



Equity and Excellence: Liberating the NHS

12 July 2010

Political Analysis

Elements of the Coalition Government's health reforms announced today reflect an extension of the last government's approach to health: broadly market-based, engaging with clinicians and, in theory, offering choice to patients. But Lansley and his team have gone much further, with a combination of the Liberal Democrat localism agenda and the Conservative's responsibility programme to deliver something genuinely radical.

The document, described by DH sources as "a white paper with a greenish tinge", is a major political gamble, transferring power and money away from Whitehall control, and it will face opposition from a host of stakeholders. However, no one can accuse the new Health Secretary of being unambitious. His department's proposals represent perhaps the greatest structural change to the NHS since its formation in 1948 – quite a surprise for some, considering Cameron's previous statement that the NHS did not need "another massive structural reorganisation".

The obvious centrepiece of the proposals are the measures to give GPs and their patients greater power over the services commissioned by the NHS, through GP-commissioning. Up to 500 GP consortia will control as much as £80 billion of public money. These structural reforms are seen by the Department as 'phase one' of the plan for healthcare, with later phases to cover public health, the Cancer Drugs Fund, social care, pharmaceutical policy and reform of the National Institute for Clinical Excellence (NICE).

Other radical changes will see a focus on health outcomes, rather than targets, to match Europe's best, and the foundation of an NHS Commissioning Board, with Strategic Health Authorities becoming regional outposts of the Board.

The Coalition Government will surely be prepared for the attacks that have already begun in earnest. MPs from all parties, as well as a host of other respected voices, are questioning the merit of insulating the NHS from the savage budget cuts that will be meted out to other departments. Lansley may in future find himself under pressure from crossbench parliamentary alliances whose constituents have missed out on care following the failure of their local consortium.

The Government is set on a collision course with unions and may have to enter into complex and possibly expensive negotiations with the British Medical Association (BMA) over changes to the GP contract to ensure GPs are rewarded appropriately for their extra responsibility. Having already threatened to block reform perhaps the BMA will seek greater powers rather than payment this time?

Andrew Lansley's first political test as Health Secretary happens as the Coalition Government's honeymoon period appears to be coming to an early end. The troubles stalking Michael Gove's flagship reforms at the Department for Education offer a valuable warning for Lansley and his team on how easy it is for

Key headlines

- Patient empowerment: "no decision about me, without me"**
- Decisive shift of power to patients and clinicians**
- New NHS Outcomes Framework to be agreed**
- SHAs and PCTs phased out over the next 4 years**
- Introduction of approx 500 GP commissioning consortia**
- All NHS trusts to become or be part of a foundation trust**
- Any "willing provider" to be used to deliver services if they can offer necessary quality of care**
- Monitor to become economic regulator**
- Stronger role for CQC**
- £20bn efficiency savings by 2014**
- NHS management costs to be cut by 45% over next four years**
- Cut quangos by a minimum of a third**
- Introduction of value based pricing in 2014**
- Cancer Drugs Fund from April 2011**

such major reform to unravel. And there can be no question that the announcements in today's white paper are every bit as radical as Gove's free schools agenda, involving significantly greater sums of public money.

Lansley also made it known that his department expects to do a serious amount of consultation over the coming months, asking for the public's thoughts on everything from the outcomes framework to GP commissioning and the dentistry contract. He should be wary that his radical zeal is not crushed under the full weight of government bureaucracy.

Major structural change

At the heart of this is the switch to GP commissioning, as Lansley laid out his plans to pass the responsibility for commissioning general healthcare services from Primary Care Trusts (PCTs) to consortia of GPs by 2012. Funds of £80bn, equivalent to around 80% of the NHS budget in England and Wales, is set to be handed to GPs as a result. An independent NHS board will be created to oversee and allocate funds for GP commissioning, while the 10 strategic health authorities (SHAs) and 152 PCTs will eventually be scrapped. All this comes against a backdrop of major cuts to public sector spending and, despite the ring-fenced NHS budget, the need for the NHS to make £20 billion in efficiency savings over the next three years.

