

From the Office of Sir David Nicholson KCB CBE
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To:

All Chief Executives in NHS Trusts in England
All Chief Executives in NHS Foundation Trusts in England
All Chief Executives in Primary Care Trusts in England
All Chief Executives in Strategic Health Authorities in England

Cc:

Commissioning consortia pathfinders
All Chairs of NHS organisations in England
All Chief Executives of Arm's Length Bodies in England
All Chief Executives of Local Authorities in England
Chief Executives of independent sector partners
Monitor
Care Quality Commission
Local Government Association

Gateway ref: 15594

17 February 2011

Dear Colleague

EQUITY AND EXCELLENCE: LIBERATING THE NHS – MANAGING THE TRANSITION

Introduction

I last wrote to you in December 2010, alongside the publication of *Liberating the NHS: Legislative framework and next steps* and the Operating Framework, to set out the overall transition path for the health and social care system over the next 4 years. There have been important developments since then with the publication of the Health and Social Care Bill; the rapid expansion in the number of pathfinder consortia, and the publication of guidance on forming PCT clusters. This letter provides an update in light of these developments, focussing in particular on the new commissioning system. The publication of the Bill in particular has prompted widespread debate about the proposals for the new system and Annex B below offers clarification on some of the most commonly raised issues.

Current performance and planning for 2011/12

It is critical during this period of complex change that maintaining day-to-day delivery of high standards of care for our patients remains our central priority. The prevalence of influenza,

combined with the exceptionally cold winter, have placed considerable pressures on the service in the last two months. Our staff across the NHS have again responded very well to this challenge, continuing to provide high quality care, in spite of these pressures, through their dedication and professionalism.

Whilst absorbing the pressures of winter, the NHS has continued to perform very well in a range of areas; among other things, continuing to reduce hospital acquired infections and maintaining short waiting times. These are fantastic achievements and we should thank our staff at all levels of the service. As is normal at this time of year, we require a renewed focus on referral to treatment times for elective patients now that planned work has restarted after the Christmas break and in time to secure the strong level of aggregate performance that we expect to see by the end of the financial year.

In my travels around the service, I have encountered some misunderstandings about the Government's intentions in respect of waiting times. Let me be clear that the Government has stated its strong support for the rights in the NHS Constitution, which established patients' right to access services within maximum waiting times or to be offered a range of alternative providers if this is not possible. Timeliness of diagnosis and treatment is what patients expect and remains essential to providing high quality care.

The Government has signalled that the process of meeting these waiting times standards should not distort clinical priorities, but patients should still be able to expect the most clinically appropriate treatment within the defined standards for elective, urgent and emergency care. Local commissioners should hold providers to the Constitutional rights and their contractual commitments, including achievement of maximum waiting times, with firm action to tackle outliers. If we are to maintain and improve quality for our patients, we cannot allow waiting times to increase, nor can we allow distortion of clinical priorities. I hope that clarity will be helpful as local organisations put together their plans for 2011/12 and as providers and commissioners agree their contractual commitments.

This planning round is more important than ever as we need to put in place plans across the system that will see continued improvement in quality, greater efficiency in the use of resources in line with QIPP, and establish the key building blocks of the reformed NHS system envisaged in the White Paper. PCTs locally and SHAs regionally remain the organisations statutorily accountable for putting together those plans and executing them. They should engage emerging GP consortia and PCT cluster leads as far as is practicable so that those new organisations will take shared ownership of those plans for the longer term during 2011/12.

It is critical that the plans we agree for 2011/12 support us to meet the QIPP challenge right up to 2014/15. The sustainable improvements in quality and productivity that we need to achieve £20bn efficiency savings over the Spending Review period will not be realised through a series of short-term solutions. They require us to plan with one eye on the medium and longer term, something we have been preparing for throughout the past 18 months, and we must lay the foundations for this in 2011/12. As part of this, it is essential that PCTs and clusters engage with providers, GP consortia and local government in order to communicate to the community a rounded, coherent and system-wide picture of local plans. Only if we do this can we have confidence in our plans to invest these savings to meet changing demands and to deliver improved clinical services.

