



<b>Briefing for:</b>	Attendees of the Overview and Scrutiny Committee NHS White paper workshop on Monday 13 <sup>th</sup> September.
<b>Title:</b>	<b>“Liberating the NHS” – Department of Health consultation on the future of the NHS</b>
<b>Purpose of briefing:</b>	To provide attendees to the NHS White paper workshop with some background information on proposals in the NHS White Paper and accompanying consultation papers.
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<b>Date:</b>	7 <sup>th</sup> September 2010
<b>Appendices</b>	<p><b>Appendix 1: Timeline for implementation of NHS White Paper</b></p> <p><b>Appendix 2: Current and Future structure of the NHS</b></p>

## 1. Background

- The Coalition Government have published a number of consultation documents along with the overarching NHS White Paper ([Equity and excellence: Liberating the NHS](#)). These are:
  - [Local Democratic Legitimacy in health](#)
  - [Commissioning for Patients](#)
  - [Regulating Healthcare Providers](#)
  - [Transparency in Outcomes](#)
- These papers set out the Governments long term vision for the National Health Service.

## 2. Responding to the consultation

- The closing date for responses to the overarching White Paper is 5th October. The closing date for responses to the accompanying consultation papers is 11th October.
- The Department of Health is asking for responses to be emailed to [NHSWhitePaper@dh.gsi.gov.uk](mailto:NHSWhitePaper@dh.gsi.gov.uk).

## 3. Equity and Excellence: Liberating the NHS

- **The White Paper outlines plans to:**
  - shift the total £80bn worth of commissioning from 152 Primary Care Trusts (PCTS) to new compulsory GP consortia by 2013
  - produce an outcomes framework for health and social care to replace the current targets
  - set up an NHS Commissioning Board in England by 2011. This will commission GPs and specialist services
  - open up health provision to “any willing provider” extending the private provider market
  - abolish PCTs from April 2013 and Strategic Health Authorities (SHAs) by 2012/2013
  - strengthen local democratic legitimacy of the NHS
  - transfer responsibility for public health and local health strategy to local authorities. Local authorities will employ a Joint Director of Public Health appointed with the newly created Public Health Service. A ring-fenced Health Improvement budget will be allocated. The Secretary of State will set national objectives for health improvement
  - set up new statutory local authority Health and Well-being Boards by April 2012
  - local authorities will get new powers in relation to joining up commissioning of local NHS services including promoting integration and partnership working, leading Joint Strategic Needs Assessments and building partnerships for service change and priorities. These will replace existing statutory health scrutiny functions
  - local authorities will progress integration between health and social care
  - local authorities will be given the role of co-ordinating health care, social care and health improvement. This function will replace current statutory health scrutiny powers as accountability for co-ordinating change will now rest with Councils rather than the NHS

- National Institute for Health and Clinical Excellence (NICE) will set standards for both health and social care. (NICE will produce 150 standards each with 5 -10 concise quality statements)
- local authorities will retain statutory duty to support patient and public involvement. As a patient voice, HealthWatch will be created as part of the Care Quality Commission (CQC) with local branches, building on the Local Involvement Networks (LINKs)
- Monitor, the independent regulator, of NHS foundation trusts will become the financial regulator
- CQC will be the quality regulator and inspect and license providers in conjunction with Monitor
- an expansion of Personal Health Budgets, currently being piloted
- an end to national pay settlements in health

#### 4. Local Democratic Legitimacy in health

##### **Proposals**

- Local Authorities to have an enhanced role in health:
  - Leading on JSNAs
  - Supporting local voice and the exercise of patient choice
  - Promoting joined up commissioning of local NHS services, social care and health improvement
  - Leading on local health improvement and prevention activity.

##### **HealthWatch**

- Local Involvement Networks (LINKs) will become HealthWatch.
- HealthWatch will undertake the functions of LINKs as well as additional functions and responsibilities, matched by additional funding. These include:
  - NHS Complaints advocacy services – the Govt. is proposing that responsibility is devolved to Local Authorities to commission through local or national HealthWatch.
  - Supporting individuals to exercise choice, for example helping them chose a GP practice.
- Local Authorities will:
  - Continue to fund and contract HealthWatch services.
  - Continue to hold them to account for service delivery and value for money.
  - Ensure that the focus of HealthWatch is representative of the local community.
- In the event of under-performance the LA will be able to re-tender the contract.
- HealthWatch will be able to report concerns to HealthWatch England (this will form a statutory part of the Care Quality Commission).

