Overview

The Health White Paper, 'Equity and Excellence: liberating the NHS' represents possibly the most radical restructuring of the NHS since its inception. It would transform how health care is commissioned, with around £80 billion pounds being transferred to new GP consortia.

The policy agenda is far reaching and the timetable for implementation extremely ambitious - given the scale of change and the context of increasing financial pressures facing the service.

Key proposals are:

- extending patient choice over providers and treatment
- establishing an independent NHS Commissioning Board
- ensuring all health trusts are foundation trusts by 2013 and giving them greater freedoms
- the transfer of commissioning to GPs and the abolition of PCTs and SHAs
- transferring the public health budget to local authorities
- giving councils the responsibility to promote integration and partnership working.

Such huge change is clearly a risk - which the government accepts, but says radical reform is essential and urgent. The disruption caused in the transition period will have a knock on effect on local authorities, especially on adult social care.

This briefing summarises the main proposals in the white paper. It comments particularly on the implications for local government, such as how the change to GP commissioning could impact on joint working between local authorities and health. The briefing also looks at how the new arrangements for public health could work - although local government will have to wait for the next white paper on public health before it is entirely clear.

The white paper could massively strengthen the role of local authorities in public health and in influencing health care commissioning. Much will depend on the details to come and on whether local government will be given the appropriate powers and resources to deliver its new roles effectively.

Briefing in full

Introduction

This briefing covers the white paper as a whole, but has a more detailed focus on the implications for local government. The reforms set out in 'Equity and excellence: liberating the NHS' are possibly the most radical since the inception of the NHS. Of course, many of the proposals are not actually new – they build on previous initiatives, such as GP fundholding, but taken as a whole, they represent huge structural change that also rapidly accelerates the directional change towards a mixed economy in the NHS we have seen over the last two decades.
There will be a further white paper published later this year setting out the programme for public health. The Health Bill, which will be introduced in parliament in the autumn, will support the creation of a new Public Health Service, to integrate and streamline existing health improvement and protection bodies and functions. Even before these are published, this white paper does propose changes to the role of local government that follow from the radical restructuring it sets out.

Consultation and timetable

The white paper applies only to the NHS in England.

There will be broad consultation on the implementation of the reforms set out in the white paper – with local government, patients and the public, as well as external organisations. The government will also formally consult wherever it is appropriate to do so, for example on strengthening the NHS Constitution, and on draft regulations.

More detailed documents will be published shortly asking for views on commissioning for patients (the implementation of the NHS Commissioning Board and GP consortia) and the changes at the local level set out in the section on local democratic legitimacy. The latter will be of particular importance to local government.

Many of the changes in the White Paper require primary legislation. The Queen’s Speech included a major Health Bill in the legislative programme for this first parliamentary session. The government will introduce this in the autumn.

Comments on the White Paper should be sent by 5 October 2010, to: NHSWhitePaper@dh.gsi.gov.uk

Main proposals

Choice, control and patient involvement

The government stated intention is to extend patient choice. The government plans to give patients choice of treatment and provider in the ‘vast majority of NHS-funded services’ by 2013/14. They will:

- increase the current offer of choice of any provider significantly
- create a presumption that all patients will have choice and control over their care and treatment, and choice of any willing provider wherever relevant
- begin to introduce choice of treatment and provider in some mental health services from April 2011
- introduce choice in care for long-term conditions as part of personalised care planning
- give every patient a clear right to choose to register with any GP practice they want with an open list, without being restricted by where they live

Patients will be given access to detailed information about hospitals and GP services to enable them to exert more choice and control over who provides their treatment and, sometimes, what the treatment should be. Some of this information already exists, but other data, such as comparative data on doctor’s performance, are not readily available currently.

The Health Bill will create HealthWatch England, a new independent consumer champion within the Care Quality Commission. Local Involvement Networks (LINks) will become the local HealthWatch, These will be funded by and accountable to local authorities. Local authorities will be able to commission Local Health Watch or Health Watch England to
provide advocacy and support, helping people access and make service choices, and supporting people who want to make a complaint.

**Healthcare outcomes and performance framework**

Many top-down targets will be abolished – “Instead of national process targets, the NHS will, wherever possible, use clinically credible and evidence-based measures that clinicians themselves use”.

The current performance regime will be replaced with separate frameworks for outcomes that set direction for the NHS, for public health and social care,

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

Progress on outcomes will be supported by quality standards. These will be developed for the NHS Commissioning Board by NICE, setting out each part of the patient pathway, and indicators for each step.

