

The Health White Paper: Setting clinicians free?

Overview

The Government's White Paper "Equity and excellence: Liberating the NHS" has arrived as the NHS faces the biggest financial challenge in its history – the need for the NHS to release up to £20 billion of efficiency savings by 2014 and the Government's pledge to reduce NHS management costs by more than 45% over the next four years – and has a radicalism to match.

Headlines

The White Paper aims to empower GPs, set NHS foundation trusts (FTs) free to innovate and improve the quality and accessibility of information about patient outcomes in the NHS. The emphasis throughout the White Paper is on removing political micromanagement, bringing decision-making closer to the patient (under the motto "*no decision about me without me*") and opening up provision to any private or public sector provider licensed by Monitor. The White Paper does not, however, espouse earlier proposals to put decision-making simply in the hands of the patient: the only nod to previous proposals for personal health budgets is to further pilots in discrete areas such as NHS continuing care.

To deliver the necessary cost savings, however, the Department of Health will reduce its own functions and (from 2012) start to abolish the 10 strategic health authorities (SHAs) and 152 primary care trusts (PCTs) in England. These employ around 64,000 people between them. The role of Local Authorities in relation to public health issues will correspondingly be strengthened.

The necessary primary legislation will be introduced through the Health Bill in the autumn, in relation to which we will circulate future briefings. The Government will in the meantime consult on its proposals, and we will be playing our own part in the debate in this area.

Unfinished business

Although the Government has indicated that this White Paper "is the long-term plan for the NHS in this Parliamentary term and beyond", important elements of the new framework, particularly in relation to social care, public sector pensions and the ownership of property currently managed by PCTs (which may need to end up residing with FTs), will have to be put in place as further reviews are published. Vexed discussions around the future of social care and continuing access to defined benefit public sector pensions during the last Parliament are going to need to give way to practical solutions that will receive Treasury backing and achieve sufficient political support. John Hutton's Pension Commission is due to report back with initial views on NHS Pensions Scheme reform in September 2010, with its definitive findings being published in time for the Spring 2011 Budget. A white paper on public health is due to be published later in 2010.

This briefing assesses three key elements of the White Paper: the proposals for commissioning, the proposals for providers and the use of information in the new framework.

Commissioning

This is the area in which the White Paper is most radical.

GP consortia

Responsibility for commissioning budgets will be passed from PCTs to as many as 500 GP consortia responsible, in partnership with other health and care professionals and local authorities, for buying the bulk of hospital and community care for patients. They will not be directly responsible for commissioning services that GPs themselves provide or certain specialist services, but they will become increasingly influential in driving up the quality of general practice.

The new consortia are likely to need considerable support from outside bodies (public and private) and other advisers in commissioning healthcare effectively, buying in the resources they need and establishing appropriate governance arrangements based on viable social enterprise models.

NHS Commissioning Board

These consortia will be accountable to a new NHS Commissioning Board, which will in turn allocate resources, support the consortia in their commissioning decisions and be accountable to the Secretary of State. The Board will provide leadership for quality improvement through guidelines in relation to best practice. It will be responsible for commissioning dentistry, community pharmacy and primary ophthalmic services itself and for setting national contracts and payment structures. It will also have a remit to promote equality in line with the Equality Act 2010. It will not manage providers or be the "NHS headquarters".

PCTs

Following the establishment of this Board and a network of GP consortia, PCTs will no longer have NHS commissioning functions. They will nevertheless have an important task in the next two years in supporting GP practices and the emerging consortia to prepare for these new arrangements. The Government will transfer PCT health improvement functions to local authorities and abolish PCTs by 2013. The ongoing PCT provider arm divestment is to continue apace with transfers of community services from PCTs to NHS trusts or social enterprises to be effected by April 2011. We anticipate that the growth of integrated care structures in the NHS is likely to accelerate.

The function of joining up the commissioning of local NHS services will be devolved to "health and wellbeing boards" at Local Authority level, allowing Local Authorities to take a strategic approach and promote integration across health and adult social care, children's services and the wider local authority agenda. The Government will seek to facilitate new local partnership arrangements in this respect.

