EQUITY AND EXCELLENCE: LIBERATING THE NHS (ENGLAND)
BMA SUMMARY

Background

The new Secretary of State for Health Andrew Lansley released a White Paper on health reform entitled Equity and Excellence: Liberating the NHS on 12 July 2010.

The White Paper sets out the Government's ambitious agenda for the NHS for the next five years and seeks views on the policies included within it. It forms part of a suite of supporting documents including the Analytical strategy for the White Paper, the Initial Equality Impact Assessment and the Draft Structural Reform Plan. The consultation period for the White Paper and associated documents is three months and comments are to be received by the Department of Health (DH) by **5 October 2010.** Further consultative documents on particular policies proposed within the White Paper are forthcoming. The Health Bill to implement various proposals will be introduced in this Parliamentary session.

The Government believes that the NHS today faces great challenges including an ageing population, medical and technological advances and rising patient expectations. It also believes that the NHS is stifled by a culture of top down bureaucracy which prevents innovation and that the NHS does not deliver outcomes in line with the best health services internationally. The Government has argued that due to the financial constraints and budgetary pressures health reform needs to be accelerated.

CHAPTER 1 – 'LIBERATING THE NHS'

This chapter provides information on the Government's values and its vision for the NHS in the future. The goal is an NHS that achieves results that are amongst the best in the world and that is admired for its consistency of excellence as well as its equity of access.

The Government's values include:

- A commitment to an NHS that is available to all, free at the point of use and based on need, not the ability to pay;
- A commitment to increase health spending in real terms in each year of this Parliament (exact figures will not be known until after the Comprehensive Spending Review reports in October 2010);
- A commitment to promoting equality, with implementation of the ban on age discrimination in NHS services and social care from 2010;
- A commitment to the NHS Constitution, with publication of the first statement of how well organisations are living by its letter and spirit by 2010;
- A commitment to greater NHS independence, with the introduction of legislation to establish more autonomous organisations, with greater freedoms, clear duties and transparency in their responsibilities.

The Government's vision is for an NHS that:

- Is genuinely centred on patients;
- 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;
- Is more efficient and dynamic with a radically smaller national, regional and local bureaucracy; and
- Is on a more stable and sustainable footing free from frequent and arbitrary political meddling.

Public health and social care

- In this new NHS, the DH will focus on improving public health, reducing health inequalities and reforming adult social care;
- **The programme for public health will be set out in a White Paper later in 2010, while the forthcoming Health Bill will support the creation of a new Public Health Service**. This will:
  - Integrate existing health improvement and protection bodies and functions, including an increased emphasis on research, analysis and evaluation;
  - Hold responsibility for vaccination and screening programmes; and
  - Manage public health emergencies.
- **Responsibility for local health improvement will transfer from Primary Care Trusts (PCTs) to local authorities, which will employ a Director of Public Health jointly appointed with the Public Health Service**;
- Directors of Public Health will be responsible for health improvements funds and the **DH will create a ring-fenced public health budget**; and
- The Government's vision for adult social care will be published in a White Paper in 2011. This will be informed by a commission on the funding of long-term care and support, whilst **the law underpinning adult social care will be reformed and consolidated, in partnership with the Law Commission**.

CHAPTER 2 – PUTTING PATIENTS AND THE PUBLIC FIRST

This chapter describes how the Government plans to make the principle of shared decision-making the norm, labelled as 'no decision about me without me' (para 2.3). The NHS Commissioning Board will champion patient and carer involvement while the DH intends to work with patients, carers and professional groups to implement proposals about transforming care through shared decision-making.

Increasing the amount of good quality information available for patients and the public is identified as one of the key ways to achieve better care, better outcomes and reduced costs. The DH is continuing to use Lord Darzi's three dimensions of quality care and there will be increasing amounts of comparable information on these:

- Safety – for example levels of adverse events and avoidable deaths broken down by providers and clinical teams;
- Effectiveness – for example emergency re-admission rates and mortality rates; and
- Experience – for example opening hours and clinic times and cancelled operations.

