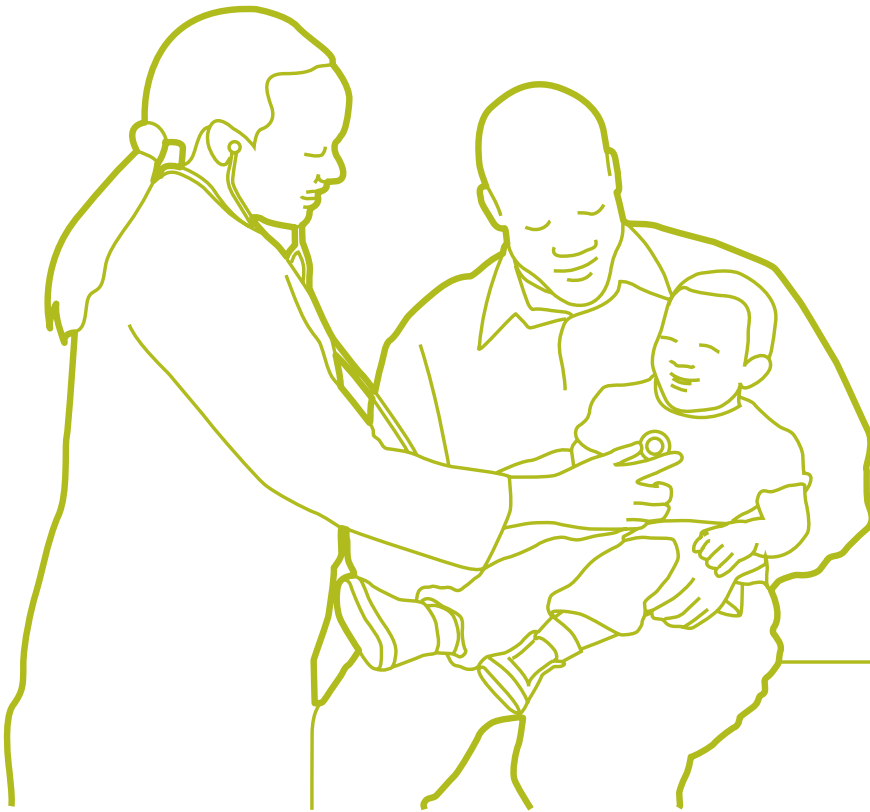


'LIBERATING THE NHS' - THE NEXT TURN IN THE CORK SCREW?

An analysis of the Coalition Government's proposals for health



Introduction

The publication of the White Paper, ‘Equity and excellence: Liberating the NHS’, is potentially the most radical plan for the reform of the NHS for a generation. Although the individual elements are familiar, taken together they represent a bold initiative to change the NHS, root and branch. Services would remain free at the time and point of need, paid for by the state, but in a few years they could be commissioned and provided by a range of organisations outside the traditional public sector.

Arguing that state management, both of commissioning and of service provision, has failed to deliver the desired quality outcomes and productivity improvements, the Coalition Government is proposing to devolve the NHS to the patients and their clinicians. Whilst in the short term the impact on patients may be limited, the implications for NHS clinicians, staff and managers are profound.

This paper, one of a continuing series over the last two decades, provides an analysis of the White Paper and begins to consider both its implications and some of the practical problems its implementation will face.

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'Liberating the NHS' - The next turn in the cork screw?

The White Paper, 'Equity and excellence: Liberating the NHS', published on the 12th July is perhaps the most important redirection of the NHS in more than a generation; which is paradoxical given that virtually all its key elements have been core components of healthcare policy for more than 20 years. Patient empowerment through information, the reform of commissioning and increased competition between providers, all working within a regulated framework, have all featured in NHS plans over the last decades, but none have been pursued to their logical conclusion. The difference is that this Secretary of State seems intent on progressing on all four fronts at the same time, going further and faster than any Secretary of State before. And the economic and political circumstances facing the country might just provide the conditions for him to overcome many of the barriers to change that have frustrated his reforming predecessors.

