about redundancy multipliers.
 - The estimates of the timing of staff redundancies in the January document were arbitrary – it was assumed that all redundancies would occur in 2011/12 and 2012/13. This was a simplifying assumption to allow the estimation of redundancy numbers and the costs associated with them.
 - The following tables compare figures for redundancies and redundancy costs between the January document and the latest versions. This is Table 3 from the January version, combined with Table 4. This is because the January document assumed a 40% staff reduction in PCTs and SHAs, to give the NHS Commissioning Board and clinical commissioning groups flexibility about who to employ (Table 4 displayed a range from 50% - 70% of PCT and SHAs staff being employed in new organisations, with 60% used as the best estimate). The second table is Table 3c from the latest version of the document:

Table 3b): Comparison of redundancy numbers and costs - figures from January document.

	Baseline staff	Total redundancy costs (£m)	Total redundancy numbers	Wastage numbers	Total reduction percentage
SHAs	3,100	59	1,000	200	40%
PCTs	50,400	768	17,400	2,800	40%
ALBs	4,700	84	1,100	300	29%
NHS Leadership plus DH	6,000	114	1,400	300	29%
Total	64,200	1,024	20,900	3,600	38%

- This table was not included within the original document – it is an amalgamation of the tables 3 and 4 that were included. Table 3b here breaks it down slightly further than the previous tables did, to give the split between PCTs and SHAs.

Table 3b): Comparison of redundancy numbers and costs – latest figures

	Baseline staff	Total redundancy costs (£m)	Total redundancy numbers	Wastage numbers	Total reduction percentage
SHAs	3,800	84	1,000	400	27%
PCTs	34,500	634	11,300	3,500	33%
ALBs	5,700	40	200	600	15%
NHS Leadership plus DH	4,200	51	400	500	21%
Total	48,300	810	12,900	5,000	29%

16. As can be seen, the figures have changed. The baseline staff numbers have been discussed above. For other figures:

- The PCT multiplier has reduced from 1.5 to 1.2 in light of better information from the Electronic Staff Records database. Similarly, the DH multiplier has been reduced from 2.0 to 1.5 in light of more information that is now available. This reduces the redundancy costs;
- Redundancies are phased over more years, which leads to more natural wastage and lower redundancy numbers, but higher unit costs of redundancy due to pay pressures in the system; and
- Differential reductions across sectors.

C Non-redundancy costs resulting from the reforms

17. The following table is for the January document, and summarises the estimated non-redundancy costs across sectors. This was Table 5 of the January impact assessment, and is compared to the revised Table 5 of the new version:

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

<i>£millions, 2010/11 prices</i>	
Sector	Non-redundancy transition costs
Abolition of PCTs	323
Abolition of SHAs	26.6
ALBs, of which:	
- Monitor (Annex B)	12
- ALBs (Annex E)	7.8
- HPA and other bodies (Annex F)	Not included
DH and NHS leadership to Commissioning Board & New DH	8.6
Total	377

18. The main change between the two versions of the documents is around estates. Estates have now been separated from the other non-redundancy transition costs and included separately, as it is difficult to look at them in isolation for any one sector. The estimate for estates costs - of £80m - £200m – is wide, and the original estimate was at the low end of this. This greater range reflects uncertainty about where new organisations are likely to be based (in terms of buildings rather than cities) and how the existing estates will be used.