

Where next for NHS reform?

A discussion paper April 2011

Key points

- Are the NHS reforms misunderstood, are substantive policy changes necessary, or should the Government simply press ahead?
- The reforms have become increasingly controversial, notably at the recent Liberal Democrat spring conference.
- Concerns expressed have focused on competition, GP commissioning consortia, accountability and the transition period.
- The NHS Confederation has supported the Government's objectives but we are disappointed that communications around the reforms have failed to support the reform programme.
- This paper analyses the concerns and suggests potential practical steps for how ministers could respond.

Context

The Government's healthcare reforms, set out in the Health and Social Care Bill currently going through Parliament, have become increasingly controversial. Over recent months, concerns have been expressed by commentators ranging from the Health Select Committee to the Royal College of Nursing and the Royal College of GPs. This has now been followed by formal declarations of opposition at the recent Liberal Democrat spring conference and at an emergency meeting of the British Medical Association.

Events at the Liberal Democrat conference were particularly significant. The party backed motions describing the Government's reforms as a "damaging and unjustified market approach". It said the changes "did not feature in our manifesto or in the agreed Coalition Programme, which instead called for an end to the large-scale top-down reorganisations". The conference saw calls for greater accountability, with a suggestion that local councillors be appointed as non-executive directors on the boards of GP commissioning consortia.

Ministers now face a dilemma, triggered both by the scale of the concerns and the political consequences of a

challenge from within one of the political parties that comprises the coalition Government. Should it press on with the reforms as planned, or should it rethink elements of the package to meet the challenges?

To answer this, ministers need to grapple with some important questions. Is it that the reforms are misunderstood, meaning that the Government simply needs to explain its plans more clearly? Is there a problem with the proposals themselves, making substantive policy changes necessary? Or do the challenges to the reforms simply represent self-interested groups resisting necessary changes, in which case the Government should press ahead?

This discussion paper

The NHS Confederation has supported the Government's objectives but has also expressed concerns about the significant risks involved with these reforms.

We are concerned that the debate about the changes has become increasingly polarised and entrenched, with little movement on practical solutions for managing these risks. This is destabilising for the

NHS, which is already making structural changes to meet the agenda set by the Government.

This paper seeks to identify the broad areas of concern and then to suggest potential options in response. There is a recurring theme running through our analysis – that there has often been a reality gap between ideas that are good in principle and the details of practical delivery, which have often looked opaque or too optimistic.

The challenges to the reforms

Concerns about the reforms fall into four broad categories.

1. The extension of **competition** and fears that this will lead to privatisation of provision and fragmentation of services.
2. The shifting of responsibility for commissioning of healthcare to **GP commissioning consortia** and fear that this goes beyond their capability and capacity and leaves them with serious conflicts of interest. There are also concerns that use of independent sector support for commissioning means the privatisation of commissioning.
3. The arrangements for **accountability** for decision-making in the new system and fears they are inadequate and insufficiently democratic.
4. The **risks in the transition** and fears these are too great, particularly at a time when the NHS faces an enormous challenge in delivering £20 billion productivity gains over the next four years in light of reduced levels of financial growth.

Responding to the challenges:

1. Competition

The debate about the use of competition and market mechanisms in healthcare is often driven by ideology. Some are implacably opposed, seeing competition as fundamentally inappropriate for healthcare and leading inexorably to the privatisation of services and the exacerbation of inequalities. Others believe competition and market mechanisms inherently drive up quality and efficiency. While recognising the strength of feelings in this debate, it is important to move beyond the ideology and rhetoric.

Despite concerns from some that competition can incentivise suppliers to encourage demand and that high transaction costs outweigh the benefits, there is some evidence, from this country and the USA, that the right sort of competition for health services leads to

improvements in quality and efficiency, particularly where prices are fixed.¹ The scale of the financial challenge facing the NHS, in both the long and short term, suggests that rejecting these potential benefits for reasons of ideology would be short-sighted and extremely unwise. Indeed, we believe the Government could make the argument more confidently for the appropriate use of competition in healthcare to drive innovation.

