The White Paper Team
Room 601
Department of Health
79 Whitehall
London
SW1A 2NS

Dear Sir,

**Equity & excellence: Liberating the NHS and associated consultation documents**

I am pleased to enclose the response of the Institute of Chartered Secretaries and Administrators (ICSA) to the above white paper and consultation documents.

ICSA is the professional body qualifying and supporting Chartered Secretaries and the response below has been developed in partnership with Members and non-members working within the NHS, advising boards and ensuring governance arrangements are robust and appropriate.

As the world’s leading authority in corporate governance, ICSA, and its Members, are well placed to provide input on the proposals for the NHS, and this combined expertise will be invaluable to those establishing new governance arrangements within commissioning consortia and existing foundation trusts.

Should you require any further clarification regarding any aspect of ICSA’s response, please do not hesitate to contact me directly.

Yours faithfully,

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The Institute of Chartered Secretaries and Administrators
Founded 1891 • Constituted under Royal Charter 1902 • Patron: Her Majesty The Queen

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Equity & excellence: Liberating the NHS and associated consultation documents

About ICSA
The Institute of Chartered Secretaries and Administrators (ICSA) is the professional body qualifying and supporting company secretaries and corporate administrators in all sectors of the UK economy. Members are educated in a range of topics including finance, HR, company law, administration and governance, which enable them to add value to any organisation.

ICSA is the leading international voice on corporate governance and delivers a professional education that gains its strength in the breadth of the syllabus; designed to assist boards and work with senior managers to identify and maximise opportunities within relevant legal frameworks and established best practice.

In order to respond constructively to the NHS white paper and supporting consultation documents, ICSA established a working group, constituted of both Members and non-members, involved in the senior management of NHS entities and experience of other sectors. This approach combined the strengths of the ICSA’s knowledge of corporate governance and compliance issues with the practical understanding of how the proposed NHS framework could impact on the day-to-day administration of an NHS body. We therefore feel that our comments are made from a good understanding of the practical issues involved.

Equity and excellence: general comments
ICSA welcomes the opportunity to respond to the white paper and supporting consultation documents outlining the future framework for the NHS in England. Chartered Secretaries are suitably qualified and uniquely placed to provide support and guidance to NHS staff in the shaping of health and care services. They have a wide understanding and expertise of governance and management systems, providing insight into ensuring appropriate, transparent and flexible arrangements are put in place to achieve better health outcomes.

ICSA supports the approach of taking commissioning decisions closer to the patient, reframing care around the needs of the local health community, and ensuring better dialogue between users and providers. The white paper’s premise of ‘nothing about me, without me’ is a step in the right direction of developing a relationship between the public and the state around life style choices and the subsequent impact that has on the health care required by individuals and the wider society. We tentatively support the proposal to establish a Public Health Service to deliver integrated health prevention and care services; however, further information is required to develop a better understanding of the proposals.

It is understood that certain services will be commissioned by the NHS Commissioning Board, such as maternity services, however, the white paper and associated consultation documents do not refer to ophthalmic or ambulance services. Given that ambulance trusts already struggle in receiving payment from PCTs for the services they have provided, it is likely that negotiating with a diverse group of commissioners and service providers will add to the strain on the
resources currently available. ICSA assumes the subsequent bill and legislation will provide a clearer picture as to how these services fit into the new NHS framework.

The proposals, as currently presented, give rise to a number of concerns that potentially build conflict and tension into the system. It is hoped that the consultation process smoothes out such tensions to ensure that the patient really is placed at the centre of health and care services in the future and the competition envisaged ultimately benefits the public.

Without further information about the Public Health Service, and more detailed aspects of the operating dynamics of commissioning consortia, it is difficult to develop a bird’s eye view of the whole service and how different aspects will mesh together. The real cuts in local authority funding present another challenge to an integrated service that encapsulates care ‘from cradle to grave’. Any lack of capacity in home care and other community service is likely to impact on bed blocking and prompt discharge from hospitals, which in turn will have a knock-on effect on the health outcomes and contractual obligations placed on providers.

With the desire to iron out potential areas of duplication, and build a system that fully embraces accountability in an appropriate manner, ICSA would be interested in exploring with the government, GP and foundation trust representative bodies, appropriate governance arrangements for both commissioning consortia and foundation trusts to secure meaningful and proportionate public involvement that supports the aims of the white paper while securing the interests of the wider taxpaying public and users.