Developing the new commissioning system

Since being asked to be the Chief Executive of the NHS Commissioning Board, I have been discussing how the new commissioning system should work with colleagues from across the NHS, and particularly with the leaders of emerging GP consortia. I want to set out some initial

thoughts about what the system is for, how it will operate, and how we will work collaboratively to develop it, building on the progress already made at national and local level.

Progress on implementation

As well as developing the statutory framework for the new commissioning system, we have made important recent progress in building the new system on the ground. Most significantly, the number of pathfinder commissioning consortia is expanding rapidly with 141 pathfinders now confirmed. Pathfinders now cover more than half the population, some 28.6 million people, and the number will continue to grow. That gives us a really strong foundation to test and develop the new arrangements and shows the energy and urgency at local level to bring the new system into being. I have been struck in my discussions with pathfinder leaders by the innovative and pragmatic approach being taken to implementation.

The 2011/12 Operating Framework set out a clear package of support for pathfinder consortia, including a £2 running cost allowance per head of population and access to key staff to support development. We are also developing guidance to support the broader assignment of suitable PCT staff to emerging consortia, an approach which will also be applicable in other areas such as public health. A formal learning network will also be available to pathfinders and this group will play an important part in developing the broader commissioning architecture.

The rapid emergence of pathfinder consortia is an important reason for consolidating PCTs into cluster arrangements: the development of clusters will create space for pathfinders to take on delegated responsibilities earlier where they are ready. In addition, the creation of clusters will allow us to sustain our focus on delivery during the transition, rather than allowing an unplanned erosion of PCT capacity and capability whilst the new system develops. We have now published guidance to support the development of clusters by June 2011, in line with our commitment in the 2011/12 Operating Framework.

We have chosen to create a national timeline and framework for the formation of clusters, although the process will be driven locally. This national consistency is important in order to keep a tight grip on finance, performance and quality during the transition, and because the end-point will be a single organisation covering the whole country and supporting a vibrant system of local consortia: the NHS Commissioning Board. That is very different from the current system of separate statutory organisations, and we therefore need to develop a more consistent and uniform approach during the transition.

As I set out in December, clusters will also identify staff whose future role will be to support commissioning. Clusters will support staff to reshape and redefine their roles and subsequently support them to create social enterprises or joint ventures to offer commissioning support services.

Regarding the development of the NHS Commissioning Board itself, my intention is to set out the high level structure of the organisation in Spring 2011. Proposed structures for the new Department of Health will be set out at the same time. The appointment of the Board's chair is now underway and my aim remains to have the Board's executive team in place by October 2011. I can also confirm that the headquarters and main base for the Board will be at Quarry House in Leeds and that the Board's London offices will be at 4-8 Maple Street, the current base of the National Patient Safety Agency.

Purpose of the system

In taking forward the legal and practical changes necessary to create the new commissioning

system, it is critical that we do not lose sight of what that system is designed to achieve. The central role of commissioners is to drive improvements in health outcomes. Trends in demography, demand and technology, alongside the need to improve quality and value for money, are driving changes in healthcare systems across the world, encouraging the development of better demand management, enhanced primary care and more preventative services. Commissioners will be active leaders of this change, pursuing a compelling vision for the future healthcare system and harnessing the opportunity of being independent of Government to create and implement such a vision.

Commissioners will lead the improvements in quality and productivity required to make the NHS sustainable, spearheading the drive to generate up to £20bn of efficiency savings by 2014/15 for reinvestment in frontline care. Realising the savings needed to invest in improving outcomes means moving from a system configured to diagnose and treat, to one configured to predict and prevent. And it means driving the improvements in clinical care that will have the greatest impact on improving quality and value, particularly by transforming the management of long-term conditions, moving services closer to patients, and containing demand for urgent care.

In order to make these improvements a reality, commissioners will need to lead efforts to empower patients by expanding access to information, extending the range and nature of patient choice, and designing clinical services to suit patient needs. Commissioners will need to harness clinical advice and leadership from across different sectors and professions. Effective information systems will be critical to enabling the development of new patterns of care, and commissioners will require sophisticated methods of gaining insight from patients, public and staff to shape decision-making. That will require an externally-oriented commissioning system, highly engaged with and learning from partners across different sectors and industries.