EU law

It is also likely that competition law will increasingly apply to health services. The Government has said that its legislation does not itself extend the applicability of current UK or European Union (EU) competition law to the healthcare sector. But, as NHS providers develop and begin to compete actively with other NHS providers and with private and voluntary providers, UK and EU competition law will increasingly become applicable. This means that resistance to any form of competition in health services would be legally challengeable. So there are pragmatic reasons for ensuring that a proper system of competition, with clear rules, applies in the UK.

Complex care

Having said all this, there are legitimate concerns about the potentially damaging effect of competition if not implemented sensibly. Most healthcare systems in the world are seeking to deliver efficiencies and to control costs by:

- improving integration of health services²
- investing more in prevention and early intervention
- reducing demand for high-tech, high-cost interventions.

It is therefore right to ask whether competition as proposed in the health reforms can deliver these objectives. They all require collaboration between different organisations and a reduction in the capacity of many existing providers.

It is not actually clear that the proposals in the legislation will not allow integrated solutions. But it is also true that the Government has failed to set out exactly how integrated services could be delivered in practice and how competition rules could be framed to allow for this. Were the Government to offer an explanation, some of the concerns would be allayed.

This explanation needs to set out how the reforms would work on complex care pathways and for people with a long-term condition such as diabetes. But, crucially, it also needs to deal with the challenges of delivering well coordinated services for people with

multiple long-term conditions, which will represent an increasing challenge to the health service as the population ages. As part of its response, the Government should consider permitting test projects to be established to allow a safe space for developing solutions to meet these challenges.

Price competition

There have been significant concerns about the potential negative impact of price competition in health services, particularly where quality is hard to define and measure. There is evidence that, in these circumstances, competition is likely to lead to reductions in quality.³

In response, the Government says it does not intend to allow price competition and has removed references to maximum tariffs from the legislation. However, only about 60 per cent of hospital income and only about a third of overall spending by primary care trusts (PCTs) is currently covered by tariffs under the Payment by Results (PbR) policy. Outside of PbR, price competition remains possible, indeed likely. This is true for mental health and community services, and for a significant proportion of specialist acute care.

The best response is to accelerate work to define and measure quality of services, building on the clinical evidence base. But the Government needs to recognise that progress on measuring of quality of care has been painfully slow, despite the good intentions expressed by the previous administration as well as the current one. The Government now needs to recognise that it will need to invest significantly in this area to have any chance of achieving its ambitions within a reasonable timescale.

The Government, in its recent mental health strategy, made a clear commitment to develop a system of PbR for adult mental health services, with rates of payment initially to be decided locally. This is welcome. However, developing PbR in mental health will require significant investment if that commitment is to be made good, and the Government will want to actively consider whether the investment currently being made is indeed adequate. The Government will also want to consider whether the levels of investment being made in developing tariffs in other areas, such as for community services, is also adequate.

The role of Monitor

Rightly or wrongly, the impression has been given that promoting competition is the primary objective of Monitor, the new economic regulator.

The legislation does in fact set out other issues that Monitor has to 'have regard to', but the idea that competition will be the dominant objective has caused significant concern.

The Government could address this by making absolutely explicit that it sees competition as a means to an end, rather than an end in itself. So the test for Monitor could be whether services provide value for money for patients and taxpayers, with competition contributing to this objective. The effectiveness of local health services should – as the Government reiterates in other parts of its policy – be judged against outcomes achieved rather than on the basis of levels of plurality of provision or use of competition per se.

Any Willing Provider

Similarly, the Government's proposals are insufficiently sophisticated in respect of the policy of allowing Any Willing Provider (AWP) to deliver services.

