FELLOWS' ASSOCIATES

Equity and Excellence: Liberating the NHS

July 2010

Contents

Introduction

Equity and excellence: liberating the NHS is a product of many years in opposition. Its far ranging proposals go beyond the lifetime of this Parliament, seeking to establish popular consensus for two terms of government based on the notion of mutuality in which patients, employees and the private sector work together to create better outcomes. The White Paper will be accompanied by a swathe of consultation documents, as organisations get to grips with the extent of its far reaching reforms.

Patient at the heart

Apart from the pre-reported news that GPs are, in future, to form consortiums to take over commissioning for much of the local health services to patients, the government pledges to put the patient at the heart of healthcare giving them more choice and control.

According to the government, in future the norm will be *no decision about me without me.* The government says that patient choice will be radically extended to include, among other things, choice of consultant-led team and treatment.

Andrew Lansley, the Secretary of State for Health, told Parliament that the system would focus on personalised care and encourage strong joint local partnerships which integrate health and social care. A new independent voice for consumers will be located in the Care Quality Commission - HealthWatch England. An 'information revolution' will further increase accountability.

Jobs on the line

Critics such as the unions and Unison, the health service workers, have complained that far from putting the patient at its heart, the Government's radical plans to

abolish Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTS) will lead to thousands of job lost, destabilisation and potential chaos which will affect patient care. In the North East, it is suggested that one in three administrative workers are set to lose their jobs, along with thousands of managers.

Healthcare outcomes and reorganisation

While the government admits there will be fewer jobs in the NHS as a result of these changes, it says that it wants to focus on quality and outcomes with money following the patient, and providers being paid according to outcomes.

The government argues that it plans to empower professionals and providers giving them more autonomy but making them more accountable for outcomes. Local authorities will be given new powers to join up local NHS services including public health, social care and health improvement.

There will be an independent NHS Commissioning Board and all trusts will become Foundation Trusts. The latter could enable the government to realise its stated vision of it being the largest social enterprise sector in the world. A number of quangos have survived the White Paper with strengthened roles. These include NICE, the Care Quality Commission, the Information Centre – which will be given a lead role in data collection, and Monitor.

Alongside this, the government repeats its commitment to preserve frontline spending and to reduce up to £20 billion of efficiency savings by 2014.

Stakeholder response

In the House of Commons, Andy Burnham, now Shadow Secretary of State and leadership contender for the Labour Party, argued that ten years of “painstaking work” to raise standard in the NHS was being “thrown in the air”. He argued that it

was a huge gamble and said that it broke the pledge of the Coalition Government to put an end to top-down reorganisation of the NHS.

UNISON, the union for healthcare workers, argued that the measures were a means to introduce further privatisation and destabilise staff through the introduction of two tier pay and conditions. *Health and Insurant Protection* suggested that the extension of Choose and Book could increase the number of private hospitals operating within the NHS.

The Social Market Foundation argued that the government should not make GP commissioners and should have focused on improving the PCTS. This change along with the squeeze on spending would impact on patient care.

Others were less critical. The British Medical Association (BMA), representing doctors, agreed that doctors were ideally placed to identify the health needs of the local population. Known as feisty negotiators, the organisation said that doctors would need to be at the heart of the decisions taken on the NHS.

Professor Chris Ham, Chief Executive of The Kings Fund, said that it believed that the ambitions set for the NHS were the right ones. It said that the test would come in its implementation. It suggested that the planned timetable for GP commissioning was over-optimistic because some doctors would not have the skills and may be reluctant to come forward. The King's Fund said that the White Paper would accelerate the mixed economy in the NHS -with the extension of social enterprises through Foundation Trusts, the involvement of the private sector in supporting GP commissioning and the extension of independent providers to deliver healthcare treatment. It welcomed the proposals on public health and local authorities, but warned that Ministers faced a significant challenge in responding to the spending squeeze and saving £20 billion while carrying out these reforms

Meanwhile, the Local Government Association (LGA) welcomed the proposals. Councillor David Rogers, Chair of the LGA's community wellbeing board said that councils should play a central role in the outcome of any NHS reorganisation: "They know their area best and working in partnership with health professionals are best placed to help improve the health of residents and respond to circumstances in their areas.'