GP commissioning and the NHS Commissioning Board

Lansley has three aims: to empower healthcare professionals, to shift to an outcomes, rather than targets, focused service, and to put patients at the centre of the NHS. His logic behind the switch to GP commissioning is widely accepted. GPs are best placed to understand the needs of the local patients and communities, and to be able to ensure the right services are available to meet them. He believes that through this better, more accurate commissioning, savings will be made and outcomes will improve.

However, while most agree that GP commissioning does have the potential to deliver and improve these services, there remains a fair degree of scepticism around implementation. Under a previous system which placed GPs on the front line of commissioning, GP fundholding, very few GPs took up the opportunity to commission services, exacerbating health inequalities in certain areas. Many expect GPs to be similarly unmotivated this time around.

The new system seeks to address this by making it compulsory for GPs to commission, but the issue now is that very few are prepared and capable enough to commission effectively. As Shadow Secretary of State, Andy Burnham noted in his reply to today's announcement, Dr Michael Dixon, chairman of the NHS Alliance, has said "only about 5 to 10 per cent of GPs are currently ready to take on hard budgets to buy care within the next few months. Perhaps 50 per cent will be within 18 months. But others will take longer." The Chief Executive of the NHS, Sir David Nicholson, shares his caution, saying at the recent NHS Confederation Conference that most GPs currently involved in purchasing care through practice-based commissioning arrangements lack the expertise to deliver this with real quality, and that, "even the most optimistic people won't say we will get this system up and running by 2012." Other organisations, such as Civitas, have predicted that the time taken to implement the changes will lead to a dip in performance and may even set the NHS back a few years.

The expectation is that, faced with mandatory commissioning, newly-formed GP consortia will seek out experienced staff from PCTs to help deliver the results they need. The white paper sets out how consortia must have an accountable

Timeline

Consultation

The government is consulting on all proposals that require primary legislation:

- creation of a Public Health Service
- transferring local health improvement functions to local authorities
- Health and Social Care Information Centre reform
- healthcare outcomes
- NICE reform
- establishing the independent NHS Commissioning Board and abolition of SHAs
- limiting the role of the Secretary of State
- local democratic legitimacy and supporting integration across social care, the NHS and public health
- GP consortia and the abolition of PCTs
- establishing HealthWatch as a statutory part of the Care Quality Commission
- reforming the foundation trust model and the abolition of the NHS trust model
- strengthening the role of the Care Quality Commission as a quality inspectorate and developing Monitor into the economic regulator for health and social care, including provisions for special administration
- reducing the number of arm's-length bodies

Responses are due by the 5 October.

July: Further publications on

- framework for transition
- NHS outcomes framework
- commissioning for patients
- local democratic legitimacy in health
- freeing providers and economic regulation

officer and will be accountable to the Commissioning Board. The PCTs are slated for closure, and their statutory functions and commissioning services that cannot be provided by GP consortia, such as maternity services, specialized commissioning and dentistry, will be delivered by the NHS Commissioning Board. Another source of commissioning assistance will come from the private sector, with many private companies expected to take up opportunities to provide support to GPs. This possibility has already led to cries from some that the Coalition's real agenda is the privatisation of the NHS by stealth.

Accountability and quality

Concerns over accountability and safeguarding of the funds to prevent overspends have been raised by a number of parties, including the Treasury. Today's announcement sought to allay those fears, stating that GPs, and their funding will be accountable for a range of outcomes, set out in the new outcomes framework, including reducing mortality, cutting premature deaths from heart and lung disease, and improving one-year and five-year cancer survival rates compared to the EU. In addition, 150 quality standards developed by NICE will be used to inform commissioning and payment, and these standards will be inspected. The first of these standards have been announced on stroke, dementia and the prevention of venous thromboembolism (VTE).

