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The Health White Paper

What it Says

Summary briefing and extracts from the Health White Paper, *Equity and excellence: liberating the NHS*

By Mike Cooper for Tamarind Chambers

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TAMARIND CHAMBERS

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The Coalition Government published its Health White Paper, *Equity and excellence: liberating the NHS*, in July 2010, and a set of associated consultation papers.

This is a summary of the main proposals contained in the White Paper.

We are producing a full response to the White Paper and further briefing materials – see http://tamarindchambers.wordpress.com.

Key extracts from the Government's *'strategy for the NHS'*:

The White Paper says that its aims are:

'Putting patients and public first'

- The 'strategy' section of the White Paper contains a number of points about patients being at the heart of the NHS; 'no decision about me without me'; control over care records; choice of provider; patients rating hospitals, personalised care.
- There is one point about the wider public: 'We will strengthen the collective voice of patients and the public through arrangements led by local authorities, and at national level, through a powerful new consumer champion, HealthWatch England, located in the Care Quality Commission.'

'Improving healthcare outcomes': Outcome measures not process targets; openness and challenge to failings; commissioning informed by quality standards; inspection against essential quality standards; money to follow patient; payment by outcome not activity.

'Autonomy, accountability and democratic legitimacy': Greater freedom, not political micromanagement, reduced role for ministers; independent and accountable NHS Commissioning Board; encourage social enterprise; all NHS Trusts to become Foundation; ring-fenced public health budgets.

'Cutting bureaucracy and improving efficiency': £20 Bn efficiency savings by 2014; reduce NHS management costs by 45%; de-layer and simplify NHS bodies, abolish quangos.

Section 1, Liberating the NHS

'Values':

- NHS is an integral part of the Big Society; available to all, free at point of use, based on need; will increase health spending, promote equality, 'mutuality' and shared decision-making.
- 'We will be clear about what the NHS should achieve; we will not prescribe how it should be achieved'. More autonomous NHS institutions, with greater freedoms, clear duties, and transparency in their 'responsibilities to patients and their accountabilities'.

The NHS scores poorly on responsiveness to patients and lacks a genuinely patient-centred approach; 'patients are expected to fit around services'. And the NHS has achieved poor outcomes in some areas.

'***Our vision for the NHS'*** (extracts) an NHS that:
- Is genuinely centred on patients and carers.
- Is more transparent, with clearer accountabilities for quality and results.
- Gives citizens a greater say in how the NHS is run.
- Is less insular and fragmented, and works much better across boundaries, including with local authorities and between hospitals and practices.

Principles: Freedom, fairness and responsibility.

Extracts:
- Power will be given to front-line clinicians and patients, DH role to be reduced and become more strategic.
- New Public Health Service to be set out in Health Bill; Primary Care Trust (PCT)role in local health improvement will transfer to local authorities.
- DH role in social care to continue, and 'seek to break down barriers between health and social care funding'. Government to set out its vision for adult social care 'later this year'.

The central purpose of the NHS will be 'improvement in health outcomes'.

Section 2. Putting patients and the public first

Aim that ***'shared decision-making'*** becomes the norm: 'no decision about me without me'.

'The new NHS Commissioning Board will champion patient and carer involvement', held to account by Secretary of State. In the meantime, 'the Department will work with patients, carers and professional groups, to bring forward proposals about transforming care through shared decision-making.'

'NHS information revolution'
An information revolution will:
- Give access to comprehensive information from range of sources; develop communication between patients and clinicians; new on-line services.
- Expand and improve use of patient generated information, patient reported outcome measures, patient experience surveys and real time feedback.

Says that 'information' and 'information about commissioning' … 'will improve accountability'.

Patient control of records – patient to determine who can see their records, and see any changes made; and can share that record with other bodies. Will start with GP records and extend to other providers over time. Government will consult on this and confidentiality safeguards 'later this year'.

Providers will be under contractual obligations re accuracy of data. Health & Social Care Information Centre to have firmer statutory footing with power regarding data collection.

Information strategy to be published 'this autumn'.

'Increased choice and control' Patients and carers will have increased 'clout' and choice. Not just where you go when but more fundamental control of circumstances of care.

Government will consult 'later this year'. NHS Commissioning Board will have role in promoting choice.

'Patient and public voice' The collective patient and public voice will be strengthened:
- HealthWatch England will be created.

- ‘LINks will become local HealthWatch’.
- Enhanced role for local authorities in promoting choice and complaints advocacy; it is proposed this could be through commissioning HealthWatch.

Local ***HealthWatch*** will:
- Ensure that the views and feedback from patients and carers are an integral part of local commissioning across health and social care.
- Be funded by and accountable to local authorities, and will be involved in local authorities’ new partnership functions.
- 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.

Local Authorities will:
- Be able to commission local HealthWatch or HealthWatch England to provide advocacy and support, in particular for people who lack the means or capacity to make choices.
- Be responsible for ensuring that local HealthWatch are operating effectively, and for putting in place better arrangements if they are not.

HealthWatch England will:
- Provide leadership, advice and support to local HealthWatch.
- Be able to provide advocacy services on their behalf if the local authority wishes.
- Provide advice to the Health and Social Care Information Centre, NHS Commissioning Board, Monitor and the Secretary of State.
- Have powers to propose Care Quality Commmission investigations of poor services, based on information received from local HealthWatch and other sources.

Section 3. Improving healthcare outcomes

Improvement in quality and healthcare outcomes will be primary purpose of all NHS-funded care.