Liberating the NHS

Following the publication of the White Paper on NHS reform, the government has reaffirmed its commitment to the values and values and principles of the NHS: of a comprehensive service, available to all, free at the point of use and based on clinical need, not the ability to pay.

The coalition government says that it envisages an NHS that:

- is genuinely centred on patients and carers
- achieves quality and outcomes that are among the best in the world
- refuses to tolerate unsafe and substandard care
- eliminates discrimination and reduces inequalities in care
- puts clinicians in the driving seat and sets hospitals and providers free to innovate, with stronger incentives to adopt best practice
- 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
- is more efficient and dynamic, with a radically smaller national, regional and local bureaucracy; and
- is put on a more stable and sustainable footing, free from frequent and arbitrary political meddling.

Under the new plans, the Department of Health will take on a different role which will focus on improving public health, tackling health inequalities and reforming adult social care. The programme for public health will be set out in a white paper later this year.

Primary Care Trust responsibilities for local health improvement will transfer to local authorities who will employ the Director of Public Health jointly with the Public Health Service. The Department of Health 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 Department of Health will continue to have a key role in setting adult social care policy. A vision for adult social care will be set out later this year which will seek to give people greater control over their care and support. A commission will also be established by the Department of Health to look at the funding of long-term care and support.

The government recognises that the reforms outlined in the White Paper will take place against the backdrop of a challenging fiscal position. The coalition pledges to increase NHS spending in real terms in each year of this Parliament, but says that local NHS organisation will need to achieve unprecedented efficiency gains. This will involve a reduction in administrative costs and a reduction in staff levels.

Putting patients and public first

The goal of the government is an NHS which achieves results that are amongst the best in the world. This can only be achieved, the government says, by involving patients in the decisions about their own care and the way it is delivered.

The coalition government has pledged to make shared decision making the norm. No decision will be made about the patient without the patient being involved. The government points out that there is significant international evidence showing that this approach can improve health outcomes whilst the Wanless Report also suggests that this approach can deliver significant cost reductions.

The government says that information, combined with the right support, is key to better care, better outcomes and reduced costs. It therefore intends to bring about an NHS information revolution. Part of this will approach will be to find new ways of delivering care such as enabling patients to communicate with their clinicians about health status on-line. The government will provide a range of on-line services which will be provided more efficiently at a time and place that is convenient for patients and carers.

The government also wants to make more use of information generated by patients themselves by making wider use of tools such as Patient Reported Outcome Measures (PROMS), patient experience data, and real time feedback. The government will expand their validity, collection and use with PROMs being extended across the NHS wherever practicable.

Patient experience surveys will also be used more widely allowing patients to rate services and clinical departments according to the quality of care they received. Hospitals will be required to be open about mistakes and tell patients when something has gone wrong and staff feedback around the quality of patient care

will be made publicly available. This information will be used to help inform other patients with similar conditions of the best choice to make.

The government believes that better information creates a clear drive for improvement in providers. The Department for Health will therefore revise and extend quality accounts to reinforce local accountability for performance, encourage peer competition, and provide a clear spur for boards of provider organisations to focus on improved outcomes. Subject to evaluation, quality accounts will be extended to all providers of NHS care from 2011. All nationally comparable information will be published in a way that is accessible for patients and their families.

Wherever possible, the coalition government wants to ensure that information about services is published on a commissioner basis. Information about the performance of commissioners will also be published so that they are held to account for their use of public money. In future, the government wants to see increasing amounts of information comparable between providers on issues such as safety, effectiveness and experience.

Patients will also be given control of their health records. This will begin with access to the records held by their GP and over time extend to those held by all providers. The patient will be able to determine who has access to their records and will be able to see changes when they are made. The aim is that people should be able to share their records with third parties, such as support groups, who can then help them understand and manage their condition better. The government will therefore enable patients to download their records in a standard format and pass them on to any organization of their choice. Further consultation will be made on these arrangements.

Data will also be aggregated in a standard format to allow intermediaries to analyse and present it to patients in an easily understandable way. There will be safeguards to protect personally identifiable information and the government will consider introducing a voluntary accreditation scheme allowing intermediaries to demonstrate they meet quality standards.

