

Equity and Excellence: Liberating the NHS White paper 2010

Proposals for legislation

Many of the changes in this 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.

The principal legislative reforms will include:

1. Enabling the creation of a Public Health Service, with a lead role on public health evidence and analysis;
2. Transferring local health improvement functions to local authorities, with ring-fenced funding and accountability to the Secretary of State for Health;
3. 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;
4. Enshrining improvement in healthcare outcomes as the central purpose of the NHS;
5. Making the National Institute for Health and Clinical Excellence a non-departmental public body, to define its role and functions, reform its processes, secure its independence, and extend its remit to social care;
6. Establishing the independent NHS Commissioning Board, accountable to the Secretary of State, paving the way for the abolition of SHAs. The NHS Commissioning Board will initially be established as a Special Health Authority; the Bill will convert it into an independent non-departmental public body;
7. Placing clear limits on the role of the Secretary of State in relation to the NHS Commissioning Board, and local NHS organisations, thereby strengthening the NHS Constitution;
8. Giving local authorities new functions to increase the local democratic legitimacy in relation to the local strategies for NHS commissioning, and support integration and partnership working across social care, the NHS and public health;
9. Establishing a statutory framework for a comprehensive system of GP consortia, paving the way for the abolition of PCTs;

10. Establishing HealthWatch as a statutory part of the Care Quality Commission to champion services users and carers across health and social care, and turning Local Involvement Networks into local HealthWatch;
11. Reforming the foundation trust model, removing restrictions and enabling new governance arrangements, increasing transparency in their functions, repealing foundation trust deauthorisation and enabling the abolition of the NHS trust model;
12. Strengthening the role of the Care Quality Commission as an effective quality inspectorate; and
13. Developing Monitor into the economic regulator for health and social care, including provisions for special administration. Associated with these changes, reducing the number of arm’s-length bodies in the health sector, and amending their roles and functions.

Please see the following Reference guide for the White paper and allocated section for any comments you may wish to make in response to points 1-13 above.

Point	Ref Page	para	White paper	Impact/Comments
1.	9	1.15	We will set out our programme for public health in a White Paper later this year. The forthcoming Health Bill will support the creation of a new Public Health Service, to integrate and streamline existing health improvement and protection bodies and functions, including an increased emphasis on research, analysis and evaluation.	The evidence based analysis of health needs for patients with skin disease was published in 2009 by the University of Nottingham. It is available on line by searching for “Skin Health Needs Assessment”.
2.	10	1.16	PCT responsibilities for local health improvement will transfer to local authorities, who will employ the Director of Public Health jointly appointed with the Public Health Service. The Department will create a ring-fenced public health budget and, within this, local Directors of Public Health will be responsible for health improvement funds allocated according to relative population health need . 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.	(1) Local Authorities will look for innovative financial ways for overcoming any attempts to ring-fence health funds and use these for other areas of local need that may be of political importance to the LA. (2) Skin disease tends to receive very variable funding according to local experience producing post-code inequalities. There should be a ‘minimum’ service which all should be mandated to provide for the 5% of patients who will require specialised services