The four pillars of this White Paper are therefore familiar to any observer of NHS policy in England since at least 1990. At its centre is the patient but now a patient empowered by a tidal-wave of information and presented with real choices from an increasing range of diverse and innovative service suppliers. On either side are the columns of the purchaser provider divide, but now strengthened and reinforced. Commissioning is to be kick-started by handing it over to the GPs, who may well come to wonder at what they have wished for. Providers are to be freed from the shackles of state interference and staff are to be encouraged to take-over their organisations but working within an open and increasingly competitive market. Overarching everything is strong regulation; Monitor as the economic regulator, CQC looking after quality, the new NHS Commissioning Board overseeing GP consortia and the role of NICE reinforced.

This White Paper is therefore entirely consistent with dominant themes of modern Conservatism and, as it increasingly appears, modern Liberalism. An acceptance of the role of the state in the funding of

services but a rejection of state management. A belief in localism and mutualism and therefore an acceptance of difference. A confidence in the role of professionals but only when subordinated to the informed individual. And a faith in the power of regulated markets to drive service improvement and productivity.

To the wider general public much of 'Liberating the NHS' will seem unremarkable, and certainly not very radical; but the reaction within the NHS is likely to be much stronger. Whilst perhaps accepting the ultimate vision, many in the NHS will feel threatened – organisations will disappear, jobs will go, clinical performances scrutinised, new competitors encouraged and power shifted. The challenge for the Coalition Government will therefore be to overcome the NHS's talent for inertia, the ability to slow unpalatable reforms to a snail's pace, in the corporate hope of a change of direction or even a change of government.

The immediate challenge, however, is cash. Even on the most optimistic assumptions the reforms set out in the White Paper will take three to four years to implement and their impact on system performance years further. The Secretary of State clearly recognises the central importance of improving productivity, of reducing the unit cost of services and his reforms may well deliver over the longer term. But in many local healthcare economies the financial crisis is already upon us.

Even with the promised, if undefined, protected increases in NHS funding, perhaps a third of England's local health systems will run out of money over the next few years without major changes in service configuration. The White Paper provides the longer term framework for tackling these immediate issues but it is less clear whether or not it provides support for their early resolution.

Patient power unleashed

The individual patient is absolutely central to the vision set out in ‘Liberating the NHS’: enhancing the role and power of the patient is the leitmotif that runs throughout the White Paper. An informed, empowered patient will take greater responsibility for their own care and can be trusted to make sensible, if shared, decisions about the care that they want the NHS to provide for them. And in making those decisions they will collectively transform the NHS to become more responsive, to deliver better outcomes and greater productivity. If patients better understood the comparatively poor clinical outcomes that the NHS too often delivers, then they would rightly demand improvements and make their choices of service provider appropriately.

The White Paper’s core principle is, therefore, that it is the service user in partnership with their clinician, not micro-management by the Secretary of State that will drive up standards. The role of the state is to pay for services, to maintain a regulatory framework and to hold the NHS accountable for how it uses tax-payers’ money. In this future there is little role for management or managers, who barely get a mention.

To fulfil their role patients need to be empowered and information is power. The Government’s intention is therefore to publish pretty much everything that can be published. Service providers, including GPs, will be contractually obliged to collect and return clinical outcome data, Patient Report Outcome Measures (PROMS) will be expanded and quality accounts will be extended and required from all NHS providers. The Health and Social Care Information Centre will have an expanded role to centralise and standardise data and assure its quality but crucially the market will be opened up to third parties to analyse and interpret the data. Patients and professionals can look forward to a wave of new web sites providing comparative information on every provider, down to named consultant-led teams.

Patient power is expressed through choice. Many NHS professionals have been sceptical about patient choice ever since it was introduced, often arguing that

all patients want are convenient, local services. There is however, good polling evidence that patients value choice. There is also reasonable empirical evidence, that when patients have hard information, for example when things are going badly for a provider or when they have to make a planned decision over elective interventions, they want to be able to make meaningful choices.

If patients have better information to underpin their choices, then they also need to be presented with meaningful alternatives. So wherever possible there will be choice of Any Willing Providers, with multiple suppliers drawn without differentiation between the NHS, voluntary and independent sectors. Those suppliers will be encouraged to offer patients choice not just in the limited area of cold elective surgery but in mental health, maternity care, diagnostics, long term conditions, end-of-life care and of course, the right to choose your GP. Given the devolution of commissioning to GP consortia, that choice of GP, perhaps the most important choice a patient makes will now be underpinned by hard information on just how well they are performing as commissioners.