Patients and carers will also be able to access the information they want through a range of means. In addition to NHS choices, a range of third party providers will be encouraged to provide information to support patient choice. Assistance will be provided for people who do no have access to online health advice or would benefit from more intensive support.

The government has pledged to ensure that the right data is collected by the Health and Social Care Information Centre to enable people to exercise choice. They will seek to centralise all data returns in the Information Centre, which will have lead responsibility for data collection and assuring the data quality of those returns, working with other interested parties such as Monitor and the Care Quality Commission.

Providers will also be under clear contractual obligations, with sanctions, in relation to accuracy and timeliness of data. Along with commissioners, they will have to use agreed data standards to promote compatibility between different standards.

The Department of Health will publish an information strategy this autumn to seek views on how best to implement these changes.

Increase choice and control

Patients will also be given more choice. The government envisages patients having a choice of any provider, consultant led team, GP practice or treatment. However, in return for this they will be expected to accept greater responsibility for the choices they make.

The government will

– Begin to introduce choice of treatment and provider in some mental health services from April 2011, and extend this wherever practicable
– Begin to introduce choice for diagnostic testing, and choice post-diagnosis, from 2011
– Introduce choice in care for long-term conditions as part of personalised care planning. In end-of-life care, we will move towards a national choice offer to support people's preferences about how to have a good death, and we will work with providers, including hospices, to ensure that people have the support they need
– Give patients more information on research studies that are relevant to them, and more scope to join in if they wish
– Give every patient a clear right to choose to register with any GP practice they

In implementing proposals for extending choice, the Department of Health has pledged to consult widely. The department recognises that there are a number of issues which must be tackled, 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.

The coalition government also believes that personal health budgets have the potential to improve outcomes, transform NHS culture by putting patients in control and enabling integration across health and social care. The government 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.

The government expects a choice of treatment and provider to become a reality for patients in the vast majority of NHS fundered services by n later than 2013/14. The NHS commissioning Board will have a key role to play in promoting and extending choice and control, the Secretary of State will hold it to account for its performance.

Patient and Public Voice

Patients will have their voice strengthened by a new independent consumer champion within CQC called HealthWatch England. Local Involvement Networks (LINks) will become the local HealthWatch, creating a strong local infrastructure, and will enhance the role of local authorities in promoting choice and complaints advocacy.

The role of HealthWatch

At 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

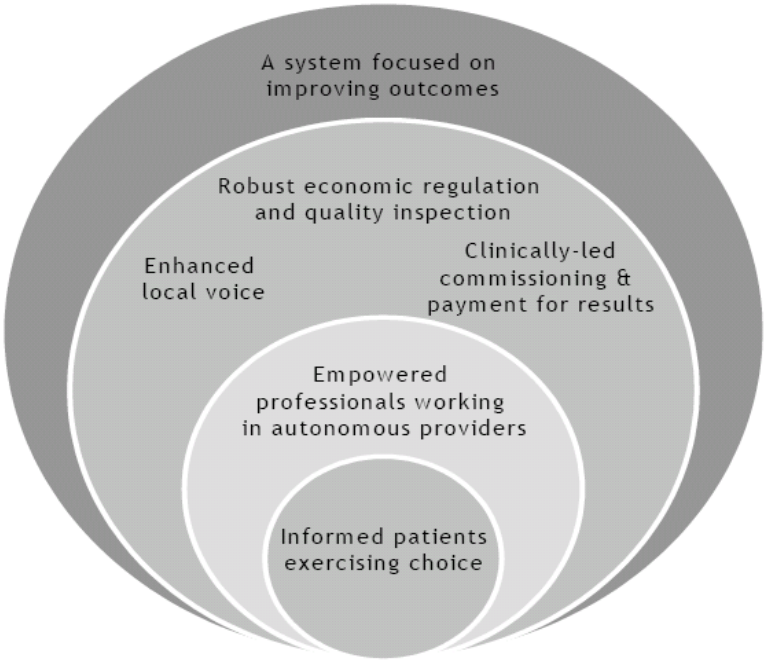
complaint. In particular, they will support people who lack the means or capacity to make choices; for example, helping them choose which General Practice to register with

- 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
- Based on information received from local HealthWatch and other sources, HealthWatch England will have powers to propose CQC investigations of poor services.