2.	22	3.5	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.	Because of past experience of how local decision making leads to unequal skin care provision, skin diseases (cancer, inflammatory and infective) should feature in the national objectives.
3.	16	2.15	We will ensure the right data is collected by the Health and Social Care Information Centre to enable people to exercise choice. We will seek to centralise all data returns in the Information Centre, which will have lead responsibility for data collection and assuring the data quality of those returns, working with other interested parties such as Monitor and the Care Quality Commission. We will also review data collections with a view to reducing burdens, as outlined in chapter 5. The forthcoming Health Bill will contain provisions to put the Information Centre on a firmer statutory footing, with clearer powers across organisations in the health and care system.	The British Association of Dermatologists has a multi-stakeholder process underway to identify evidenced based outcome measures for skin disease. This Minimum Data Set should be published in July 2011.
4.	21	3.1	The primary purpose of the NHS is to improve the outcomes of healthcare for all: to deliver care that is safer, more effective, and that provides a better experience for patients. Building on Lord Darzi's work, the Government will now establish improvement in quality and healthcare outcomes as the primary purpose of all NHS-funded care. This primary purpose will be enshrined in statute, the NHS Constitution, and model contracts for services, ensuring that the focus is always on what matters most to patients and professionals.	Existing evidence suggests quality outcomes result from integrated pathways between primary and secondary care with which the 'any willing provider' model does not fit. There is a risk that local commissioners will avoid guidance on quality outcomes given by NICE and National Commissioning and just focus on cost. This is likely to happen as budgets are cut and the jobs of managers depend on balancing these budgets. The outcomes guidance must have teeth. The benefits of process targets that have been achieved particularly in skin cancer should not be lost. Some process targets relating to time in cancer should be maintained to avoid differential care according to which cancer is suspected.

				Outcome tariffs for outpatient care as part of value based pricing will help maintain high standards for skin disease care and need to be integrated.
4.	21	3.4	Instead of national process targets, the NHS will, wherever possible, use clinically credible and evidence-based measures that clinicians themselves use. The Government believes that outcomes will improve most rapidly when clinicians are engaged, and creativity, research participation and professionalism are allowed to flourish. In future, the Secretary of State will hold the NHS to account for improving healthcare outcomes. The NHS, not politicians, will be responsible for determining how best to deliver this within a clear and coherent national policy framework.	The BAD Minimum Dataset will be of use to the NHS in setting evidence based quality standards. The skin health needs assessment provides further evidence.
4.	22	3.10	The NHS Commissioning Board will work with clinicians, patients and the public at every level of the system to develop the NHS Outcomes Framework into a more comprehensive set of indicators, reflecting the quality standards developed by NICE. The framework and its constituent indicators will enable international comparisons wherever possible, and reflect the Board's duties to promote equality and tackle inequalities in healthcare outcomes. It will ensure that clinical values direct managerial activity and that every part of the NHS is focusing on the right goals for patients. The main purpose of the programme of reform set out in this White Paper is to change the NHS environment so that it is easier to progress against those goals.	Linkage between the outcomes in skin disease and the need for adequate numbers of dermatology trained doctors will involve engagement with DH managers involved with workforce planning. There are currently 125 empty or locum filled consultant dermatology posts in the UK reflecting inadequate training numbers for the demands of the health service. This is not a new or a short term problem.
4.	17	2.20	However, we do not see choice as just being about where you go and when, but a more fundamental control of the circumstances of the treatment and care you receive. The Government will 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. People should be able to expect that they can change their GP quickly and straightforwardly if and when it is right for them, but equally that they can stay with their GP if they wish when they move house.	No comment
4.	21	3.2	already revised, the NHS Operating Framework for 2010/11, setting	See above