An integrated commissioning system

These are stretching ambitions, and commissioners will need strong levers and a pro-active approach in order to achieve them. GP consortia, working individually and together, will provide the engine for the commissioning system locally, assuming statutory responsibility for commissioning the bulk of services. Consortia will need support and direction in order to carry out this critical role effectively and providing and shaping that support will be the central role of the NHS Commissioning Board. The Board will be confident about leading change at scale – not through top down diktat, but neither being shy about claiming a leadership role.

This national role of the Board is a vital aspect of the new commissioning system, although it has not been the main focus of public discussion and debate. My ambition is to lead a Board at the centre of a wider commissioning system focused on improving quality and outcomes for patients and making the NHS sustainable for the future. The Board will safeguard the core values of the NHS, ensuring a fair and comprehensive service across the country and promoting the NHS Constitution. It will champion the interests of patients, using choice and information to empower people to improve services. It will directly commission a wide range of services, including both local primary care and the most specialised services in the country, meaning it will have direct responsibility for around £20bn of commissioning spend. It will be accountable nationally for the outcomes achieved by the NHS, as set out in the national mandate, and for contributing to improving broader public health outcomes, as well as for how the NHS commissioning budget, totalling around £80bn, is spent and for maintaining financial control across the system.

In order to discharge these vitally important accountabilities, the Board will provide support to consortia and provide a national framework for local commissioning. It will offer a spectrum of support, from empowering and facilitating success, to intervening to support consortia in difficulty. In particular, it will:

- Provide **leadership** to the commissioning system in improving health outcomes;
- Describe the **challenges and priorities** for the commissioning system, based on patient and public insight and the requirements of the national mandate;
- Support consortia to achieve **authorisation**, and will operate a rules-based **intervention** regime to ensure consortia remain fit for purpose;
- Make financial allocations to consortia and set the **financial strategy** for the commissioning system;
- Provide leadership and support for **quality improvement** across the system;
- Champion a **patient-centred** approach to developing health services;
- Set the **Commissioning Outcomes Framework** to track local delivery and design the quality premium to create financial incentives for consortia to improve quality and outcomes and drive value for money, and
- Translate national Quality Standards into commissioning guidance for consortia and standard **contract and pricing mechanisms** for local use.

So while consortia will have the freedom to shape services and drive improvements locally, they will do so within a national framework and with support and guidance from the NHS Commissioning Board. This will mean creating an integrated system between consortia and the Board, which supports the delivery of national accountabilities as well as local priorities. At local level, consortia will also need to work closely with health and wellbeing boards to ensure alignment and integration between commissioning for the NHS, public health and social care.

Our approach to developing the new system

The way we go about developing the new system will shape the outcomes we ultimately achieve. In September 2010, I set out ten "design rules" for how we should approach the transition as a whole. These rules highlight the critical importance of focussing on purpose; continuing to deliver; working collaboratively; and maximising local freedoms, whilst maintaining clear accountability. A summary of these rules is at Annex C and I believe they continue to hold good.

Alongside these broad design rules, I want to stress some particular features of the approach to developing the new commissioning system which draw on our four principles of change. First, **co-production** is more important than ever. In developing the new system of authorisation and the Commissioning Outcomes Framework, the Board and consortia must work together. In designing local commissioning arrangements, NHS commissioners and local authorities must work together. In driving the redesign of services to improve quality and productivity, commissioners and providers must work together. And if we are to realise the ambition of truly empowering patients, of ensuring there it "*no decision about me, without me*", then we must work with patients, carers and the public on all aspects of the design of the new system. It is vital that this co-production characterises our approach from the outset, both nationally and locally.

Second, our assumption will be that things are done locally unless they need to be done at another level of the system, what I have referred to in the past as **subsidiarity**. I have described a strong national framework for commissioning, but the bulk of powers and responsibilities nonetheless remain with local consortia. Inherent in the design of the legislation is an assumption that services are commissioned locally unless otherwise specified or agreed, so this approach is built into the new commissioning arrangements.

Third, **clinical leadership** will drive the commissioning system at all levels and the way we build that system. Clinicians will be at the heart of local consortia and the Commissioning Board will have strong clinical input across all of its functions. And the commissioning system will be

underpinned by the evidence-based Quality Standards produced by NICE, meaning the pursuit of clinical quality is written into the DNA of the commissioning system.

