

GLOUCESTERSHIRE LMC DOCUMENT SUMMARY

<u>Document Title:</u> Liberating the NHS: Legislative Framework and Next Steps	
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<i>N.B. This summary was correct when issued. Its accuracy cannot be guaranteed in the long term, since policies and organisations change. Although every effort will be made to ensure that it is updated the Reader is urged to exercise caution if the document at the time of reading is more than a year old.</i>	
<u>Bottom Line:</u> The legislation will reflect the White Paper, with a few minor amendments.	

The subject paper is the government's response to the various strands of consultation that ended in October; at 180-odd pages this will be a very high level view. The GPC will be replying to it in detail on behalf of GPs.

The reforms are planned to be patient-centred, focused on outcomes rather than processes, more democratic and will give more power to clinicians. The NHS Bill to put this into effect will be introduced in January 2011; everything obviously hangs on that Bill being enacted.

Patient Focus. While patient focus requires 'choice' there is to be further consultation until 14th January 2011 on what 'choice' actually means for the NHS and on what information revolution is required to support it. In the meantime the pilots for personal health budgets are pressing ahead. The Health and Social Care Information Centre will become a statutory, non-departmental body. The jury is out on whether increased patient participation will increase the length of consultations in surgeries. HealthWatch (which will take over from, and have a broader remit than, LINKs) will help patients to make health and social care choices. Just as GP Commissioning will have pathfinder projects, so too will local HealthWatch organisations.

Outcomes. The current targets will not be abandoned, but will cease to be micromanaged by central government. Outcomes will be best achieved by integrating the work of health, social care and public health (e.g. those discharged as cured from hospital have to be cared for afterwards; both parts are essential to a good outcome). Outcome frameworks may point the way, but nothing beats close cooperation in practice. Moreover the national Outcome Framework needs to reflect, rather than conflict with, local priorities. The NHS Commissioning Board, and GP Commissioning Consortia, will be held to account in meeting laid-down 'levels of ambition' for each of 50 indicators clustered into 5 domains:

- Domain 1: Preventing people from dying prematurely;
- Domain 2: Enhancing the quality of life for people with long-term conditions;
- Domain 3: Helping people to recover from episodes of ill health or following injury;
- Domain 4: Ensuring people have a positive experience of care; and
- Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.

NICE will develop the applicable quality standards.

GP Commissioning. 'The need to increase productivity and reduce administrative costs calls for a significant simplification of administrative structures'. From this it follows that:

- The GP Consortia will be statutory bodies but will be able to flex in size and area, merge, dissolve, co-operate, share financial risks etc. In establishing them the criteria used by the NHS Commissioning Board will be whether each consortium has workable arrangements to carry out its statutory duties (including the duty to secure continuous improvements in quality of services and the duty to keep within their allotted budget) and whether its area of coverage is 'appropriate'.
- Only a very small minority of GPs will be needed to actually run the commissioning – most will continue to treat patients as before – but each practice will nominate a

clinician to represent it on the consortium (para 4.30). The Accountable Officer will not have to be a GP, but probably will be. It will be up to consortia whether to have lay or patient representation on their boards. Every consortium must have a constitution.

- While every consortium must ensure that it receives impartial clinical advice it is up to the consortium to arrange how that is done.
- There will be procedures to deal with failing consortia, but the NHS Commissioning Board and consortia will not be in a hierarchical relationship. While holding consortia to account, the NHS Commissioning Board is also meant to be supporting consortia in many specific ways (para 4.54). The Board might even place a liaison officer in each consortium.
- Since GPs lack experience in managing huge budgets they will need to hire suitable help, and obtain suitable training. *(There has been an announcement recently that GP Commissioning Consortia will not inherit debts from PCTs that arise before 31st March 2011, but that if GPs allow PCTs to rack up debts after that date then they will inherit those debts. QIPP is very much the theme of the next 2 or 3 years).*
- Another unanswered question is what the 'quality premium' should be, how large and how it is to be calculated if it is not to damage the GP's relationship with the patient.
- The government is also conscious of the risk that consortia could let contracts in a way that is neither fair nor transparent; boldly, they are working on the basis of 'assumed responsibility' i.e. giving trust until that trust is shown to have been broken, but Monitor and the NHS Commissioning Board will be putting out rules and guidance.
- The way that failing doctors or practices will be managed has yet to be settled; GP commissioning consortia will be best placed to detect the problem but will not hold the contract. Very careful definition of the boundaries of responsibility will be needed in this area.
- Similarly it is not yet clear which specialised commissioning responsibilities will be held nationally and which locally. Some GPs lack experience in such areas as child welfare and mental health.
- The commissioning of maternity services will not now be taken from GP Commissioning Consortia, but the NHS Commissioning Board will exercise a close interest and may retain some responsibilities for the more specialised services in this area.
- The list of what duties GP Commissioning Consortia will have to perform will first be published in the Bill in January. Until then it is a waste of time to speculate on it.
- Political vacillation will be taken out of the equation, although there will be the usual 'exceptional circumstances' let-out clause. The Secretary of State will issue a 3-year plan, revised annually, to the NHS Commissioning Board which will then be responsible for its implementation, through the GP Commissioning Consortia.
- 'The success of commissioning consortia will depend critically on leadership, behaviours and relationships – and on the work done during the transitional period to prepare consortia and the NHS Commissioning Board to take on their new roles.' (4.117)
- Consortia will start to be formally established in April 2012. The pathfinders may become the final consortia, but equally they may not. *(It would be worth looking at para 4.125 for a list of what the pathfinders are expected to do.)* 'Any group of practices that wishes to become a pathfinder consortium will be able to do so, provided that they are able to demonstrate evidence of GP leadership and GP support and local authority engagement, and an ability to contribute to the delivery of the QIPP plans for their locality.' (4.126)