Figure 1


A system focused on improving outcomes
Robust economic regulation and quality inspection
Enhanced local voice
Clinically-led commissioning & payment for results
Empowered professionals working in autonomous providers
Informed patients exercising choice

Improving Healthcare outcomes

The government says that the primary purpose of the NHS is to improve the outcomes of healthcare for all, to deliver care that is safer, more effective, and that provides a better experience for patients. Building on Lord Darzi's work, the Government now intends to establish improvement in quality and healthcare outcomes as the primary purpose of all NHS-funded care. This primary purpose will be enshrined in statute - the NHS Constitution - and model contracts for services, ensuring that the focus is always on what matters most to patients and professionals.

The NHS Outcomes Framework

The current performance regime will be replaced with separate frameworks for outcomes that set direction for the NHS, for public health and social care, which provide for clear and unambiguous accountability, and enable better joint working.

The Secretary of State, through the Public Health Service, will set local authorities national objectives for improving population health outcomes. It will be for local authorities to determine how best to secure those objectives, including by commissioning services from providers of NHS care.

A new NHS Outcomes Framework will provide direction for the NHS. It will include a focused set of national outcome goals determined by the Secretary of State, against which the NHS Commissioning Board will be held to account, alongside overall improvements in the NHS.

In turn, the NHS Outcomes Framework will be translated into a commissioning outcomes framework for GP consortia, to create powerful incentives for effective commissioning.

The NHS Outcomes Framework will span the three domains of quality:

— the effectiveness of the treatment and care provided to patients – measured by both clinical outcomes and patient-reported outcomes
— the safety of the treatment and care provided to patients; and
— the broader experience patients have of the treatment and care they receive.

The Department of Health will launch a consultation on the development of the national outcome goals.

Autonomy, accountability and democratic legitimacy

The Government's reforms are designed to liberate professionals and providers from top-down control. The coalition has pledged to give responsibility for commissioning and budgets to groups of GP practices, and providers will be freed from government control to shape their services around the needs and choices of patients. Greater autonomy will be matched by increased accountability to patients.

GP Consortia

The government intends to devolve power and responsibility for commissioning services to GPs and their practice teams working in consortia. It is envisaged that GP commissioning will be put on a statutory basis. It is hoped that commissioning led by GP consortia will mean that the redesign of patient pathways and local services will always be clinically led and based on more effective dialogue and partnership with hospital specialists.

An autonomous NHS Commissioning Board

To support GP consortia in their commissioning decisions, the Department of Health has pledged to create a statutory NHS Commissioning Board which will provide leadership for quality improvement through commissioning and help standardise good practice.

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 also 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.

A new relationship between the NHS and the Government

It is intended that the forthcoming Health Bill will introduce provisions to limit the ability of the Secretary of State to micromanage and intervene in the NHS. The forthcoming Health Bill will formalise the relationship between the government and the NHS, to improve transparency and increase stability, while maintaining the necessary level of political accountability for such large amounts of taxpayers' money.

In future, the Secretary of State will be obliged to lay out a short formal mandate for the NHS Commissioning Board. This will be subject to public consultation and Parliamentary scrutiny, including by the Health Select Committee. The mandate is likely to be over a three year period, updated annually. The mandate will set out the totality of what the Government expects from the NHS Commissioning Board on behalf of the taxpayer for that period. This will comprise progress against outcomes specified by the Secretary of State, and objectives in relation to its core functions. Should the Government wish, by exception, to impose additional performance requirements on the Board in-year, it will on each occasion be obliged to lay a report in Parliament to explain why. The Secretary of State will also lose existing powers to intervene in relation to any specific commissioner other than in discharging defined statutory responsibilities. To ensure transparency, a public record will be made of all meetings between the Board and the Secretary of State.

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. The government expects that 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.