Finally, **alignment** of the different parts of the system will be critical to developing effective commissioning at local and national level. Locally, alignment between NHS, public health and social care and other commissioners in local and national government will be vital, and health and well-being boards will provide an essential forum for achieving this. Nationally, the Board will need to work closely with a range of key partners: with CQC on maintaining quality and safety; with Monitor on critical processes such as price-setting and the approach to identifying "designated" services, and with the Department of Health and Ministers on agreeing and aligning priorities. During a complex change, maintaining alignment is more important than ever and we are planning to hold a series of whole system alignment testing events in SHAs, starting in March, to begin to test out processes, policies and behaviours.

To many people reading this I know these will seem like warm words. And I fully accept that we should be judged in the coming weeks and months by what we do, not what we say. But I sincerely believe that if we remain true to the approach I have described then we will give ourselves the best possible chance of building a strong and effective commissioning system which can bring the *Liberating the NHS* vision to life and drive better outcomes for patients across the NHS.

Progress on other aspects of the transition

In general, the approach to the transition I set out in December remains in place and the timetable, subject to Parliamentary approval of the new arrangements, is broadly unchanged, with some exceptions noted in this letter. An updated timetable is provided at Annex A and this section provides further detail on the various aspects of the transition which have emerged since December.

Developing the new provider landscape

Work on the Foundation Trust pipeline continues with SHAs and individual NHS Trusts working towards an all FT sector. Following the 30 November returns from the NHS, the Managing Director of Provider Development has visited SHAs to meet with aspirant FTs, commissioner and SHA teams to understand the specific actions required for all Trusts to become an FT; be part of an existing FT, or move to another organisational form by 1 April 2014. These visits will inform accountability agreements to be signed by the end of March 2011 by aspirant Trusts, SHAs and DH. In each case the agreement will set out what needs to be done to support FT status, who is going to do this and by when issues will be resolved and an application made. The Provider Development Authority, which will take over the responsibility for NHS Trusts in governance, performance management and pipeline management terms, will begin in shadow form later in 2011, working with SHAs, before assuming its full responsibilities from April 2012.

Good progress has been made on Transforming Community Services and the Operating Framework objective of separation of provider arms from PCTs has been achieved in all but two cases where specific issues are being addressed. Substantial progress towards divestment has also been largely achieved across the service and I am grateful for all the hard work of PCTs, Trusts and SHAs in achieving this. We have made real progress with this agenda including the development of a significant social enterprise sector and other new organisational forms that will deliver improved pathways of care for patients. Regarding PCT estates, David Flory will shortly be writing to Chief Executives of PCTs and SHAs to set out that PCTs should not enter into transactions involving property without the prior written consent of the SHA. This is to ensure such transactions do not adversely affect the transfer of PCT owned property to other NHS or

non-NHS organisations. Community services have a critical role in delivering the quality and productivity improvements we seek across our system and this part of the provider sector is now well placed to deliver.

We also need to continue to embed patient choice and control in the culture of the NHS. An important first step is the management of the transition of independent sector providers from the current Extended Choice Network by PCTs, which must be done in a way that maintains patient choice and fair competition. We also need to prepare for the gradual introduction of choice of Any Willing Provider – we anticipate issuing detailed guidance on this in the Spring. We are particularly keen to involve patient groups in developing policy in this area and in helping us to decide how to sequence this introduction of Any Willing Provider.

Increasing patient information, empowerment and choice

As set out in my most recent letter on the transition, I have put in place a programme to deliver a culture shift at every level of the system to realise the vision set out in the White Paper. The Transforming the Relationship Across Citizen and Service programme has been further developed in the spirit of ‘no decision about me, without me’, with the content of the programme drawing on the series of recent public consultations, in particular those for *Liberating the NHS*, extending choice and the information revolution. In January, a dedicated workshop brought together a wide range of perspectives in order to develop the content of the programme.

The programme will focus on the transformation in relationships which will be required to achieve our goal of delivering better health outcomes; the technical changes required to support this, and how we can significantly raise the offer of how services are experienced by individuals and their communities. Particular focus will be on increasing the visibility of information to support informed choice and a greater sense of control; development of multi-channel services for convenience and access for all parts of society, and community accountability for health and care services through HealthWatch and a variety of approaches to public participation.