The measures that make up this 'information revolution' are:

- A wide range of online services, which will mean more efficient services being provided more at a time and place that is convenient for patients and carers;
- **The validity, collection and use of tools such as Patient Reported Outcome Measures (PROMs), patient experience data and real-time feedback will be expanded. National clinical audit will be extended. PROMS will be used across the NHS wherever practicable**;
- **Patients will be able to rate services and clinical departments according to the quality of care they receive**. Hospitals will be required to tell patients if something has gone wrong;
- **Staff feedback about the quality of patient care provided must be publicly available**;

- **Subject to evaluation, quality accounts will be extended to all providers of NHS care from 2011**, in order to reinforce local accountability, encourage peer competition and provide a spur for boards of providers to focus on improving outcomes. Nationally comparable information will be published in a way that patients, families and clinical teams can use;
- Information about services will be published on a commissioner basis to improve public accountability. **Assessments of how well commissioners are performing will be published;**
- **Patients will have control of their health records, starting with access to the record held by their GP, extending to health records held by all providers.** The DH will consult on arrangements including confidentially safeguards later in 2010;
- It will be simpler for patients to download their record and pass it on, in a standard format, to any organisation of their choice, e.g. support groups;
- **Aggregated, anonymised data will be made available to the university and research sectors and intermediaries, with safeguards to protect personally identifiable information**;
- **A voluntary accreditation system, to allow information intermediaries to apply for a kitemark to demonstrate to the public that they meet quality standards, will be considered**;
- **A range of third parties will be encouraged to provide information to support patient choice, in addition to NHS Choices**;
- **The DH will seek to centralise all data returns to the Health and Social Care Information Centre**, which will have lead responsibility for data collection and quality assurance; and
- **Providers will be under clear contractual obligations in relation to accuracy and timeliness of data**. They will have to use agreed technical and data standards to promote compatibility. These will be determined by the NHS Commissioning Board but will include record keeping and data security. **The DH will consult on arrangements for the legal ownership and responsibilities of people who manage health data**, which may require primary legislation, later in 2010.

Increased choice and control
In the future, the Government wants patients and the public to have more influence and choice in the NHS, which will lead to a more responsive system.

- **Ways to increase the number of patients being offered choice of provider by their GP will be explored with GPs and patient groups**;
- **All patients will have a choice of any willing provider wherever relevant**;
- **Choice of named consultant-led team for elective care where clinically appropriate will be introduced by April 2011.** The appropriate standard acute contract will be amended to ensure providers list named consultants on Choose and Book;
- Maternity choice will be extended by developing new provider networks;
- **Choice of treatment and provider in some mental health services will be introduced from April 2011**;
- **Choice for diagnostic testing and choice post-diagnosis will be introduced from 2011**;
- **Choice in care for long-term conditions will be introduced** and the DH will work with providers such as hospices to introduce a **national choice offer to support people's preferences in end-of-life care**;
- Patients will receive more information about research studies that are relevant to them and more scope to join if they wish;
- **Every patient will have the right to choose to register with any GP practice with an open list**;
- **A coherent 24-hour urgent care service in every area will be developed, incorporating GP out-of-hours services and a single telephone number for all kinds of urgent and social care**;
- **Choice of treatment, including the potential introduction of new contractual requirements on providers, will be consulted on later in 2010**;
- **Further personal health budget pilots will be encouraged and the potential for introducing a right to a personal health budget in discrete areas such as NHS continuing care will be**

explored. The results of the evaluation of the scheme due in 2012 will be used to inform a wider roll-out; and
- The NHS Commissioning Board will be responsible for developing and agreeing guarantees for patients about choice, with the Secretary of State. One of its first tasks will be to develop an implementation plan on choice, working with patient and professional groups.

Patient and public voice
- HealthWatch England will be created in the forthcoming Health Bill, as a new independent consumer champion within the Care Quality Commission (CQC). Local Involvement Networks will become the local HealthWatch;
- Arrangements for information sharing, building on existing complaints handling structures, will be strengthened and the **local HealthWatch will be able to recommend that poor services are investigated**;
- Local authorities will be able to commission local HealthWatch or HealthWatch England to provide advocacy and support, in particular for people who lack the means or capacity to make choices;
- **Local HealthWatch will be funded by and accountable to local authorities** but will be able to report concerns about the quality of providers independently of the local authority;
- HealthWatch England will provide advice to the Health and Social Care Information Centre on the information that would be of most use to patient to facilitate choices about care; and
- **HealthWatch England will have powers to propose CQC investigations of poor services**.

