Briefing note on the NHS White Paper July 2010

Equity & Excellence: Liberating the NHS

Report Author – Hilary Martin, Lancashire Joint Health Unit, Tel. 01772 534226

Background

The Health White Paper, 'Equity and Excellence: liberating the NHS' represents possibly the most radical restructuring of the NHS since its creation. Responsibility for commissioning the bulk of services will be transferred from PCTs to new GP consortia, which will be responsible for approximately £80m of funding. This briefing paper summarise the main proposals in the white paper. The full document can be found at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf

Proposals are informed by a number of key principles:

- Putting patients and the public first
- Focusing on improvements in quality and healthcare outcomes;
- Autonomy, accountability and democratic legitimacy; and
- Cutting bureaucracy and improving efficiency.

Key proposals include:

- extending patient choice over providers and treatment
- establishing an independent NHS Commissioning Board
- ensuring all health trusts are foundation trusts by 2013 and giving them greater freedoms
- the transfer of commissioning responsibilities to GPs and the abolition of PCTs and SHAs by 2013
- transferring the responsibility for health improvement to local authorities
- giving councils the responsibility to promote integration and partnership working.
- establishment of HealthWatch to replace existing Local Involvement Networks (LINks), to be commissioned by local authorities.
- Creation of a national Public Health Service, incorporating the functions of the current Health Protection agency and the National Treatment agency for substance misuse

There will be a further white paper published later this year setting on public health. The Health Bill will be introduced in parliament in the autumn, following extensive consultation on a number of aspects of the white paper.
1. Putting patients and the public first

ii. Information

Access to understandable information from a variety of sources is seen as key to improving patient choice, accountability and driving up standards. More weight will also be given to gathering and acting upon feedback on patient experience. A comprehensive information strategy will be published in the autumn.

ii. Choice

Patient choice will be extended to "any willing provider" wherever possible, and will be extended gradually to include choice of named consultant lead team, maternity services, mental health services, diagnostics testing, care for long-term conditions, and end of life care.

Choice will be extended to cover treatment as well as provider.

Patients will have the choice to register with any GP with an open list.

iii. Patient and Public Voice

HealthWatch England will be established, within the Care Quality Commission, whose role will be that of an "independent consumer champion" to promote the interests of all NHS patients.

Local HealthWatch will replace LINks. They will be funded and commissioned by and accountable to local authorities and their role will be:

- To ensure that patient views inform local commissioning of health and social care
- Provide advocacy and support for individuals, particularly in relation to making complaints and exercising choice over services
- To provide independent feedback to the national HealthWatch on the quality of providers locally

National HealthWatch will be set up by April 2012 and LINks will work towards becoming local HealthWatches during 2011.

2. Improving healthcare outcomes

A new NHS outcomes framework will be developed, focusing on the effectiveness and safety of treatment and care provided to patients, and their broader experience of care and treatment. It will be supported by quality standards developed by NICE. Separate frameworks will be developed for both public health and social care.

A payment and tariffs system will be devised to encourage improved outcomes, increased efficiency and increased patient choice. This will be the responsibility of the NHS Commissioning Board (see 3.ii below). This will include the potential for both primary care and secondary care providers to attract a "quality increment" for excellent performance, as well as penalties for delivering poor quality care.
3. Autonomy, accountability and democratic legitimacy

3. i. GP consortia

GP Consortia will be created to take on the responsibility for the commissioning of the bulk of services, including elective hospital care, rehabilitative care, urgent and emergency care, most community health services, mental health and learning disability services. This should ensure that commissioning decisions are clinically led and based analysis of local healthcare needs, including working with the Joint Strategic Needs assessment.

Consortia will be established on a statutory basis and all GP practices will have to belong to a consortium. Consortia will be responsible for holding individual practices to account.

There is no prescribed size for consortia, but they need to be of sufficient size to be able to agree and monitor contacts for locally based services.

GP will have the duty to work in partnership with local authorities in relation to health and adult social care, early year’s services, public health, safeguarding, services for carers and criminal justice.

ii. NHS Commissioning Board

A statutory NHS Commissioning Board will be created to support the GP consortia’s commissioning function, their accountability for outcomes, promoting patient choice and allocating resources to the consortia.

