

# **A critique of 'Equity and Excellence: Liberating the NHS'**

**For BACCH members**

**October 2010**

This paper provides a critique of the White Paper "Equity and excellence: liberating the NHS to:

- identify policy elements which we should support,
- highlight areas of concern and
- propose ideas for improvement.

The key issues from the 'chapters' of the White Paper most relevant to children and families are highlighted, comparisons made with the recommendations made in *Modelling the Future*, with the similarities and differences identified, and finally proposals are made to address concerns raised in the analysis.

## **1. Introduction**

The White Paper entitled *Equity and Excellence: Liberating the NHS* is a summary document reflecting the content of a suite of documents published under 'Liberating the NHS'. All of the consultation documents contain a wide range of proposals affecting the future of the NHS. Included are:

- a. Commissioning for patients
- b. Transparency in outcomes-the framework of the NHS
- c. Regulating healthcare providers
- d. Local democratic legitimacy in health

Plus the Report of the arm's-length bodies review which is not for consultation.

It is important to read all of the documents as much of the details are included in the consultation papers rather than the White Paper. Additional papers are expected in the near future. These include the future of Public Health, choice of treatment (2.20), NHS outcomes framework (3.10), information strategy (2.17), quality accounts (6.11), and NHS pensions (4.37) provider-led education and training (6.11) a review of data returns (6.11) and the funding of long-term care in 2011 (1.19). Frank Fields enquiry into inequalities and no doubt there will be others.

## **2. The key messages of *Liberating the NHS***

The intention is to change NHS culture to provide a quality service improvement framework that:

- is patient centred,
- achieves high quality outcomes,
- refuses to tolerate unsafe or substandard care,

- eliminates discrimination and inequalities,
- puts clinicians in the driving seat to innovate,
- is transparent and accountable,
- gives citizens a greater say,
- is less fragmented,
- is more efficient, dynamic with reduced bureaucracy and,
- is sustainable and free from day to day political interference (1.10).

In the future NHS clinicians, not politicians, will be responsible for determining how best to deliver safe and effective care within a clear and coherent national policy framework (3.4). The intention is therefore to support professionals to do the right things with and on behalf of patients, to innovate and improve outcomes (1.12) all within the economic climate of substantial cost-savings.

The plans are interconnected, mutually reinforcing and all within a very challenging timescale.

***Putting patients and public first***

Patients are described as ‘joint providers of their own care and recovery’, with the principle of ‘shared decision-making’ to be the norm. Key phrases used include:

- personalised care,
- shared decision-making,
- accessible information for choice and accountability,
- a choice of providers,
- a greater voice in the system.

New information systems will be focused on safety, effectiveness and experience with a greater emphasis on patient reported experience measures and health outcomes.

***Improving healthcare outcomes***

Targets based on process measures are to be abolished and replaced by three quality domains: effectiveness, safety and experience, the key components of which include:

- outcomes measures not targets,
- a culture of patient safety,
- quality standards developed by NICE,
- inspection against quality standards by Care Quality Commission,
- money follows patients,
- providers paid by performance and quality improvement.

NICE will develop authoritative standards spanning health and social care (3.14) setting out each part of the patient pathway with 5-10 specific indicators/measures for each step within the pathway (3.12).

Linking this quality framework with payment systems for improvement will be a challenge. There is talk of new 'currencies' (3.18) to complement best practice tariffs so providers are paid according to the costs of excellent care rather than an average price (3.19).

### ***Autonomy, accountability and democratic legitimacy***

The intention is to liberate professionals and providers from top-down control. Increased accountability and democratic legitimacy systems are to be put in place, supported by a transparent regime of economic and quality regulation which holds providers to account. This should enable:

- freedom from political micromanagement,
- the establishment of an NHS Commissioning Board to allocate resources,
- devolution of local commissioning to GP Consortia,
- Local Authorities to promote alignment of NHS services, social care and with health improvement,
- the creation of a strong social enterprise sector,
- Monitor to become an economic regulator,
- CQC to become the quality inspectorate for health and social care,
- a ring fenced Public Health budget.

The NHS Commissioning Board is portrayed as a lean and expert organisation which will draw upon best international practice, to standardise practice, provide leadership and quality improvement through commissioning guidelines (4.10). Fundamental to its success will be the promotion of equality and the reduction in unnecessary variations in health service outcomes. It will also assume responsibility for assessing the performance and quality of GP Consortia commissioners.

GP Commissioning Consortia (GPCC) are to redesign patient pathways in partnership with other health and care professionals (4.4, 4.6), will have a duty to promote equality and work in partnership with Local Authorities in relation to early years, public health, safeguarding and the well-being of local populations (4.6).