##### **Improving integrated working**

- Aims to strengthen integration in a number of ways including:
  - Extending the availability of personal budgets in the NHS and social care, with joint assessments and care planning.
  - Payment systems being used to support joint working, e.g. around hospital readmissions.
  - Freeing up providers for example, the govt is proposing to remove constraints for foundation trusts which could, for example, enable them to expand into social care.

- The Govt believes there is scope for stronger institutional arrangements, within Local Authorities, led by elected members, to support partnership working across health, social care and public health.
- Option of “leav[ing] it up to” NHS Commissioners and Local Authorities as to whether they want to work together and top devise their own local arrangements if they wish or by the establishment of a statutory role (this is the Govt preferred option).

### **Statutory Health and Wellbeing Boards**

- Would have four main functions:
  1. Assess needs of local population and lead JSN
  2. Promote integration and partnership, including around joint commissioning
  3. Support joint commissioning and pooled budget arrangements
  4. Undertake scrutiny role in relation to major service redesign
- Statutory obligation for LA and commissioners to participate as members of the board and act in partnership on the above functions.
- Would have an ‘escalation role’ e.g. should the Local Children’s Safeguarding Board have concerns about local safeguarding arrangements they could raise this with the Health and Wellbeing Board who could in turn escalate to the NHS Commissioning Board should local resolution not be forthcoming.
- Members would include: Leader, social care, NHS Commissioners, patient champions, local govt including DPH, HealthWatch and GP consortia. Would also include representation from NHS Commissioning Board where relevant issues are being discussed. Elected members would decide who chaired the board.

### **Overview and Scrutiny Function**

- Statutory health scrutiny powers would transfer to the Health and Wellbeing Boards.
- Govt believes this would give HealthWatch a stronger formal role as it would have representation on the Health and Wellbeing boards.
- Consultation document notes that “a formal health scrutiny function will continue to be important within the local authority, and the local authority will need to assure itself that it has a process in place to adequately scrutinise the functioning of the health and wellbeing board and health improvement policy decisions” (p13)

### **Local authority leadership for health improvement**

- Local improvement activity would be transferred to Local Authorities once PCTs ceased to exist, along with an, as yet, unspecified resource allocation.
- A National Public Health Service (PHS) will be created to secure the delivery of public health that need to be undertaken at a national level.
- Local Directors of Public Health will be jointly appointed between Local Authorities and the PHS, they will have a ring-fenced budget and will be directly accountable to the LA and, through the PHS, the Secretary of State.
- The Secretary of State, through the PHS, will agree with Local Authorities the local application of national health improvement outcomes.
  - Local authorities will determine how best to secure these outcomes.

## **5. [Commissioning for Patients](#)**

### **Proposals**

- The intention is to put GP commissioning on a statutory basis. Every GP practice will be a member of a consortium.
- Most commissioning arrangements to be made by consortia of GP practices which will be made accountable to the proposed NHS Commissioning Board.

- The Govt. envisages that a smaller group of practitioners will lead the consortium.
- Consortia will be able to employ staff or buy in support from external organisations (including LA, voluntary sector and independent providers) to carry out certain functions, for example to analyse population needs, manage contracts and monitor expenditure and outcomes.

#### **GP consortia will:**

- commission the majority of NHS Services on behalf of patients including: elective and rehabilitative care; urgent and emergency care; most community health services; mental health services; and learning disability services.
- Manage allocated budgets from NHS Commissioning Board and deciding how best to use the resources for the needs of their patients (these budgets will be kept separate from GP practice income).
- Work closely with patients and local communities, including through LINKs (HealthWatch).
- Determining healthcare needs, including contributing to JSNAs.
- To fulfil effectively their duties in areas such as safeguarding of children.

#### **The NHS Commissioning Board will:**

- Be an independent statutory authority that provides national leadership.
- Promote patient and public involvement
- Be accountable to the Secretary of State.
- Ensure the development of consortia and hold them to account for outcomes and financial performance
- Allocate and account for NHS resources e.g. calculate practice-level budgets and allocate these resources directly to consortia.
- Develop a commissioning outcomes framework, with support from NICE.