CHAPTER 3 – IMPROVING HEALTHCARE OUTCOMES

This chapter provides details on how **quality outcomes** will be improved, to deliver care that is safer, more effective, and that provides a better experience for patients. The Government will build on Lord Darzi's previous work *The Next Stage Review*.

- The Government will discard importance attached to certain top-down targets;
- Replacing the relationship between politicians and professionals with relationships between professionals and patients; and
- Instead of national process targets, the NHS will, wherever possible, use clinically credible and evidence-based measures that clinicians themselves use.

The NHS Outcomes Framework
- **The current performance regime will be replaced with separate frameworks for outcomes**;
- A new NHS Outcomes Framework spanning Lord Darzi's three dimensions of quality (as mentioned in Chapter 2) 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;
- The NHS Outcomes Framework will be translated into a commissioning outcomes framework for GP consortia to create incentives;
- The Government will **launch a consultation on the development of the national outcome goals**;
- **The first NHS Outcomes Framework is meant to be available to support NHS organisations in delivering improved outcomes from April 2011**, with full implementation by April 2012; and
- The NHS Commissioning Board will work with clinicians, patients and public to develop the NHS Outcomes Framework, reflecting NICE quality standards. It will enable **international comparisons wherever possible.**

Developing and implementing quality standards

- Progress on outcomes will be supported by quality standards, developed for the NHS Commissioning Board by NICE. A library of standards for the main pathways of care will be developed by NICE. The first three on stroke, dementia and prevention of venous thromboembolism were published in June 2010;
- **Within the next five years, NICE expects to produce 150 standards**;
- **The role of NICE will be expanded to develop quality standards for social care**; and
- GP consortia and providers will agree local priorities for implementation each year, (taking into account the NHS Outcomes Framework).

Research

- The Government is committed to the promotion and conduct of research as a core NHS role. The DH will continue to promote the role of the Biomedical Research Centres and Units, Academic Health Science Centres and Collaborations for Leadership in Applied Health Research and Care.

Incentives for quality improvement

- The structure of payment systems will be the responsibility of the NHS Commissioning Board, and Monitor will be responsible for pricing;
- The DH will:
  - Implement a set of currencies for adult mental health services for use from 2012/13, and develop currencies for child and adolescent services;
  - Develop payment systems for the commission of talking therapies;
  - Mandate national currencies for adult and neonatal critical care in 2011/12;
  - Review payment systems to support end-of-life care, including exploring options for per-patient funding;
  - Accelerate the development of pathway tariffs for use by commissioners;
  - Implement further incentives to reduce avoidable readmissions and encourage more joined-up working between hospitals and social care for service following discharge in 2011/12; and
  - Link quality measures in national clinical audits to payment arrangements.
- The development of best-practice tariffs will be accelerated, so that **providers are paid according to the costs of excellent care, rather that average price**;
- In 2011/12 best-practice tariffs will be introduced for interventional radiology, day-case surgery for breast surgery, hernia repairs and some orthopaedic surgery;
- **The DH will extend the scope and value of the Commissioning for Quality and Innovation (CQUIN) payment framework**, to support local quality improvement goals;
- **If providers deliver poor quality care, the commissioner will be able to impose a contractual penalty.** The DH will work to impose fines for extended list of 'never events', such as wrong site surgery, from October 2010;
- **In general practice, the DH will establish a single contractual and funding model to promote quality improvement;**
- **Funding is to follow the registered patient,** on a weighted capitation model adjusted for quality;
- **The Government will also reform the way that drug companies are paid for NHS medicines**, moving to a system of value-based funding when the current scheme expires. This will ensure better access for patients to effective drugs; and
- As an interim measure a new Cancer Drug Fund will operate from April 2011 to enable better access to cancer drugs.

CHAPTER 4 – AUTONOMY, ACCOUNTABILITY AND DEMOCRATIC LEGITIMACY

This chapter details the removal of top-down control. Responsibility for commissioning and budgets will be given to groups of GP practices.

GP commissioning consortia

- The DH will devolve power and responsibility for commissioning and services to local consortia of GP practices;
- This will reinforce the crucial role that GPs already play in committing NHS resources through their daily clinical decisions (not only in terms of referrals and prescribing, but also how well they manage long-term conditions, and the accessibility of their services); and
- The Government will shortly issue a document setting out the proposals in more detail and then bring forward legislation in the forthcoming Health Bill.

