Briefing - Equity and Excellence White Paper: Implications for Rotherham

The Government's Health White Paper precedes legislation to be placed before Parliament in the current parliamentary session. It proposes major reforms to the NHS and also changes roles for local government.

The Headlines

- NHS Principles remain: available to all, free at point of use, based on clinical need etc
- Health spending in real terms will increase – still 'ring fencing' NHS spend
- Comparisons with clinical outcomes in UK v Europe (esp. on cancer and stroke – we may have 'best' system but not 'best' outcomes)

Main proposals

- **Choice, control and patient involvement**
  - the government plans to give patients choice of treatment and provider in the vast majority of NHS-funded services by 2013/14
  - every patient will have a right to choose to register with any GP practice they want
  - 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
  - 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

- **Healthcare outcomes and performance framework**
  - Many top-down targets will be abolished Not about process targets – about clinical measures **(if there is no clinical justification, we will remove the target ie 18 wk wait**)
  - The current performance regime will be replaced with separate frameworks for outcomes that set direction for the NHS, for public health and social care, payment by performance – outcomes not activity providing incentives for better quality
  - 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
  - The Secretary of State, proposes to create a new Public Health Service, proposals are to be set out in the Health Bill and 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

- **NHS Commissioning Board**
  - An autonomous statutory NHS Commissioning Board will be established. The board will take over the current Care Quality Commission's (CQC) responsibility of assessing NHS commissioners and will hold GP consortia to account for their performance and quality.

- **GP Commissioning**
  - Commissioning will be transferred from PCTs to local consortia of GPs – in shadow form from 2011/12. (probably 1 or 2 consortia likely in Rotherham though no absolute clarity yet on this). Following the passage of the Health Bill, consortia will take on responsibility for commissioning in 2012-13.

- **Administration and savings**
  - The government is committed to reducing NHS management costs by more than 45 percent over the next four years.
  - The NHS is to release £20 billion of efficiency savings by 2014 to be reinvested to support improvements
  - Strategic Health Authorities (SHAs) will be abolished
  - PCTs will be replaced by GP consortia

- The Department of Health (DH) will also radically reduce its own NHS functions and become more strategic – focus will be on improving public health and reforming adult social care
- A review of DH arm's-length bodies will shortly be published

The Heath Bill will be presented to Parliament in autumn and will support the creation of a new national Public Health Service, to integrate and streamline existing health improvement and protection bodies and functions.

Overview of New Roles and Resources for Local Councils

- Greater accountability, local autonomy and democratic legitimacy through the development of GP consortia, working in partnership with local authorities
- PCT public health improvement functions will be transferred to local councils after the abolition of PCTs in 2013.
- Local Directors of Public Health will be jointly appointed by local authorities and the national Public Health Service. Further clarity is required around the arrangements for the employment of public health teams and the accountability of the Local Director of Public Health
- A ring-fenced public health budget will be allocated to local authorities (currently around £4bn) to support their public health and health improvement functions, the allocation formula for those funds will include a new "health premium" designed to promote action to improve population-wide health and reduce health inequalities.
- Councils will be required to establish "health and wellbeing boards" or within existing strategic partnerships, to join up the commissioning of local NHS services, social care and health improvement. This will allow local authorities to take a strategic approach on promoting integration across health and adult social care, children's services (including safeguarding) and the wider local authority agenda.
- An extension and simplification of powers to enable joint working between the NHS and local authorities.
- Specific responsibilities for Local Authorities will be:
    - Promoting integration and partnership working between NHS, social care public health and other local services and strategies
    - Leading Joint Strategic Needs assessments and promoting collaboration on local commissioning plans
    - Building partnerships for service changes and priorities
- Health Overview and Scrutiny Committees (HOSCs) will be replaced by the above functions.
- Elected Members, relevant NHS commissioners, Directors of Public Health adult social services and children's services will all be under a duty of partnership and involved in carrying out the responsibilities above.
- Creation of a national HealthWatch for England to be the national voice for patients and the public. Local Involvement Networks (LINks) will become local Health Watch branches. Local Health Watch will have a role in ensuring patient feedback is reflected in commissioning plans

Implications for Rotherham

- PCTs to be abolished from 2013, when RMBC will need to take responsibility for health improvement and;
- Appoint the DPH jointly with the Public Health Service – The Director of Public Health in Rotherham is a joint appointment with NHSR and sits on the Council's SLT, but is employed by NHSR currently
- It is not yet known what the arrangements will be for Public Health teams within the authority, this will become clearer when the Health Bill and public health white paper are published.
- RMBC will receive a ring-fenced PH budget to undertake their new roles and responsibilities, however there is a suggestion that mainstream services such as housing, early years, transport, leisure and social care make a far more significant contribution to public health and health improvement than the resource in the ring-fence - LGA will be putting forward that the ring-fenced is removed, further details on this will be available on the publication of the Public Health White Paper.