#### **Health and Wellbeing Board**

- The proposed new local authority **health and wellbeing boards** would enable consortia alongside other partners to contribute to joint action to promote the health and well-being.

#### **Financial risk**

- The principles for managing over and under spends, will be agreed between the NHS Commissioning Board, the DoH and HM Treasury.
- There will also be incentives, including benefits for good financial management.
- The NHS Commissioning Board will have intervention powers in the event of poor financial management.

#### **Transparency and fairness**

- The Department of Health proposes that wherever possible services should be commissioned that enable patients to choose from any willing provider.

## **6. [Regulating Healthcare Providers](#)**

#### **Freeing providers**

- The Government's intention is to focus foundation trusts on improving outcomes and innovate improvements to care for patients' better care. Patients will choose care from the provider they want. The Government will give more freedoms to foundation trusts such as removal of the private income cap to expand private

healthcare provision; and some trusts, such as community services, will be able to operate with staff-only membership.

- The consultation also proposes that all NHS trusts must become foundation trusts in three years. In the transition period to the new system, Monitor will continue to apply its current standards to those organisations applying to become Foundation Trusts.
- The legislative framework for trusts will continue to have their unique legal form. They will be regulated in the same way as other providers, whether from the private or voluntary sector. Any surplus will be reinvested or to pay off debts rather than distributed externally.

### **Economic regulation**

- Monitor will be the economic regulator for health and adult social care in England. Its main duty will be to protect the interests of patients and the public and exercise functions in three areas: regulating prices, promoting competition and supporting service continuity. Its statutory remit will be limited to the provision of health and adult social care services.

### **Licensing**

- In the new system, the CQC and Monitor will be jointly responsible for quality assurance, inspection and enforcement. It will be a requirement of Monitor's licence that organisations have gained CQC registration. Monitor will need to license some providers of NHS services for delivering its regulatory functions. This will supersede and replace elements of Monitor's existing authorisation and compliance regime.
- CQC and Monitor will retain separate responsibilities, however both regulators will need to work together to develop streamlined procedures. Monitor's powers to regulate prices and license providers will only cover NHS services. Monitor will be responsible for developing a general licence and special licence conditions (for individual providers in certain cases) for all relevant providers of NHS services. Providers of other care services, including adult social care, would still be required to register with the CQC but would not be required to hold Monitor's licence.

### **Price regulation and setting**

- Monitor will be responsible for setting prices and devising a pricing methodology for NHS-funded services to promote fair competition and drive productivity. This will include price caps for services subject to national tariffs.
- Monitor and the NHS Commissioning Board will need to work closely together in deciding which services should be subject to national tariffs, and in developing appropriate currencies for pricing and payment purposes. Monitor will also need to consult with the Board on its proposed methodology and prices for services under national tariffs, variations to the tariff in individual cases and in relation to some pricing disputes.

### **Promoting competition**

- The NHS Commissioning Board will have a duty to promote patient choice. All patients will have choice and control over their treatment and choice of any willing provider.

- Monitor will have a duty to promote competition. It will have powers to impose remedies and sanctions to address restrictions on competition, through its licensing regime, and through concurrent powers with the Office of Fair Trading (OFT) to enforce key aspects of competition law. Monitor will have powers to enforce competition law and impose sanctions and remedies in relation to providers of health or adult social care services irrespective of whether they are required to hold a licence.
- Monitor will have powers to investigate and remedy complaints regarding commissioners' procurement decisions and other anticompetitive conduct; and to regulate mergers to maintain sufficient competition in the public interest.

### **Supporting continuity of services**

- Consortia of GP practices will commission the vast majority of NHS services for their patients, including elective hospital care, rehabilitative care, urgent and emergency care, most community services, and mental health services. Commissioners will retain primary responsibility for ensuring the continuity of service provision, although Monitor may intervene to ensure continued access to key services in limited circumstances.
- Foundation trusts are not allowed to withdraw 'mandatory services' without Monitor's permission. In the event of special administration Monitor will be responsible for funding arrangements to finance the continued provision of services and they will decide on the best approach, including determining an appropriate approach to risk assessment.