Role of GP commissioning consortia

- The Government envisages **putting GP commissioning on a statutory basis;**
- **Consortia of GP practices, working with other health and care professionals, and local communities and authorities, will commission the great majority of NHS services for their patients;**
- GP commissioners will not be directly responsible for commissioning services that GPs themselves provide;
- **They will not commission family health services of dentistry, community pharmacy and primary ophthalmic services or maternity services;**
- The NHS Commissioning Board will calculate practice-level budgets and allocated these directly to consortia;
- GP consortia will include an Accountable Officer, and the NHS Commissioning Board will be responsible for holding consortia to account;
- Every GP practice will be a member of a consortium, as a corollary of holding a registered list of patients;
- **The NHS Commissioning Board will be under a duty to establish a comprehensive system of GP consortia and will have a reserve power to assign practices to consortia;**
- GP consortia will have a responsibility for commissioning services for people who are not registered with a GP practice, and to commission services jointly with local authorities;
- **The Government will discuss with the BMA and the profession how primary medical care contracts can best reflect new complementary responsibilities** for individual GP practices, including being a member of a consortium and supporting the consortium in ensuring efficient and effective use of NHS resources;
- **GP consortia will have the freedom to decide what commissioning activities they undertake for themselves and for what activities they may choose to buy in support from external organisations including local authorities, private and voluntary sector bodies;**
- **It is intended that consortia will receive a maximum management allowance to reflect the costs associated with commissioning;**
- GP consortia will have a duty to promote equalities and to promote 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;
- GP consortia 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;
- Through its local infrastructure, HealthWatch will provide evidence about local communities and their needs and aspirations; and
- **Through the transitional arrangements, the DH will seek to ensure that existing expertise and capability in PCTs is maintained during the transition period where this is the wish of GP consortia.**

The indicative timetable is for GP consortia commissioning arrangements is as follows:

- **A comprehensive system of GP consortia in place in shadow form during 2011/12, taking on increased delegated responsibility from PCTs;**
- **Following passage of the Health Bill, consortia to take responsibility for commissioning in 2012/13;**
- **The NHS Commissioning Board to make allocations for 2013/14 directly to GP consortia in late 2012; and**
- **GP consortia to take full financial responsibility from April 2013.**

An autonomous NHS Commissioning Board

- **A statutory NHS Commissioning Board, free from day-to-day political interference will be created.**
- To avoid 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.

The Board will have five main functions:

1. Providing national leadership on commissioning for quality improvement;
2. Promoting and extending public and patient involvement and choice;
3. Ensuring the development of GP commissioning consortia;
4. Commissioning certain services that cannot solely be commissioned by consortia (including dentistry, community pharmacy, primary ophthalmic services, maternity services and specialised services); and
5. Allocating and accounting for NHS resources.

The Board will not have the power to restrict the scope of services offered by the NHS.

Establishing the Board and managing the transition

- **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 forthcoming Health Bill into a statutory body, and will go live in April 2012;**
- From this year Strategic Health Authorities (SHAs) will separate their commissioning and provider oversight functions. They will support the board during its preparatory year;
- **SHAs will be abolished as statutory bodies during 2012/13; and**
- From 2012 the Board will perform those national functions relevant to its new role that are currently carried out by the DH.

A new relationship between the NHS and the Government

The Government is determined to change the relationship between itself and the NHS to prevent political micro-management of the health service. The forthcoming Health Bill will introduce provisions to limit the ability of the Secretary of State to intervene in the NHS. The new NHS-related role of the Secretary of State will include:

- Setting a formal mandate for the NHS Commissioning Board;
- Holding the NHS Commissioning Board to account;
- Acting as an arbiter of last resort in disputes that arise between NHS commissioners and local authorities (this will be a statutory role);
- Setting the legislative and policy framework (responsibility for Department of State functions will remain with the Secretary of State);
- Accounting annually to Parliament; and

- To lay out a short formal mandate for the NHS Commissioning Board. This mandate is likely to be over a three year period, updated annually.

Local democratic legitimacy

- **The White Paper proposes transferring PCT health improvement functions to local authorities and giving local authorities influence over NHS commissioning; and**
- The Government will create Health and Wellbeing Boards. 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.