**Transitional arrangements**

While ICSA agrees with the principles of taking health and care decisions closer to the patients and public, the speed with which the changes are to be implemented presents further challenges at a time of ongoing efficiency savings and increasing public expectations of the services they use.

Anecdotal evidence suggests that PCT non-executive directors are feeling disengaged from the transitional process, especially with strategic decision making and commissioning functions being transferred to a range of bodies likely to become commissioning consortia. This poses an increase in risk by way of non-executive directors resigning and imperilling the quorum required to make decisions, not meeting as regularly as required to successfully implement a change programme, and not monitoring delegated authorities. In extreme cases there is the possibility of boards abdicating their responsibilities entirely by permitting ‘shadow’ entities to act within powers that cannot be delegated by the board, under the current legal framework.

With the legal authority and responsibility resting with the PCT board in the interim, the transition period requires extra vigilance to ensure that an accountability vacuum does not appear, with the inherent risk that poses to patients and the threat of legal challenges to decisions made. Robust assurance frameworks are required by PCT boards to ensure that transitional arrangements are undertaken within a framework that continues to ensure patient safety, clinical quality and the effective and efficient use of limited resources.

Adding to the concern regarding the performance of PCT boards in the transition period, is the reality that experienced staff required to support the board in their oversight and leadership roles will leave to pursue their careers elsewhere before the functions of the PCT are transferred.
In order to mitigate any potential accountability vacuum, one option may be to include GPs interested in establishing and playing a role in commissioning consortia to become ‘associate directors’ of PCT boards. This will provide GPs with an opportunity to familiarise themselves with current commissioning practice, inform and shape future arrangements, and develop a body of corporate memory to transfer to the new commissioning arrangements. Importantly, the PCT board would retain its legal functions of oversight.

Alternatively, two different decision-making bodies may be run in parallel, with the PCT boards’ functions, and appropriate staff, being incrementally transferred to the commissioning consortia within a mutually agreed and legally sound framework. Duplication of efforts could therefore be managed and reduced during the transition, until responsibilities and resources (including relevant PCT documents and records) are fully and legally transferred.

As detailed below, the proposed new framework for the NHS presents inherent conflicts of interest at each stage. Those conflicts for individual GPs and practices are starting to become obvious and potentially problematic in the current transition period. There is a clear need for a mechanism for conflicts of interests and loyalty to be put in place along with policies for the declaration of gifts and hospitality to ensure transparency and protect the reputation of care professionals within key patient and stakeholder groups as developments progress.

For secondary care providers there are a number of transitional concerns that require attention. With a significant number of trusts failing to become FTs already, a range of inducements and other measures may be required to encourage complete take up. These might include:

- Specific resources made available to help aspirant FTs in their application process
- Financial inducements to existing FTs to acquire other trusts, especially those that may be resource poor and facing increasing operational challenges
- Changes to the application process to ensure more trusts are successful.

All three examples have risks that will impact adversely on financial savings; both in the short and medium term or otherwise threaten to undermine the FT brand. Mergers and acquisitions are recognised as increasing costs in the short to medium term as efforts to integrate systems and culture divert resources away from other activities.

NHS trust boards also need to remain alert to the dangers of concentrating on financial and business matters in their FT application process, or merger discussions, at the expense of clinical and quality care issues. Recent examples have highlighted the dangers of boards not focussing sufficiently on the quality of care provided during times of financial and structural stress.

Commissioning for patients
It is understood that there is public demand for greater involvement and choice in the type of healthcare provided by the NHS in England, and the white paper provides, as a central tenet of change, that health prevention and care should centre on the individual. ICSA supports the spirit of the principle, but tempers this with the reality that not every patient and member of the public is going to be fully satisfied. Resources will need to be used in the most beneficial manner to achieve the highest quality outcomes achievable within these constraints.
For successful commissioning within the proposed framework, public health needs should be embedded into the commissioning process to ensure that health prevention and protection priorities are marbled throughout the system. The Public Health Service consultation and subsequent Bill should ensure a smooth pathway for all users across the services provided. This aspect of public health and wellbeing should also provide a mechanism by which those members of the community that do not regularly visit their GP; the young or healthy, those not registered with a GP and transient communities are represented within any future health and care service provisions.

