

**EQUITY AND EXCELLENCE: LIBERATING THE NHS
BRIEFING FOR MEMBERS
13 JULY 2010**

Equity and excellence: liberating the NHS, the coalition Government's white paper, was published on 12 July 2010. It has at its heart three key principles:

- patients at the centre of the NHS
- changing the emphasis to clinical outcomes
- empowering health professionals, in particular GPs.

There is no doubt the white paper signals the biggest reorganisation of the NHS in its history and, as expected, almost every part of the NHS will see significant change if the proposals are fully implemented.

The white paper is structured as follows:

Chapter 1. **Liberating the NHS** – covers the Government's vision for health, and sets it in context alongside its approach to public health and social care.

Chapter 2. **Putting patients and the public first** – covers shared decision making between clinicians and patients, an information revolution for patients, increased choice and control for patients and carers, and HealthWatch that will strengthen the voice of patients and the public.

Chapter 3. **Improving healthcare outcomes** – covers a new NHS Outcomes Framework, new quality standards to support progress on outcomes, and financial incentives for quality improvement.

Chapter 4. **Autonomy, accountability and democratic legitimacy** – covers GP commissioning consortia, an NHS Commissioning Board, a new relationship between the NHS and Government, local democratic legitimacy, freedom for existing NHS providers, changing roles for the Care Quality Commission and Monitor, and NHS pay and pensions.

Chapter 5. **Cutting bureaucracy and improving efficiency** – covers cutting bureaucracy and administrative costs, increasing NHS productivity and quality, enhanced financial controls, and making savings during the transition.

Chapter 6. **Conclusion: making it happen** – covers proposals for legislation, the transition to the new systems, and a timetable for action.

This briefing sets out the key points from the white paper. For ease of reference we have structured it along the following themes:

- Commissioning
- Financial controls
- Risk pooling
- Future of providers
- Regulation and inspection
- Efficiency and bureaucracy
- Quality and outcomes
- Choice and control
- Public health
- Social care
- Workforce
- Mental health
- Information revolution
- Patient and public engagement.

The white paper sets out an ambitious timetable. By April 2012 it proposes establishing the Independent NHS Commissioning Board and new local authority health and wellbeing boards, and developing Monitor as an economic regulator. The new commissioning system is expected to be in place by April 2013 by which time SHAs and PCTs will be abolished.

The Department of Health (DH) will be consulting on the white paper proposals until 5 October 2010. The NHS Confederation will set in place a number of opportunities for members to inform our work to influence the debate, including an event for members in September and our response to the consultation on the white paper itself. Please send any comments to sam.hunt@nhsconfed.org.

Commissioning

- GP commissioning will be changed so it operates on a statutory basis, with commissioners' powers and duties enshrined in legislation.
- All GP practices are to become part of a consortium. Consortia will need to have sufficient geographical focus. They will also assume responsibility for commissioning services for those people not currently registered with a GP and for commissioning a comprehensive urgent care service.
- Consortia will have a "maximum management allowance", although the limit is not specified.
- A comprehensive system of GP consortia in shadow form is expected to be in place by 2011/12. The consortia will then begin to assume commissioning responsibility in the following year before taking full responsibility from 2013/14.
- NHS Commissioning Board (NHSCB) will commission GPs and family health services (dentistry, pharmacy and primary ophthalmic services). The NHSCB

will have a duty to establish a comprehensive system of GP consortia and the power to assign practices to consortia.

- The NHSCB will be in shadow form from April 2011 as a special health authority before becoming a statutory body in April 2012. The Secretary of State will determine the board's 'formal mandate' (covers three years, updated annually) and holds the board to account for delivery against those objectives. The Government may intervene in-year, but would have to lay a report in Parliament to explain why.
- Both Monitor and the NHSCB will ensure that competing to provide services is a fair and transparent process.

Financial controls

- NHS Commissioning Board will be accountable to the DH for managing within an annual revenue limit and will allocate resources to GP consortia on basis of need.
- GP consortia will be accountable to the NHSCB for managing public funds and will have an accountable officer.
- Commissioners will be free to buy services from any willing provider.
- Monitor will be able to allow transparent subsidies where these are "objectively justified and agreed by commissioners."