We know from experience that the benefits of patient choice, as delivered through AWP, are real. What is highly questionable is the appropriateness of this policy to complex care pathways, particularly for long-term conditions where effective coordination of services is essential to delivering good patient care. For these services it is likely to be better to allow patients to choose from a consortia-approved provider or list of providers that have met a well-defined service specification, rather than any willing provider that is licensed to enter the market.

Even where services are appropriate for AWP, it is critical that the challenge of developing pricing, quality and outcome-based service specifications, as well as referral management protocols is not underestimated. If these are mismanaged, the policy could be highly counter-productive, with a risk of higher overall costs and lower quality of care.

A pragmatic and sophisticated response to these complex issues would be for the Government to move to a phased timetable for implementation, with a limited list of services that are mandated for AWP implementation each year.

This would allow the immediate application of the policy to the areas where it is likely to be of most benefit – for example, where care is elective, episodic and the outcome is easy to measure. It would enable the provision of structured national support to commissioners, and provide an opportunity to demonstrate proof of concept to sceptics. It would allow a clearly managed approach in the areas where concerns are greatest – for example, where care is

complex, long term and involves a number of different healthcare professionals and organisations. The aim should be to apply the policy as widely as is in the interests of patients.

When thinking about implementation, it is important to understand that the point at which a patient exercises choice between providers is likely to need to vary according to the circumstances. So, for instance, the point of choice is clear in the case of a patient needing a single hip operation. But where a complex or long-term care pathway is required, the points at which a patient can sensibly exercise choice are more open to debate.

Responding to concerns about competition

In summary, potential Government responses in relation to concerns about use of competition include:

- making the argument more confidently for the appropriate use of competition in healthcare to drive innovation
- providing a clear explanation of how integrated services could be put in place, covering people with multiple long-term conditions, not just individual care pathways, and allowing test projects if appropriate
- accelerating work on defining and measuring quality of health services, backing this with investment
- introducing a more sophisticated, phased approach to the expansion of the Any Willing Provider policy
- making it clear that competition is seen as a means rather than an end, and clarifying that Monitor will operate with this in mind.

2. GP commissioning consortia

A range of concerns have been raised about the introduction of commissioning consortia to replace PCTs. Many relate to the willingness, capability and capacity of GPs to take on these roles.

GP engagement

The Government points, rightly, to the uptake of pathfinder commissioning consortia, now covering two thirds of the country, as evidence of the willingness of GPs to engage with the policy. But there is a lot of survey evidence that GPs in general are not yet fully convinced. This should hardly be a surprise given the scale of the implications for GPs and the early stage we are at in the process. Indeed, if GPs were universally enthusiastic, it would probably suggest they did not understand what was being asked of them.

But there is clearly plenty of work to do to ensure that more GPs are willing participants in their new commissioning responsibilities. It would, therefore, be helpful for the Government to acknowledge this more directly so as to demonstrate a willingness to work constructively with all constituencies within the profession.

Support for consortia

In relation to the capability and capacity of GPs, the Government is right to emphasise that its intention is not for GPs to become experts at the technical aspects of commissioning. Instead, the intention is for commissioning to be clinically led, with clinicians having access to appropriate support.

As with other aspects of competition, it would be a mistake to take an ideological stance on whether support is delivered by existing NHS staff or by independent sector organisations. Currently, PCTs already invest in external support where they think it will add value. It therefore seems sensible for commissioning consortia to be able to do the same. The Government should avoid the temptation to set targets for commissioning consortia in this regard as this would be excessive micro-management.

As we have repeatedly emphasised on this issue, care will need to be taken to ensure that consortia do not lose the expertise on commissioning that PCTs have built. It will also be important for the Government to ensure that commissioning consortia wishing to use external support have access to help. Consortia need to:

- be able to be expert clients
- get value for money from any such arrangements
- not allow a highly concentrated support service market to run the system.

To build the credibility of the system, it will also be important for the Government to make it absolutely clear that consortia cannot delegate accountability for functions for which they choose to buy support. As publicly accountable statutory bodies, the commissioning consortia retain full responsibility for overall commissioning performance.