**Informing patient choice**

Increasing access to a wider range of data to support patients in their healthcare choices is to be applauded, but does present a number of challenges. In tasking commissioning consortia to promote equity and equality of access, the following issues need to be considered and managed:

- Informed decisions will require additional data sources, with associated resource implications. Other examples of increasing public choice, e.g. state education, has resulted in such arrangements being navigated better by those with higher educational achievement or longer-term understanding of the way the system operates. It is, therefore, essential that those providing healthcare information are able to present that data in a manner easily understood and meaningful to as wide a range of people as possible. GPs and clinicians will need to be able to impart that information to their patients in a balanced and objective manner if the final decision is to be truly that of the patient, albeit appropriately advised by a medical professional. The diversity of information and format offered is likely to have a price impact within the NHS at one or more points. For example, foundation trusts will have to develop marketing resources to offer details as to the services they provide and the success they achieve, if they are to compete with other NHS, private and third sector providers. Such activity will require resources that could have been used in other ways.

- Real time and other forms of, patient feedback should be developed in a manner that is meaningful to commissioners, providers and patients, as well as being fair to providers. A balanced account of patient experience is imperative to building a realistic account of the care received, not unduly skewed by the audibly dissatisfied to the disadvantage of the silently satisfied. Reaching out to the grateful and those unwilling to air concerns about their treatment, along with minority groups, will require specialised facilitation and interpretation of results.

- Competition between providers is likely to place additional demands on NHS commissioners and service providers for an array of data. Without appropriate co-ordination by a central entity, those demands could conceivably increase staff workloads, unduly directing resources away from the provision of care and treatment. Balance needs to be attained between a relevant and necessary level of information, and excessive demands stretching limited resources for minimal returns.

- To achieve the aim of patients having greater control over their health records will require significant efforts by NHS providers to convince the public that it can be trusted to keep personal information confidential. The ‘Connecting for Health’ programme was unsuccessful in its aims within the current NHS framework; a more fragmented system with competing private and public entities providing services adds extra complexity to achieving a similar aim. ICSA notes that a consultation document is due later in the autumn to cover aspects of the proposed Health and Social Care Information Centre and its oversight of patient information. The exact nature of the proposals must provide reassurance that health records will only be used to inform healthcare needs and decisions, ICSA will therefore reserve further comments on this aspect of the new framework for that document.
Another dimension of informed choice will centre on the need for commissioning consortia to continually engage with the public and patient groups to explain commissioning decisions. With a diverse range of commissioners contracting services in response to local health needs, it is feasible that there will be an increase in ‘post code lottery’ complaints. Commissioning consortia will, therefore, be obliged to ensure resources are available to educate and inform a local population of how and why particular decisions were made, especially in relation to local context, and defend any adverse media or public attention that highlights those differentials.

The propensity for an increase in conflict could occur between the GP and patient at the first consultation, with different views as to the appropriate treatment or service to be accessed. An increase in information available for patients and a more inclusive approach to care decisions between patient and GP will have a knock-on effect on the length of GP appointments and associated challenges in accessing a GP.

**Patient champions**
Having a central patient champion (HealthWatch England) with local presence will always be welcome for the most disadvantaged and vulnerable in society and those confused by the healthcare system. The lack of detail regarding how local and national HealthWatch will operate, are funded and held to account deprives commentators of the ability to judge whether the proposal adds anything new to previous examples of healthcare and consumer interaction, such as CHCs.

Further clarification as to the role of local HealthWatch, criteria used for triggering local inspections of services, interface with commissioning consortia, providers and health and wellbeing boards, along with to which body they are ultimately accountable would be welcome.

As with current relationships between NHS foundation trusts and LINks, there is likely to be some confusion as to the supremacy of FT members and the local HealthWatch. Clarity and differentiation is required to ensure that all stakeholders are aware of the purposes of each. Within foundation trusts, the members have generally taken precedence in any consultation exercise or ongoing dialogue regarding the services provided and proposed changes to them.