The National Institute for Health and Clinical Excellence will be made into a non-departmental public body, to define its role and functions, reform its processes, secure its independence, and, interestingly, to extend its remit to social care. The paper does not talk about the implications of this for the Social Care Institute for Excellence (Scie).

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”.

**NHS Commissioning Board**

An autonomous statutory NHS Commissioning Board will be established. The board will take over the current Care Quality Commission’s responsibility of assessing NHS commissioners and will hold GP consortia to account for their performance and quality. Its five main functions will be:

- providing national leadership on commissioning for quality improvement
- promoting and extending public and patient involvement and choice
- ensuring the development of GP commissioning consortia
- commissioning services that cannot be solely commissioned by consortia, including dentistry, community pharmacy and primary ophthalmic services
- allocating and accounting for NHS resources.

The board will be set up in shadow form as a special health authority from April 2011. It will be converted by the Health Bill into a statutory body, and go live in April 2012.

**GP Commissioning**

The most far-reaching reform in the White Paper is the transfer of commissioning from PCTs to local consortia of GPs. This builds on practice-based commissioning but under these proposals, this will not be voluntary and GP commissioning will be on a statutory basis, with powers and duties set out in primary and secondary legislation.

Consortia of GP practices, working with other health and care professionals, and in partnership with local communities and local authorities, will commission the great majority of NHS services for their patients. They will not commission the other family health services of dentistry, community pharmacy and primary ophthalmic services. These will be the responsibility of the NHS Commissioning Board,
The size of consortia is not specified but the paper says that they will need to have a sufficient geographic focus to be able to take responsibility for agreeing and monitoring contracts for locality-based services (such as urgent care services), to have responsibility for commissioning services for people who are not registered with a GP practice, and to commission services jointly with local authorities.

Each consortia will have be able to decide what commissioning activities they undertake for themselves and for what activities, such as demographic analysis, contract negotiation, performance monitoring and aspects of financial management, they may choose to buy in. They could therefore choose to buy in these types of services from local authorities, as well as from other public, private and voluntary sector bodies.

GP consortia will have a duty to promote equalities and to work in partnership with local authorities, for instance in relation to health and adult social care, early years services, public health, safeguarding, and the wellbeing of local populations.

It is intended that a comprehensive system of GP consortia will be in place in shadow form during 2011-12, taking on increased delegated responsibility from PCTs. Following the passage of the Health Bill, consortia will take on responsibility for commissioning in 2012-13.

**Providers**

The government will reform the way foundation trusts function and bring forward the timetable for all NHS trusts to become foundation trusts. Every NHS trust will have to become a foundation trust and the government want all trusts to have converted within three years. From April 2013, Monitor will take on the responsibility of regulating all providers of NHS care, irrespective of their status. The CQC will continue to act as quality inspectorate across health and social care for both publicly and privately funded care.

- The barriers to entry by new suppliers for community health services currently provided by PCTs will be removed
- Trusts will, in future, be regulated in the same way as other providers, whether from the private or voluntary sector. Patients will be able to choose care from any provider.
- Employees will be able to transform the trust to an employee-led social enterprise.
- The arbitrary cap on the amount of income foundation trusts can earn from other sources to reinvest in their services will be abolished

**Administration and savings**

The government is committed to reducing the NHS’s management costs by more than 45 per cent over the next four years, which it says can only be achieved “by radically simplifying the architecture of the health and care system”.

The new arrangements will mean that Strategic Health Authorities (SHAs) will be abolished and PCTs – with administrative costs of over a billion pounds a year – will be replaced by GP consortia. The Department of Health will also radically reduce its own NHS functions. A review of DH arm’s-length bodies will shortly be published.

The paper acknowledges that these changes will be profound:

‘Taken together, they amount to a major delayering, which will cause significant disruption and loss of jobs, and incur transitional costs between now and 2013, even as we are cutting the management cost of the NHS’.

It goes on to say, however, that the existing bureaucracy can no longer be afforded and these reforms are essential.
Role of local authorities: public health and service integration

The paper sets out how the government intends to reform the arrangements for public health. A Public Health Service will be created to cover public health evidence and analysis. Local health improvement functions will be transferred to local authorities. Councils will become responsible for a newly ring-fenced public health budget, currently around £4bn a year.