Conflicts of interest

There are legitimate concerns that some GPs may have a conflict of interest should they be both providers and commissioners of care. The legislation makes clear that the NHS Commissioning Board will be responsible for commissioning primary care, so GPs will not commission themselves for core general

practice. But it is possible that GPs as providers may want to deliver some services that commissioning consortia are responsible for. They would have a conflict of interest in such circumstances.

The Government needs to set out more clearly how it expects such conflicts to be managed. The experience of PCTs with practice-based commissioning was that rules to manage this can be cumbersome and may deter GPs from enthusiastic engagement in commissioning, so it will be very important to get this right. Measures such as open-book accounting, which gives the public greater access to financial information, might be a simple way of ensuring effective scrutiny of GPs' profits.

Similarly, there is a need to carefully handle concerns that GPs might personally benefit from decisions not to refer patients for care. It would be extremely serious if any patients lost confidence that their GP is focusing on their health needs because of financial incentives. To allay these concerns, we urge the Government to provide a clearer explanation of how any commissioning outcomes framework might work.

Responding to concerns about GP commissioning

In summary, potential Government responses in relation to concerns about use of GP commissioning consortia include:

- acknowledging that more needs to be done to encourage more GPs to enthusiastically take on new commissioning responsibilities
- clarifying that commissioning consortia will be free to decide how much commissioning support they want from external organisations
- making clear that commissioning consortia remain publicly accountable for their commissioning performance regardless of any external support arrangements
- providing support to commissioning consortia to help them get value for money from external support for commissioning
- giving a detailed explanation of how conflicts of interests for GPs will be managed, considering steps such as open-book accounting
- allaying fears about financial incentives for GPs by giving a detailed explanation of how the commissioning outcomes framework will avoid conflicts of interest.

3. Accountability

The range of concerns in relation to accountability in the health system broadly fall into three groups:

1. Proposed accountability mechanisms are unclear.
2. Unclear governance structures for commissioning consortia and worries that decisions will be less transparent under the new system.
3. There is insufficient democratic accountability in the new system.

Clarity of accountability arrangements

At one level the system is clear. Commissioning consortia are accountable:

- upwards to the NHS Commissioning Board for performance on outcomes and money
- locally to overview and scrutiny committees and health and well-being boards for their commissioning decisions
- at a practice level to the patients on their GP lists.

Similarly, it is clear that:

- the NHS Commissioning Board is accountable to the Secretary of State
- foundation trusts are accountable to their governors and members
- local authorities are accountable to their electorates.

In many ways these arrangements look similar to the current accountability structures. The reforms substitute the new commissioning consortia, the NHS Commissioning Board and health and well-being boards for the existing PCTs, strategic health authorities and local strategic partnerships. It would therefore be helpful for the Government to spell out how the new system differs from the old.

However, the biggest concern is that how the new arrangements for accountability will work in practice remains vague. For instance:

- How will the accountability of commissioning consortia to the NHS Commissioning Board work?
- What are the consequences of failure and how will 'coasting' consortia be incentivised to improve?
- How might consortia manage poor performance among their own GPs?
- How transparent will consortia decision making be?

- Does the accountability of consortia to the health and well-being boards have any teeth?
- Will local authorities give sufficient priority to their public health responsibilities if accountability is limited to publication of performance data on outcomes?

While, realistically, it is bound to take time to work through these crucial issues, the absence of detail continues to cause concern. The establishment of the NHS Commissioning Board, in shadow form from April 2011, gives the Government an opportunity to accelerate work on these areas and to bring some much-needed clarity.

Governance and transparency of decision making

There are a separate but related set of concerns about the governance and transparency of decision making for commissioning consortia. While doubts have been raised about their public profile, PCTs and strategic health authorities have clearly specified governance structures and boards that must meet publicly and include independently appointed non-executive directors.