Local authorities' new functions will be:

- Promoting integration and partnership working;
- Leading joint strategic needs assessments; and
- Building partnership for service changes and priorities.
- **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.; and
- Local **HealthWatch representatives will also pay a formal role to ensure that feedback from patients and service users is reflected in commissioning plans**.

Freeing existing NHS providers

- **The Government's ambition is to create the largest and most vibrant social enterprise sector in the world;**
- As all NHS trusts become foundation trusts, staff will have an opportunity to transform their organisations into employee-led social enterprises that they themselves control, freeing them to use their front-line experience to structure services around what works best for patients;
- **A consultation on options to provide foundation trusts with new freedoms will include the following proposals:**
  - **Abolishing the cap on the amount of income foundation trusts may earn from other sources (e.g. private patients) to reinvest in their services;**
  - **Enabling foundation trusts to more easily merge; and**
  - **Enabling foundation trusts to tailor their governance arrangements to their local needs.**
- **Within three years, all NHS trusts will become foundation trusts;**
- **It will not be an option for organisations to remain as an NHS trust and the NHS trust legislative model is to be repealed;**
- From April 2013, Monitor will take on the responsibility of regulating all providers of NHS care, irrespective of their status;
- The Government will complete the separation of commissioning from provision by April 2011 and move as soon as possible to an 'any willing provider' approach for community services; and
- **Special statutory arrangements will be made for the three high secure psychiatric hospitals** allowing them to benefit from the independence of foundation trust status while retaining appropriate safeguards reflecting their role in the criminal justice system.

Economic regulation and quality inspection to enable provider freedom

As now, the Care Quality Commission will act as quality inspectorate across health and social care. In addition, Monitor will be developed into an economic regulator from April 2010, for all providers of NHS care by April 2013.

The role of the Care Quality Commission

- Licensing - Together with Monitor, CQC will operate a joint licensing regime; and
- Inspections - CQC will inspect providers against the essential levels of safety and quality.

The role of Monitor
Monitor's role as an economic regulator will be strengthened and include:

- **Promoting competition -** To ensure that competition works effectively in the interests of patients and taxpayers;
- **Price regulation -** To set efficient prices, or maximum prices, for NHS- funded services; and
- **Supporting continuity of services.**

Monitor's scope and powers

- Monitor should have proactive "ex ante" powers to protect services, as well as being able to take "ex post" enforcement action reactively; and
- Monitor's powers to regulate prices and license providers will only cover publicly funded health services. However, **its powers to apply competition law will extend to both publicly and privately funded health care, and to social care.**

Valuing staff
The Government will promote staff engagement, and the implementation of the recommendations from the Boorman Review into NHS Staff health and wellbeing.

Training and Education

- **The DH will reduce its role in overseeing education and training**;
- The intention is to **give employers greater autonomy and accountability for planning and developing the workforce,** alongside greater professional ownership of the quality of education and training;
- A new system will be designed to ensure that education and training commissioning is aligned locally and nationally with the commissioning of patient care;
- **The professions will have a leading role in deciding the structure and content of training and quality standards;**
- **All providers of healthcare services will pay to meet the costs of education and training. Transparent funding flows for education and training will support the level playing field between providers;**
- **The NHS Commissioning Board will provide national patient and public oversight of healthcare providers' funding plans for training and education, checking that these reflect its strategic commissioning intentions;**
- **The Centre for Workforce Intelligence will act as a source of information and analysis; and**
- **The DH will publish further proposals for consultation.**

NHS pay

- The Government will pursue the Coalition Agreement and policies announced in the Budget on 22 June 2010 in relation to public sector pay restraint;
- The Government has stated that **pay decisions should be led by healthcare employers rather than imposed by the Government;**
- **In the future, all individual employers will have the right (as foundation trusts currently do) to determine pay for their own staff;**
- As announced in the Budget there will be a two year pay freeze for those earning more than £21,000 and the Government will ask the Pay Review Bodies to make recommendations on pay for those earning below this threshold with a minimum increase of £250 for each year of the freeze;

- **In the longer term the Government will work with NHS employers and trade unions to explore appropriate arrangements for setting pay; and**
- Ministers will retain responsibility for determining overall resources and affordability, but employers should expect to take the lead in providing advice on staffing and cost pressures. **Employers would also be responsible for leading negotiations on new employment contracts**.