The plan is for the outcomes framework and quality standards to inform commissioning and become quality indicators, which will enable international comparisons and help raise standards. These changes in accountability have brought predictions of increasing, rather than decreasing, levels of bureaucracy, with the need to monitor 500 GP consortia rather than the existing 152 PCTs.

The government also acknowledged that there needs to be reform of the payment systems used by the NHS in order for the new accountability to work. It proposes that money will follow the patient through transparent, comprehensive and stable payment systems across the NHS to promote quality, efficiency and supporting choice.

Free choice of GP and consultant

A key element of the plan is the abolition of GP boundaries, leaving patients free to choose any GP they want. This policy has been proposed a number of times in the past, most recently by then Secretary of State Andy Burnham prior to the election, but if successful this time, the coalition believes it would deliver an injection of choice into the system. This in turn will help introduce market-style levers into primary care and the wider NHS, with GPs needing to commission and deliver quality in order to secure funds. Going even further, the white paper sets out that patients can choose from any willing provider, opening the way for the private sector to extend its role in delivering healthcare.

Hospitals, competition and regulation

The white paper sets out the government's intention to 'free NHS providers from Whitehall control', and states that all NHS trusts must become Foundation Trusts (FTs) within 3 years. The detail of this will be set out in a further consultation document which may include moving FTs off the public sector balance sheet. Lansley sets out that FTs will be able to become "employee led social enterprises", regulated in the same as any other provider whether from the private or voluntary sector. It states that FTs will 'not be privatised'. However, the proposals mean that hospitals can become independent providers to the NHS.

Summer 2010

Publication of report of the arm's length bodies review

Autumn 2010

Health Bill introduced in Parliament

Late 2010

Public Health white paper

End of 2010: Further publications on:

- vision for adult social care
- information strategy
- patient choice
- a provider-led education and training
- review of data returns

2011

White paper on social care reform

By April 2011

Choice of consultant-led team

April 2011

Shadow NHS Commissioning Board established as a special health authority

Cancer Drug Fund established

From 2011

Choice of treatment and provider in some mental health services

Expand validity, collection and use of PROMs

Develop pathway tariffs for use by commissioners

June 2011

Quality accounts: nationally comparable information published

By July 2011

Report on the funding of long-term care and support

Summer 2011

Hospitals required to be open about mistakes

2011/12

GP consortia established in shadow form

The forthcoming consultation will also consider:

- Whether the cap on the amount of private work undertaken by FTs should be removed
- Enabling FTs to merge more easily
- Whether FTs should be able to tailor their governance arrangements to local needs.

Supporters of the move suggest this will encourage FTs to be more efficient. It will mean that FTs no longer have access to public money for capital projects, and that the government will not step in to bail out FTs in difficulty. The accompanying 'analytical strategy' sets out that failure must be dealt with in a robust and transparent manner.

The Care Quality Commission will continue to regulate quality across all health and social care providers. Monitor will be the economic regulator for all providers of NHS care from April 2013. Providers will have a joint licence overseen by both Monitor and CQC. Monitor will have a remit to prevent anti-competitive behaviour by purchasers, for example commissioners who fail to tender for service or discriminate in favour of incumbent providers.

The document also states that *all* providers of healthcare services, presumably including independent sector providers, will have to meet the costs of staff education and training and it will publish proposals on this.

Information provision

To deliver this properly, a revolution in information provision is planned. Detailed information about the performance of hospitals across a range of therapy areas is set to be made available to patients, along with the freedom to see the consultant of their choosing. The current system, NHS Choose and Book, has been widely ignored by many GPs.

The GP contract

The BMA will have a vital role to play if these changes are to be successfully implemented. The BMA has already spoken of blocking future reform once handed commissioning powers, and has heavily criticised the plans to scrap GP boundaries, saying it could undermine the commissioning plans. The current GP contract and quality outcomes framework will need to be renegotiated in order for the plans to proceed and the white paper states that the government will discuss this with the BMA.