The Government’s ambitions for choice are impressive. By April 2011 patients will not only have a choice of a provider but also choice of a named consultant-led team. Going further, the White Paper proposes to examine the possibility of giving patients a choice of the treatment they are to receive. By 2013/2014 choice is to cover the vast majority of NHS-funded services.

There will not however be any rapid progress on Personal Budgets. A review is planned, but handing more money directly to patients to control, rather than to their GPs, seems to be a step too far; at least for the time being.

In this world of informed patients with multiple choices of treatments and providers, the Secretary of State becomes the patient advocate in chief. Denying himself many of the powers to intervene in the day-

to-day operations of the NHS, he will hold the NHS, primarily through the new NHS Commissioning Board, accountable for delivering better clinical outcomes, improving service quality and extending patient choice, as set out in the NHS Outcomes Framework. Of these, healthcare outcomes become the governing principle, in terms not only of clinical outcomes from interventions, but also patient experience and a continuing reduction in morbidity and mortality.

GPs and commissioning

The most striking structural shift within the White Paper and the development which is likely to cause the greatest concern for many within the NHS, is the creation of GP consortia to take on the role of commissioning. These are to be established in shadow form during 2011/2012 and to have full financial responsibility from April 2013, from which date Primary Care Trusts (PCTs) will cease to exist.

The argument appears powerful: GPs make the key decisions which determine to a great degree how NHS resources are spent, so those decisions should be aligned with real money and crucially with corporate responsibility for how it is used. The sub-text is that for years GPs have argued that NHS managers – the system, the PCTs – have stood in their way; stopping them innovating, inhibiting their ability to redesign care pathways to reflect the real needs of their patients. Whilst Practice Based Commissioning (PBC) was a step in the right direction, it was ill-thought out and subject to interference from PCTs; it simply didn’t go far enough.

So although PBC provides a precedent, there are very important differences. Although budgets will be calculated at the level of the practice, the budget will be allocated to and held by each consortium, which will also hold the contracts with providers. Membership of a consortium, established initially at least with a geographical focus, will not be an option. If a practice does not volunteer then the NHS Commissioning Board will have the powers to assign a practice to a consortium and the consortium will hold its member practices accountable for the achievement of its objectives.

The Government has already announced its intention of renegotiating the GP contract and, as part of that renegotiation, it will doubtless seek to define the GP’s individual responsibilities with respect to consortia. So the quid pro quo for gaining real commissioning power is the mandatory acceptance of managerial responsibility for the local health system.

The consortia, reportedly between 500 and 600 of them organised predominantly on a geographical basis, will have an average budget of more than a £100m and will together manage some £70 billion of NHS funds – of tax-payers’ money. They will be responsible for commissioning and contracting for the majority of health services – although ophthalmology, dentistry and community pharmacy will be excluded and consortia will have the freedom to work collaboratively, for example to establish a lead commissioner role.

To help consortia, NICE will be developing 150 clinical quality standards, which consortia will be required to use for commissioning; so local freedom will not be unlimited. The formation of consortia does, however, implicitly accept and at least in the short term reinforce local differences. Given the size of consortia, they will have very different and distinct characteristics – of wealth and poverty, of ethnicity and religion and of competency and capability.

An individual’s choice of GP is already amongst the most important healthcare choices they make and that choice, often made casually and with no appropriate information, will now become even more important. As the public become aware of the difference and as the information becomes available, individuals may well begin to move, favouring GPs and consortia that have a demonstrable track-record of success. Or perhaps favouring consortia that differentiate themselves by specialising in particular areas – there is certainly a market opportunity for a consortium that specialises in the problems of middle-aged men heading for retirement!

One of the questions that the White Paper doesn’t address is why commissioning consortia are restricted to GPs. If patients are to be empowered and to have real choices why shouldn’t they have a choice as to

who commissions their healthcare? If parents can set up schools, why can’t patients set up their own commissioning groups?

Managing the consortia

Whilst consortia will receive a management fee, they are unlikely to be of a sufficient size to carry out many of the day-to-day functions of contracting and commissioning, so they will have the freedom to contract-out support functions to third parties, including the private sector.