### **Implications for local authorities**

- The consultation document specifically refers to Monitor's role in relation to both health and social care. For example, 'providing equitable access to essential health and adult social care services' and 'making best use of limited NHS and adult social care resources' (3.2). Its strategic remit will be confined to health and adult social care, for example – it will not cover supply of pharmaceuticals. However, the document does not give any examples of how it will exercise its functions over social care, and, in relation to licensing, social care is specifically excluded. The reason given is that there are already mature markets and choice in social care.

## **7. Transparency in outcomes**

- The Government's proposals are based on their belief that, for the past ten years, doctors and nurses have been forced to meet government targets that often did little to improve patients' health. The Government plans to free the NHS to work towards what really matters to patients and clinicians – what actually happens to the patient's health as a result of the treatment and care they receive. They intend to do this by creating an NHS that is transparent about the outcomes it is achieving for patients.

### **What will the NHS Outcomes Framework do?**

- It will motivate service improvements and ensure there is accountability for performance at the most senior levels. It will do this by:
  - helping patients, the public and Parliament understand how well the NHS overall is doing in terms of improving the health outcomes of the patients it treats and cares for.

- allowing the Secretary of State for Health to hold the new NHS Commissioning **Board to account** for the outcomes it is securing for patients. This new Board will be independent of the Government and responsible for allocating a budget of approximately £80bn to groups of GPs who will then purchase healthcare services to meet the needs of their local populations.
- having **greater transparency** to drive improvements in what actually happens to patients' health as a result of the treatment and care they receive.

### Principles of the NHS Outcomes Framework

- Accountability and transparency.
- Balanced – outcomes will be chosen to look across the whole NHS.
- Internationally comparable – to compare the NHS against other countries.
- Focused on what matters to patients and clinicians.
- Promoting excellence and equality.
- Focused on outcomes that the NHS can influence but working in partnership with other public services where required
- Evolving **over time** – the NHS Outcomes Framework will be based on what we can measure now, but will be updated in coming years.

### What will be included in the NHS Outcomes Framework?

- The proposed NHS Outcomes Framework is structured around five very high level outcome domains. **These are intended to cover everything the NHS is there to do.** These five outcome domains are:

Outcome domain:	Underlying principles used to decide on outcome indicators for each domain:	This domain will measure:
1. Preventing people from dying prematurely	<ul style="list-style-type: none"> <li>• People should not die early where medical intervention could make a difference</li> <li>• Focus on what the NHS can do</li> </ul>	Effectiveness
2. Enhancing the quality of life for people with long-term conditions	<ul style="list-style-type: none"> <li>• Treating the individual</li> <li>• Functional and episodic outcomes</li> <li>• Meeting the needs of all age groups</li> </ul>	
3. Helping people to recover from episodes of ill health or following injury	<ul style="list-style-type: none"> <li>• Preventing conditions from becoming more serious</li> <li>• Helping people recover from serious illness or injury</li> </ul>	Patient experience



Outcome domain:	Underlying principles used to decide on outcome indicators for each domain:	This domain will measure:
<b>4. Ensuring people have a positive experience of care</b>	<ul style="list-style-type: none"> <li>• Patient experience must be a vital element of the NHS Outcomes Framework</li> <li>• Existing arrangements for collecting patient experience information do not lend themselves well to the requirements of the Framework</li> <li>• It is necessary to measure patient experience now, to drive a step change in improvement</li> <li>• Ensuring that a balanced approach is achieved – so that this work fully supports and complements locally-led innovation and focused improvement activity</li> </ul>	
<b>5. Treating &amp; caring for people in a safe environment &amp; protecting them from avoidable harm</b>	<ul style="list-style-type: none"> <li>• Protecting people from further harm</li> <li>• An open and honest culture</li> <li>• Learning from mistakes</li> </ul>	Safety

- Each of the five domains will have:
  - An overarching outcome indicator (or set of indicators) to measure the overall progress of the NHS across the breadth of activity covered by the domain.
  - A small number of specific improvement areas (five or more is suggested) where the evidence suggests better outcomes are possible or areas that are identified as being particularly important to patients.
  - Supporting Quality Standards developed by the National Institute for Health and Clinical Excellence (NICE) to help patients, clinicians and commissioners understand how to deliver better care.