Local Authorities will be focused on improving health will be responsible for integration and partnership working between the NHS, social care, public health and other local services (4.17, 4.19). The intention is to do this through 'Health and Well-being Boards' or existing strategic partnerships structures (4.17). This will be important for children's services generally, and especially so for safeguarding.

All NHS Trusts are to become Foundation Trusts with employees having the opportunity to transform organisations into employee led social enterprise organisations (4.21). Monitor is to take on the responsibility

of economic regulation of all providers of NHS care and simultaneously promote competition between organisations (4.23, 4.27).

### ***Cutting bureaucracy and improving efficiency***

The intention is to radically simplify the architecture of health and care systems with the abolition of organisations that do not need to exist with a clarification about roles and responsibilities of others (5.4). This is to be achieved through:

- £20 billion efficiency savings by 2014,
- reduction of NHS management costs by 45% in four years,
- radical reduction in Department of Health functions, and
- streamlining and abolition of quangos and arms-length bodies.

The move is towards a system of control based on quality and economic regulation, commissioning and payment by results rather than a national or regional system of management (5.10). National data returns are to be reduced (5.7) and resources are to be released by Local Authorities through more efficient working with other organisations (5.12). The QIPP programme is to continue with even greater urgency and a particular focus on Local Authorities and general practice leadership (5.17, 5.18).

## **4. The vision of paediatricians**

Modelling the Future (MtF) I, II and III articulated the aspirations of paediatricians for models of service delivery that reflect the needs of children and families and deliver better experience and outcomes. The key messages from clinicians in Modelling the Future were that services should be:

- focused on improving health, reducing inequalities and being sustainable;
- value driven, meaning 'family friendly',
- based on pathways, with provision delivered by teams working in networks,

MtF III then focused on the practical implementation at a national, regional and local level using three concepts:

- systems alignment
- creating a sustainable workforce
- commitment to innovation and quality improvement

which were then interpreted for commissioner, provider and regulator elements of the "whole system".

### ***So how do the aspirations of 'Liberating the NHS' compare to those of 'Modelling the Future'?***

Modelling the Future advocated that services should be designed around 'pathways' and delivered according to evidence based guidelines by competent clinicians working in teams, in the right place, at the right time, with

appropriate supporting services (e.g. investigations, records and information technology, for example) to provide seamless services across health, education, social care and the voluntary sector.

For this proposal to be effective there must be alignment in the approach taken by commissioners, providers and regulators. They need to share both values (their philosophy and principles i.e. their 'culture') and their purpose - to improve health, reduce inequalities and to be sustainable within the resources available. From a child's perspective the key values include being family friendly (considering more than the management of the condition - the impact on the child and consequences to the family while involving them in decision-making).

Key recommendations of Modelling the Future included the need for:

- government departments to model better collaboration,
- a reduction in the number of different commissioners responsible for a pathway of care,
- greater integration between providers,
- the creation of networks of teams
- regulators to start inspecting across pathways of care/networks, rather than single organisations or individual professional groups.

Other recommendations of Modelling the Future included the need for clarity of the role of Children's Trusts, the need to develop a new metrics framework based on pathways, supported by integrated working across national improvement agencies.

The importance of maintaining confidence of individuals and teams was stressed in Modelling the Future, along with the need to link education and training with continuous learning from quality improvement initiatives. The importance of engaging families in decision-making, raising their expectations, as well as encouraging their active feedback to improve services were all proposed.

## **5. Equity and excellence: Liberating the NHS – the positive elements**

The values of social solidarity, of shared access to collective health care and shared responsibility for the use of resources to deliver better more effective health care, available to all, free at the point of use and based on need not ability to pay, are all excellent and when coupled with the key messages already outlined provide a sound basis from which to build a better future NHS (1.1-5).

'Equity and excellence' proposes that services should be designed around patient pathways, with NICE developing 150 'standards for each part of the pathway'. Standards are to be developed in a way that makes sense for patients and will extend beyond the NHS, into local authorities and the public health service. The standards will be accompanied by outcome measures with a series of measures across the pathway, driving

improvement through QUIPP (Quality, Innovation, Productivity and Prevention) and other improvement programmes (3.12, 3.13)

Equity and Excellence intends to accelerate the development of pathway tariffs, currencies and tariffs for community services (3.18) as well as best practice tariffs paid according to excellence of care (3.19). Commissioners will be able to pay a quality increment and CQUIN will be developed to support local quality improvement goals (3.20). It should be noted that the principle of rewarding quality will also apply in primary care (3.21). The principle of linking clinical decision-making and financial consequences is a logical proposal especially when linked to tariff systems/currencies that reward excellence, innovation and improvement.