Local Democratic Legitimacy. Local authorities will have an enhanced health role, through statutory Health and Wellbeing Boards which will enjoy flexible geographical boundaries and will have representation from the relevant GP Commissioning Consortia. The main

purpose of these Boards will be to produce enhanced joint strategic needs assessments as the main tool in securing better health and wellbeing outcomes and better value for the taxpayer. But they have to go further, in conjunction with GP Commissioning consortia, by producing Joint Health and Wellbeing Strategies (5.22 – 5.24). However these Boards will not have authority over GP commissioning consortia. There is also the intention that budgets can be coordinated, if not actually pooled, in order to achieve these ends. The Boards' remit can be as narrow or as wide as local authorities are prepared to make them. The Health and Wellbeing Boards will not take over the functions of the Health Overview and Scrutiny Committees. Note that local authorities will be given the right to scrutinise all providers of NHS-funded services (so GP practices will presumably be included). *Have a look at para 5.51 for a list of the things which shadow consortia members should be discussing with shadow Health and Wellbeing Boards over the next year or so.*

Regulating Healthcare Providers. The responses to the White Paper reflected strongly held and differing views. The government is therefore prepared to take a little longer and move more carefully than originally suggested. All NHS trusts will become foundation trusts within 3 years; they will not be privatised but their directors and governors will be more directly accountable for the results they achieve. Monitor will therefore be less responsible for holding foundation trusts to account, for instance (simplifying things a bit) permission to change the constitution of a foundation trust will now have to be sought from its governors, not Monitor. Monitor will become the economic regulator, while CQC will be strengthened as an effective quality inspectorate. Monitor's three core functions will be to promote competition, to set or regulate prices and to support continuity of services, and it will do so through licensing providers of NHS-funded care, and enforcing obedience to the terms of those licenses. In doing so it will be entitled to charge a fee – details not yet known. Monitor will also have powers to investigate accusations that commissioners are not commissioning fairly. Monitor will be obliged to work in close collaboration with CQC.

Implementation and Transition. There will be revisions to the NHS Constitution in 2012. But the main thing is for the NHS to produce massive reductions in costs, and improvements in efficiency and quality, and to do so in a context of massive structural reform. There are risks, but the government considers that the structural reform is essential to make savings on the scale required. Removing functions (such as monitoring the meeting of targets) will allow the slimming down of intermediate organisations across the board, and a reduction of administrative costs by one third. Outline timings for the programme are attached.

TUPE. Since many functions performed by current organisations will continue to be performed by new organisations, TUPE will apply to a significant proportion of the functions carried out by new organisations. Further guidance on the detail of this is expected in due course.

Summary. Government sets the strategy and overall aims; local people will not only have to find the tactics to implement the strategy and achieve their part of the aim, but will actually have to invent the local organisations to do so. We are not used to doing that, or to having such freedom. It will take a bit of getting used to.

TRANSITION PHASED OVER FOUR CALENDAR YEARS

2010/11 Design and early adoption

- The Department of Health confirms the design framework, subject to Parliamentary approval.
- The Department of Health gives permission to pathfinders and early implementers to model the new arrangements and explore key issues for wider roll-out.
- Refinement of HealthWatch following the choice and information consultations.
- The Department of Health publishes transition plan setting out the role of LINKs in influencing local services while local HealthWatch prepares to start exercising functions.
- The Government begins working with local authorities as they prepare for their new role in commissioning support for choice and complaints advocacy

2011/12 Learning and planning for roll-out.

- Shadow national arrangements progressively implemented for the NHS Commissioning Board, new Monitor, and the Public Health England programme.
- Sharing lessons from the GP consortia pathfinder programme and early implementer health and wellbeing boards.
- More pathfinders and early implementers, including local HealthWatch.
- Plans drawn up for GP consortia, involving all GP practices.
- Emerging consortia to lead the process for identifying which PCT-employed staff should be "assigned" to them.
- Plans to be drawn up for health and wellbeing boards.
- NHS trusts to apply for foundation trust status, or be planning to apply in 2012/13.
- The new Provider Development Authority to be established by 1 April 2012.
- SHAs to establish PCT cluster arrangements in preparation for the NHS Commissioning Board

2012/13 Full dry run.

- From April 2012, NHS Commissioning Board and new Monitor come into effect, SHAs are abolished, PCT clusters are accountable to the Board, and the change programme and established Public Health oversee NHS trusts.
- More learning from GP pathfinders and health and wellbeing board early implementers.
- Authorisation process of comprehensive system of GP consortia begins, with all practices becoming members, acting under delegated arrangements with PCTs.
- Health and wellbeing boards are in place.
- Comprehensive local HealthWatch arrangements in place.
- From April 2012, local authorities to fund local HealthWatch to deliver most of their new functions.
- Consortia notified on 2013/14 allocations.
- By the end of the year, a significant number of NHS trusts have achieved Foundation Trust status.
- All applications for FT status to be made by end March 2013.

2013/14 - First full year of the new system

- From April 2013:
 - PCTs abolished and all consortia assume new statutory responsibilities
 - Health and wellbeing boards assume their statutory responsibilities.
 - Monitor's licensing regime is fully operational, and the government aims to have the new special administration regime in place.
 - Local authorities to have responsibility for commissioning NHS complaints advocacy
- At end March 2013 the Provider Development Authority (responsible for moving NHS trusts to foundation trust status) ceases to exist since by 1st April 2014 all NHS trusts are to become foundation trusts and NHS trust legislation will be repealed.