



# White Paper

July 2010

## Equity and excellence: Liberating the NHS

**Published on 12 July 2010, the Department of Health White Paper sets out a new strategy for the NHS in England. The aims of the new strategy are to put patients first, improve patient choice and healthcare outcomes, empower professionals and providers within the NHS, cut bureaucracy and improve efficiency.**

Some of the key means of achieving those aims have been identified as:

- The devolving of power and responsibility for commissioning services to GPs and practice teams working in consortia.
- Making it the responsibility of local authorities to promote partnership working between the NHS, social care and health improvement.
- The establishment of an independent and accountable NHS Commissioning Board.
- Giving patients the choice of any provider, consultant-led team, GP practice and treatment.
- The use of clinically credible and evidence based outcome measures, rather than process targets, to measure performance.
- The development of quality standards by NICE.

The most radical reform proposed in the White Paper is the devolution of commissioning responsibilities to GP consortia and the development of the NHS Commissioning Board, with SHAs and PCTs being abolished.

GP consortia will, in partnership with other health and care professionals and local authorities, commission the great majority of NHS services for their patients. Those services excluded from remit of the consortia will be dentistry, community pharmacy and primary ophthalmic. The consortia will be responsible for agreeing and monitoring contracts and managing the commissioning budgets of their member GP practices. A duty will be placed on the consortia to engage patients and the public in the commissioning process.

The NHS Commissioning Board ('the Board') will provide support to the consortia. It will produce commissioning guidelines to help standardise good practice. It will manage some national and regional specialised commissioning, as well as dentistry, community pharmacy and ophthalmology. The Board will also allocate and account for NHS resources.

The White Paper does not go into detail as regards where responsibility for the various regulatory functions presently performed by PCTs and SHAs will lie after this re-organisation. However, the following can be gleaned:

- The Board will be responsible for assessing commissioners and holding consortia to account for management of resources, performance and quality. The Board is envisaged as being under a duty to establish a comprehensive system of consortia and having the power to assign practices.
- GP consortia will have an accountable officer and each consortium will be responsible to holding each of its constituent practices to account for resource management, performance and quality. Every GP practice must be a member of a consortium as a corollary of holding a registered list of patients. If providers deliver poor quality care, then the commissioner will be able to impose a contractual penalty.

- The Care Quality Commission will take on a strengthened role as a quality inspectorate.
- Local authorities will take on the responsibility for local health improvement from PCTs and will employ Directors of Public Health jointly appointed with the Public Health Service. GP consortia will have a duty to work in partnership with the local authority.
- HealthWatch England will be created as a new consumer champion within the Care Quality Commission. Local authorities will be able to commission a local HealthWatch to provide advocacy and support to patients. The local HealthWatch will be funded by and accountable to the local authority.
- Monitor will become the economic regulator for health and social care.

Although unclear, it would seem that the Board may be the body tasked with taking on regulatory functions, given its role as the body to which commissioners and consortia must account. It is worth noting, however, that at paragraph 5.10 of the White Paper, it is stated 'we are committed to reducing the overall burdens of regulation across health and social care sectors. We will therefore undertake a wide ranging review of all health and social care regulation'. It may be the case that, by the time that the proposals outlined in this White Paper are put into practice, at least some of the regulatory functions undertaken by SHAs and PCTs will have been abolished or earmarked for abolition.

An important function for PCT's has been the management of the whole Performer's List process. The future of the List, how it will be managed and poor clinical performance regulated, where intervention becomes appropriate, remains open to speculation until more detailed plans emerge.

### **More information**

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