



# **CVS Rochdale** **Policy Briefing**

## **Equity and excellence: Liberating the NHS**

In July 2010 produced a white paper which is a blend of Conservative and Liberal Democrat ideas and sets out plans to "once again make the NHS the envy of the world".

### **Vision for the NHS**

The paper outlines a vision of a better 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 radically smaller national, regional and local bureaucracy; and
- Is put on a more stable and sustainable footing, free from frequent and arbitrary political meddling.

### **Putting Patients and the public first**

Patients will be involved fully in their own care, their ability to exercise extended choice and to manage their own care will be strengthened. The voice of patients experiences will also be increased within the NHS.

- Information Revolution

The government intends to bring about an information revolution and aims to give people access to comprehensive, trustworthy and easy to understand information on a range of sources on conditions, treatments, lifestyle choices and how to look after their own and their family's health. This will also include online communication with clinicians and a range of other online services.

Information generated by patients, such as Patient- Reported Outcome Measures (PROMS), patient experience data, and real time feedback will be used more widely across the NHS. Patients will be able to rate services and clinical departments

according to the quality of care they received. The public will be able to see where unacceptable services are being provided and to be able to exert local pressure for them to be improved.

More information about commissioning of healthcare will be published so that commissioners are held accountable for their use of public money.

- Increased Choice and Control

In implementing proposals for extending choice, the Department will tackle a range of issues including: professional and patient engagement; reform to payment systems so that money follows 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. Choice of treatment and provider is expected to become the reality for patients in the vast majority of NHS funded services by no later than 2013/14

- Patient and Public Voice

The strengthening of patient and public voice will be through the creation of "Health Watch" organisations. Local Involvement Networks will become Health Watch and will be funded by and accountable to local authorities. This will enhance the role of local authorities in promoting choice and complaints advocacy, through the Health Watch arrangements they commission.

The role of local Health Watch will be

- To ensure that the views and feedback from patients and carers are an integral part of local commissioning across health and social care
- 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 with General Practitioner to register with.
- Provide a source of intelligence for national Health Watch and be able to report concerns about the quality of providers, independently of the local authority. They will have the power to recommend that poor services are investigated.

Health Watch England, a new independent consumer champion within the Care Quality Commission will be created through the forthcoming Health Bill which will provide

- Leadership, advice and support to local Health Watch, and will be able to provide advocacy services on their behalf if the local authority wishes;
- 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;

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- Advice to the NHS Commissioning Board, Monitor and the Secretary of State; and based on information received from local Health Watch and other sources, Health Watch England will have the powers to propose Care Quality Commission investigations of poor services.

## **Improving Healthcare outcomes**

There has already been a revision of the NHS Operating Framework for 2010/11 setting out how existing targets should be treated this year – those with no clinical relevance have been removed. Current focus and resources will be directed towards better healthcare outcomes through the development of the NHS Outcomes Framework.

- The NHS Outcomes Framework

The framework will set direction for the NHS, for public health and social care, will 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 up to local authorities to determine how best to secure those objectives, including by commissioning services from providers of NHS care. It will also be translated into a commissioning outcomes framework for GP Consortia, to create powerful incentives for effective commissioning. It is expected that the first NHS Outcomes framework will be available to support NHS organisations in delivering improved outcomes from April 2011 with full implementation from April 2012.

- Developing and implementing quality standards

Progress on outcomes will be supported by quality standards which will be developed for the NHS Commissioning Board which will include a comprehensive library of standards for all the main pathways of care. Commissioners will draw on the library of standards as they commission care. GP consortia and providers will agree local priorities for implementation each year, taking account of the NHS Outcomes Framework.

- Research

The government is committed to the promotion and conduct of research as a core NHS role and will continue to promote the role of Biomedical Research Centres and Units, Academic Health Science Centres and Collaborations for Leadership in Applied Health Research Care, to develop research and unlock synergies between research, education and patient care.

- Incentives for quality improvement

The structure of payment systems will be the responsibility of the NHS Commissioning Board, and the economic regulator will be responsible for pricing. In the meantime 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. Providers will be paid

according to the cost of excellent care, rather than average price. If providers deliver excellent care in line with commissioners priorities, the commissioners will be able to pay a quality increment. The principle of rewarding quality will also apply to primary care and will incentivise ways of improving access to primary care in disadvantaged areas.

Following consultation and piloting a new dentistry contract will be introduced focusing on improving quality, achieving good dental health and increasing access to NHS dentistry, and an additional focus on the oral health of schoolchildren.