Risk pooling

- The white paper stipulates that current risk pooling arrangements will migrate away from SHAs.
- Monitor will be able to authorise special funding arrangements to ensure that essential services can be maintained in circumstances where they would usually have become unviable. Providers may be asked for contributions towards a risk pool by Monitor.
- GP consortia will be required to take part in risk pooling arrangements, overseen by the NHSCB.

Future of providers

- All NHS trusts will be part of or become foundation trusts (FTs) by 2013, with the abolition of the NHS trust model
- New FT models with staff-only membership (social enterprise) are intended for community FTs but not limited to them.
- The white paper contains a clear commitment that FTs "will not be privatised."
- Consultation proposed on increasing FT freedoms including:
 - abolition of the cap on income that can be earned from other sources
 - enabling FTs to merge more easily
 - enabling FTs to tailor their governance to local needs.
- DH will assume responsibility for provider development.
- Community services will operate under the Any Willing Provider ethos.
- Monitor takes over responsibility for regulating all NHS providers from April 2013, irrespective of status.
- Commissioning will be separate from provision by April 2011.

- Special arrangements will be made for three high secure psychiatric hospitals to benefit from FT status.

Regulation and inspection

- The white paper stipulates a stable, transparent and rules based system of regulation
- The Care Quality Commission (CQC) will have “a clearer focus on the essential levels of safety and quality of providers.” It will inspect providers with a “targeted and risk-based” approach in accordance with those levels.
- CQC and Monitor will deliver a joint licensing regime, to cover essential levels of safety and quality and ensure continuity of essential services.
- Monitor as economic regulator for both health and social care will:
 - promote competition and concurrent powers with OFT to apply competition law. Powers apply to privately and publicly funded health and social care services
 - regulate pricing but only “where necessary” and with flexibility between ‘efficient’ and/or ‘maximum’ price. Monitor’s powers to regulate pricing only relate to publicly funded health services
 - have responsibility for FT continuity of service – “continued access to key services in some cases”
 - authorise “special funding arrangements for essential services that would otherwise be unviable” (with agreement of NHSCB and subject to rules on state aid)
 - have powers to intervene directly in the event of failure.
- There is reference made to enforcing competition law. Monitor will be able to undertake market studies and refer structural problems to the Competition Commission.

Efficiency and bureaucracy

- The Government acknowledges that the cuts in administrative costs represent an “important but modest contribution” to the overall NHS efficiency drive.
- NHS management costs will be reduced by more than 45 per cent over the next four years.
- Strategic health authorities will be abolished by 2012/2013.
- Tight cost reduction will apply to centrally managed DH programmes.
- Other potential cost cutting solutions include: the forthcoming review of arms-length bodies; NHS services increasingly empowered to be “customers of a more plural system of IT and other suppliers”; a reduction in the regulatory burden; and energy efficiency and sustainability.
- Existing providers will be freed from central and regional management and they will be supported by a system of economic regulation, overseen by Monitor.
- GP consortia will align clinical decisions in general practice with the financial consequences of those decisions.
- There is a commitment that the QIPP programme “will continue with even greater urgency” and it is hoped that SHAs and PCTs will devolve leadership of this agenda to GP consortia and local authorities as soon as practicable.

- The DH will place requirement on SHAs and PCTs to ensure rigorous financial control over the transition period, supported in this task by Monitor.
- Best practice pricing, increased use of quality incentives and a move away from average cost prices, will be an important feature of the new system.