**Commissioning consortia**
The areas that require considerable additional information as to how the proposed NHS framework will operate are those surrounding the commissioning consortia. While ICSA welcomes the freedom offered to consortia to establish themselves and their governance arrangements in the most appropriate manner, there are ongoing concerns regarding the management of conflicts of interest, accountability, risk, and the insolvency framework. For example, how will conflicts of interest be managed appropriately and transparently without risking any commercially sensitive information while ensuring accountability to the local authority and public interest? Without further enlightenment, it is hard to fully understand how the proposals will deliver the aims outlined without undue risk and duplication.

Chartered Secretaries are well placed to advise on all these matters, supported by a professional qualification that has a broad business grounding that includes governance, risk management, strategic development, and financial planning along with knowing when and what professional advice is sought and acting on that information appropriately.
With freedom for statutory commissioning consortia to establish themselves in the manner most appropriate for the local situation, but with certain statutory duties and responsibilities placed upon the corporate body and individual officers, it is essential that they are provided with insight into the options available to them. The recognition that a particular type of corporate structure will not necessarily suit all commissioning consortia is one that provides flexibility for commissioners to establish consortia in a manner that suits their needs and the demands of their stakeholders.

Whatever the structure adopted, the following elements will be required to ensure public funds are expended appropriately and commissioning functions are undertaken in the public’s interests:

- A governing document that provides flexibility for internal administration arrangements while protecting public assets. A public benefit protection clause will, therefore, be required along with the prohibition on assets being disbursed by dividend. The governing document should make it clear as to the purpose of the organisation and all resources and activities should support the organisation in fulfilling that aim. Proposed changes to the governing document that affect the statutory duties of the consortia should acquire the approval of a relevant regulator.

- A legally accountable body, including the statutory accountable officer and finance director, will need to be established to lead strategic direction and provide oversight for the implementation of decisions made. The responsibility for making decisions that balance competing demands must rest within the accountable body, taking consideration of the opinions of members and other stakeholder groups.

- It is likely that the accountable body will comprise professionals and independent lay persons to represent GP practices, patients and the wider public interest. These interests will need to be represented and balanced in a meaningful and appropriate manner that adds value to the work of the commissioning consortia. For some consortia, it may be determined that a formal dual board approach is required to collect the views of GPs along with those of users. Other consortia may establish more informal advisory groups and engagement fora to ensure all voices are heard.

- The legal duties, responsibilities and liabilities of the members of the accountable body are likely to be defined in existing and new legislation. Additional powers of the accountable body will be contained within the governing document and any supporting documents.

- Strong and robust financial reporting, risk management and internal audit functions. An audit committee will provide additional oversight and scrutiny to support the accountable body in this area of its responsibilities.

- Defined arrangements for the appointment, evaluation, re-appointment and removal of members of the accountable body, including external involvement by interested groups, i.e. members of commissioning consortia, patient groups and other public representatives. Details as to the remuneration package of members should also be subject to external ratification.

- Powers to collaborate or merge with other commissioning consortia outside of specific boundaries should also enable the organisation to manoeuvre itself to optimise opportunities in commissioning intelligently for the local community.

- A real commitment to whistleblowing and the protection of those raising valid concerns in the public’s interest should also be embedded within governance arrangements for commissioning consortia, ensuring a real commitment to the efficient and effective use of public funds.
GP consortia could therefore take the form of a number of existing corporate structures; however it has been suggested that the public benefit corporation model could be extended to commissioning consortia, providing a membership body consisting of different constituencies, but with the freedom to modify aspects to best suit the commissioning purpose.

**Accountability**
With the establishment of commissioning consortia, it is essential that the accountable body is clear as to its purpose and for whom it works. There is the potential for confusion if the accountable body sees itself as being predominantly ‘owned’ by GP practices, the NHS Commissioning board or the government. At its heart, the accountable body has to act in the best interests of the patients and the population it is commissioning on behalf of, and consistently deliver that message to all stakeholders.

As such, there has to be some formal mechanism for the patients and the public to hold the commissioning consortia to account in a relevant manner. While the proposed health and wellbeing boards may be one opportunity to hold consortia to account, it is a process one step from direct public interaction. There are also concerns that the proposed health and wellbeing boards will have less ‘teeth’ than those currently available to oversight and scrutiny committees.