NHS Pensions
Lord John Hutton will chair an independent review of public pensions. This review will look at the affordability and sustainability of public sector pensions, and will also consider access, the impact on labour market mobility between public and private sectors and **the extent to which pensions may act as a barrier to greater plurality of provision of public services.**

CHAPTER 5 – CUTTING BUREAUCRACY AND IMPROVING EFFICIENCY

Like other parts of the pubic sector, the NHS has an obligation to cut waste and transform productivity (para 5.1).

Cutting bureaucracy and administrative costs

- The Government will impose the largest reduction in administrative costs in NHS history. **Over the next four years the NHS's management costs will be reduced by more than 45%;**
- **This will only be achieved by a radically simplifying the architecture of the health and care system;**
- **PCTs and practice based commissioners will be replaced by GP consortia;**
- **The DH will radically reduce its own NHS functions;**
- **SHAs will be abolished;**
- **A review of the DH's arm's-length bodies will soon be published.** The Government intends to abolish organisations that do not need to exist (para 5.5);
- In the future the DH will impose tight governance over the costs and scope of all its arm's-length bodies. The Secretary of State will consider for any particular arm's-length body setting out an explicit list of functions that it is not to undertake, and a positive list of what it is expected to do. Quangos' independence will be about how they perform clear and agreed functions, not the freedom to assume new roles;
- The Government recognises that **these changes will cause significant disruption and loss of jobs, and incur transactional costs between now and 2013** but argues it has a moral obligation to release as much money as possible to support front-line care;
- Later in 2010 the DH will initiate a review of data returns with a view to cull returns of limited value. This is to support the information strategy by collecting more meaningful data. There is a commitment to consult on the findings of the review prior to implementation;
- The Academy of Medical Sciences has been asked to conduct an **independent review of the regulation and governance of medical research with a view to reducing the bureaucracy involved.** Legislation will be considered for simplification;
- The DH will cut its budgets for centrally managed programmes, such as consultancy services and advertising spend; and
- NHS services will be empowered to be customers of **a more plural system of IT** and other suppliers.

Increasing NHS productivity and quality
The reforms mentioned in the White are to provide the NHS with greater incentives to increase efficiency and quality and the Government believes that they will help put the NHS on a more sustainable footing.

Enhanced financial controls

- NHS services will continue to be funded by the taxpayer. **The DH will receive funding voted by Parliament** and will remain accountable to Parliament and HM Treasury for NHS spend;
- The NHS Commissioning Board will be accountable to the DH for living within an annual NHS revenue limit and subject to clear financial rules to create greater transparency;
- The NHS Commissioning Board will allocate resources to GP consortia on the basis of need;
- GP consortia will be accountable to the NHS Commissioning Board for managing public funds. They will be subject to transparent controls and incentives for financial performance and will have clear relationships with their constituent practices;
- Consortia will be required to take part in risk-pooling arrangements overseen by the Commissioning Board;
- **The Government will not bail out commissioners who fail**. Regulations will specify a failure regime for commissioners;
- **Commissioners will be free to buy services from any willing provider, and providers will compete to provide services;**
- **Providers who wish to provide NHS-funded services must be licensed by Monitor which will assess financial viability;**
- **Providers of essential services may be required to take part in risk-pooling arrangements to ensure that if a provider becomes financially unsustainable, Monitor can intervene to keep services running without recourse to the DH; and**
- **The Government will not provide additional resources for failing providers but Monitor will be able to allow transparent subsidies where these are objectively justified, and agreed by commissioners.**

Making savings during the transition

- **Work has begun to release £15-20 billion of efficiency savings to reinvest across the system over the next four years** whilst maintaining a focus on improving quality;
- **The existing QIPP (Quality, Innovation, Productivity and Prevention) initiative to address this challenge will continue with greater urgency but with a stronger focus on general practice leadership;**
- Under QIPP, work has already started in improving care for stroke patients, the productive ward programme, increased self-care and the use of new technologies for people with long-term conditions;
- Further efficiencies need to be made from improving energy efficiency and developing more sustainable forms of NHS delivery with a focus on carbon reduction programmes that reduce energy consumption and expenditure;
- **SHAs and PCTs have a current role in supporting QIPP. To pave the way for new arrangements, they must now seek to devolve leadership of QIPP to emerging GP consortia and local authorities as soon as possible;**
- **The DH will require SHAs and PCTs to have an increased focus on maintaining financial control during this transition period and they will be supported in this task by Monitor; and**
- **The DH will increase financial control arrangements during the transition wherever necessary to maintain financial balance; in such circumstances, central control will be a necessary precursor to subsequent devolution to GP consortia.**