Quality and outcomes

- The document reaffirms the Government's commitment to hold the NHS to account "against clinically credible and evidence-based outcome measures."
- The new NHS Outcomes Framework will include national outcome goals, chosen by the Secretary of State (following consultation), with the NHSCB held accountable for attainment. The first framework will be available in April 2011, with full implementation expected a year later. It encompasses the domains of quality, safety and patient experience.
- GP consortia will have a commissioning outcomes framework, which should "create powerful incentives for effective commissioning."
- The National Institute for Health and Clinical Excellence (NICE) will develop quality standards for the NHSCB, with 150 different standards ultimately expected. The library of standards should be "reflected in commissioning contracts and financial incentives."
- The NHSCB will be responsible for a payment system structure, with the economic regulator looking after pricing.
- Current Payment by Results tariffs will be refined, with the introduction of best practice tariffs to be accelerated. The DH will evaluate the scope for a benchmarking approach.
- Commissioners will be able to pay a quality increment if providers deliver excellent patient care in line with commissioner priorities.
- CQUIN will be extended to support local quality improvement goals.
- Commissioners will be enabled to impose penalties on providers delivering substandard care.
- A "single contractual and funding model to promote quality improvement" will be developed.
- The Cancer Drug Fund will come into operation from April 2011. Value-based pricing for NHS medication will be introduced once the current scheme expires.

Choice and control

- From April 2011, patients will be able to choose their consultant-led team for elective care where clinically appropriate.
- Choice will be extended to include mental health providers from April 2011, and for diagnostic testing and choice post-diagnosis from 2011 onwards.
- Patients will be able to choose a GP practice (with an open list), not limited to where they live.
- A consultation on choice of treatment is expected later in 2010, including "potential introduction of new requirements on providers, and collecting and publishing information on whether this is happening to support patients."

- Patients will have choice of treatment and provider for most NHS-funded services no later than 2013/14.
- A single number for all types of urgent and social care will be established and technology developed to help people communicate with their clinicians.
- A further tranche of Personal Health Budget (PHB) pilots will be encouraged with general roll out informed by evaluation in 2012. This includes the potential for introducing PHBs for NHS continuing care.
- The Government has confirmed there will be no bail-outs for organisations that overspend public budgets.

Public health

- A Public Health Service will be established, encompassing the existing health improvement and protection bodies and responsibilities.
- Local authorities will assume the responsibilities for local health improvement currently held by primary care trusts. While the Public Health Service will set national objectives for improving population health, local authorities will have the freedom to determine the means by which these are achieved.
- Directors of Public Health (DPHs) will be jointly appointed by the Public Health Service and local authorities. They will be given control over ring-fenced public health budgets in their local area.
- A 'health premium' will be introduced, aimed at alleviating health inequalities.
- A separate Public Health White Paper is due for publication later this year.
- Health and Wellbeing Boards will be created within local government in an attempt to coordinate commissioning of NHS services, social care and health improvement.

Social care

- The Department of Health will establish a commission on the funding of long term care and support to report within one year. A white paper is then expected in 2011, with the aim of introducing legislation in the second session of this Parliament.

Workforce

- The Government advocates allowing all employers the right to determine their own pay levels. However it acknowledges that many providers will wish to utilise national remuneration contracts.
- The DH will take more of a back seat role in relation to education and training. The Government wishes to see employers agreeing plans and resources for workforce development with their staff. Healthcare professions at both a local and national level will assume leadership for education commissioning.
- The review of public sector pensions chaired by Lord Hutton will examine issues including labour market mobility and the potential impact upon plurality of provision, alongside affordability and sustainability.

Mental health

- Choice of both treatment and provider will be extended into some mental health services from April 2011.

- The importance of decision aids to enable effective patient choice is particularly acknowledged for mental health and community services.
- A set of Payment by Results 'currencies' for adult mental health services will be introduced from 2012/13. There are also plans to develop currencies for child and adolescent services.
- Payment mechanisms to support the commissioning of talking therapies will be formulated.
- An assurance is made that the criteria utilised within the NHS Outcomes Framework will ensure that mental health outcomes are included.
- The NHSCB will take responsibility for commissioning some specialist mental health services.

