Department of Health White Paper - *Equity and Excellence: Liberating the NHS*

(Presented to Parliament by the Secretary of State for Health, Andrew Lansley, 12 July 2010)

Introduction

This White paper is being reported as the most dramatic reform to the National Health Service (NHS) since its inception, setting out the plan to completely transform the way health and social care is delivered in England today. These reforms are being driven by the need to reduce costs by £20 billion by 2014, drive up quality and ensure patients are involved in decisions affecting them in a systematic way and reducing bureaucracy and increasing accountability. The coalition government says that it will not write another policy of this nature during the next 5 years.

Summary of Key Changes:

- ✓ The creation of a **Public Health Service**, with a lead role on public health evidence and analysis;
- ✓ Transferring **local health improvement functions** to local authorities, with ring-fenced funding and accountability to the Secretary of State for Health;
- ✓ Putting the **Health and Social Care Information Centre**, currently a Special Health Authority, on a firmer statutory footing, with powers over other organisations in relation to information collection;
- ✓ Enshrining **improvement in healthcare outcomes** as the central purpose of the NHS;
- ✓ Making the **National Institute for Health and Clinical Excellence (NICE)** a non-departmental public body, to define its role and functions, reform its processes, secure its independence, and extend its remit to social care;
- ✓ Establishing the independent **NHS Commissioning Board**, accountable to the Secretary of State, paving the way for the abolition of Strategic Health Authorities (SHA's). The NHS Commissioning Board will initially be established as a Special Health Authority; the Bill will convert it into an independent non-departmental public body;
- ✓ Placing **clear limits on the role of the Secretary of State** in relation to the NHS Commissioning Board, and local NHS organisations, thereby strengthening the NHS Constitution;
- ✓ Giving **local authorities new functions** to increase the local democratic legitimacy in relation to the local strategies for NHS commissioning, and support integration and partnership working across social care, the NHS and public health;
- ✓ Establishing a statutory framework for a **comprehensive system of GP consortia**, paving the way for the **abolition of Primary Care Trusts (PCTs)**;
- ✓ Establishing **HealthWatch** as a statutory part of the Care Quality Commission to champion services users and carers across health and social care, and **turning Local Involvement Networks into local HealthWatch;**
- ✓ Reforming the **foundation trust** model, removing restrictions and enabling new governance arrangements, increasing transparency in their functions, repealing foundation trust deauthorisation and **enabling the abolition of the NHS trust model**;
- ✓ Strengthening the role of the **Care Quality Commission (CQC)** as an effective quality inspectorate; and

- ✓ Developing **Monitor** into the **economic regulator** for health and social care, including provisions for special administration.
- ✓ Associated with these changes, reducing the number of **arm's-length bodies** in the health sector, and amending their roles and functions.

Headline Statements – What's the Plan?

1. **Social Enterprise**

The coalition government **aims to create the largest social enterprise sector in the world** by increasing the freedoms of foundation trusts and giving NHS staff the opportunity to have a greater say in the future of their organisations, including as **employee-led social enterprises. All NHS trusts will become or be part of a foundation trust.**

2. **Devolution of power**

The headquarters of the NHS will not be in the Department of Health or the new NHS Commissioning Board but instead, power will be given to the front-line clinicians and patients. The headquarters will be in the consulting room and clinic. The Government will liberate the NHS from excessive bureaucratic and political control, and make it easier for professionals to do the right things for and with patients, to innovate and improve outcomes. **They aim to create an environment where staff and organisations enjoy greater freedom and clearer incentives to flourish, but also know the consequences of failing the patients they serve and the taxpayers who fund them.**

3. **Health Improvement**

PCT responsibilities for local health improvement will transfer to local authorities, who will **employ the Director of Public Health jointly appointed with the Public Health Service.** The Department will create a ring-fenced public health budget and, within this, local Directors of Public Health will be responsible for health improvement funds allocated according to relative population health need. The allocation formula for those funds will include a new "health premium" designed to promote action to improve population-wide health and reduce health inequalities.

4. **Adult Social Care**

The Department will continue to have a vital role in setting adult social care policy. They want to create a sustainable adult social care system that gives people support and freedom to lead the life they choose, with dignity and recognise the critical interdependence between the NHS and the adult social care system in securing better outcomes for people, including carers. **They will seek to break down barriers between health and social care funding to encourage preventative action**.