Shared decision-making, based on clear data and information, coupled with choice and empowerment are central to a new way of working with individuals. The re-focus on health and the support for local health, education and social care services working together for children and families is welcomed (1.17). Specific details on the new Public Health service to create health improvement at a population level are awaited

The proposals for a National Commissioning Board (NCB) that will capture best evidence and practice developed by NICE into commissioning specifications for use and adaption to suit local circumstances by GP Commissioning Consortia is welcomed. Likewise the regulation of GP Consortia by the National Commissioning Board introduces a long overdue element of regulation into the commissioning process. The reduction of the number of commissioning bodies should result in a better more coordinated and collaborative approach between the remaining commissioners.

The proposals for improving health care outcomes linked to an NHS outcomes framework supported by indicators based on pathways and linked to improvement programmes such as QUIPP are welcomed particularly if the learning can be spread and adopted rapidly throughout all similar services.

Proposals to radically simplify the architecture of the health and social care system are cautiously welcomed, if they can truly deliver better services at least cost by devolving responsibility from central government and unlocking the inefficiencies that exist across different sectors.

## **6. Equity and excellence: Liberating the NHS – the concerns**

The proposals contained within 'Equity and excellence' are the largest reforms since the inception of the NHS. The sheer size of simultaneous multiple changes in commissioning, service delivery and regulation will exceed the capacity to change and is the greatest concern - together with the inevitable risks of unintended consequences.

The Government is committed to evidence-based policy making and a culture of evaluation and learning (1.23) yet there is little evidence to demonstrate that the proposed changes will be a significant improvement on what currently exists. Equity and excellence assumes that a 'consumer culture' (largely based on information and choice) is the correct value to drive improvement for all users of the NHS. Most commentators agree that information and choice works well for elective procedures, but not for emergency care, the management of long-term conditions, or public health services. Neither does it work well for individuals whose 'voice' cannot be heard clearly, for example, children, people with mental health problems and some elderly people. It is also well established that where 'consumerism' is the predominant driver efficiency does result, but this is usually at a cost of increasing inequities either in terms of access or outcomes of health services for the more vulnerable in society.

The majority of children and parents desire safe, effective and sustainable health services delivered locally, ideally at home, close to home and in schools. The agenda becomes one of how services can be incrementally improved and how learning and knowledge can be spread and implemented in other services. The policy emphasis then shifts to effectiveness and equity, rather than merely efficacy and efficiency.

In economic terms 'Liberating the NHS' assumes, indeed requires, increased demand-side aspirations to drive quality, rather than supply-side driven continuous quality improvement, to generate better value.

The transition costs (between old and new systems) are likely to be high, and transaction costs (of the new systems) are also likely to increase rather than decrease due to the increased number of both GP Commissioning consortia and organisations providing services. Whether improved outcomes, improved safety and more efficiency outweigh the additional costs is currently an unknown.

We would advocate that a system of control based on competition, quality and economic regulation, commissioning and Payment by Results (5.10) and tariffs for quality needs to be fully evaluated before being rolled out across all services provided by the NHS. The policy of increased choice, coupled with devolved control is extremely data dependent. Historically timely information has not been a strength within the NHS or the other organisations contributing to health gain. 'Liberating the NHS' promises an NHS information revolution (2.5) but we know information systems have not been able to rise to the challenge of a more market orientated health care system in recent years.

Services for children and families are relatively unique within the health service. Children are high frequency users of both primary care and urgent/emergency services and there are increasing numbers of long-term conditions where services need to be delivered in homes and schools, in conjunction with local authorities' particularly social care and education services.

For a small group where there are child protection concerns services there has to be integration between health, local authority, the criminal justice system and the community/voluntary sector. Within the health service there should be closer working arrangements between services for children and adult services where there are concerns about the impact of parental mental health, substance misuse, learning difficulties or domestic violence on children's health and well being. Certainly 'choice' is not the best driver for service improvement in this group and a similar argument can be made for emergency services, which almost by definition, need to be accessible locally to a guaranteed high level of quality.

The sheer number of GP Commissioning Consortia and their collective competence in the process of commissioning is a major concern, as is the cost of taking clinicians away from clinical care into the commissioning environment. GP Commissioning Consortia effectively trebles the number of commissioning bodies at a time when 150 PCT's were considered by many to be excessive.

