BRIEFING

The Nuffield Trust
FOR RESEARCH AND POLICY
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The Coalition Government's NHS reforms: an assessment of the White Paper

The NHS is facing a major financial challenge. Official NHS sources suggest that, to meet rising demand, there will be a funding shortfall between 2011 and 2014 of £15 to £20bn. The Coalition Government has revealed its plans for reforming the NHS in England in the White Paper *Equity and Excellence: Liberating the NHS*. This briefing outlines the main features of the proposed reforms and assesses whether they are fit for purpose.

Key points

- The White Paper outlines a number of key reforms, including:
  - giving groups of GP practices 'real' budgets to buy care
  - abolishing all PCTs and SHAs, and creating a new NHS Commissioning Board
  - scrapping performance targets, including waiting times
  - transforming Monitor into an economic regulator of all NHS providers.
- The main thrust is to devolve decision-making in the NHS towards the front line, with the emphasis on competition, patient choice, contracting and public reporting of outcomes to achieve higher-quality care.
- This approach carries significant risks. Competition and patient choice are both currently weak, and it is not known how much of either is needed to encourage providers towards better performance. PCT commissioning is also weak and GP commissioning consortia are likely to take several years to develop adequate skills for the job.
- The reforms are substantial and will require significant management expertise to implement smoothly. They will occur at the same time as the NHS faces financial challenge, management capacity is being slashed and arms-length bodies are merged or abolished. A real concern is whether this level of reform can be implemented without risk of major failure.
- GP commissioning consortia are the centrepiece of the reforms. However these will need significant support in several areas, including:
  - handling public funds on such a large scale to achieve value for money
  - making intelligent purchasing decisions when faced with powerful hospital providers
  - managing demand
  - negotiating the significant service reconfiguration (hospital closure) that will be necessary.
- The move to outcome targets rather than process targets is welcome. But given that waiting for care is such a key part of patient experience on which the NHS is judged by the public, and the miserable history of long waiting times in the NHS in the past, waiting times should remain firm targets.

Background

From 1997/8 to 2010/11 the NHS budget grew in real terms at on average 5.7 per cent per year. Over the period of the next spending review – 2011/12 to 2013/14 – the settlement is likely to be at best between 0 and 2 per cent. Official NHS sources suggest the gap between the funds needed to service forecast growth in demand for care and funds available will be £15–20bn between 2011 and the end of 2013/14 in England on a 2010/11 budget of just over £100bn. This would require efficiency improvements of about 4 to 5 per cent per year – an unprecedented challenge.

The NHS is in a better state than ever to identify where efficiencies can be made, yet evidence suggests that there is still significant waste and that it can be reduced. Radical change is now thought to be needed by many in the service to meet the challenges outlined above, in particular a reduction in the amount of care delivered in hospitals. The Coalition Government revealed in July its plans for reforming the NHS in England in the White Paper *Equity and Excellence: Liberating the NHS*; this was followed by five consultation documents (Department of Health, 2010a–f). The NHS in Scotland, Wales and Northern Ireland is the responsibility of the respective devolved administrations.

Outline of the key reforms

Funding of health improvement to be transferred to local authorities, who will jointly appoint local directors of public health with a new national Public Health Service.	April 2012
Local 'HealthWatch' groups will replace the existing Local Involvement Networks, to help involve the public and patients in shaping local health services. Local authorities are to fund local HealthWatch groups. A national HealthWatch body will be located within the Care Quality Commission.	April 2012
A statutory national NHS Commissioning Board will be set up to support GP commissioning consortia.	Established in shadow form in 2011; 'go live' in April 2012
New GP commissioning consortia – groups of GP practices. They will hold a budget to buy care (all but maternity care and highly specialist care) on behalf of their registered patients.	Introduced by 2013
The ten strategic health authorities (SHAs) will be abolished.	During 2012/13
All 152 primary care trusts (PCTs) will be abolished.	From 2013
All NHS trusts will become, or become part of, autonomous foundation trusts.	By 2013/14
The foundation trust regulator Monitor will be transformed into an economic regulator of providers of NHS-funded care.	During 2013/14
Key performance targets, such as waiting times, will be scrapped (except for waiting in A&E).	By end 2014
NHS management costs will be cut by 45 per cent.	By end 2014

Comment and analysis

New GP commissioning consortia

Under the new arrangements GP practices will remain as providers of primary care and as independent businesses. They will also group to form new organisations – GP commissioning consortia – and be allocated a budget with which to buy hospital care (except maternity care and certain specialised services). The Government is planning to create around 500 such groups. All GP practices will have to be part of a commissioning consortia, although they will have a degree of choice over which consortium they join.