The Department will continue to work closely with the Department for Education on services for children, to ensure that the changes in this White Paper and the subsequent public health White Paper **support local health, education and social care services to work together for children and families.**

5. **Research and evidenced of outcomes will be key**

The Government is committed to the promotion and conduct of research as a core NHS role. They say that research is vital in providing the new knowledge needed to improve health outcomes and reduce inequalities and that research is even more important when resources are under pressure – as it identifies new ways of preventing, diagnosing and treating disease, essential if they are to increase the quality and productivity of the NHS, and to support growth in the economy.

6. **"Nothing about me without me"**

Patients and carers will be involved in shared decision making, as joint providers in their own care and recovery.

The outcomes patients experience reflect the quality of interaction with the professionals that serve them, but compared to other sectors, healthcare systems are in their infancy in putting the experience of the user first, and have barely started to realise the potential of patients as joint providers of their own care and recovery. Progress has been limited in making the NHS truly patient led. They intend to put that right

7. **An Information Revolution – Safety, Effectiveness and Experience**

To correct the imbalance in 'who knows what'. **Giving people access to comprehensive, trustworthy and easy to understand information from a range of sources on conditions, treatments, lifestyle choices and how they look at their own and their family's health**. Information will be gathered in a verity of ways and will be generated by patients themselves through wider use of effective tools such as Patient-Reported Outcomes Measures (PROMs), patient experience surveys etc. These will be used in giving patients real-time feedback, enabling them to rate services and clinical departments on the care they receive. It will require hospitals to be open about mistakes and always tell people if something has gone wrong. This will enable pressure from local people to force improvements. Information about commissioning will spur provider boards to focus on improving outcomes, and provide accountability to the public.

8. **Patients to have control of their health records**

Initially through GP's but eventually through all providers.

The aim is that people should be able to share their records with third parties, such as support groups for patients, who can help patients understand their records and manage their condition better. It will be simpler for patients to download their record and pass them, in a standard format, to any organisation of their choice.

We intend to make aggregate data available in a standard format to allow intermediaries to analyse and present it to patients in an easily understandable way. Making aggregated, anonymised data available to the university and research sectors also has the potential to suggest new areas of research through medical and scientific analysis. **There will be safeguards to protect personally identifiable information.**

We will consider introducing a voluntary accreditation system, which will allow information intermediaries to apply for a kitemark to demonstrate to the public that they meet quality standards

Patients and carers will be able to access the information they want through a range of means, to ensure that no individual or section of the community is left out. In addition to NHS Choices, a range of third parties will be encouraged to provide information to support patient choice. Assistance will be provided for people who do not access on-line health advice, or who would particularly benefit from more intensive support. **A central health and social care information centre w**ill have the lead responsibility for the above data collection.

9. **Increased Choice and Control**

In future, patients and carers **will have far more clout and choice in the system; and as a result, the NHS will become more responsive to their needs and wishes**. People want choice, and evidence at home and abroad shows that it improves quality. They cite **increasing patient choice is not a one-way street. In return for greater choice and control, patients should accept responsibility for the choices they make, concordance with treatment programmes and the implications for their lifestyle.**

To achieve this the department will consult widely, tackling a range of issues, including: professional and patient engagement; reform to payment systems so that money follows the patient and enables choices to work; information availability and accessibility to enable choice of treatment, including decision aids, particularly in mental health and community services; support to patients with different language needs and patients with disabilities to ensure that they can exercise choice; ensuring that local commissioners fully support rather than restrict choice; and maximising use of Choose and Book.

Personal health budget pilots. International evidence, and evidence from social care, shows that these have much potential to help improve outcomes, transform NHS culture by putting patients in control, and enable integration across health and social care. As part of personalised care planning, the Department will encourage further pilots to come forward and explore the potential for introducing a right to a personal health budget in discrete areas such as NHS continuing care. We also recognise that introducing personal budgets is operationally complex and the Government will use the results of the evaluation in 2012 to inform a wider, more general roll-out.

10. Patient and public voice

The collective voice of patients is to be strengthen by creating HealthWatch England, a new independent consumer champion within the Care Quality Commission. **Local Involvement Networks (LINks) will become the local HealthWatch, creating a strong local infrastructure, and we will enhance the role of local authorities in promoting choice and complaints advocacy, through the HealthWatch arrangements they commission.**

We will also look at existing mechanisms, including relevant legislation, to ensure that public engagement is fully effective in future, and that services meet the needs of neighbourhoods.