Providers

Patients will have a choice of any provider, consultant-led team, GP practice or treatment (with, for instance, providers being required to list named consultants on Choose and Book). Independent, as well as public sector, providers will, subject to being jointly licensed by the Care Quality Commission (CQC) and Monitor, be encouraged to become "willing providers" of NHS services with their success increasingly dependent on the exercise of individual patient choice.

Roll-out of FT status

Within three years all NHS trusts will need to become FTs. Those that fail to make the grade will either be absorbed by other organisations or put through the regime for failing trusts introduced by the last government (or any replacement regime). We anticipate an acceleration in the consolidation of NHS acute providers as a result, although steps may need to be taken first to revisit existing processes for mergers and acquisitions of trusts to ensure that these can be achieved in a sufficiently fast timescale.

Increasing FT freedoms

The Government aims to create the "largest and most vibrant social enterprise sector in the world," and to this end will free FTs from their current constraints. The Government envisages that some FTs will become employee-led social enterprises, whilst others will have a wider membership. The Government will consult on various options including:

- Abolishing the "arbitrary" private patient income cap to which FTs are currently subject
- Enabling FTs to merge more easily
- Enabling FTs to tailor their governance arrangements to their local needs, including by becoming employee-run social enterprises.

Consultation on the first of these options is, in particular, likely to spark a lively debate, with many FTs keen to develop their private patient units and explore new partnership arrangements with the independent sector in the face of union opposition, and with concerns from many private sector providers that FTs' private patient services are unfairly cross-subsidised by their NHS-funded services.

Regulation

Independent regulation of providers will be strengthened.

The CQC will have an expanded role as an effective quality inspectorate across health and social care, whether publicly or privately funded. A new independent consumer champion, HealthWatch England, will be created within the CQC. Local HealthWatch organisations will be accountable to Local Authorities.

Monitor will be developed into a more fully-fledged economic regulator for all FTs from 2012 and all providers of NHS-funded care, whether public or private sector, from 2013. In addition to licensing providers (on the basis of financial viability) and regulating prices, it will have new powers, concurrent

with those of the Office of Fair Trading, to apply competition law to both private and public providers of NHS-funded services. It will thus absorb and put on a new statutory footing the functions of the Cooperation and Competition Panel and help to create more of a level playing field between public and independent sector providers (while increasing the scope for organisations to challenge procurement decisions). Monitor will also have powers to step in to protect essential NHS services with a risk pool levy across providers being established to spread the cost of provider failure, and a remit to "promote effective and efficient providers of health and care".

Information

The Government is promising an "information revolution" in the NHS.

Apart from an increase in the range of on-line services, the collection, use and publication of patient reported outcome measures (PROMs) and other evidence-based outcome measures is to be significantly expanded. This is intended to improve the accountability of clinical providers, so that the public can see where unacceptable services are being provided and exert local pressure for them to be improved. Peer competition is also expected to drive improvement in providers. Subject to evaluation, the Government proposes at the same time to extend quality accounts to all providers of NHS care from 2011 and to strengthen the independent assurance of quality accounts.

Assessments of how commissioners are performing are also to be published. They can thus be held to account for their use of public money and patients can decide whether they are being well served by their practice.

All data returns will be centralised in the Health and Social Care Information Centre, which will be put on a new statutory footing in the Health Bill and will have lead responsibility for data collection and assuring the data quality of returns. In addition to NHS Choices, a range of third parties will be encouraged to become involved in the interpretation of those data.

Progress on outcomes will be supported by quality standards which will be developed for the NHS Commissioning Board by the National Institute of Health and Clinical Excellence (NICE). The Health Bill will put NICE on a firmer statutory footing, securing its independence (as a Non-Departmental Public Body) and core functions and extending its remit to include standards of both health and social care pathways.

We will follow up this briefing with a number of events and further briefings in the autumn. We will also be continuing to examine these proposals closely ahead of the consultation deadline of 5 October 2010, for instance considering the extent to which these proposals will ensure a genuinely level playing field in terms of competition and procurement; enable GP commissioners to deliver innovative, more patient-centred and more cost-effective solutions; and affect NHS staff and the NHS estate. Should you wish to discuss any of the matters covered in this briefing or in the White Paper in the meantime, please do not hesitate to get in touch with your usual Beachcroft contact or email Nigel Montgomery, our Health Sector Head, at nmontgomery@beachcroft.com