Together these consortia will hold between £70 and 80bn of taxpayers' funds. Because of this, they are being set up as statutory public bodies, which means that they will have an official accounting officer and must have their accounts audited and made public. These arrangements do not currently hold true for GP practices, which are private partnerships most of which contract exclusively with the NHS. The consortia will be accountable to the new NHS Commissioning Board (see below). 'New' primary care providers (for example private providers) will be able to join consortia, which opens the door for non-NHS bodies to have a direct influence over commissioning decisions using NHS funds. To help motivate GPs, it is mooted that part of the payment received by practices for providing primary care will be contingent on performance in the commissioning consortia.

Our verdict

- A key issue regarding this reform is that GP practices lack commissioning experience, and will take time to develop the necessary infrastructure and skills, for example in contracting, analysing data on quality against contract, checking billing and financial management. GP practices are used to acting as small businesses, not large conglomerates handling millions of pounds.
- To make efficiency savings in the NHS and improve quality, it is widely recognised that more effort should be made to prevent costly hospital care where avoidable, through integrated care. The ability of undeveloped GP consortia to make these changes, in part through commissioning negotiations with hospitals, is very doubtful in the short term. This poses the considerable risk that consortia are unable to manage demand within the budget allocated, and incur deficits.
- A failure regime will be needed and executed by the new NHS Commissioning Board (see below), and the appropriate triggers are currently being identified.
- GP commissioning consortia will be able to buy in skills from the independent sector, but these skills will be in limited supply and likely to be expensive – consortia will have a limited budget for management. How the accounts of consortia will be audited, and the arrangements for independent assessment of whether they are achieving value for money, is as yet unclear. With the large sums of money involved, it is crucial that these arrangements are robust.

An NHS Commissioning Board

The White Paper states clearly that the Board is not meant to be the 'headquarters' of the NHS, but a body providing guidance and support to GP commissioning consortia. Yet the Board will not only hold the GP commissioning consortia to account, but also GP practices from which the Board will directly commission primary care. The Board will be accountable to the Secretary of State for Health for managing within an overall budget and for delivering against a range of outcome measures.

The main functions will be:

- providing leadership on commissioning for quality
- promoting patient and public involvement and choice
- supporting the development of GP commissioning consortia
- commissioning specific services (maternity, highly specialised services, primary care, dentistry, community pharmacy and primary ophthalmic services)
- allocating and accounting for NHS resources.

It is unclear why the purchase of maternity services is the preserve of the Board and not GP consortia. Although the Board is accountable for achieving value for money within a global budget, the national tariff (price) to be paid to providers by GP commissioners will be set by the new economic regulator (see below).

Our verdict

- The new NHS Commissioning Board may help reduce involvement by ministers in the day-to-day running of the NHS, which is to be welcomed. But the test of the independence of the new national Board will be if the Secretary of State for Health can stay above what will be highly contentious political decisions made locally, such as hospital closures.

- A key issue is to what extent the Board will be independent of political interference in key areas and to what extent it will exercise central control and active 'performance management' (rather than offer supportive guidance) if the performance of GP commissioning consortia is deemed poor.

Abolishing PCTs and SHAs

The NHS has been subject to several reorganisations over the past two decades. Despite pre-election pledges not to subject the NHS to a further structural change, the Coalition Government is proposing radical changes that will see all 152 PCTs in England abolished (from 2013), together with all ten SHAs. PCTs currently buy the care that GP commissioning consortia will now purchase under the new reforms. PCTs were first introduced in 2002 and in 2006 their number was cut in half from 303 to 152, while the number of SHAs was reduced from 28 to 10. The latest reforms will result in GP commissioning consortia seeking management support from a range of options, including from the public and private sectors.

Our verdict

- This is a huge undertaking and will distract management attention at a time when the NHS needs to make rapid efficiency savings. There is a separate requirement that management costs are to be cut by 45 per cent over the next four years.
- To enable GP commissioning consortia to work effectively, GPs and specialist clinicians will require high-level general and specialist management support from people who understand the nature of general practice, primary and acute care, and have sophisticated commissioning skills. This will be a particular challenge at a time when management costs, as well as training budgets, are being significantly reduced.

All NHS trusts to become foundation trusts

The creation of foundation trust status for high-performing hospitals was a key reform of the previous Labour Government. There are now 160 foundation trusts (over half of all NHS trusts) and the Coalition Government is aiming for all NHS trusts to become foundations. The latest reforms will also seek to provide more freedoms for those trusts that have foundation status.

Our verdict

- Two critical issues here are what to do with NHS trusts that cannot achieve the standard demanded by Monitor to become a foundation trust, and how foundation trusts can be motivated more to take advantage of the freedoms already granted. Many have not been as entrepreneurial as originally hoped.