All sources of feedback, of which complaints are an important part, should be a central mechanism for providers to assess the quality of their services. We want to avoid the experience of Mid-Staffordshire,

where patient and staff concerns were continually overlooked while systemic failure in the quality of care went unchecked. Building on existing complaints handling structures, we will strengthen arrangements for information sharing. Local HealthWatch will also have the power to recommend that poor services are investigated.

The role of HealthWatch (replacing LINks)

local level:

- ✓ Local HealthWatch organisations will ensure that the views and feedback from patients and carers are an integral part of local commissioning across health and social care;
- ✓ Local authorities will be able to commission local HealthWatch or HealthWatch England to provide advocacy and support, helping people access and make choices about services, and supporting individuals who want to make a complaint. In particular, they will support people who lack the means or capacity to make choices; for example, helping them choose which General Practice to register with;
- ✓ Local HealthWatch will be funded by and accountable to local authorities, and will be involved in local authorities' new partnership functions, described in chapter 4. To reinforce local accountability, local authorities will be responsible for ensuring that local HealthWatch are operating effectively, and for putting in place better arrangements if they are not; and
- ✓ Local HealthWatch will provide a source of intelligence for national HealthWatch and will be able to report concerns about the quality of providers, independently of the local authority.

At national level:

- ✓ HealthWatch England will provide leadership, advice and support to local HealthWatch, and will be able to provide advocacy services on their behalf if the local authority wishes;
- ✓ HealthWatch England will provide advice to the Health and Social Care Information Centre on the information which would be of most use to patients to facilitate their choices about their care;
- ✓ HealthWatch England will provide advice to the NHS Commissioning Board, Monitor and the Secretary of State; and
- ✓ Based on information received from local HealthWatch and other sources, HealthWatch England will have powers to propose CQC investigations of poor services.

11. Effective payment by results schemes including primary care and community services.

The Department will start designing and implementing a more comprehensive, transparent and sustainable structure of payment for performance so that money follows the patient and reflects quality. Payments and the 'currencies' they are based on will be structured in the way that is most relevant to the service being provided, and will be conditional on achieving quality goals.

12. GP Commissioning Consortia – Their role

- ✓ Putting GP commissioning on a statutory basis, with powers and duties set out in primary and secondary legislation.
- ✓ **Consortia of GP practices, working with other health and care professionals, and in partnership with local communities and local authorities, will commission the great majority of NHS services for their patients.** They will not be directly responsible for commissioning services that GPs themselves provide, but they will become increasingly influential in driving up the quality of general practice. They will not commission the other family health services of dentistry, community pharmacy and primary ophthalmic services. These will be the responsibility of the NHS Commissioning Board, as will national and regional specialised services, although consortia will have influence and involvement.
- ✓ **The NHS Commissioning Board will calculate practice-level budgets and allocate these directly to consortia**. The consortia will hold contracts with providers and may choose to adopt a lead commissioner model, for example in relation to large teaching hospitals.
- ✓ GP consortia will include an accountable officer, and the **NHS Commissioning Board will be responsible for holding consortia to account for stewardship of NHS resources and for the outcomes they achieve as commissioners**. In turn, each consortium will hold its constituent practices to account against these objectives.
- ✓ A fundamental principle of the new arrangements is that **every GP practice will be a member of a consortium, as a corollary of holding a registered list of patients**. Practices will have flexibility within the new legislative framework to form consortia in ways that they think will secure the best healthcare and health outcomes for their patients and locality.
- ✓ GP consortia will need to have a sufficient geographic focus to be able to take responsibility for agreeing and monitoring contracts for locality-based services (such as urgent care services), to have responsibility for commissioning services for people who are not registered with a GP practice, and to commission services jointly with local authorities. The consortia will also need to be of sufficient size to manage financial risk and allow for accurate allocations.
- ✓ GP consortia will need to have sufficient freedoms to use resources in ways that achieve the best and most cost-efficient outcomes for patients. **Monitor and the NHS Commissioning Board will ensure that commissioning decisions are fair and transparent, and will promote competition**.
- ✓ GP consortia will have the freedom to decide what commissioning activities they undertake for themselves and for what activities (such as demographic analysis, contract negotiation, performance monitoring and aspects of financial management) **they may choose to buy in support from external organisations, including local authorities, private and voluntary sector bodies.**
- ✓ Consortia will receive a maximum management allowance to reflect the costs associated with commissioning, with a premium for achieving high quality outcomes and for financial performance.
- ✓ GP consortia will have a duty to **promote equalities and to work in partnership with local authorities, for instance in relation to health and adult social care, early years services, public health, safeguarding, and the wellbeing of local populations.**
- ✓ **GP consortia will have a duty of public and patient involvement, and will need to engage patients and the public in their neighbourhoods in the commissioning process. Through its local infrastructure, HealthWatch**