**Size and area of commissioning consortia**
It is currently unclear how many consortia will be established to commission services for a given population. As a consequence of existing political and natural boundaries, it is plausible that the consortia will be coterminous with recognised areas. Working within existing boundaries provides an easy opportunity for consortia to work with public health directors to commission care and welfare services appropriate to the area. Alternatively, some regions would prefer to work with services currently outside of an existing boundary, but with an area that has a similar demographic, health needs or geographical fit. For some the ‘cookie-cutter’ approach will prove more attractive in the initial period. In all cases, it is likely that commissioning consortia will need to flex and bend to population and health changes to continue to commission services that are relevant and appropriate.

Within any pre-existing or new boundaries there are potential conflicts between the needs and wants of the local communities and the desire of providers to deal with as few commissioners as possible in order to ensure resources are concentrated on service provision rather than undue contract and relationship management. The tension of using limited resources wisely and the requirement to provide for local health needs is something that will need constant monitoring and management by commissioners and providers alike.

Competing interests exists within the very nature of commissioning care close to the needs of the community, and the requirement to manage risk appropriately. The desire to commission for a specific locality to address their particular health requirements is likely to lose out to the need for commissioning consortia to be such a size as to mitigate risks across a larger group or seek out economies of scale. While some consortia may develop federated structures with others facing similar healthcare challenges to pool their risk or achieve efficiencies, this option might not always be possible or appropriate. Unless the system provides a weighted priority to delivering healthcare specific to the needs of a defined population it is likely to lose out to other considerations.
Further consideration needs to be given to the mix of socio-economic groups and public health factors included in each consortium. Consortia sited within disadvantaged communities will face greater challenges than those consortia serving wealthier populations. Mechanisms are required to ensure that resources and health outcomes are weighted appropriately to balance out the disadvantages that some consortia will face. For example, a largely rural patient base will experience additional obstacles regarding the ability to choose the hospital where they receive treatment because of transport concerns. These factors must be included in the outcomes set for each consortia.

Foundation Trusts

Governance arrangements

ICSA welcomes the opportunity for foundation trusts to choose the governance arrangements more appropriate for their organisation throughout its evolution. As foundation trusts have discovered, the appointment of a full time Chartered Secretary has improved the governance arrangements and support the board receives in fulfilling its duties, ICSA anticipates that greater importance and understanding of the role will be achieved in a competitive environment.

It could be argued that the arrangements for governors and members need to be reviewed and overhauled in order to develop meaningful governance. Governors currently have legal responsibilities, but are not provided with the necessary tools to fulfil them and to hold the board of directors to account. Foundation trusts have been encouraged by politicians to build up significant memberships, but have then failed to fully engage with them in a manner that has driven noticeable improvements, to the dissatisfaction of FTs and members alike.

Some foundation trusts may decide to change the governance arrangements regarding the role and responsibilities of governors and their relations with members. Freedom to change governance arrangements could result in the governor role being augmented within individual foundation trusts with an increase in their accountability to members, or diminished as the membership voice is enhanced.

For both governors and members, there is currently little incentive for them to join and participate, outside of their inherent desire to be a part of their local health community. Providing a way of influencing decisions and holding the board of directors to account may encourage wider participation. Such an approach, however, does put foundation trusts at a disadvantage to commercial health service competitors.

Where a commercial health provider may be accountable to its shareholders, and then a wider stakeholder community, they are free to choose how they engage with them, including whether to hold an annual general meeting or not. Commercial enterprises will also be free from the costs and administrative implications of running a secondary board to monitor the decisions and actions of the directors. FTs should therefore, be given the freedom to decide how best they can engage meaningfully with their actual, and potential, members.

PPI cap and commercial borrowing

By removing the private patient income (PPI) cap, foundation trusts will effectively be able to compete with other healthcare providers as well as being bound by the legal obligations and contract to supply specific NHS activities. To avoid any legal challenges from private providers there will need to be significantly robust governance frameworks in place to ensure that state funds are not used unduly to provide cheaper private services.
It has already been mooted that private companies may seek EU clarification as to the potential state aid implications that may arise. Any legal challenges from private and third sector service providers as to any funding that could be deemed state aid or unfair advantage in an open market place will result in resources expended in matters not directly benefiting frontline services. Additionally, any requirements for FTs to account separately for the different income streams (NHS versus private income activity) will increase administration costs and bureaucracy.