Monitor as an economic regulator

The foundation trust regulator Monitor will be developed into an economic regulator of 'providers of NHS care' with its main functions to promote competition between providers, set (maximum) prices, and help the NHS Commissioning Board to ensure continuity of care (in other words, to make sure all populations have access to care in the event of provider failure).

Our verdict

- The critical issues are whether Monitor will have the resources to develop adequately into a full-blown economic regulator, the principles and rules under which it will operate, and the huge task it will have in ensuring that all remaining NHS trusts in some way or other achieve and maintain foundation status. It is not clear if, in future, primary care providers will come under the aegis of Monitor.
- More fundamentally, it is unclear how narrowly Monitor will stick to its remit of promoting competition between health providers if it becomes more obvious that better quality and value for money for patients and taxpayers can be achieved through greater vertical integration (mergers between primary and secondary care providers).

HealthWatch

Local 'HealthWatch' groups are to replace the existing Local Involvement Networks, to help involve the public and patients in shaping services locally. Local authorities are to fund local HealthWatch groups. A national HealthWatch body will be located within the Care Quality Commission. Local authorities will operate statutory health and wellbeing boards, which can agree local joint commissioning across health and social care, and scrutinise local service reconfigurations proposed by GP consortia and be able to refer them to the NHS Commissioning Board, or ultimately the Secretary of State for Health. Local Overview and Scrutiny Committees would transfer to the health and wellbeing boards.

Our verdict

- A critical issue is that the health and wellbeing boards may be very political, and refer significant numbers of proposals for service reconfiguration to the Commissioning Board and Secretary of State.

Key performance targets to be scrapped

The Coalition Government's NHS reforms outline plans to move to outcome targets and relax 'process' targets such as the 18-week wait target for planned care and the 48-hour GP access target. However, the four-hour A&E target will continue to be performance-managed, although the target will be revised to 95 per cent of all patients being seen within four hours rather than the current target of 98 per cent. It is intended that greater public reporting of outcomes will result in patients choosing better providers, and pressure from commissioners through contracting will provide the stimulus for providers (mainly hospitals) to keep waiting times down.

Our verdict

- The Coalition Government's plans to move to outcome targets rather than process targets are welcome. However, waiting is an iconic issue in the NHS and central performance management with targets has proved the most effective way of reducing waiting times in the NHS in England.
- It remains to be seen whether, in a stringent economic climate, that competition, choice and contracting will exert enough pressure on healthcare providers to keep waiting down. And if they do not, then what action will be taken? Given that waiting for care is such a key part of patient experience on which the NHS is judged by the public, and given the miserable history of long waiting times in the NHS in the past, waiting times should remain firm targets.

Conclusion

The broad direction of travel of the Coalition Government's NHS reforms is logical, given the reforms over the past 20 years. The main thrust is to devolve decision-making in the NHS towards the front line. The emphasis is on competition, patient choice, contracting and public reporting of outcomes to achieve better quality care. This approach, however, carries significant risks. Competition (although it is showing some benefits) and patient choice are both currently weak, and it is not known how much of either is needed to encourage providers towards sufficiently better performance. PCT commissioning is also weak and GP commissioning consortia are likely to take several years to develop the skills needed.

Taken together these reforms are substantial and will require significant management expertise to implement smoothly. Yet they will occur at the same time as the NHS faces a sustained financial challenge, upheaval and cuts in management, and arms-length bodies are merged or abolished. There is a huge risk that this level of reform cannot be implemented without major failure.

In particular, GP commissioning consortia will need significant support in several areas, including:

- handling public funds on such a large scale to achieve value for money.
- moving more care from hospitals into the community, when faced with the vested interests of powerful hospital providers
- negotiating the significant service reconfiguration (hospital closure) that will be necessary.

References

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Nuffield Trust

The Nuffield Trust is a charitable trust carrying out research and health policy analysis on health services. Our focus is on the reform of health services to improve the efficiency, effectiveness, equity and responsiveness of care.

Key current work themes include:

- new forms of care provision
- commissioning
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- national and international comparisons
- competition policy.

Recent Nuffield Trust briefings and reports

We have recently published a number of briefings and reports dealing with several of the key themes identified in the White Paper:

Beyond Practice-based Commissioning: The local clinical partnership (Nuffield Trust/NHS Alliance)

Giving GPs Budgets for Commissioning: What needs to be done?

Making Progress on Efficiency in the NHS in England: Options for system reform

Trends in Emergency Admissions 2004–2009: Is greater efficiency breeding inefficiency?

Where Next for Commissioning in the English NHS? (Nuffield Trust/The King's Fund)

Where Next for Integrated Care Organisations in the English NHS? (Nuffield Trust/The King's Fund)

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