			out how existing targets should be treated this year. Some targets are clinically justifiable and deliver significant benefits. Others, that have no clinical relevance, have been removed. In future, performance will be driven by patient choice and commissioning	
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6.	5.	6q	establish an independent and accountable NHS Commissioning Board . The Board will lead on the achievement of health outcomes, allocate and account for NHS resources, lead on quality improvement and promoting patient involvement and choice. The Board will have an explicit duty to promote equality and tackle inequalities in access to healthcare. We will limit the powers of Ministers over day-to-day NHS decisions.	The effectiveness of the NHS commissioning board will depend on its method of enforcement. Many NICE rules are ignored at present particularly those relating to safe provision of skin care by intermediate care. The reason that the rules are ignored is that managers are more likely to be penalised for failing to meet financial and process targets than for ignoring NICE safety and quality rules. Management theory on “satisficing” explains why this will happen.
6.	13	2.4	The new NHS Commissioning Board will champion patient and carer involvement, and the Secretary of State will hold it to account for progress. In the meantime, the Department will work with patients, carers and professional groups, to bring forward proposals about transforming care through shared decision-making.	Unless the board has teeth then it will probably be ignored or “gaming” will take place to avoid its rules and bypass patients.
6.	16	2.16	Providers will be under clear contractual obligations, with sanctions, in relation to accuracy and timeliness of data. Along with commissioners, they will have to use agreed technical and data standards to promote compatibility between different systems. The NHS Commissioning Board will determine these standards but they will include, for example, record keeping, data sharing capabilities, efficiency of data transfer and data security. We will clarify the legal ownership and responsibilities of organisations and people who manage health data. This may require primary legislation and we will consult on arrangements later this year.	This describes a process for monitoring but not for enforcing.
6.	18	2.23	We expect choice of treatment and provider to become the reality for patients in the vast majority of NHS-funded services by no later than 2013/14. In future, the NHS Commissioning Board will have a key role in promoting and extending choice and control. It will be responsible for developing and agreeing with the Secretary of State guarantees for	Patient choice makes local commissioning very difficult as patients may choose to go to providers that are not fully funded. There should be measures in place to identify if patients truly consider that they have had a choice.

			patients about the choices they can make, in order to provide clarity for patients and providers alike, ensuring the advice of Monitor is sought on any implications for competition. The Government will require the NHS Commissioning Board to develop an implementation plan as one of its first tasks, working with patient and professional groups; and the Secretary of State will hold it to account for progress.	'Any willing provider' services 'cherry pick' simple aspects of the service and may disadvantage those with more complex needs
6.	22	3.10	The NHS Commissioning Board will work with clinicians, patients and the public at every level of the system to develop the NHS Outcomes Framework into a more comprehensive set of indicators, reflecting the quality standards developed by NICE. The framework and its constituent indicators will enable international comparisons wherever possible, and reflect the Board's duties to promote equality and tackle inequalities in healthcare outcomes. It will ensure that clinical values direct managerial activity and that every part of the NHS is focusing on the right goals for patients. The main purpose of the programme of reform set out in this White Paper is to change the NHS environment so that it is easier to progress against those goals.	Duplication of 4
6.	24	3.17	The absence of an effective payment system in many parts of the NHS severely restricts the ability of commissioners and providers to improve outcomes, increase efficiency and increase patient choice. In future, the structure of payment systems will be the responsibility of the NHS Commissioning Board, and the economic regulator will be responsible for pricing. The Department will start designing and implementing a more comprehensive, transparent and sustainable structure of payment for performance so that money follows the patient and reflects quality. Payments and the 'currencies' they are based on will be structured in the way that is most relevant to the service being provided, and will be conditional on achieving quality goals.	If tariff prices are unrealistic then providers will not bid therefore limiting choice. Mandatory outpatient costs will ensure that treatment costs are achievable to a provider.
6.	25	3.19	The Department will also refine the basis of current tariffs. We will rapidly accelerate the development of best-practice tariffs, introducing an increasing number each year, so that providers are paid according to the costs of excellent care, rather than average price. The Department will also introduce the latest version of the	See above

			International Classification of Disease (ICD) 10 clinical diagnosis coding system from 2012/13, and explore the scope for developing a benchmarking approach, with greater local flexibility, including for local marginal rates.	
6.	30	4.11	The NHS Commissioning Board will promote patient and carer involvement and choice, championing the interests of the patient rather than the interests of particular providers. It will involve patients as a matter of course in its business, for example in developing commissioning guidelines. To avoid double jeopardy and 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. It will allocate and account for NHS resources. It will have a role in supporting the Secretary of State and the Public Health Service to ensure that the NHS in England is resilient and able to be mobilised during any emergency it faces, or as part of a national response to threats external to the NHS. It will promote involvement in research and the use of research evidence.	Expertise of secondary care clinicians is one of the major NHS resources and should not be overlooked in setting commissioning guidelines.
7.	22	3.5	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.	See earlier comments.
7.	33	4.14	At present the Secretary of State enjoys extraordinarily wide powers over the NHS. It is intended that the forthcoming Health Bill will introduce provisions to limit the ability of the Secretary of State to micromanage and intervene. The forthcoming Health Bill will formalise the relationship between the government and the NHS, to improve transparency and increase stability, while maintaining the necessary level of political accountability for such large amounts of taxpayers' money.	No comment