Without a cap, foundation trusts may be encouraged to focus on private income, as a way of increasing revenue, to the detriment of NHS provision. Some FTs will not have the capacity to take advantage of a lifting of the PPI cap in the short or medium term, but that may change in the future. It could be advantageous for governance arrangements to be strengthened now to ensure that foundation trusts are not easily able to relegate NHS provision secondary to private incomes as boards become interested in diversifying income streams from more lucrative activities. In public bodies the delivery of NHS activity must not be undermined and public assets must be protected and used accordingly.

Where foundation trusts seek to develop new opportunities for income generation, they could be pursued via a wholly owned subsidiary of the trust. This will then ringfence any liabilities and protects the trust, while providing the subsidiary company with the freedom to pursue those business opportunities that support the ongoing work of the trust. Any profits would go back to the trust to use at it deems appropriate.

There are equally valid points to arguments in favour and against the removal of statutory oversight on FTs borrowing. For some, as any borrowing by a foundation trust is likely to be secured by public assets, it would be inappropriate for statutory controls to be removed completely. A flexible approach that takes into account the business proposal and associated risks may be more appropriate. Conversely, providing FTs with the freedom to borrow commercially will enable them to derive the capital required to significantly improve patient care and compete against other providers.

**Constitutional changes**

ICSA suggests that those constitutional changes that will improve the internal running of the organisation should not require consent from an appropriate regulator. Where the proposed changes will impact on the nature of the foundation trust, its primary purpose, distribution of profits or accountability, then prior approval from an appropriate regulator should be required, along with the majority vote of members. Due to the desire to increase competition in the sector however, those requirements should not be unduly bureaucratic so as to disadvantage the foundation trust against other healthcare providers competing in the same market.

Given the proposed changes to Monitor, as a regulator, it is debatable as to whether they should retain such powers to veto constitutional changes. The inherent conflict of interest in the economic regulator might suggest that an alternative oversight body was sought for specific issues.

**Mergers**

It is arguable whether the current legislation is more of a barrier to foundation trusts merging, than the lack of interest in successful foundation trusts taking on failing trusts without some financial support from the government. In the commercial world, businesses will take on failing companies to gain some kind of advantage in terms of building a better brand, income generation via a turnaround team or asset stripping. For FTs the benefits of merger are not
always so obvious or easily achieved. Some inducements will be needed to encourage successful foundation trusts to take on failing trusts, though opportunities for successful trusts to deliver services at the sites of other trusts, as some form of franchise, may be more palatable.

As with some charitable mergers, both foundation trusts are currently required to dissolve and then incorporate, as a new public benefit entity, arising out of the ashes of the redundant bodies. This presents an inefficient use of resources, more questionable at a time when resources need to be expended more intelligently. Furthermore, those few foundation trusts keen to expand by acquisition are likely to face a referral to the competition panel, thereby adding a further disincentive to any expansionary strategy.

Where acquisition and merger is made easier, a similarly straightforward approach should be available to de-merge foundation trusts. A framework for a clean separation should be established ahead of any urgent need for demergers to take place.

There is currently no mention of the future of AHSCs within the proposed new framework. If the government is still supportive of developing internationally recognised health research and development, further thought as to how this young project can be encouraged and promoted would be welcome.

Transparency in outcomes

**NHS outcomes framework**

It is inevitable that some sectors of the health community and public will be left disappointed by commissioning decisions and the way that outcomes will be measured. Public expectations will need to be managed to neutralise any running disgruntlement about the availability of new and existing treatments, especially when compared to other consortia that have made different choices for their patients. Without a central voice to co-ordinate messages to counter vocal disappointment, commissioning consortia will exert limited resources 'fire-fighting' local media campaigns regarding perceptions of different services for different patient groups across neighbouring localities.

Any success in ensuring that NHS money will follow the patient and ensuring providers are paid on outcomes, not processes, will encourage clinicians to get the treatment right first time. There are certain situations, however, where getting it right first time could mean a more intrusive treatment without attempting less invasive treatments first. The mantra of getting it right first time is also likely to be at odds with the patient’s choice in some circumstances. Without guidance as to established care pathways in specific cases and in-built systemic flexibility to achieve balance between the two visions, GPs may find themselves struggling to implement fully shared decision-making with patients and ensuring treatment provides the optimum outcome first time.