The changes will have major implications for local authorities. Following the establishment of the NHS Commissioning Board and a comprehensive network of GP consortia, PCTs will no longer have NHS commissioning functions. The government will transfer PCT health improvement functions to local authorities and abolish PCTs. Related measures are:

- 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
- Building on the power of the local authority to promote local wellbeing, new statutory arrangements will be set up 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 boards will 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.
- The use of powers that enable joint working between the NHS and local authorities will be simplified and extended. 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, our aim is 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".

Each local authority will take on the function of joining up the commissioning of local NHS services, social care and health improvement. Local authorities will therefore be responsible 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 arrangements where each party wants to do so.
- building partnership for service changes and priorities. There will be an escalation process to the NHS Commissioning Board and the Secretary of State, which retain accountability for NHS commissioning decisions.
These functions would replace the current statutory functions of Health Overview and Scrutiny Committees.

As well as elected members of the local authority, all relevant NHS commissioners will be involved in carrying out these functions, as will the Directors of Public Health, adult social services, and children's services. They will all be under duties of partnership. Local HealthWatch representatives will also play a formal role to ensure that feedback from patients and service users is reflected in commissioning plans.

**Comment**

The reforms in the white paper are far reaching and very ambitious: they are particularly ambitious in relation to the timetable for implementation of the transfer of commissioning to GPs.

Local government will welcome the commitment in the white paper to linking adult social care, public health and health services at the community level, with a strengthened role for local authorities. The future white paper on public health will clarify whether the vision in the white paper will be translated into reality.

There are obvious risks in undertaking such a profound reorganisation at a time of unprecedented financial pressure, with about £80 billion being handed over to untested GP consortia. The government is clear that the reforms themselves will save billions in management costs, but there is no hard evidence about the scale of savings, given the restructuring will itself be costly in the short and medium term.

The transition period is especially problematic: there will be huge job losses and redeployments, and performance and robust financial management will need to be assured whilst the service is severely disrupted. There are bound to be knock on effects on social care.

The most visible change is the transfer of commissioning to GP consortia. GPs are trusted by their patients and close to communities. However, not all GPs will be enthusiastic about taking on their new role. Most will not yet have the capacity and skills to do so effectively. Private sector companies that already work in the health sector have welcomed the opportunities the white paper suggests to support consortia. The BMA has expressed concern at the increased role for the private sector and believe that many GPs will not want to see vastly increased private sector involvement. Local authorities should, perhaps start now to consider how they could themselves provide support services.

What could be the main implications for local authorities of the commissioning changes? Councils have been building up strong relationships with PCTs and there is increasingly positive joint working around, for example, needs assessments and health improvement. Councils will have to start to build relationships with GPs where they do not exist or are weak.

The involvement of GPs in joint strategic needs assessments will be crucial. The new consortia will need to understand the relationship between health and social care and that there are good systems for cross-referral and close working between the two. They will be given powers to make arrangements now covered by S75 of the National Health Act 2006 to work jointly with councils, for example on learning disability and mental health services, but how far will some GPs want to go in, for example, pooling budgets?

There may be practical difficulties, such as boundaries not being co-terminous. A practical but also key policy issue is that richer populations have more GPs per head than poor ones - which was commented on by the recent NAO report on health inequalities. Will the
new NHS board be able to influence the distribution of GPs or councils have any powers in relation to this?

Local authorities will undoubtedly welcome the transfer of responsibilities for health improvement and the new role in coordinating commissioning. Again, we need to see the public health white paper for the details. It is impossible to judge how well, for example, the new health and well-being boards will work - the existing ones under LSPs have not been universally effective. Bringing in safeguarding may strengthen these new boards.

Clearly, taking on more responsibilities for coordination and promotion requires councils to have the appropriate powers, resources and authority. GPs, particularly, will not be used to working in collaboration. The government will need to give councils the means to take on this role effectively. The transfer of the public health budget will be welcomed, but, again, there are concerns - will there be adequate funding for any additional managerial costs?

The future of health scrutiny is somewhat ambiguous - with the functions outlined replacing the current statutory functions of health overview and scrutiny committees. Will health scrutiny committees be abolished or will they be taking on a wider and different role? Taking on an executive role seems inappropriate and would undermine their accountability role.

The white paper clearly does not answer all the questions about the future relationship of local government to health. On balance, the white paper seems to be a positive step forward: it recognises the central role of local government in promoting health and well-being and gives councils additional responsibilities and powers. The proposed public health service and the transfer of the budget could be a massive opportunity for local government to take the lead in promoting health and tackling health inequalities. However, there may be risks in separating public health from the rest of the health service, leading to greater fragmentation, rather than coherence and integration.

(Thanks also for contributions from Fiona Campbell)