Key emerging workstreams within the programme include shared decision making, community accountability and participation, multi-channel delivery of services, visibility and availability of information, and the technical infrastructure to support greater access to personal information, and the efficiency and safety of clinical practice. The programme will be a cross-cutting programme drawing on activities and resources which sit across a variety of organisations. As a programme which is about transforming a relationship, it will also explore how we can drive and capitalise on the active participation and support of the broader system and public to deliver a lasting and transformational impact.

Health and wellbeing boards

David Behan wrote to all local authority Chief Executives in January 2011 setting out the leadership role for councils and in particular the role of health and wellbeing boards. The Government’s vision is for health and wellbeing boards to drive a genuinely collaborative approach to commissioning. GP consortia and councils’ commissioning plans will be firmly underpinned by a shared understanding of the needs of the community, through joint strategic needs assessments, and by a shared strategy which addresses those needs within the collective resources available through the joint health and wellbeing strategies.

Subject to Parliamentary approval, health and wellbeing boards will be established from 2013, running in shadow form from 2012. Our ambition is for shadow health and wellbeing boards to be in place in each local authority area by April 2012. Many councils are already considering how to enhance existing partnership arrangements with PCTs in order to lay the foundations for new

health and wellbeing boards. It will be crucial to learn from developing good practice and so we have been working with an initial group of 25 councils to design the focus and approach of a broad network of early implementers.

We cannot deliver this agenda from Whitehall – it will be driven by local councils, health bodies and their partners. Our role at national level will be to hold the agenda together and provide support, working with Local Government Group and SHAs. We would like as many people as possible to be early implementers, to support our ambition of shadow health and wellbeing boards being in place in every top tier local authority by April 2012. To become an early implementer, you can write to earlyimplementer@dh.gsi.gov.uk. The initial deadline for applications is by 1 March 2011, but further expressions of interest are welcome after that date.

Public health

Anita Marsland, Chief Executive of NHS Knowsley and Executive Director of Wellbeing Services for Knowsley Metropolitan Borough Council, has been appointed to lead the transition to the new public health system. This work will involve establishing clear ways of working between Public Health England, local Directors of Public Health, health and wellbeing boards and GP Consortia to deliver public health services at local level. This will include setting out the roles and responsibilities of local Directors of Public Health for achieving outcomes for health improvement for their local population. It will also include working in partnership with local authorities, the NHS Commissioning Board and GP consortia on the delivery of Public Health England.

We have been very clear in the Operating Framework that, during the transition year 2011-12 the NHS must continue to lead on improvements to public health, ensuring that public health services are in the strongest possible position when responsibilities are devolved to local authorities. As we deliver the very significant cost savings required of us, it is important that our plans reflect the need to retain staff with scarce specialist public health skills. This will ensure that sufficient resources are retained within the system to deliver critical public health functions during transition to the new arrangements and in the future.

A detailed implementation plan to deliver our objectives for public health is due for completion in March 2011. By October 2011, the Chief Operating Officer for Public Health England (PHE) will be in post.

Informatics

Information and Information Technology are essential components required to deliver the ambitions outlined in the White Paper and a strong informatics capability is necessary to deliver on our intent. The consultation on the 'Information Revolution' closed on January 14th with around 750 responses received. These responses are being analysed and will be an important input to the Information Strategy document due in the Spring.

We continue to work to develop the arrangements for delivering informatics functions during the transition. SHAs and PCTs were asked to provide a detailed analysis of their current systems and informatics capability by January 31st. This has created a baseline that will be used to form the transition plan. We expect to continue to refine the information received through the month of February with the baseline finalised early in March. One major issue identified is the need to clarify how the National Programme for IT services currently delivered by the SHAs and PCTs will be maintained during the transition. Proposals on this are being prepared for consideration by the National Programme Board.

A working hypothesis for the 'future state' of informatics delivery has also been developed and is currently being tested with key stakeholders. The model includes dedicated informatics teams in each part of the organisation as well as arrangements to share scarce skills and improve efficiency.

Education and training

Liberating the NHS - Developing the Healthcare Workforce was published on 20 December, setting out proposals for the new framework for planning and commissioning education and training. This framework envisages healthcare providers as the engine of the new system. Providers would take on existing SHA workforce functions, with quality of education and training remaining under the stewardship of healthcare professions and clinical leadership raising standards at every level. All providers of NHS-funded services would have an obligation to work together in networks to commission the whole workforce and ensure longer-term sustainability, working with social care providers, Local Authorities, public health and the education sector.