The five domains detailed in the consultation document are currently weighted toward effectiveness rather than safety or patient experience and could, therefore, be seen to unduly undermine the government’s commitment to measuring and valuing patient experience and safety. Any activities that inadvertently impact on the drive to include patient input and improve patient safety and experience could reduce the potential for greater and more meaningful public and patient involvement.

Further evidence is required to assess whether the costs associated with the proposed NHS outcomes framework represent value for money on the ongoing development and delivery of
healthcare. Certain NHS outcomes will be aligned to improving public health and, therefore, will not see an immediate improvement with a single intervention, but will require a range of programmes over a period of time to ensure continuous improvement. Such long-term planning has to be included in the annual drafting of national and regional outcomes to avoid the early abandonment of measures that appear to have resolved the problem identified. This matter should also inform thinking on any initiatives to permit commissioning consortia to award bonuses for short term performance at the expense of lasting changes in patient lifestyle.

Sophisticated outcome measures to be presented for public consumption will require an approach that lends itself to explaining differentials in performance across providers and commissioners. Whatever system is put in place must enable context and explanation as to the decisions made and the healthcare received. In short, a league table approach to health performance would be too simplistic and lead to unduly negative perceptions of healthcare provision amongst the public.

Quality accounts
The government’s aim to ensure the NHS is focused on outcomes with quality standards that deliver reductions in mortality and morbidity, increase safety, and improve patient experience should be universally accepted. The move, however, to evidence-based outcomes rather than process driven targets is easier in theory than reality. Benchmarking and monitoring arrangements will need to take into consideration a multitude of factors that can impact on health outcomes, both within and beyond the control and influence of service providers. Regulators and the public have a propensity to favour more simplistic reporting and monitoring arrangements to facilitate comparison between providers; thereby moving towards measuring processes rather than outcomes. Quality accounts have been held up as an example of providing more information to patients about a trust’s outcomes, however, the formulaic and rigid approach to them by regulators have diminished the potential impact that could have been achieved.

ICSA has long championed the need for intelligent reporting when organisations disclose statutory or regulatory required information, thereby providing valuable context to the narrative of the performance of an organisation. Recent experience shows that health regulators prefer a tight framework for compliance reporting, with little appetite for individual trust’s to break out of the mould and deliver something more meaningful to patients, public and regulators alike. Some of the criteria included in the quality accounts framework disadvantage certain specialist trusts, and with little opportunity to explain why there may be such a divergence from national benchmarks will reduce that trust’s public reputation, as it will have been adjudged to be below par in areas that are not appropriate or applicable.

This narrow approach has to be challenged and changed if evidence-based reporting is to supplant processes and outputs. ICSA and Hermes challenged FTSE companies to improve their narrative reporting via the Transparency in Governance Awards, which has garnered much political interest and support. A similar scheme could be established, in partnership with ICSA, to celebrate improved reporting within the NHS, and used to encourage others to be innovative in their reporting and to eschew the ‘boiler-plate’ approach to performance disclosure.
Local democratic legitimacy
The involvement of the public and patients within the existing NHS framework has not been widely accepted as successful. The foundation trust model aimed to improve local accountability and involvement, but has had mixed results with a number of FTs looking to strengthen stakeholder engagement. Attempts by commissioning consortia to improve public and patient engagement and accountability must reverse the trend of public disinterest and tap into the momentum built up by ‘Big Society’ activities. Success will also depend on working collaboratively with local authorities, existing voluntary and community organisations and other fora that enable the exchange of ideas and input into improving aspects of local societies.

HealthWatch
The proposal for local HealthWatches would benefit from a sharper outline as to the primary purpose of the organisation; is it to act as a local arm of the national body, or is to represent the interests of the local authority? In both cases, the provider organisation undertaking the local HealthWatch function has to balance the demands of funders (i.e. the local authority) with the requirements of HealthWatch England to feed clinical and quality issues into CQC. There is a distinct difference between being a consumer champion and a regional representative of a regulator, and combining both functions in one organisation is unlikely to satisfy each purpose effectively.

Furthermore, by having, in effect, two line managers: local authority funders and HealthWatch England within the CQC, there needs to be effective communication between all agencies to ensure that duplication of effort is minimised and competing priorities are managed satisfactorily.