13. **An Autonomous NHS Commissioning Board**

A statutory NHS Commissioning Board will be created to support GP consortia in their commissioning decisions. This will be a lean and expert organisation, free from day-to-day political interference, with a commissioning model that draws from best international practice. The NHS Commissioning Board will provide leadership for quality improvement through commissioning: through commissioning guidelines, it will help standardise what is known good practice, for example improving discharge from hospital, maximising the number of day care operations, reducing delays prior to operations, and enabling community access to care and treatments. **It will play its full part in promoting equality in line with the Equality Act 2010. It will not manage providers or be the NHS headquarters.**

The Board will promote patient and carer involvement and choice, championing the interests of the patient rather than the interests of particular providers. It will involve patients as a matter of course in its business, for example in developing commissioning guidelines. **To avoid double jeopardy and duplication, it will take over the current CQC responsibility of assessing NHS commissioners and will hold GP consortia to account for their performance and quality.** It will manage some national and regional commissioning. It will allocate and account for NHS resources. It will have a role in supporting the Secretary of State and the Public Health Service to ensure that the NHS in England is resilient and able to be mobilised during any emergency it faces, or as part of a national response to threats external to the NHS. It will promote involvement in research and the use of research evidence.

14. **Local democratic legitimacy**

Following the establishment of the NHS Commissioning Board and a comprehensive network of GP consortia, PCTs will no longer have NHS commissioning functions. To realise administrative cost savings, and achieve greater alignment with local government responsibilities for local health and wellbeing, the **Government will transfer PCT health improvement functions to local authorities and abolish PCTs -** PCTs will cease to exist from 2013, in light of the successful establishment of GP consortia. Local Directors of Public Health will be jointly appointed by local authorities and the Public Health Service. Local Directors of Public Health will also have statutory duties in respect of the Public Health Service.

The Government will strengthen the local democratic legitimacy of the NHS. Building on the power of the local authority to promote local wellbeing, we will establish new statutory arrangements within local authorities – which will be established as "health and wellbeing boards" or within existing strategic partnerships – to take on the function of joining up the commissioning of local NHS services, social care and health improvement. These health and wellbeing boards allow local authorities to take a strategic approach and promote integration across health and adult social care, children's services, including safeguarding, and the wider local authority agenda.

We will simplify and extend the use of powers that enable joint working between the NHS and local authorities. 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.** While NHS commissioning

will be the sole preserve of the NHS Commissioning Board and GP consortia, the aim is to ensure coherent and coordinated local commissioning strategies across all three services, for example in relation to mental health or elderly care. The Secretary of State will seek to ensure strategic coordination nationally; the local authority's new functions will enable strategic coordination locally. It will not involve day-to-day interventions in NHS services. The Government will consult fully on the details of the new arrangements.

Local authorities' new functions

Each local authority will take on the function of joining up the commissioning of local NHS services, social care and health improvement.

Local authorities will therefore be responsible for:

- ✓ Promoting **integration and partnership working** between the NHS, social care, public health and other local services and strategies;
- ✓ Leading **joint strategic needs assessments**, and promoting collaboration on local commissioning plans, including by supporting joint commissioning arrangements where each party so wishes; and
- ✓ Building partnership for **service changes and priorities**. There will be an escalation process to the NHS Commissioning Board and the Secretary of State, which retain accountability for NHS commissioning decisions.

These functions would replace the current statutory functions of Health Overview and Scrutiny Committees.

As well as elected members of the local authority, all relevant NHS commissioners will be involved in carrying out these functions, as will the Directors of Public Health, adult social services, and children's services. They will all be under duties of partnership. Local HealthWatch representatives will also play a formal role to ensure that feedback from patients and service users is reflected in commissioning plans.

Summary – What does it mean for the sector?

The impact of these changes will be unlike any seen in the NHS before, for patients, carers, and professionals from all sectors alike. They will take time to initiate, to implement and to evaluate so this process is at the moment a long and uncertain one, but are likely to bring with them opportunities for the sector as well as many challenges. Currently these changes are being analysed by local, regional and national level by organisations involved in delivering services and those supporting the third sector, and network members will be kept informed about developments, local significance and potential implications for voluntary, community and faith groups involved in services delivery.

The full version of this white paper can be found at:
http://www.gmcvo.org.uk/files/Equity%20&%20Excellence.pdf