Separation of commissioners and providers

The white paper also stipulates that by 2011 commissioning and provider functions must be separated and can no longer be provided by the same organisation. This means, for example, that the 250,000 community nurses and therapists who work for the provider arms of PCTs, will need to find new employers, or set themselves up as independent sector providers.

Staff pay and pensions

The white paper gives all NHS trusts the right to negotiate pay for their own staff (although it states many providers will want to continue to use national contracts as the basis for their local terms and conditions). This will be a huge change for the NHS and is likely to be controversial amongst staff-side unions. Advocates

2011/12 : Tariffs

- Adult mental health currencies developed
- National currencies introduced for critical care
- Further incentives to reduce avoidable readmissions
- Best-practice tariffs introduced for interventional radiology, day-case surgery for breast surgery, hernia repairs, and some orthopaedic surgery

By April 2012

NHS Outcomes Framework fully implemented

April 2012: Majority of reforms come into effect:

- NHS Commissioning Board fully established
- New local authority health and wellbeing boards in place
- Limits on the ability of the Secretary of State to micromanage and intervene
- Public record of all meetings between the Board and the Secretary of State
- Public Health Service in place, with ring-fenced budget and local health improvement led by Directors of Public Health in local authorities
- NICE put on a firmer statutory footing
- HealthWatch established
- Monitor established as economic regulator

From 2012/13

International Classification of Disease (ICD) 10 clinical diagnosis coding system introduced

2012

Free choice of GP practice

Formal establishment of all GP consortia

2012/13

SHAs are abolished

From April 2013

PCTs are abolished

will argue it enables employers to respond to local market conditions; detractors will point to potential time wasted in local pay bargaining, which individual providers will have to take on. The document also references the independent review of public sector pensions being chaired by Lord John Hutton – another red rag to the union bull.

Reforming tariffs

The reformation of tariffs will create a new ‘best practice tariff’. The white paper outlines, “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. 2011/12 will see the introduction of best-practice tariffs for interventional radiology, day-case surgery for breast surgery, hernia repairs and some orthopaedic surgery.”

Best practice tariffs represent a fork in the road for the new GP commissioners and the acute providers. The lack of detail on this could mean an opportunity for industry to input and drive quality or it could be a tariff that seeks to push the price down without thought for the consequence on outcomes.

Pharmaceutical industry

The white paper reiterates the Coalition Government’s commitments to reforming the way the NHS pays for medicines and states that the Cancer Drugs Fund will be set up in April 2011. The NHS will “pay drug companies according to the value of new medicines” in order to promote innovation, improve patient access to effective medicines and “improve value for money”. As expected, the white paper confirms that value-based pricing will be introduced 2013/14.

NICE’s role will be expanded and it will be responsible for developing the new quality standards. Over the coming five years, it will develop a “comprehensive library of standards” for the major patient pathways. Andrew Lansley has previously stated that NICE will no longer be in a position to accept or deny the use of drugs on the NHS, which is a fundamental change to the organisation’s role.

Pharmacists will also play a greater role “optimizing the use of medicines”, although precisely what this entails is not clear. The government also be consulting later this year on giving patients the authority to have a greater say in determining their treatment, but further details are not given.

Further consultation

All measures that require primary legislation will be consulted on, including the plans to implement the NHS Commissioning Board and GP Commissioning. More detailed information will be published by the government in July. However, both initiatives are set to run in shadow form from 2011, prior to the passing of the necessary legislation.

Consultation responses are due by the 5th October. The full document can be found [here](#).

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2013/14

All NHS trusts become, or are part of, foundation trusts

All providers subject to Monitor regulation

By 2013/14

Choice of treatment and provider for patients in the vast majority of NHS-funded services

Introduction of value-based approach to the way that drug companies are paid for NHS medicines

By July 2015

NICE expected to produce 150 quality standards