The legislation places no such responsibilities on commissioning consortia. It merely makes reference to the requirement for the NHS Commissioning Board to develop guidance. While the Government's aim of allowing local flexibility is in many ways laudable, it has allowed an impression to be formed that there could be a lack of proper and effective governance in place.

A simple response to this would be for the Government to include in the legislation a requirement for commissioning consortia to comply with the Nolan principles of public life (see box opposite).

Democratic accountability

There has been an ongoing debate for some years about the lack of effective democratic accountability of the NHS at local level. This does not seem to have been assuaged by the Government's proposals to establish health and well-being boards.

Before examining potential solutions, it is worth exploring the rationale for local democratic accountability in the NHS.

As a national health service funded through national taxation, there is a strong sense among the general public that the NHS should deliver consistent standards of service across the country. There is little doubt that voters in general elections see the NHS as a major national issue. The Government of the day appoints a Secretary of State for Health who is accountable to Parliament for health policy and NHS

The Nolan principles of public life

Selflessness – Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.

Integrity – Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

Objectivity – In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

Accountability – Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness – Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty – Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership – Holders of public office should promote and support these principles by leadership and example.

delivery. So, at national level, there is currently no shortage of democratic accountability.

Through its reforms, the Government has made clear its intent to distance politicians from detailed decision making at national level. But commentators remain sceptical that this will happen in practice given the political pressures the Government will face and the expectations of the public. Indeed, the legislation leaves the Secretary of State and the NHS Commissioning Board with considerable reserve powers over commissioning consortia, so this scepticism may yet be justified.

However, let us assume that the stated intention is achieved and that local commissioning consortia are free to make commissioning decisions based on their view of local priorities. This will inevitably mean a degree of variation of approach across the country and, in all likelihood, an increase in the variability of access to services. This raises the question: how is the legitimacy for this local variation derived?

The Liberal Democrat manifesto before the election proposed to address this issue by transferring commissioning responsibility to local government. Clearly that is not compatible with establishing commissioning consortia. Consortia themselves derive their legitimacy from their constituent GP practices, with all the local clinical expertise and knowledge this gives them.

But this is not the same as democratic legitimacy. Local patients will not vote for the consortia leadership. Their right of redress is limited to changing GP practice (and potentially changing consortia as a result) but clearly this is a limited power.

Some have argued for local councillors to be appointed to boards of commissioning consortia as one approach to strengthening democratic accountability. But there are a number of reasons why this is problematic, both in principle and in practice, specifically:

- the intention of reducing political interference in the NHS at national level is not compatible with increasing political influence at local level
- there would be concerns about giving councillors power over commissioning consortia decision making without direct accountability for their actions
- there are also practical issues in relation to geography as commissioning consortia need not match local authority boundaries.

A better solution might be for the Government to strengthen powers of local scrutiny. This could be done by requiring consortia to account for their decision making to local overview and scrutiny committees and to health and well-being boards.

Responding to concerns about accountability

In summary, potential Government responses in relation to concerns about accountability include:

- accelerating work – following establishment of the NHS Commissioning Board – to set out in detail how accountability arrangements will work in practice
- requiring commissioning consortia to comply with the Nolan principles of public life, through the legislation
- strengthening powers of scrutiny at local level so that commissioning consortia are required to account for their decisions to local overview and scrutiny committees and to health and well-being boards.

4. Risks in transition

The NHS Confederation, with others, has consistently highlighted that there will be significant risks during the transition to the new system. These include the possible loss of grip on money and quality during the process of change, as well as the loss of skilled commissioning staff from PCTs .

The Government has responded by clustering PCTs and aligning existing staff to commissioning consortia, but it is not clear that these steps fully address the risks effectively. Indeed, in some cases new risks arise from these arrangements, with disruption to existing relationships with local government being one example.

Some have argued that the pace of the reforms is too fast and that they should be slowed down. However, this is in itself a risky strategy as it may simply prolong the uncertainties for staff and increase the potential for problems with services.