Patient experience and outcomes will be improved by:
- Measuring outcomes not processes, payment for performance not activity.
- Using clinically credible and evidence-based measures, with quality standards for health and social care to be developed by NICE.
- Discarding top-down targets.
- A culture of openness and challenge that ensures patient safety is placed above all else.

New ***NHS outcomes framework***, to replace current performance regime, and set direction for NHS, public health and social care. To hold NHS Commissioning Board to account and to provide commissioning framework for GP consortia. Quality standards developed by NICE. NICE to be made more independent and its remit extended to social care.

A new ***Public Health Service*** will be created, through which SofS will set local authorities national objectives for improving population health outcomes; local authorities will determine how, including by commissioning services from providers of NHS care.

Payment by results and tariffs will be extended, with a quality increment and penalties for poor quality care. New ‘value based’ pricing for payments to drug companies.

Section 4. Autonomy, accountability and democratic legitimacy

Reforms will:
- ‘Shift decision-making as close as possible to individual patients’.

- Liberate professionals and providers from top-down government control, so they can shape their services around the needs and choices of patients.
- Devolve power and responsibility for commissioning services to local consortia of GP practices.

To be matched by increased accountability to patients and democratic legitimacy, with a transparent regime of economic regulation and quality inspection to hold providers to account.

GP Consortia (GPC) will:
- Commission the majority of NHS services for their patients, working with other health and care professionals, and in partnership with local communities and local authorities.
- Be responsible for managing the combined commissioning budgets of their GP practices.
- Have responsibility for commissioning services for people who are not registered with a GP practice, and to commission services jointly with local authorities.
- Decide what commissioning activities they undertake for themselves and which they buy in from external organisations, including local authorities, private and voluntary sector bodies.
- Have a duty to promote equalities and to work in partnership with local authorities, eg on health and adult social care, early years, public health, safeguarding, and wellbeing of local people.
- 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.
- ***Not***: commission services that GPs themselves provide.

Every GP will be a member of a GPC.

An 'independent and autonomous' ***NHS Commissioning Board*** will:
- Provide national leadership on commissioning, set quality standards and guidelines.
- Promote and extend patient choice.
- Support the development of GP commissioning consortia and ensure coverage.
- Allocate practice level budgets to consortia.
- Hold GP consortia to account for stewardship of NHS resources and outcomes.
- Commission services that cannot be commissioned by consortia: primary dental and ophthalmic and community pharmacy services; national and regional specialised services.
- Hold GP contracts and allocate funding.
- Be accountable to Secretary of State and allow abolition of Strategic Health Authorities (SHAs).

Timetable:
- Shadow GPC taking increased delegated role from PCTs during 2011/12.
- GPC to take responsibility for commissioning in 2012/13.
- NHS Commissioning Board to make funding allocations to GPC late 2012.
- GPC to take full financial responsibility from April 2013.

New relationship between NHS and government; Secretary of State will:
- Have clear limits on his/her ability to micromanage the NHS and intervene.
- Set brief formal mandate for NHS Commissioning Board and hold it to account.
- Be arbiter of last resort between NHS commissioners and local authorities.

New functions for local authorities to increase local democratic legitimacy:
- Local authorities will take on the function of joining up the commissioning of local NHS services, social care and health improvement.
- Health improvement functions will be transferred from PCTs to local authorities with ring-fenced budget – PCTs will cease to exist from 2013.
- Local Directors of Public Health will be jointly appointed by local authorities and the Public Health Service and will have statutory duties in respect of the Public Health Service.

New statutory 'health and wellbeing boards' will be established, which will:
- 'Join up the commissioning of local NHS services' and 'make joint working and partnership arrangements easier'.
- Allow local authorities to take strategic approach, promote integration of health and social care

and other services; to build on power of wellbeing and 'strengthen local democratic legitimacy of the NHS'.
- Give local authorities influence over NHS commissioning, and NHS commissioners influence over public health and social care.

Local authorities will have responsibility 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 where each party so wishes.
- Building partnership for service changes and priorities. (With escalation process to the NHS Commissioning Board and the Secretary of State which retain accountability for NHS commissioning).

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

Carrying out these functions will involve, as well as elected members, relevant NHS commissioners, Directors of Public Health, adult social services and children's services, who will all be under a duty of partnership. There will be a formal role for local HealthWatch representatives.

Freeing NHS providers – greater autonomy:
- Government will encourage social enterprise.
- All NHS trusts to become Foundation Trusts within three years and be regulated by Monitor.
- Free foundation trusts from constraints so they can innovate for patients.
- Consult on abolishing cap on Foundation Trust income from other sources; allowing Foundation Trusts to 'tailor governance to their local needs', greater flexibility in governance (eg all employee, wider membership).
- Complete separation of commissioning from provision by April 2011. All community health to be provided by Foundation Trusts or other providers.

The Care Quality Commission (CQC) will have a strengthened role as an effective quality inspectorate across both health and social care.
Monitor will be the economic regulator of NHS; regulate pricing where necessary, promote competition and safeguard the continuity of services.
Joint licensing regime – CQC and Monitor.

Section 5. Cutting bureaucracy and Improving efficiency

Outcomes will be improved, costs reduced and productivity increased by greater patient involvement, choice, and freedom for commissioners and providers, cutting bureaucracy and administrative costs, reducing micromanagement and targets, and improved joint working, enhanced financial control and transparency.

The NHS will be required to cut bureaucracy and make efficiency savings; it will be 'delayered' and there will be a reduction in 'arms-length bodies' and quangos, and savings reinvested in improving quality and outcomes.