[Annex A on page 45 of the consultation report](#) sets out a list of potential indicators for each domain. It is acknowledged that the delivery of outcomes is likely to vary according to geographical area and across different population groups. The framework should not be considered as a performance management tool for NHS providers – **the Care Quality Commission will continue to be responsible for ensuring that providers meet minimum standards and essential levels of quality and safety.**

## Appendix 1: Timeline for implementation of NHS White Paper

**Timetable for action**  
The high level timetable below outlines the Government's proposals (subject to Parliamentary approval for legislation)

Commitment	Date
Further publications on: <ul style="list-style-type: none"> <li>• framework for transition</li> <li>• NHS outcomes framework</li> <li>• commissioning for patients</li> <li>• local democratic legitimacy in health</li> <li>• freeing providers and economic regulation</li> </ul>	July 2010
Report of the arm's length bodies review published	Summer 2010
Health Bill introduced in Parliament	Autumn 2010
Further publications on: <ul style="list-style-type: none"> <li>• vision for adult social care</li> <li>• information strategy</li> <li>• patient choice</li> <li>• a provider-led education and training</li> <li>• review of data returns</li> </ul>	By end 2010
Separation of SHAs' commissioning and provider oversight functions	
Public Health White Paper	Late 2010
<b>Commitment Date</b> Introduction of choice for: <ul style="list-style-type: none"> <li>• care for long-term conditions</li> <li>• diagnostic testing, and post-diagnosis</li> </ul>	From 2011
White Paper on social care reform	2011
Choice of consultant-led team	By April 2011
Shadow NHS Commissioning Board established as a special health authority	April 2011
Arrangements to support shadow health and wellbeing partnerships begin to be put in place	
Quality accounts expanded to all providers of NHS care	
Cancer Drug Fund established	
Choice of treatment and provider in some mental health services	From April 2011
Improved outcomes from NHS Outcomes Framework	
Expand validity, collection and use of PROMs	
Develop pathway tariffs for use by commissioners	

<b>Commitment</b>	<b>Date</b>
Quality accounts: nationally comparable information published	June 2011
Report on the funding of long-term care and support	By July 2011
Hospitals required to be open about mistakes	Summer 2011
GP consortia established in shadow form	2011/12
Tariffs: <ul style="list-style-type: none"> <li>• Adult mental health currencies developed</li> <li>• National currencies introduced for critical care</li> <li>• Further incentives to reduce avoidable readmissions</li> <li>• Best-practice tariffs introduced for interventional radiology, day-case surgery for breast surgery, hernia repairs, and some orthopaedic surgery</li> </ul>	2011/12
NHS Outcomes Framework fully implemented	By April 2012
<b>Commitment Date</b> Majority of reforms come into effect: <ul style="list-style-type: none"> <li>• NHS Commissioning Board fully established</li> <li>• New local authority health and wellbeing boards in place</li> <li>• Limits on the ability of the Secretary of State to micromanage and intervene</li> <li>• Public record of all meetings between the Board and the Secretary of State</li> <li>• Public Health Service in place, with ring-fenced budget and local health improvement led by Directors of Public Health in local authorities</li> <li>• NICE put on a firmer statutory footing</li> <li>• HealthWatch established</li> <li>• Monitor established as economic regulator</li> </ul>	April 2012
International Classification of Disease (ICD) 10 clinical diagnosis coding system introduced	From 2012/13
NHS Commissioning Board makes allocations for 2013/14 direct to GP consortia	Autumn 2012
Free choice of GP practice	2012
Formal establishment of all GP consortia	
SHAs are abolished	2012/13
GP consortia hold contracts with providers	April 2013
PCTs are abolished	From April 2013
All NHS trusts become, or are part of, foundation trusts	2013/14
All providers subject to Monitor regulation	
Choice of treatment and provider for patients in the vast majority of NHS-funded services	By 2013/14
Introduction of value-based approach to the way that drug	

<b>Commitment</b>	<b>Date</b>
companies are paid for NHS medicines	
NHS management costs reduced by over 45%	By end 2014
NICE expected to produce 150 quality standards	By July 2015

## Appendix 2: Current and Future structure of the NHS – BBC website