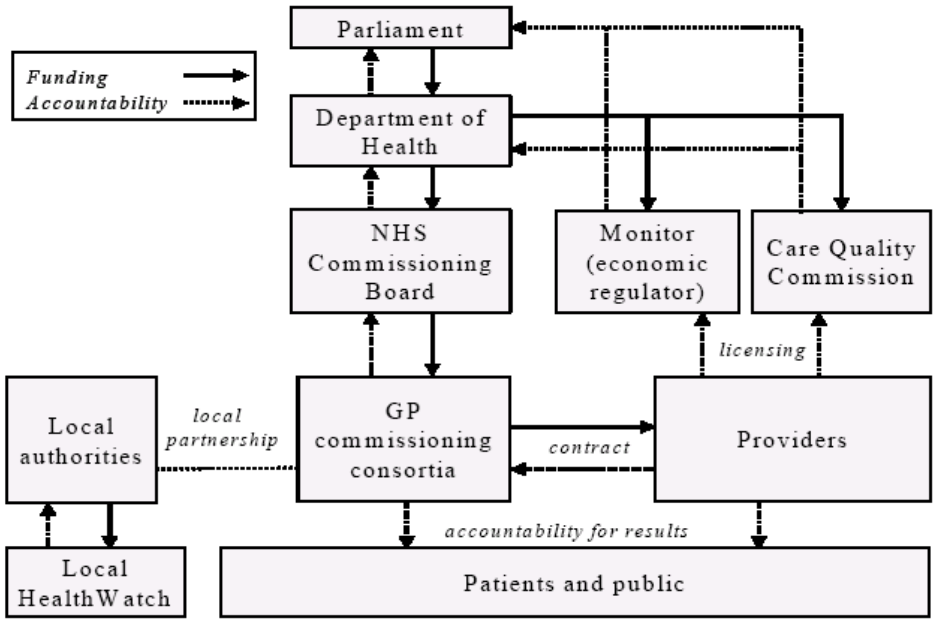
The Government will strengthen the local democratic legitimacy of the NHS. Building on the power of the local authority to promote local wellbeing, they will establish new statutory arrangements within local authorities – which will be established as "health and wellbeing boards" or within existing strategic 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.

Further to this, the use of powers that enable joint working between the NHS and local authorities will be extended and simplified. 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 will be 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.

Figure 2



Monitor will become an economic regulator, to promote effective and efficient providers of health and care, to promote competition, regulate prices and safeguard the continuity of services.

The role of the Care Quality Commission will be strengthened as an effective quality inspectorate across health and social care.

Cutting bureaucracy and improving efficiency

The government has guaranteed that health spending will increase in real terms in every year of the parliament. However, the NHS will still have to achieve unprecendented efficiency gains to meet the current financial challenge, all of which will be reinvested in frontline services. The NHS will release up to £20 billion of efficiency savings by 2014 and over the same period the government intends to reduce the NHS's management costs by more than 45 per cent.

The government will also radically delay and simplify the number of NHS bodies whilst reducing the Department of Health's own NHS functions. A number of Quangos will be abolished and other functions will be streamlined.

Timetable for action

Commitment	Date
Further publications on: • framework for transition • NHS outcomes framework • commissioning for patients • local democratic legitimacy in health • freeing providers and economic regulation	July 2010
Report of the arm's length bodies review published	Summer 2010
Health Bill introduced in Parliament	Autumn 2010
Further publications on: • vision for adult social care • information strategy • patient choice • a provider-led education and training • review of data returns	By end 2010
Separation of SHAs' commissioning and provider oversight functions	
Public Health White Paper	Late 2010

Commitment	Date
Introduction of choice for: • care for long-term conditions • diagnostic testing, and post-diagnosis	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	
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: • Adult mental health currencies developed • National currencies introduced for critical care • Further incentives to reduce avoidable readmissions • Best-practice tariffs introduced for interventional radiology, day-case surgery for breast surgery, hernia repairs, and some orthopaedic surgery	2011/12
NHS Outcomes Framework fully implemented	By April 2012

Commitment	Date
Majority of reforms come into effect: • NHS Commissioning Board fully established • New local authority health and wellbeing boards in place • Limits on the ability of the Secretary of State to micromanage and intervene • Public record of all meetings between the Board and the Secretary of State • Public Health Service in place, with ring-fenced budget and local health improvement led by Directors of Public Health in local authorities • NICE put on a firmer statutory footing • HealthWatch established • Monitor established as economic regulator	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 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

Fellows' Associates, July 2010