The responsibilities between GP Commissioning Consortia, Local Authority/Public Health commissioning arrangements and commissioning by the National Commissioning Board are still extremely unclear. What is essential is that all commissioners' use the same model for commissioning, the same priority-setting criteria and all are committed to incremental quality improvement based on pathways.

A specific issue, unique to acute paediatric services, is the impact of the European Working Time Directive on middle grade rotas and the sustainability of the number of acute paediatric inpatient units. Resolution of this issue will require a high degree of cooperation between multiple GP Commissioning Consortia. Similar concerns regarding the commissioning of local (as opposed to national) specialist services which will either require some form of collaboration between Commissioning Consortia, or some level of devolution from the National NHS Commissioning Board.

Strengthening local democratic legitimacy, increasing patient voice within the system particularly through the development of patient reported experience and outcomes measures is important. There are concerns that due to the difficulties of ascertaining children's views and their involvement/engagement in local democracy that they will be further disadvantaged in a system that currently does not adequately address their needs. The majority of adult health conditions start in childhood and there is a wealth of evidence that can demonstrate investment in childhood services pays dividends in the long-term, but the majority of this evidence is not translated into services.

Devolution of responsibility from central government requires competence and capacity to assume responsibility for local decision-making. Effective knowledge and experience required is to achieve maximum health gain with limited resources for a local population. Currently this capability does not reside within one professional group and therefore effective teamwork is required to bring together collective competence.

Leadership is acknowledged to be important but there is little mention of teamwork, or its development, in the proposals.

The roles of Monitor, CQC, Health Watch, Health and Social Care Information Centre in providing information both to individual patients and those commissioning services is extremely unclear. More importantly the alignment between these organisations to pathways and networks is not mentioned.

### **Three examples demonstrating the complexity of commissioning arrangements**

**1. Cystic fibrosis** is a good example of a complex long-term condition which is largely managed within the health service, but has a significant impact on social and family life.

In the UK, cystic fibrosis is identified on the blood spot screening programme, and then confirmed with sweat test and genetic tests. Initial treatment is with physiotherapy and antibiotics to prevent chest infections. Genetic counselling, information and emotional support for families are needed.

Having established the diagnosis and initial treatment, ongoing care is orientated to preventing or identifying early these secondary complications of the disease predominantly bronchiectasis, pancreatic insufficiency, diabetes, liver disease. The impact on the child and the consequences of the family should be considered particularly the psychological and emotional impact on intensive treatment and disruption to family life. At some later stage heart-lung transplantation may need to be considered, and eventually end of life planning.

This complex condition requires a variety of commissioners to come together to plan, design, finance and deliver services with the relevant providers not only to manage the condition across different health sectors, and also provide support for families to mitigate the negative impact of this long-term condition on family life.

**2. Head injury.** The commissioning of head injury services must start with prevention, for example reducing road traffic speeding in areas where there is a high density of young children, providing safe play spaces, and safe routes to school. When an injury does occur for whatever reasons, prompt emergency services, active resuscitation and assessment of the severity of the head injury needs to happen promptly, and if surgery is required better outcomes are achieved when this is accessed as soon as possible.

Post significant head injury the physical, social, emotional, psychological and educational consequences of brain injury needs be assessed in managed. Early active rehabilitation improves long-term outcomes. In the longer term, it is the educational, psychological and memory problems that determine whether young people can succeed in life.

Occasionally head injuries that due to non-accidental injury and the police and children's social care are involved.

Commissioners across all sectors, health education, social care, local planning all have a role in ensuring all the parts of the service are in place and working well together to achieve the best outcomes.

**3. Mental health problems.** A substantial number of young people within the criminal justice system have unrecognised learning difficulties, psychological problems and poor social skills. Imprisonment is the endpoint for a history of poor parenting, violence, educational failure and behaviour problems. The prevention of this outcome requires a range of effective interventions from both "adult" and "children's" services. The worst outcomes are associated with parents who have learning difficulties, mental health problems, who experience domestic violence coupled with substance misuse. Commissioners from all sectors need to work together using effective interventions, delivered locally to prevent this outcome.

### **6. Proposals to overcome the identifying difficulties**

The fundamental problem with 'Equity and Excellence: Liberating the NHS' from a 'children and families perspective' is that the proposals for integration do not go far enough. To create really effective services for children and families there should be greater integration between the commissioners of services, between individual providers and between the regulators of services. By working to the same values, with the same models and to achieve the same outcomes all the elements could be aligned to create a system that would be more effective, efficient and equitable, as well as more accessible, acceptable and affordable.