Timetable

One possible solution is for the Government to be less directive in terms of its timetable for implementation. It could allow local flexibilities in how and when the reforms are put in place. This would acknowledge that some areas are more ready than others to take on their new responsibilities, reducing the chances of problems. It would recognise that the changes are cultural as well as structural. Culture change takes time and happens at different speeds in different circumstances.

So, for example, commissioning consortia could be allowed to take on new commissioning responsibilities at a pace they feel comfortable with, not by 1 April 2013, a timetable dictated from the centre. The transfer of responsibility for public health to local government could operate in a similar way.

If such an approach were taken, it would be important to ensure that the decisions were left to the commissioning consortia or local authorities. The Government should not try to control this from the centre through authorisation processes as this could be used to delay transfer of authority.

Decision making

There are other areas where the Government needs to speed up action to reduce transition risks. It is important to understand that GP consortia will be young, inexperienced organisations that will make mistakes and take time to settle down. With this in mind, it will be critical not to hand them major

financial and structural problems that the current NHS system has been aware of for some time but has failed to tackle. To do so would create a high risk of the consortia mishandling the issue and losing the confidence of their local populations.

There are two areas of concern. Firstly, decisions over some hospital reconfigurations have not been taken for a number of years, despite clinical support and overwhelming evidence for change. This is often because the changes have failed to attract political support. It will be crucial that the Government grasps the nettle and gets these situations resolved. The NHS trusts affected need to move into the new NHS system on a stable financial footing. If they do not, the pressures of the market will force change and it will be harder to manage the implications for patients. This is a particularly important issue in London where plans to move services from Chase Farm Hospital are a key test case.

Secondly, a number of NHS trusts are unlikely ever to be ready for foundation trust status. This is often because they have underlying financial problems that cannot be resolved with the organisation in its current form. These trusts now face significant uncertainty because they do not know what will happen to them under the new NHS system where non-foundation trusts will no longer exist. The Government needs to give them certainty. It needs to set out which organisations are at risk of not achieving foundation trust status and explain what the process will be for resolving their particular problems.

Communications

Effective communications are essential to reducing the risks of any reform programme. We have said on a number of occasions that the Government needs a compelling narrative about why the reforms matter, so as to engage patients, the public and NHS staff in the enterprise. This narrative continues to be lacking.

Not only are the Government's communications failing to support the reforms, they are adding to the

risks of failure. We have been hugely disappointed that the Government has seemed to want to label all non-clinicians as 'bureaucrats', devalue NHS managers, and downplay the achievements of the NHS. This approach is inaccurate, inappropriate and counterproductive. It damages trust in the Government and undermines the energy and enthusiasm of those responsible for making the reforms a success.

Responding to concerns about transition

In summary, potential Government responses in relation to concerns about risks in transition include:

- considering whether the Government should be less directive in terms of its timetable for implementation, allowing local flexibilities in how and when the reforms were put in place
- resolving the futures of NHS trusts with significant structural problems, taking decisions on reconfiguration and providing greater certainty for trusts unlikely to achieve foundation trust status
- improving the Government's communications by developing a compelling narrative in favour of the reforms, and not devaluing the NHS staff responsible for making the changes.

Summary

This paper has considered the concerns that have been raised with regard to the Government's healthcare reforms. We have explored a number of potential responses, summarised in the table opposite.