There is scant detail in the White Paper on how a consortium will be established and operated; they will however be established on a statutory basis, through primary and secondary legislation. Some flexibility would be attractive so that consortia can evolve, perhaps consolidating or becoming more specialised. It seems likely, however, that arrangements will have to include some form of incentive for GPs to participate; though it’s unclear what appetite there will be in the Treasury or even amongst the public for paying GPs more.

Importantly, every consortium will have to include an Accountable Officer and their performance and outcomes will be overseen by the NHS Commissioning Board. Given the amounts of public money involved and the political consequences of failure it hardly seems likely that the Board’s stewardship will be exactly light touch.

To cover for the possibility of failure, consortia will be required to take part in risk-pooling arrangements; successful consortia may have views about picking-up the bill for their failing colleagues. The Government will not, however, bail out GP consortia that fail. There will be failure regime but it remains to be seen just what will happen when a consortium runs out of money in the middle of January and just what failure would mean for the constituent GP practices.

A crucial test of the Government’s proposals will therefore be their ability to get the GPs to play ball without having to pay out yet more money in incentives.

For GPs the prospect is deliciously balanced. In return for a much greater role, a role that their leaders have been campaigning for, they will have to accept corporate, indeed managerial responsibility coupled with unprecedented degree of public scrutiny of their individual professional performance. One of the untoward if not necessarily undesirable outcomes of this process, might well be a radical reform of primary care and the inevitable decline of the GP practice as an independent small business.

The NHS Commissioning Board

If the development and oversight of GP consortia is to be the central role of the autonomous NHS Commissioning Board, it will not be the only function of this ‘...lean and expert organisation’. With no role in managing providers the Board is to provide national leadership for quality improvement, exercising that leadership through the commissioning activities of the 500 plus GP consortia. Where it is inappropriate for GP consortia to commission services directly, for example national and specialised services, this will be undertaken by the Board. For some unspecified reason, maternity services, the most local of services, where choice is arguably most appropriate, will also be commissioned nationally.

In addition the Board will have a responsibility for tackling health inequalities and for promoting patient choice and involvement. Again, this is a responsibility it will fulfil through the autonomous GP consortia.

Of most concern to any potential member of the NHS Board will be the responsibility to allocate NHS resources and to manage the overall commissioner revenue limit; in other words to ensure that the system doesn’t run out of money half way through the year. Given the number of GP consortia this could prove quite a task; following the demise of Strategic Health Authorities in 2012/2013 and PCTs from April 2013, the Board will have outposts, which could be pretty busy.

An expanded role for local authorities

With the abolition of PCTs local authorities are to have an expanded role, taking on responsibility for public health and health improvement and will be the employer of the local Director of Public Health, appointed jointly with the new Public Health Service. Presumably the LAs will get funding to carry out these functions from the Commissioning Board and if it were on a similar level to current PCT spending this would amount some £20 million for each authority. The separation of public health, particularly health education and improvement programmes, from service commissioning, is however disappointing, as it will decouple the incentives to invest now, to reduce service demand later.

Reflecting the influence of their coalition partners, there will be new statutory arrangements to establish ‘health and wellbeing boards’ within local authorities, which will replace the Health Overview and Scrutiny Committees. It is not clear from the White Paper whether the desire to achieve democratic legitimacy, extends to having directly elected members of these boards, though local patient representatives will have a ‘formal’ role.

The purpose of these new boards is to allow local authorities to promote integration and strategic coordination across health and adult social care and children’s services, however there is to be no further integration of health and social care budgets. Whilst joint budgets and commissioning, between PCTs and LAs, has made at least fitful progress, it is difficult to see how three times as many GP consortia are going to work more closely or more effectively with their local authorities. Particularly as the White Paper suggests joint commissioning arrangements will require the agreement of both parties; the GP consortia and the local authority.

Similarly the overlapping interests of the GP consortia and local authorities with regard to service changes and priorities will obviously take some working out. The White Paper is clear that local authorities will not be involved in day-to-day interventions in NHS services and that NHS commissioning is the sole

preserve of GP consortia. But the boards will have a role in considering commissioning plans and in any resulting changes in services, with the Secretary of State remaining as the final arbitrator on service reconfigurations. Not surprisingly the Government is to consult fully on the details of the new arrangements.

Freeing NHS providers – the rise of the social enterprise

If the Government’s ambitions to create in the NHS, the ‘...largest and most vibrant social enterprise sector in the world’ were to be fulfilled than we would be witnessing the drawing to a close of 60 years of the state management and control of health care providers.