- Creation of a 'Health and Wellbeing Board' within the existing Partnership structures of the authority – this will need to be considered in relation to current partnership arrangements and how it will impact on current themes and Community Strategy
- Health Overview and Scrutiny Committees' functions will be superseded by the new proposals, further details on how this will effect local authorities is yet to be published
- LINks will become the new local HealthWatch, the paper suggests arrangements for these will be similar to how LINks works currently, with RMBC funding and holding them to account.
- With commissioning transferring to the new GP consortia from PCTs, greater partnership working will be required with GPs, current arrangements and relationships will therefore need to be looked at.
- Work is currently on-going to establish what joint working arrangements are currently in place between RMBC and NHSR. Some joint working exists currently but this is not as advanced locally as in some other areas and it is clear there is significant scope for more joint commissioning and greater integration.

Overview of roles and responsibilities

Government
- Health Bill intends to limit role of Sec of State but will still include:
    - Setting a formal mandate for NHS Commissioning Board
    - Holding the NHS Commissioning Board to account
    - Arbitration
    - Legislative and policy framework
    - Accounting annually to Parliament

NHS Commissioning Board…
- Help standardise best practice and promote equality – it will not manage providers or be the NHS headquarters
- It will champion patient and public involvement not providers
- It will have 5 main functions…
    - Provide national leadership on commissioning for quality improvement (working with NICE, Monitor)
    - Promote and extend public and patient involvement and choice
    - Ensure the development of GP commissioning consortia
    - Commissioning certain services (GPs, dentistry, community pharmacy, primary ophthalmic services)
    - Allocating and accounting for NHS resources
- The Board would not have the scope to restrict the scope of the services offered by the NHS
- Board will operate in a shadow form as a special health authority from April 2011. Converted by forthcoming Health Bill into a statutory body to go live in April 2012
- From this year, SHAs will separate their commissioning and provider oversight functions and support the Board in its preparatory year
- The Board itself will decide what presence, if any, it needs in different parts of the country
- SHAs will be abolished during 2012/2013

PCTs
- Cease to exist from 2013

GP Commissioning
- This is not a return to GP fundholding (which led to 2 tier NHS) nor a rejection of Practice Based Commissioning (which never saw real transfer of responsibility)
- Consortia of GP practices working with other professionals in partnership with local communities and local authorities will commission majority of services for their patients
- They will not commission GP services, other family health services (ie dentistry, community pharmacy, primary ophthalmic services –the NHS Commissioning Board will do this) though they will be 'involved'

- NHS Commissioning Board will calculate practice-level budgets and allocate them to consortia and may adopt a lead commissioner model
- They will have an accountable officer – and every GP practice will have to be a member of a consortium (if they hold a patient list they have to be part of a consortia)
- Consortia will need to be big enough to manage financial risk, allow for accurate allocations and have sufficient geographic focus
- They can choose what they do themselves and what they 'buy in' from VCS, local authorities and private companies
- Capitalise on PCT commissioning experience during transitional period but timetable is…
    - GP consortia in shadow form 2011/2012
    - After Health Bill, consortia take on commissioning 2012/2013
    - NHS Commissioning Board allocate resources for 2013/2014 to consortia in late 2012
    - GP Consortia to take full financial responsibility from April 2013

Providers

- To create the largest and most vibrant social enterprise sector in the world – to free FTs from the constraints they are under
- Regulated as all other providers – be they voluntary or private
- As all NHS Trusts become FTs staff will have the opportunity to transform their organisations into employee-led social enterprises
- Foundation Trusts will not be privatised
- They will consult on options for increasing FT freedoms including abolishing the cap on income you can earn from other sources, enabling FTs to merge more easily and whether they should be able to tailor governance arrangements to meet their own local needs
- All Trusts to be FTs within 3 years
- Continue with plan to transfer community services by April 2011 and move as soon as possible to an "any willing provider" model. In future all community services will be provided by an FT or other types of provider
- Providers will have a joint licence overseen by Monitor and CQC to maintain essential levels of safety and quality and ensure continuity of essential services

CQC

- Role will include Licensing and Inspections

Monitor

- Monitor's role will be as an Economic regulator, to promote effective and efficient provision, to promote competition, regulate prices and safeguard continuity of services. The CQC will continue to act as quality inspectorate across health and social care for both publicly and privately funded care**.**
- This will include powers to protect assets or facilities required for continuity of services, authorising special funding arrangements for essential services, powers to levy providers for contributions to a risk pool and intervening directly in the event of failure

Further detail and White Papers are expected as follows:

- The Public Health White Paper will be published late 2010 – which will support creation of a new public health service and make clearer the implications for local authorities in relation to their new roles and responsibilities
- Adult Social Care White Paper is due to be published in 2011
- There will be a further consultation on extending choice later in 2010. The White Paper reiterates the Government's commitment to extending choice through a roll-out of personal budgets for health. The NHS Commissioning Board will have a key role in extending choice and control, and Monitor will ensure that patients have a choice

Timeline:

Health Bill introduced to Parliament	autumn 2010
Separation of SHAs' commissioning and provider oversight	by end 2010
Public Health White Paper	late 2010
White Paper on social care reform	During 2011
NHS Commissioning Board fully established	April 2012
New Local Authority Health and Wellbeing Boards in place	April 2012
Public Health Service in place, with ring-fenced budget and local health improvement led by DPH in local authorities	April 2012
Health Watch established	April 2012
Formal establishment of all GP consortia	During 2012
SHAs are abolished	2012-13
PCTs are abolished	From April 2013