For more information about the issues covered in this paper, please contact david.thomas@nhsconfed.org

Concern	Possible responses
<p>Concerns about the emphasis given to competition in the reforms, and fears that this will lead to privatisation of the provision of health services and fragmentation of services.</p>	<ul style="list-style-type: none"> • making the argument more confidently for the appropriate use of competition in healthcare care to drive innovation • providing a clear explanation of how integrated services could be put in place, covering people with multiple long-term conditions, not just individual care pathways, and allowing test projects if appropriate • accelerating work on defining and measuring quality of health services, and backing this with investment • introducing a more sophisticated, phased approach to the expansion of the Any Willing Provider policy • making it clear competition is seen as a means rather than an end and clarifying that Monitor will operate with this in mind.
<p>Concerns that the shift in responsibility for commissioning of healthcare to GP commissioning consortia goes beyond their capability and capacity and leaves them with serious conflicts of interest. There are also concerns that use of independent sector support for commissioning means the privatisation of commissioning.</p>	<ul style="list-style-type: none"> • acknowledging that more needs to be done to encourage more GPs to enthusiastically take on new commissioning responsibilities • clarifying that commissioning consortia will be free to decide how much commissioning support they want from external organisations • making it clear that commissioning consortia remain publicly accountable for their commissioning performance, regardless of any external support arrangements • providing support to commissioning consortia to help them get value for money from external support for commissioning • giving a detailed explanation of how conflicts of interests for GPs will be managed, considering steps such as open-book accounting • allaying fears about financial incentives for GPs by giving a detailed explanation of how the commissioning outcomes framework will avoid conflicts of interest.
<p>Concerns that the arrangements for accountability for decision making in the new system are inadequate and insufficiently democratic.</p>	<ul style="list-style-type: none"> • accelerating work – following establishment of the NHS Commissioning Board – to set out in detail how accountability arrangements will work in practice • requiring, through the legislation, GP commissioning consortia to comply with the Nolan principles of public life • strengthening powers of scrutiny at local level so that GP commissioning consortia are required to account for their decisions to local overview and scrutiny committees and to health and well-being boards.
<p>Concerns that the risks in the transition are too great, particularly at a time when the NHS faces an enormous challenge in delivering £20 billion productivity gains over the next four years in light of reduced levels of financial growth.</p>	<ul style="list-style-type: none"> • considering whether the Government should be less directive in terms of its timetable for implementation, allowing local flexibilities in how and when the reforms were put in place • resolving the futures of NHS trusts with significant structural problems, taking decisions on reconfiguration and providing greater certainty for trusts unlikely to achieve foundation trust status • improving the Government’s communications by developing a compelling narrative in favour of the reforms and not devaluing the NHS staff responsible for making the changes.

Further information

Details about the work of the NHS Confederation on the proposed health service reforms, together with comprehensive information to help you understand the impact of the reforms, is available at:

www.nhsconfed.org/healthwhitepaper

References

1. Bloom N, Propper C, Seiler S and van Reenan J (2010) *The impact of competition on management quality: evidence from UK public hospitals*. NBER WP 16032.
2. Ham C and Smith J (2010) *Removing the policy barriers to integrated care in England*. The Nuffield Trust.

The NHS Confederation

The NHS Confederation is the only body to bring together the full range of organisations that make up the modern NHS to help improve the health of patients and the public. We are an independent membership organisation that represents all types of providers and commissioners of NHS services.

We focus on:

- **influencing** healthcare policy and providing a strong voice for healthcare leaders on the issues that matter to all those involved in healthcare
- helping our members to **make sense** of the whole health and social care system
- **bringing people together** from across the health and social care system to tackle the issues that matter most to our members, patients and the public.

Further copies or alternative formats can be requested from:

Tel 0870 444 5841 Email publications@nhsconfed.org
or visit www.nhsconfed.org/publications

This publication was produced by NHS Confederation Events & Publishing.
Engage more effectively with your audience, tel 0844 800 9753

© The NHS Confederation 2011. You may copy or distribute this work, but you must give the author credit, you may not use it for commercial purposes, and you may not alter, transform or build upon this work.

Registered Charity no: 1090329

INF26501

NHS CONFEDERATION 

The NHS Confederation
29 Bressenden Place London SW1E 5DD
Tel 020 7074 3200 Fax 0844 774 4319
Email enquiries@nhsconfed.org
www.nhsconfed.org