#### ***Improving services***

'Liberating the NHS' builds on the Darzi agenda namely improving safety, experience and outcomes of services. The proposals link choice, competition and tariffs for quality as the primary drivers. This model is less appropriate to services for children and families due to the complexities of interventions covering both the management of the condition, the impact on the child and the consequences of the family especially when these need to be delivered jointly by health, education and social care services - with all the parts being in place and working well together to achieve safety, coupled with better experience in outcomes. For this to be achieved there needs to be integrated commissioning, with all commissioners using the same model, the same improvement and investment strategy and shared measures to determine priorities and success.

Likewise regulators should inspect pathways from the perspective of patients rather than taking an organisational or a professional regulatory perspective. Where poor performance is identified that should be an explicit link to information/knowledge to improve the 'weakest link' in the pathway. Further investment in quality improvement, shared by all agencies involved in delivering the pathway should be the outcome of inspection processes.

Fragmentation of providers into multiple competing units of 'business' will create increased costs not the desired efficiencies. However integrated organisations sharing medical records/IT systems/quality improvement where multidisciplinary teams work together have a greater chance of success.

Dismantling 'improvement organisations', such as the NHS Institute before a culture of continuous quality improvement has been robustly established within public services is premature.

### ***Commissioning***

Maternity services, neonatal services, specialist paediatric services are already part of the National Commissioning Board remit. Public health services, safeguarding services, and local health improvement appear to be the remit of Local Authorities, with the remainder being the responsibility of GP Commissioning Consortia. The intention is to commission networks, based on pathways, and this will require the active involvement of all three commissioning bodies (see examples above).

A better long-term commissioning strategy would be to base commissioners on the population served by a large specialist centre (a 'Specialist Commissioning Board'). They would then be responsible for **all** commissioning (including national specialist commissioning which would require joint working and risk-sharing across those commissioning bodies)

Local commissioning could be led by Children's Trusts/Local Partnerships informed by Local Health and Well-Being Boards, or by the Local Health and Well-Being Boards themselves using the expertise of local professionals coupled with the priorities of 'Specialist Commissioning Boards'.

### ***Provision***

Community Child Health Services need to integrate in two directions - both with hospital-based paediatric services and the professional groups within the Local Authority to create competent teams. In the ideal world there would be a single provider of secondary children's services including paediatric, community child health, child mental health, safeguarding and special educational needs services. The management of maternity and neonatal services should always be considered together and could be integrated in some localities.

The future of Children's Trusts needs to be reviewed and clarified; currently they exist in many different forms. They have the potential to evolve into Community Foundation Trusts (or a Social Enterprise Organisation) which could provide hospital-based services with an 'in reach' arrangement with the local district general hospital foundation trust.

## **Regulation**

The simplification of regulation is welcomed, but the regulation of commissioning, service provision and economic perspectives should be integrated. In a world demanding cost-effective care, it is inappropriate to disassociate the regulation of cost with the regulation of effectiveness. Both need to be based on a whole system approach designed around pathways and networks.

As the purpose of regulation is to drive improvement there needs to be a more explicit link between regulation/inspection, improvement and measuring the impact of improvement.

To support the process of both regulation and improvement there should be a logical and effective process to gather, analyse, compare, and feedback information. This is a current weakness within the whole system, which 'Equity and Excellence: Liberating the NHS' does not effectively address.

## **7. Summary of proposals for BACCH members**

### **1. Retain the Proposal for a National Commissioning Board**

#### ***Purpose***

- to bring together NICE standards, measures and tariffs for pathways/networks into outline contracts for GP commissioning consortia, regional commissioning board's and local family service commissioning board's
- to regulate the various commissioners

### **2. Create Specialist Commissioning Board's**

#### ***Purpose***

- to undertake regional and national specialist health service commissioning
- to combine the commissioning of other specialist services such as secure accommodation, residential educational provision

### **3. Create Local Family Service Commissioning Board's**

#### ***Purpose***

- to focus on local needs assessment
- commission local services across health, education and social care and where appropriate voluntary/community sectors
- set at local priorities for improvement

### **4. Create Integrated Children's Foundation Trusts**

#### ***Purpose***

- bring together children's service providers across health, education and social care

- provide professional advice to Local Family Service Commissioning Board's

5. ***Merge the regulation of health/social care/education and integrate the work of improvement agencies***

***Purpose***

- to work closely with NICE to develop standards based on pathways
- develop measures and outcomes based on pathway/networks
- work with improvement agencies to create a culture of assurance leading to improvement

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