Health and wellbeing boards
ICSA would welcome further information on the establishment of health and wellbeing boards, especially with regards to clarification as to the board’s role and responsibilities. It is questionable whether the board should be involved in assuring clinical and quality issues, or if they are best placed to provide oversight of commissioning consortia. It is essential that commissioning consortia are not only responsible for those commissioning decisions, but also for ensuring quality outcomes are met satisfactorily and activating appropriate mechanisms within contracts where quality failures are identified. Consortia will have to depend on a number of other organisations and stimuli to trigger closer investigation of quality concerns, but as the gatekeeper of funds to providers it is essential that they are at the centre of discussions regarding clinical and quality issues.

If health and wellbeing boards are to be established to provide input into commissioning decisions, the ‘cookie-cutter’ approach to commissioning consortia areas may be prudent in mirroring existing populations and reducing any duplication of effort and the attendance of consortia staff/representatives at a multitude of meetings.

The membership requirements for health and wellbeing boards, set out in the consultation document, do not present the best environment for decision making. With so many people eligible to sit on health and wellbeing boards, it is likely that decision making will become difficult and meetings overly long. Boards should be large enough to represent the community it serves, but not so unwieldy to inhibit and prevent decision making. ICSA would recommend a smaller board, with supporting bodies to help provide insight from, and engagement with, particular groups and sectors of the health community.
Competition and conflicts of interest and loyalty

Within the current proposals, there appear to be areas of potential conflict at every stage. While those conflicts may not be fatal to the success of the new NHS framework, they will require a professional, robust and systematic approach to recognising conflicts and managing them.

Commissioning consortia

Additional care will be required for commissioning consortia to develop robust and effective systems for managing conflicts of interest when the consortia consider the commissioning of services from GP practices. It will be essential for the integrity of those involved in the commissioning consortia to be seen to be free from any conflicts of interest or loyalty.

There are a number of potential conflicts of interest and loyalty within the proposed consortia arrangements, between:

- Commissioning consortia and GP practices providing other services;
- The need to make commissioning decisions that reflect local requirements and a desire to pool risk and achieve economies of scale;
- The personal choices of patients and the treatment pathways they prefer with the advice of GPs;
- Different patient groups within the consortia’ boundaries
- The stakeholders within the consortia itself.

Monitor

Monitor’s new role as an economic regulator responsible for regulating prices and ensuring competition presents an inherent conflict of interest. Furthermore, its current role of regulating foundation trusts will require additional effort to ensure that its future role in regulating all providers is seen to be objective, balanced and proportionate. An alternative approach could be for the OFT to establish a dedicated health unit within its auspices.

If Monitor is to regulate transparently, proportionately, consistently and only in those cases where action is needed, then a framework of consultation and appeal must be built into the system. There must also be ability for a provider to appeal to an external body on specific matters, but should not be unduly expensive in using public funds (for both the provider and the regulator).

The proposed roles of both the NHS Commissioning Board and Monitor could become a focus of tension between who has supremacy in influencing the activity of foundation trusts. There is also concern that Monitor and CQC will continue to work with some friction, impacting adversely on service providers caught in the middle of any sporadic tensions. ICSA suggests that CQC should be left to focus on care quality issues and Monitor to concentrate on economic regulation, excluding competition matters.

Competition

There are arguments on both sides as to whether increased competition within the health service will provide benefits to patients or increase risks as a result of fragmentation. With a multitude of providers competing in a similar market place and locality, it may become more difficult for seamless integration of care to be delivered. Furthermore, such fragmentation may have an impact on the wider training needs of clinicians.
Without enforceable arrangements in place to prevent ‘cherry picking’ by health providers, it is feasible that providers more concerned with the bottom line will choose to treat those patients which present less complicated conditions. This is likely to disadvantage those with long term medical conditions, those with co-morbidity issues and the elderly. Sophisticated tariffs will therefore need to be developed by the NHS Commissioning Board and Monitor to prevent such selectivity, and commissioning consortia will require the data to monitor contract delivery and to terminate those arrangements where providers are off-loading those cases that are likely to have an adverse impact on their health outcome measurements or finances because of the nature of the illness or patient in question.