7.	34	4.15	<p>In future, the Secretary of State will be obliged to lay out a short formal mandate for the NHS Commissioning Board.</p> <p>The Secretary of State will also lose existing powers to intervene in relation to any specific commissioner other than in discharging defined statutory responsibilities.</p> <p>Responsibility for Department of State functions will remain with the Secretary of State. This includes determining the comprehensive service which the NHS provides, and developing and publishing national service strategies which will enable the roles of NHS, public health services and social care services to be better coordinated.</p> <p>Accounting annually to Parliament for the overall performance of the NHS, public health and social care systems.</p>	<p>Commissioners should be required to provide a 'minimum' service for dermatology patients as per the 'Skin Needs Assessment' mentioned in 1.9</p> <p>Commissioners should be required to include 'teaching and training' to ensure sustainability of commissioned services. This was ignored under CC2H.</p>
7.	49	6.7	Placing clear limits on the role of the Secretary of State in relation to the NHS Commissioning Board, and local NHS organisations, thereby strengthening the NHS Constitution;	No comment
8.	34	4.16	<p>Following the establishment of the NHS Commissioning Board and a comprehensive network of GP consortia, PCTs will no longer have NHS commissioning functions. To realise administrative cost savings, and achieve greater alignment with local government responsibilities for local health and wellbeing, the Government will transfer PCT health improvement functions to local authorities and abolish PCTs. We expect that PCTs will cease to exist from 2013, in light of the successful establishment of GP consortia. 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.</p>	It is to be hoped this latest in a long series of NHS structural reorganisations is worth the expense to tax payers.
8.	34	4.17	The Government will strengthen the local democratic legitimacy of the NHS. Building on the power of the local authority to promote	We support the strengthening of the patient voice in overseeing broad areas of health care. Patients may

			local wellbeing, we will establish new statutory arrangements 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 health and wellbeing boards 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.	not have the expertise in rare conditions that affect only a few people in each local authority. There are over 2000 skin conditions, many are very rare and patients with these must be protected against unintended unfairness. Consultant Dermatologists are experts in these diseases and can provide advice to protect these susceptible individuals.
8.	35	4.19	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. The Government will consult fully on the details of the new arrangements.	As above
9.	4.	6o	devolve power and responsibility for commissioning services to the healthcare professionals closest to patients: GPs and their practice teams working in consortia.	The great risk of this system is that GPs may have substantial conflicts of interest.
9.	27	4.4	Commissioning by GP consortia will mean that the redesign of patient pathways and local services is always clinically-led and based on more effective dialogue and partnership with hospital specialists. It will bring together responsibility for clinical decisions and for the financial consequences of these decisions. 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. It will increase efficiency, by enabling GPs to strip out activities that do not have appreciable benefits for patients' health or healthcare.	This depends on GPs acting purely in the interests of the patient and not for their own financial interest if they are shareholders in provider systems. GP training in dermatology for most is limited to one or two weeks at most as students. Whilst GPs become experienced in basic skin disease through their work (which is 20% skin problems) they usually do not have sufficient expertise in complex dermatology secondary care investigations and treatments to understand these fully and use appropriately. It is important the hospital specialists