A new executive body, Health Education England, will be in place by April 2012 to provide leadership and support to provider 'networks', in the same way that the Commissioning Board will support consortia within an integrated system. HEE will bring together the interests of providers, the professions, staff and patients, building on the work of Medical Education England and professional advisory bodies, involving patients and promoting equality. HEE will work with the professional regulators to assure national standards for professional training that are responsive to the changing needs of patient and local communities. The provider networks and HEE will work together and with partners in education, to commission high quality education and training in response to the strategic commissioning plans of consortia and the Commissioning Board.

SHAs will lead the transition and support a smooth migration of functions to providers so that there is continuity of planning for education programmes. Providers would need to work closely with SHAs as they set up new arrangements for 2012. They should consider how to retain knowledge and expertise in the system on workforce planning, education commissioning and to take on deanery functions. There is scope now to design a more streamlined system that gives providers greater autonomy and accountability and creates the environment where people and organisations have more freedom to improve outcomes and respond to their patients and communities. The consultation closes on 31 March and it is important that those who will be leading in the new framework get involved now and share their views on design and implementation. SHAs will be running consultation events throughout February and March.

Quality and safety

I explained in December that I have asked the National Quality Board to advise on what changes are needed to ensure we have the optimal ability to prevent, detect and respond to quality failings within the NHS. I asked the NQB to take on this role as quality is a systemic issues and the NQB brings together all the national level bodies currently responsible for quality in the NHS.

The NQB will issue a first phase report in the next few weeks providing advice on how to strengthen resilience for quality during 2011/12. This report will emphasise the importance of all parts of the system understanding and implementing the NQB's previous report "Review of Early Warning Systems in the NHS" published in February 2010. Although there will be many changes taking place next year as we pave the way for the formal implementation of the new system architecture from April 2012, the current statutory responsibilities of organisations remain unchanged which means the roles and responsibilities set out in that report hold good. The first phase report is also likely to emphasise the need to:

- Listen to and **capitalise on those parts of the current system that remain constant** throughout the transition. For example, the roles played CQC, GPs as providers and patients;
- Promote the critical **importance of the culture and behaviours within and between organisations** in maintaining and improving quality;
- Harness **existing and new processes to provide further assurance around quality**. For example, ensuring that quality is put at the heart of the approval process for applicant Foundation Trusts and the future authorisation process for GP commissioning consortia;
- Keep the service **focussed on delivering continuous improvements in quality** rather than just focussing on mitigating any risks, and
- Put in place **robust handover strategies** to ensure the wealth of soft intelligence on quality in the system does not get lost.

Following publication of the first phase report, the NQB will turn its attention to describing how quality will be stitched into the fabric of the new system architecture set out in the White Paper-looking across commissioning, provision and regulation.

Human Resources

We continue to develop the strategy and detailed processes to support the changes to staff roles and responsibilities needed to ensure a successful transition. The national Mutually Agreed Resignation scheme attracted nearly 2200 applicants. The scheme will provide a significant saving to the NHS whilst also avoiding redundancies. The MAR scheme was extended to 31 January 2011 and further applications are being processed.

The Pre-authorized MAR scheme announced in December 2010 will now be known as the Retention and Exit Terms Scheme (RETS). The scheme will support one of our key HR objectives: to sustain business continuity during the transition. It will identify and help to retain those staff who are critical to sustaining such capacity and capability by offering some certainty around severance terms during the transition and on exit. Details of the scheme will be published shortly.

In December 2010 we also set out the policy of assigning to consortia relevant staff in PCTs who currently work the majority of their time in functions which are scheduled to transfer to consortia. Assignment will also be applicable to other functions including commissioning support, provider development, public health and workforce and education. For consortia, assignment will take place in the context of their freedom to decide how they will carry out their future functions but with a recognition that existing staff skills and experience should be retained and utilised to support the transition and minimise redundancy costs. We are working with PCTs and GP consortia to develop national guidance on assignment and best practice case studies to show how assignment is already being used effectively at local level. Guidance will be finalised by March 2011.