As a first step, all existing NHS trusts will become, or become part of, a Foundation Trust (FT) within three years. Any trusts that cannot find a home, as or with an FT, could be put into administration; whilst the Department obviously hopes that the numbers will be low, the administrators could be busy. This has immediate consequences for PCT community providers, where in accordance with the revised 2010/2011 Operating Framework, current plans would have seen more than 80% of services being absorbed through vertical integrations with local acute providers. These plans are to be reviewed with a reinvigorated enthusiasm for social enterprises and a more purposeful consideration of the competition issues.

As most NHS organisations become FTs they will also be given increased freedoms, including a removal of the income cap on non-NHS income and the opportunity to tailor their governance arrangements to their local needs. All foundation trusts will also have the opportunity to transform themselves into employee-led social enterprises that they themselves control. This transformation holds out the prospect that FTs will move out of state control, out of the core public sector; which was of course envisaged in the early papers proposing the establishment of NHS Trusts in the late 1980s.

Such a wide-scale adoption of a social enterprise model is without precedent in the British public sector and would in effect be denationalisation through mutualisation. Presumably the creation of employee controlled organisations as not-for-profit, independent, autonomous providers, would have the added attraction of moving these organisations off the government’s balance sheet.

This radical proposal, which could see the transfer of billions of tax-payers’ assets to employee controlled businesses, would indeed be a revolution. Undoubtedly there will be many FTs that will be interested but staff will naturally be cautious about leaving behind the past certainties in exchange for the freedom to have a say in the development of their own organisations.

The future of pay and pensions will surely figure high on their list of questions and whilst the Paper envisages the retention of Pay Review Bodies, clearly their decisions would not be binding on independent providers. With respect to pensions the White Paper goes no further than to await the outcome of Lord Hutton’s current review of public sector pensions.

Opening-up the market

Whilst previous governments have embraced tentatively the market, the Coalition Government is intent on ensuring that there really is a level playing field for all providers, whether from the independent, voluntary or not-for-profit sectors. For this government, whilst the market will be a regulated, social market, it will deliver innovation, spur productivity and, crucially, make patient choice a reality. As NHS providers gain greater freedoms, perhaps as employee-led organisations and control and commissioning decisions have passed to local, clinically led commissioners, the daunting difficulties of dealing with provider failures are substantially reduced. In any event, as we shall see, the Government has neatly passed to Monitor the responsibility both for dealing with failure and for ensuring service continuity.

Crucial to making the market work will be a shift to an Any Willing Provider (AWP) model for contracting for services. In effect this model is already in place in mental health services and elective surgery, with any appropriately regulated supplier, prepared to work to NHS terms and conditions, being able to supply services. From April 2011 the Government intends to adopt progressively the same approach for an increasing range of community services. In due course, multi-year block contracts will disappear, to be replaced by an increasing range of suppliers contracting and selling directly to GP consortia on a case-by-case basis.

To underpin the development of the market the Government appears intent on removing many of the barriers that have so far consigned non-NHS providers to supplying less than 3% of NHS services. However there is no commitment on the subject of NHS-pensions portability; this awaits the outcome of Lord Hutton’s review. For the independent sector it will also be important to see what safeguards are put in place to limit the ability of GP consortia to buy services from favoured suppliers, doubtless including those where their members might have a financial interest.

A key component in making all of this work will be a reinforcement and extension of Payment by Results (PBR) and therefore of Tariffs. Although the structure of Tariffs will be set by the NHS Commissioning Board the actual prices will be set by Monitor. Tariffs will be developed for community services and mental health and there will be national currencies for critical care and specialist palliative care; pathway tariffs will be developed, which will support commissioners contracting on a risk-transfer basis for an extended and complex package of care. With a shift to Best Practice Tariffs, an increasing proportion of payments linked to quality, rising competition and increasing local flexibility over local marginal rates, there is only one way that NHS prices are going: down.

The prospect of declining prices is only one factor that may dampen the excitement of the independent sector, faced with the prospect of the opening-up of the NHS market. Having to sell services to more than 500 GP-led consortia is daunting, requiring both deep

pockets and much stoicism. Even if the playing field is level, there will remain well-established incumbents, with the possibility of using their new freedoms to become effective competitors. Over time the private sector will doubtless expand its currently tiny share of the market but organic growth will be comparatively slow. The major opportunity for the private sector would come if and when current NHS incumbents fail to make the transition to the new regime. Under those circumstances the Government might well expect, if not invite, the private sector to step in.