				have a role in commissioning to educate GPs and protect patients.
9.	28-29	4.6	The Government will shortly issue a document setting out our proposals in more detail, and providing the basis for fuller engagement with primary care professionals, patients and the public. We will then bring forward legislation in the forthcoming Health Bill. We envisage putting GP commissioning on a statutory basis, with powers and duties set out in primary and secondary legislation. GP consortia will include an accountable officer, and the NHS Commissioning Board will be responsible for holding consortia to account for stewardship of NHS resources and for the outcomes they achieve as commissioners. In turn, each consortium will hold its constituent practices to account against these objectives.	The conflict of interest issue is paramount here.
9.	46	5.14	As well as providing incentives for greater efficiency, the new arrangements will provide for enhanced financial control: GP consortia will have a high level of freedom; but in return they 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 enjoy a clear relationship with their constituent practices. Consortia will be required to take part in risk-pooling arrangements overseen by the NHS Commissioning Board; the Government will not bail out commissioners who fail. Regulations will specify a failure regime for commissioners.	Details of exactly what will happen to existing contracts and payment to providers if commissioners fail should be provided. Will providers have to share the risk or will government guarantee the contracts?
10.	19	2.24	We will strengthen the collective voice of patients, and we will bring forward provisions in the forthcoming Health Bill to create HealthWatch England, a new independent consumer champion within the Care Quality Commission. Local Involvement Networks (LINKs) will become the local HealthWatch , creating a strong local infrastructure, and we will enhance the role of local authorities in promoting choice and complaints advocacy, through the HealthWatch	The BAD supports this.

			arrangements they commission.	
11.	36	4.21	The Government's intention is to free foundation trusts from constraints they are under, they will be regulated in the same way as any other providers, whether from the private or voluntary sector. Patients will be able to choose care from the provider they think to be the best. 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. Foundation trusts will not be privatised.	No comment.
11.	36	4.23	Within three years, we will support all NHS trusts to become foundation trusts. It will not be an option for organisations to decide to remain as an NHS trust rather than become or be part of a foundation trust and in due course, we will repeal the NHS trust legislative model. From April 2013, Monitor will take on the responsibility of regulating all providers of NHS care, irrespective of their status. Financial control will be maintained during the transition, with the Department, Monitor and SHAs taking any necessary steps.	No comment.
	37	4.24	The Government will end the uncertainty and delay about the future of community health services currently provided within PCTs. They will move as soon as possible to an "any willing provider" approach for community services, reducing barriers to entry by new suppliers. In future, all community services will be provided by foundation trusts or other types of provider.	Most dermatology community services tend inherently to be expensive and inefficient when assessed after several years. We recommend that such services are watched very carefully to avoid wasting large sums of set-up money and generating large numbers of partially treated "follow-up" patients over several years.
	37	4.26	Providers will be governed by a stable, transparent and rules-based system of regulation. The aim is to free up provision of healthcare, so that in most sectors of care, any willing provider can provide services, giving patients greater choice and ensuring effective competition stimulates innovation and improvements, and increases productivity within a social market.	We support reductions in regulation to free up resources for patient care.

12.	6.	6t	strengthen the role of the Care Quality Commission as an effective quality inspectorate across both health and social care.	We support this.
12.	37	4.27	As now, the Care Quality Commission will act as quality inspectorate across health and social care for both publicly and privately funded care . In addition, we will develop Monitor, the current independent regulator of foundation trusts, into an economic regulator from April 2012, with responsibility for all providers of NHS care from April 2013. Providers will have a joint licence overseen by both Monitor and CQC, to maintain essential levels of safety and quality and ensure continuity of essential services.	We support this.
13.	5.	6s	Monitor will become an economic regulator, to promote effective and efficient providers of health and care, to promote competition, regulate prices and safeguard the continuity of services.	
13.	46	5.14	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 , who will assess financial viability.	AWP should be able to meet NICE standards and should be required to ensure that those who will be providing any particular service will satisfy appropriate guidance for the role. –in addition to providing a financial model for the service The CQC license should be linked to meeting minimum safe standards to protect patients from “Any willing cowboy/cowgirl”