From the Rt Hon Andrew Lansley CBE MP
Secretary of State for Health

Department of Health

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Thank you for sharing with me your initial thoughts on the White Paper and its implications, and the copy of the BMA guidance on consultant involvement in the commissioning process. I will ensure that your comments are considered alongside the other responses we are receiving on the consultation, and would encourage you and your members to send in any more detailed responses you have to the consultation mailbox (NHSWhitePaper@dh.gsi.gov.uk).

You asked for clarification about the effects of patient pathways on the PbR tariff. We want to facilitate a more co-ordinated approach to care for people with long-term conditions, involving GPs, consultants and community services. We will work closely with clinicians in developing our approach and are already looking to introduce such an approach to payment for cystic fibrosis in 2011-12.

You also asked about the adjustment of payment to account for the continuity of care of a patient where readmission is a probability. We understand that some conditions are complex and we do not wish unfairly to penalise healthcare providers treating such cases or provide any form of perverse incentive. We are therefore taking advice from the Payment by Results Clinical Advisory Panel on possible exclusions to the policy and adjustments to the tariff where readmission may be unavoidable.

Also attached are responses to your individual initial thoughts:

Commissioning

Commissioning by GP consortia will mean that the redesign of patient's care pathways and locality services are always clinically led. The changes will create an effective dialogue across all health, and where appropriate social care, professionals.

This new model of commissioning is based on the general practice registered list of patients and builds on the contact primary care clinicians have with patients, children and families, and their community knowledge. The model ensures working with others to design the best local health services. GP commissioning recognises the crucial role GPs play in co-ordinating patient care and committing NHS resources through daily clinical decisions.

Effective GP commissioning will require the full range of clinical and professional input alongside that of local people. Hospital doctors, nurses, Allied Health Professionals and others, all have a vital role to play and a real opportunity to develop services and improve the health outcomes of their local populations.

Education & Training

The education and training of both existing and future staff is an integral part of delivering high quality services. It is important that future arrangements are coherent and that the system is driven by provider decisions, underpinned by strong clinical leadership. Therefore, we will be consulting on the future education and training system later in the year and welcome JMCC's offer to engage on the proposals.

The consultation will be set within the context of delivering appropriate investment in workforce education and training, whilst ensuring better outcomes for patients and value for money. It will also need to ensure appropriate checks, balances and accountability. The arrangements for commissioning and delivery will be transparent and more efficient.

The systems for healthcare education require complex training and supervision programmes with rotations through different specialties and contexts. The professions will have a key role to play in commissioning the future system for education and training. We will be working closely with the professions as part of the consultation and the implementation that follows from this.

Payment tarrifs

The *Revision to the Operating Framework for the NHS in England in 2010/11* set out the expectation that payments should "be capable of aggregation along patient pathways." We are therefore progressing an ambitious programme of developing such pathway tariffs.

This is building on existing work, in 2010-11, when as part of the best practice tariff programme the Department introduced a pathway tariff for cataract treatment. This

focuses on the pathway from initial assessment through to the follow-up assessment following surgery, and moves from an episodic approach towards a pathway.

In 2011-12, we are introducing a number of new currencies that will eventually support tariffs, one of which – for cystic fibrosis – is based on a complexity-adjusted year of care model.

Maternity is a good example of where we can make further progress. We are developing a small number of simple and practical pathway tariffs for maternity care, covering the whole period from the booking-in clinic through to postnatal care, and we hope to implement these for payment from 2012-13. . The system will also be flexible enough to allow for choice and specialist transfer in cases of need. The focus will be on outcomes and the highest quality of care. We are involving representatives from trusts, commissioners, the Royal Colleges of Midwives and Obstetricians and Gynaecologists, patient organisations and other NHS organisations to help us develop these pathways.

As we look to extend pathway tariffs to long term conditions and complex needs, there will be a need to align current payment models for episodic referrals to secondary care (HRG tariffs), and other payment models. We greatly value clinical input into the design of the tariff, and that will continue to be the case as we work through these challenging issues.

Hospital: Readmissions

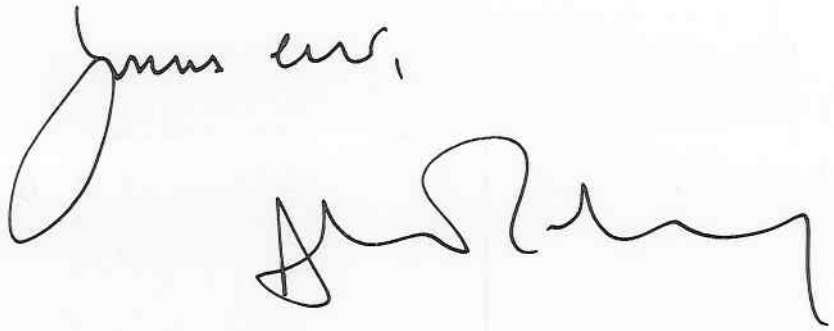
Although from 1 April 2011, the intention is that there will be no payment for emergency readmissions within 30 days of discharge, it is recognised that for some cases, re-admission is an acceptable part of the normal delivery of care and so unavoidable. Therefore, we expect to increase some non-elective prices in recognition of these unavoidable re-admissions. Work on this is still on going and will be informed by advice from clinicians and others through our established Payment by Results advisory groups and confirmed when the tariff is released for road testing later in the year.

Outcomes Framework

Your support for the approach of focussing accountabilities within the NHS on the outcomes of care for patients rather than the processes and structures through which care is delivered is reassuring. Our challenge now is to make sure the right indicators which most reflect the outcomes that matter to patients and that are clinically relevant, are presented in the framework

We are currently running an active engagement process as part of the consultation on *Transparency in outcomes - a framework for the NHS* and are very keen if the JMCC or its members were able to take the time to set out their thoughts on the proposals or principles behind the proposals in general, as well as on the detail of how the framework might be constructed and the indicators which could be presented in it.

I hope you find this reply helpful.



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