The regulators

Effective social markets need strong regulators and the NHS is going to have four and a half of them. The NHS Commissioning Board will in effect, regulate the GP consortia. Dispersing resources, monitoring performance and intervening where there is failure. Given the amount of public money involved and the potential for political embarrassment, the Board may talk of a light touch but in its early years its oversight is likely to be close and detailed.

Monitor, the economic regulator will have greater powers and broader responsibilities, regulating all providers of services to the NHS, irrespective of ownership and governance. Not only will Monitor oversee the journey of NHS providers to FT status and beyond, it will also be responsible for maintaining an orderly market, setting prices, ensuring fair competition and assuring continuity of services. Its powers will be significant, not very different from the economic regulators it is modelled on. Where current suppliers seek to block the entry of a new provider, they can be obliged to make their premises available.

The position of the Care Quality Commission is reinforced, with overall responsibility for ensuring the quality of services. As the number, range and diversity of providers increases this is a task that will only get harder and carry ever greater risks.

Despite some sniping criticism whilst in opposition, NICE is to be strengthened and put on an appropriate statutory footing. Not only will it continue with its

current role but its reach will be extended through the development of quality standards to be used as the basis for commissioning by GP consortia – 150 standards over the next 5 years.

And finally there is a new arms length body: HealthWatch, which will part of CQC to help patients make complaints; state-aided patient power.

Will it work?

This is a bold White Paper, even if it contains a great deal that Milburn and Blair would have introduced, if only they had had the courage, and so therefore represents yet another turn in the cork screw of healthcare policy. The vision offered is beguiling and logically coherent. The real tests, however, are more practical and pragmatic.

Whilst the White Paper recognises the need for substantial improvements in productivity, releasing £20 billion to reinvest in the NHS, there are no details of how these savings are to be made, though there is a recognition that the NHS will end up employing fewer people. The proposed reforms may deliver substantial benefits in the longer term, but over the next year or two they will have little or no impact, other than perhaps increasing costs, for example, through redundancies.

Engaging the public and the GPs in major decisions over the configuration of local health services may, in due course, make the closure of excess capacity easier, but that will take time. These reforms offer little immediate comfort to those local health systems, we estimate something like a third of all the health economies in England, which are facing unbridgeable, structural deficits in the current year.

Those difficulties will have to be managed during a period of unparalleled transition. The NHS is very good at reorganising itself; it has had plenty of practice, but on this occasion many of those involved are heading for an uncertain if not a redundant future. The PCTs and the SHAs can indeed be criticised for failing to get a grip on commissioning but they have been the

lightning rod, the system managers, for sorting out little local difficulties. In the new world there will no room for these bureaucrats, so who in the coming months and years will be there when the inevitable crises arise? The lean regulators and the expert Commissioning Board could indeed be busy.

Doing away with these managers will doubtless be popular, even if the amount of money involved is relatively modest by comparison to the total savings required, and in many cases their jobs will have to be done by somebody else. Furthermore, the Department will be vulnerable to the accusation that in creating 500 plus consortia and an open market, overall administration and transaction costs may actually increase.

This problem will become acute if the GPs fail to respond with enthusiasm to Mr Lansley’s invitation. Even with the power to direct, achieving both the timetable and the desired impact requires the positive engagement of a majority of GPs. There will doubtless be enthusiasts but will they constitute a majority, will they provide sufficient apostles to lead 500 consortia? It would be very unfortunate if PCTs had to be kept going in parallel for any length of time.

Mr Lansley’s faith in GPs is impressive and of course shared by the great majority of their patients. The key test for the next few months will be the extent to which the GPs reciprocate and respond to the Secretary of State’s entreaties. In the longer term the key measure of success will be how successful the GPs are in rising to the challenge, not of commissioning services for the healthy well-off in the home counties, but of making a difference to the outcomes and inequalities for the long-term sick and invariably deprived groups, particularly the elderly, who are the major consumers of health resources.

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We work with a wide range of organisations including schools, hospitals, local authorities, housing associations and government departments.

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