We also committed in December 2010 to publishing a more detailed update of the people and functions mapping work by the end of January 2011. This work has two aims: to identify existing business functions and staff numbers in the current system; and to outline how this will map across to the new organisations. To support this we have recently asked all SHAs and PCTs to provide us with a comprehensive picture of current functions and staffing by mid February 2011. We are carrying out a similar exercise for DH and the ALBs. The information will be used to develop assignment, transfer and selection plans for the new organisations.

Work on the over-arching HR Frameworks is progressing. These frameworks will outline the principles covering transfers between different organisations, including TUPE, with different terms

and conditions. The NHS, DH and the ALBs also have individual detailed frameworks to describe the specific arrangements for staff working within their own organisations. The draft Department of Health HR framework was sent out in December 2010 and staff comments were received back during the week of 17 January. In the NHS, every SHA has a regional HR Framework in place, although some are being updated to achieve consistency where needed.

Conclusions

Looking across this very challenging agenda, I am once again struck by the dedication and professionalism of managers, clinicians and other staff across the NHS who continue to deliver high quality care for patients whilst building the new system, even at a time of personal and professional uncertainty for many. I want to thank you and your staff for your continuing efforts, particularly during the challenging recent winter period. We have made real progress on developing and beginning to implement the new arrangements while maintaining delivery, and leaders across the NHS should take real credit for that.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'D Nicholson', with a long horizontal flourish extending to the right.

Sir David Nicholson, KCB CBE
NHS Chief Executive

Annex A: Summary timeline

2010/11: Design and early adoption

- Design framework confirmed, subject to Parliamentary approval, and Health and Social Care Bill introduced
- Pathfinders and early implementers model the new arrangements and explore key issues for wider roll-out

2011/12: Learning and planning for roll-out

- First year of QIPP delivery as part of broader delivery on Operating Framework priorities
- SHAs to establish PCT cluster arrangements by June 2011
- High level structure for NHS Commissioning Board and Department of Health set out in Spring 2011
- NHS Commissioning Board executive appointments completed by October 2011
- Shadow national arrangements progressively implemented for the NHS Commissioning Board, new Monitor, Public Health England, Health Education England and the Provider Development Authority
- Sharing lessons from first wave adopters of consortia pathfinder and early implementer systems of health and wellbeing boards
- More pathfinders and early implementers, including local HealthWatch
- Plans drawn up for consortia, involving all GP practices
- Emerging consortia to lead the process of securing staff, including PCT staff being made available
- Plans to be drawn up for health and wellbeing boards
- NHS trusts to apply for foundation trust status, or be planning application in 2012/13

2012/13: Full preparatory year

- Second year of QIPP delivery
- From April 2012, NHS Commissioning Board and new Monitor come into effect, SHAs are abolished, PCT clusters become accountable to the Board, and the Department will have

made substantial progress on its change programme and established Public Health England. The Provider Development Authority oversees NHS trusts

- More learning from GP pathfinders and health and wellbeing board early implementers
- Authorisation process of comprehensive system of consortia begins, with all practices as members, acting under delegated arrangements with PCTs
- Health and wellbeing boards are in place
- Comprehensive local HealthWatch arrangements in place
- From April 2012, local authorities to fund local HealthWatch to deliver most of their new functions
- Consortia notified of 2013/14 allocations
- By the end of the year, a significant number of NHS trusts have achieved foundation trust status

2013/14: First full year of the new system

- Third year of QIPP delivery
- April 2013, PCTs abolished and all consortia assume new statutory responsibilities
- April 2013, health and well being boards assume their statutory responsibilities
- April 2013, Monitor's licensing regime is fully operational
- April 2013, local authorities to have responsibility for commissioning NHS complaints advocacy
- By March 2014, the firm aim is that all NHS trusts have become foundation trusts. NHS trust legislation is repealed, and the Provider Development Authority ceases to exist.

Annex B: Frequently Asked Questions on the Health and Social Care Bill

1) Do the new proposals mean the introduction of price competition in the NHS?

Services subject to tariff will continue to compete on quality: there is no question of introducing price competition. We want patients to be able to choose, where appropriate, from a range of qualified providers that are accredited to provide safe, high quality care and treatment. In its new role, Monitor will ensure that competition works in the public interest, widening choice and driving improvements in quality and efficiency. From 2012, Monitor and the NHS Commissioning Board will decide the best structure and price levels without interference from government.