CHAPTER 6 – CONCLUSION: MAKING IT HAPPEN

Proposals for legislation

The Government will introduce a new Health Bill in the autumn. The principal legal reforms will include:

- Enabling the creation of a Public Health Service with a lead role on public health evidence and analysis;
- Transferring local health improvement functions to local authorities with ring fenced funding and accountability to the Secretary of State for Health;
- Placing the Health and Social Care Information Centre, currently a Special Health Authority, on a firmer statutory footing, with powers over other organisations in relation to information collection;
- Enshrining improvement in healthcare outcomes as the central purpose of the NHS;
- Making NICE a non-departmental public body, define its role and functions, reform its processes, securing its independence, and extending its remit to social care;
- Establishing the independent NHS Commissioning Board, accountable to the Secretary of State, paving the way for the abolition of SHAs. The Board will initially be established as a Special Health Authority; the Bill will convert it into an independent non-departmental public body;
- Placing clear limits on the role of the Secretary of State for Health;
- Giving local authorities new functions to support integration and partnership working across social care, the NHS and public health;
- Establishing a statutory framework for a comprehensive system of GP consortia, paving the way for the abolition of PCTs;
- Establishing HealthWatch as a statutory part of the CQC to champion service users and carers across health and social care. Turning Local Involvement Networks into local HealthWatch;
- Reforming the Foundation Trust model, removing restrictions and enabling new governance arrangements, increasing transparency in their functions, repealing foundation trust deauthoriatsation, and enabling the abolition of the NHS trust model;
- Strengthening the role of the CQC as a quality inspectorate;
- Developing Monitor into the economic regulator for health and social care, including provisions for special administration; and
- Reducing the number of arm's-length bodies in the health sector, amending their roles and functions.

PRELIMINARY ANALYSIS

A number of initiatives within the White Paper can be seen as a continuation of the previous Government's agenda particularly in regards to patient choice, Quality Accounts and personal health budgets. The White Paper also confirms the Government's commitment to finding £20 billion in efficiency savings in the NHS through the Quality, Innovation, Productivity and Prevention (QIPP) initiative.

However the White Paper sets out a radical reform and restructuring agenda. It proposes change at every level of the NHS in England. The proposals contained within the White Paper are intended to be mutually reinforcing and as noted in the Analytical Strategy accompanying the White Paper there is a risk 'if some of these reforms are not fully implemented.' The White Paper recognises that the pace of change will vary across the country according to organisations' readiness to assume their new roles and responsibilities.

There is a significant devolution of power and responsibility from the Secretary of State to the independent NHS Commissioning Board, the regulators Monitor and the Care Quality Commission, GP commissioning consortia and providers of health services. The original proposal in the Coalition's *Programme for Government* (released in May 2010) for directly elected PCT Boards has been

discarded as PCTs are to be abolished. However, the perceived need for greater 'democratic' accountability will see new roles and responsibilities created for local authorities. Promoting better public health and reforming social care are clear priorities for the DH and the Government over the next few years.

There is a clear shift in the policy focus towards favouring private sector involvement. The previous Government's policy of the NHS as a preferred provider has clearly been replaced in favour of an any willing provider model.

The moves towards a more localised system for pay negotiations and the commissioning of education and training will need to be carefully considered by the BMA.

There is recognition that the costs of implementing the White Paper will be front-loaded. There will be a significant number of redundancies that will incur costs. There are also costs associated with a loss of productivity and potential relocation of staff during the transition and restructuring period. The Government believes that these are short-term costs which will be accompanied by reductions in bureaucracy spend in the longer term, with the aim being an overall cut by at least a third in real terms.

As outlined in its press release in response to the launch of the White Paper the BMA is 'looking forward to discussing the details behind these new initiatives in more depth and playing an active role in the consultations that follow.'