Information revolution

- The white paper includes a focus on the publication of "comprehensive, trustworthy and easy to understand information" from a range of sources.
- Patient Reported Outcome Measures (PROMs), patient experience data and real-time feedback are all expected to be utilised more frequently in the future. Patients will have the opportunity to rate services and specific clinical departments.
- National clinical audit will be broadened out across a larger range of treatments and conditions.
- Quality Accounts will be revised in an attempt to enhance local accountability. The White Paper also states all providers of NHS care will have to publish accounts from 2011, subject to evaluation.
- Hospitals will be required to be open about mistakes and to always inform patients of errors made with their care.
- A consultation on health records will be held later in 2010 to determine the appropriate confidentiality safeguards. Records will be made available in a standardised format, with patients enabled to provide access to third parties if they wish to.
- The virtues of a voluntary accreditation system will be examined, which would allow organisations to apply for a quality standards kitemark.
- The Information Centre will have an enhanced role, with centralised data returns and the responsibility for reviewing existing data collections.
- Clear contractual obligations around accuracy and timeliness of data will be placed on providers. Compatibility of data among both providers and commissioners is paramount.
- There will be a consultation on the information strategy in autumn 2010.

Patient and public engagement

- The NHSCB is to act as a champion for patient and carer involvement.
- HealthWatch England will sit inside the Care Quality Commission. LINKs will become the local arms of HealthWatch and will be both funded by and accountable to local authorities.
- Local HealthWatch and HealthWatch England will play crucial roles in providing advocacy and support and within the complaints procedure.

- Local HealthWatch will also be empowered to recommend investigating services deemed to be inadequate.

Further documentation

NHS chief executive Sir David Nicholson wrote to NHS leaders on 13 July about managing the transition and we expect a number of detailed documents to be published in the near future on:

- commissioning
- local democratic legitimacy in health
- freeing providers and economic regulation
- NHS outcomes framework
- ALB review
- social care
- information strategy
- patient choice
- education
- data returns.

Viewpoint

The plans laid out in *Equity and Excellence: Liberating the NHS* indicate the most significant restructuring of the NHS in its history. The paper sets out a very major shift in where power and accountability lie in the health service, and in where responsibility for public health will lie in future.

A large number of unanswered questions remain which we hope will be addressed over the summer as detailed policy documents are published but it is clear that some solutions will have to be determined locally. Key questions about the proposed approach include the nature of accountability for GP consortia, how the areas of commissioning that fall outside the scope of consortia will be dealt with, and how the large scale change needed to move responsibility from PCTs to GP consortia will be accomplished. For providers, the implications of new freedoms and the development of a new economic regulator are just as significant. For example, Monitor will have the power to require providers to grant access to their facilities to third parties. For patients, there is a strong emphasis on increased choice and control, but previous white papers have had similar ambitions and the difficulty of converting rhetoric into reality has been considerable. For GPs, there are new challenges and the difficult task of balancing patient centred and population viewpoints.

The new system will look very different to the current NHS. It is clear that GP consortia will not be mini-PCTs, and the driver of change in this new system seems to be individual choices by GPs rather than traditional planning approaches. Accountability will be for outcomes rather than process measures or targets. The system will be rules based, subject to competition law, and governed by standards for commissioning that will create a more explicit statement of what patients can expect. It is clear that there will be fewer policy initiatives from the centre.

The end point of these reforms will be a radical shift from where we are now, but there are risks and uncertainties about the journey that mean adjustments will be made as the policy is implemented. The transition risks are significant, and David Nicholson's letter on transition sets out the extensive programme of change, restructuring, capacity building and policy development that will be required.

It is unfortunate that the way the reforms have been portrayed has failed to acknowledge the progress that has been made in commissioning and PCTs over the past few years, and keeping SHA and PCT staff motivated during the transition period will be important. Staff working within SHAs and PCTs will be asked to continue to manage performance and finances tightly; it will not be seen as politically acceptable for performance or financial management to slip over the next few years because the NHS budget is being protected relative to other public sector services.

The NHS Confederation and its networks will be working with the Department of Health to influence the policy as it develops and to help members to make sense of what is an emerging picture. As ever, we are keen to hear your views to inform our response to the white paper consultation. Please send any comments to sam.hunt@nhsconfed.org.