Final guidance on the 2011/12 tariff rules clarifies that the introduction of a new flexibility to agree prices below the national tariff rate is not intended to facilitate a move towards price competition. The guidance makes clear that the flexibility is intended for use in exceptional circumstances. The use of this flexibility should not in any way affect quality, patient choice or competition. Commissioners will be responsible for ensuring that the quality of services purchased using this flexibility is at least equal to, if not better than, services purchased at full tariff price.

2) What do the proposals mean for integrated care? Will this prevent primary and secondary care clinicians from working together?

The Department intends for more integration of services and more competition – these things are not in conflict. In future, commissioners will have greater scope to develop integrated care pathways where this makes sense, working with a range of local clinicians, and new health and wellbeing boards will promote integration across the NHS, social care and public health. We are encouraging GPs to work with local hospitals to improve care pathways. This is clearly good practice and is not anti-competitive. Clinician-led commissioning will support integrated care and commissioners will have the flexibility they need to be able to bundle services together across a pathway where this makes most sense.

3) What impact will the extension of the “any willing provider” model have on the commissioning of services?

The consultation on plans for developing patient choice, including the extension of “any willing provider” (AWP) model, closed in January and the Department is currently considering its response. This means that several key policy decisions are yet to be determined, in particular whether and to what extent AWP would be mandated nationally for particular services, and whether the accreditation process would be undertaken at national or local level, or whether responsibility would be shared. Subject to the outcome of the consultation, we would expect AWP to apply to many NHS-funded services in future. The 2011/12 Operating Framework made clear that AWP will be introduced for community services during 2011/12.

There have also been questions about the implications of AWP for contracting and tendering. This will also be addressed in the response to the recent consultation. In essence, providers will need to be licensed (where this is required by CQC) and hold an appropriate NHS Standard Contract. They will be obliged to work within the standard business terms of that contract, including meeting specified national quality standards, where appropriate additional local standards and referral protocols, and the agreed price.

Where service integration and continuity of care is important to secure the best clinical outcomes, patient experience and value for money (for example, in end of life care), the intention is that commissioners will be able to go to competitive tender and offer the service to one provider or 'prime contractor'. Under this model, patients would still have choice of treatment, setting and

lead clinician, and potentially of provider for certain services within the pathway. In essence, we want commissioners to adopt the model of commissioning (AWP or tendering) which delivers the best results for patients and taxpayers.

Annex C: Summary of design rules

1. Delivering high quality care within the available resources whilst making the transition to the new system is our central priority. These remain the twin responsibilities for current boards and of new organisations as they are formed through the transition period. No one should drop any of their current roles and accountabilities, unless these are transferred, handed over, or have been formally agreed to stop;
2. At every level, clinical and managerial leaders, from both primary and secondary care, should work together across organisations to design the new arrangements;
3. We will only do at national level what needs to be done at national level, leaving the maximum possible opportunities for flexible local implementation and innovation;
4. Strategic Health Authorities will hold the ring on the transition process during 2011/12 and on balancing differing interests in implementing the new system. The SHA's role should include overseeing the shift of functions required to create the new Public Health service;
5. Authority and accountability will be inextricably and transparently linked at every stage of the transition. This encompasses both accountability within the system, which will not be reduced, but also to local communities. The engagement with local authorities on the creation of Health and Wellbeing Boards and the future Public Health Service is critically important;
6. In designing the new system, the test for us will be what provides the best quality and outcomes for our patients and the best value for our communities, not the preferences of sectional interest groups within or outside the system. To this end, patients also need to be involved at every level in creating the new arrangements;
7. We will not wait for all of the elements of the new system to be in place before seeking to provide more information to the public on quality and outcomes and further support patients in making informed choices about their care;
8. Running costs need to start and remain low in the new system in line with the reductions already planned. This will require lean solutions, shared capacity and focussing of management effort on the areas of highest priority;
9. We want to enable new organisations, and particularly GP consortia, to have the maximum possible choice of how they operate and who works for them;
10. At the same time, we want to support current employees of SHAs and PCTs through the change and, where it is the right thing to do, support them in moving into new organisations, minimising the cost and complexity and ensuring we retain essential talent and capability through the transition. Those creating new organisations, and individuals in the change process, will need to be provided with developmental support to enable them to undertake their future roles.