### **Autonomy, accountability and democratic legitimacy**

The reforms will give responsibility for commissioning and budgets to groups of GP practices. The Department will devolve power and responsibility for the commissioning of services to local consortia of GP practices.

- GP commissioning consortia

The consortia of GP practices, working with other health and care professionals, and in partnership with local communities and local authorities will be statutorily responsible for the commissioning of the great majority of NHS services, including elective hospital care and rehabilitative care, urgent and emergency care (including out of hours services), most community health services and mental health and learning disability services. They will not be directly responsible for commissioning services that GPs themselves provide, but will become increasingly influential in driving up the quality of general practice and will not commission the other family health services of dentistry, community pharmacy and primary ophthalmic services or maternity services. These will be the responsibility of the NHS Commissioning Board, as will national and regional specialised services.

The NHS Commissioning Board will calculate practice level budgets and allocate these directly to consortia. The 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 the outcomes they achieve as commissioners. In turn, each consortium will hold its constituent practices to account against these objectives.

Every GP practice will be a member of a consortium. Practices will have flexibility to form consortia in way that they think will secure the best healthcare and health outcomes for their patients and locality.

Each consortium will need to have a geographical focus to enable them to take responsibility for agreeing and monitoring contracts for locally based services, to have responsibilities for commissioning services for people who are 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 have the freedom to choose what commissioning activities they undertake for themselves such as demographic analysis, contract negotiation,

performance monitoring or aspects of financial management and may choose to buy in this support from external organisations including local authorities, private and voluntary sector organisations.

GP consortia will have a duty to promote equalities and to work in partnership with local authorities in relation to health and adult social care, early years services, public health, safeguarding and the wellbeing of local populations and 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. Health Watch will provide evidence about local communities and their needs and aspirations.

Primary Care Trusts over the next two years will support practices to prepare for the new arrangements with new GP consortia taking on their new responsibilities as rapidly as possible. The indicative timetable is:-

- for a comprehensive system of GP consortia in place during 2011/12, taking on increased delegated responsibilities from PCT's.
- Following passage of the Health Bill, consortia will take on responsibility for commissioning in 2012/13;
- the NHS Commissioning Board to make allocations for 2013/14 directly to GP consortia in late 2012;
- GP consortia take full financial responsibility from April 2013

To support GP Consortia in their commissioning decisions a statutory NHS Commissioning Board will be created

- **NHS Commissioning Board**

The Board will have five main functions

1. Providing national leadership on commissioning for quality improvements
2. Promoting and extending public and patient involvement and choice
3. Ensuring the development of GP commissioning consortia
4. Commissioning services that cannot solely be commissioned by consortia
5. Allocating and accounting for NHS resources

The Board will be established in shadow form as a special health authority from April 2011. In 2011/12 it will develop its future business model, organisational structure and staffing. It will be converted by the Health Bill into a statutory body, with its own powers and duties and will go live in April 2012.

From this year Strategic Health Authorities will separate their commissioning and provider oversight functions and will support the Board during its preparatory year. Strategic Health Authorities will be abolished as statutory bodies during 2012/13. From 2012 the Board will perform those national functions.

Following the establishment of the NHS Commissioning Board and a comprehensive network of GP Consortia, PCT's will no longer have NHS Commissioning functions. In order 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 PCT's.

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PCT's will cease to exist from 2013.

### **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 and will be responsible for the following:-

- 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 part so wishes; and
- Building partnership for service changes and priorities

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

### **Role of the Care Quality Commission**

This will be strengthened as a quality inspectorate. In relation to the NHS its responsibilities will include Licensing and Inspections.

### **Role of Monitor**

Monitor is the current independent regulator of foundation trusts. This will become an economic regulator from April 2012, with responsibility for all providers of NHS care from April 2013 and will have the following three key functions:-

- Promoting competition
- Price Regulation
- Supporting continuity of services

### **Cutting Bureaucracy and Improving Efficiency**

The government has guaranteed the health spending will increase in real terms every year and are committed to cutting waste by reducing management costs by more than 45%. This will be done through decentralisation, abolition of PCT's and Strategic Health Authorities which will save over a billion pounds which will be released into supporting frontline care. The Department of Health will also apply cuts to its budgets for centrally managed programmes such as consultancy services and advertising spend.

### **Conclusion**

Many of the changes in this white paper require primary legislation which will be introduced in Autumn 2010. The government are currently consulting on proposals in their consultation document "Liberating the NHS Commissioning for patients".