A formula for allocating resources will be developed, on the basis of seeking to ensure equivalent access to NHS services for all relative to the prospective burden of disease.

It will also have responsibility for commissioning services such GP, dentistry, community pharmacy and maternity services, plus some specialist services.

iii. Local Democratic legitimacy

A national Public Health Service will be created to take a cross-departmental approach within government. It will have a ring-fenced budget, and will incorporate the existing functions of the current Health Protection agency and the National Treatment agency for substance misuse, which will be abolished.

The health improvement function which currently sits with PCTs will be transferred to local authorities.

Local Directors of Public Health will be employed by upper-tier local authorities and will be jointly appointed with the newly created Public Health Service. Local Directors of Public Health will also have statutory duties in respect of the Public Health Service. They will receive a ring-fenced budget.

‘Health and Wellbeing boards’ are proposed at upper tier local authority level and possibly within existing partnership arrangements, with four main functions of:
• Lead the Joint Strategic Needs Assessment (JSNA);
• Promote joined up commissioning across the NHS, (including GP consortia) social care and public health;
• Support joint commissioning and pooled budget arrangements; and
• Undertake a scrutiny role in relation to major service redesign

These functions would replace existing statutory health overview and scrutiny functions; however there is a suggestion in the accompanying consultation that the local authority would need to establish separate arrangements to scrutinise the work of the Health and Wellbeing Board

The use of powers that enable joint working between the NHS and local authorities will be simplified and extended. It will be easier for commissioners and providers to adopt partnership arrangements, and adapt them to local circumstances.

These arrangements will give local authorities influence over NHS commissioning, and corresponding influence for NHS commissioners in relation to public health and social care.

Health and wellbeing boards should be in place and operational by April 2012 but it is anticipated that work to implement the shadow arrangements for the boards should commence in April 2011.

Implementation
The white paper sets out an ambitious timescale to implement these changes which are included in full at appendix A.

The Strategic Health Authority is responsible for overseeing the smooth transition to the new arrangements.

In relation to the Public Health Service, a North West Public Health Transition Board is being established, which it is proposed is co-chaired by a Local Authority and PCT Chief Executive. This is supported by a Transition group which will focus on the delivery of work streams set by the Board.

Similar structures are likely to be established to manage the transition to GP consortia and the NHS Commissioning Board in the North West.

Ruth Hussey has written to Ged and the three PCT Chief Executives to propose a joint meeting to include Helen Denton, Richard Jones, the DsPH along with David Jones (Deputy Regional Director of Social Care) and Ann Hoskins (SHA Director for Children, Young People and Maternity). The letter also asks for advice about the best way to engage district councils in these discussions.

Consultations
Public consultations on a number of aspects of the white paper are now underway, as follows:

• Local democratic legitimacy in health:
• Commissioning for patients:
- Regulating health care providers
  http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_117782
- Transparency in outcomes – A framework for the NHS:
  http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_117583

There is also a report which examines options for the review of arms lengths bodies, which will be the subject of further consultations with those organisations over the coming months.
## Provisional overall timeline: July 2010 - June 2012

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<td><strong>Jul 2010</strong></td>
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<td>Additional White Paper Consultations</td>
<td>Publications on social care, choice, information, education and data return</td>
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<td>Health Bill</td>
<td>Spending Review released</td>
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<td>2011/12 allocations</td>
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<td><strong>Choice extended to long-term conditions and diagnostics (from 2011)</strong></td>
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<td><strong>Key milestones</strong></td>
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Early engagement and action timeline: July 2010 – Mar 2011

- **Jul 2010**
  - Planning, performance and QIPP
    - New commissioner/provider leads and bridging functions in place at DH and in SHAs

- **Aug**
  - Development of QIPP plans to include reform

- **Sep**
  - First submission QIPP and Reform plan and QIPP tariff review at SHA level
  - NHS Chief Executive visits every region

- **Oct**
  - National stakeholder engagement

- **Nov**
  - Regional and local stakeholder engagement

- **Dec**
  - Policy design and implementation
    - DH planning with Monitor and CCG for creation of Economic Regulator

- **Jan**
  - Work to drive and accelerate the Foundation Trust pipeline
    - Identification of likely first GP commissioning consortia
    - Development process for first GP commissioning consortia
    - Capability development for GP commissioning consortia (ongoing)