

the voice of NHS leadership



Liberating the NHS. What might happen?

The Roger Bannister Health Summit, Leeds Castle, 2010



The voice of NHS leadership

The NHS Confederation is the only independent membership body for the full range of organisations that make up today's NHS.

We represent over 95 per cent of NHS organisations as well as a growing number of independent healthcare providers.

Our ambition is a health system that delivers first-class services and improved health for all. We work with our members to ensure that we are an independent driving force for positive change by:

- influencing policy, implementation and the public debate
- supporting leaders through networking, sharing information and learning
- promoting excellence in employment.

All of our work is underpinned by our core values:

- ensuring we are member driven
- putting patients and the public first
- providing independent challenge
- creating dialogue and consensus.

For more information on our work, please contact:

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

Cover image: istockphoto.com
ISBN: 978-1-85947-189-0
BOK60040

Registered Charity no. 1090329

Published by the NHS Confederation © The NHS Confederation 2011
The use of this publication is covered by the conditions of Creative Commons Attribution-Non-Commercial-No Derivative Works License: www.creativecommons.org/licenses/by-nc-nd/2.0/uk. 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.

Contents

Introduction	2
Making the changes happen	3
Picturing the future	6
Issues about implementation	11
Conclusions	14
Reducing the risks – implications for policy-makers	16
Appendix: Leeds Castle summit participants	17

Introduction

The Government's health reform proposals, announced in July 2010, undoubtedly represent the biggest shake up of the NHS in its history. Radical changes to where power sits in the system are proposed, along with a very different hierarchy and a move to full-blooded market mechanisms with limited, if any, system management. The Government also proposes having a much lighter touch itself in managing both the system and the way the NHS is held to account for its performance.

In November 2010, we brought together a wide mix of patient groups, professional leaders, local government and health policy experts in a summit at Leeds Castle. Using the wide range of their perspectives, we asked them to:

- understand some of the main drivers of change that underpin the proposals and how these might work in practice
- think about how the reforms might play out over the next five to seven years in the context of a very difficult financial situation

- consider what changes to the reforms might improve their effectiveness
- identify how some of the transition risks can be managed.

The Government confirmed its intention to press ahead with the reforms in December 2010 and went some way to addressing our concerns, including making progress on establishing the NHS Commissioning Board and a more realistic timescale for making the necessary efficiency savings. However, we hope that much more detail will be ironed out in the Health and Social Care Bill.

This report sets out the key points from the discussions at the November summit and what we see as the outstanding issues that the Health and Social Care Bill must address as it enters Parliament. We end by setting out 12 points for policy-makers to bear in mind to minimise the risks associated with moving to a new system.

Making the changes happen

Our Leeds Castle summit participants looked in detail at aspects of the white paper that will make the changes happen (the change drivers), how they might work in practice and what the Government still needs to address. They discussed:

- GP commissioning
- markets and system change
- the impact of new entrants to the market
- the tariff and payment systems
- accountability.

This section summarises their views under each heading.

GP commissioning

If GP commissioning is simply to be primary care trust (PCT) commissioning done by GPs, then the scale of reforms is probably disproportionate and the results may be unexceptional.

The Government seems to have systematically underestimated the very significant cultural and behavioural changes required, in particular from GPs who will need to retain their role as patient advocate and their focus on individuals, balanced with a population health viewpoint and use this to make difficult trade-offs.

A key determinant of how the new system evolves will be the extent to which the consortia are willing to take responsibility for rationing decisions and large-scale change such as hospital closures and service reconfiguration.

Markets and system change

Markets work best if suppliers can make quick adjustments in their prices, costs or what they supply. This assumption does not easily translate into the NHS as it is currently constructed and the new world does not yet appear to have machinery to allow this. Without it, a likely scenario is a large amount of 'stranded' capacity, widespread deficits and political noise, but not the scale of widespread closure necessary to unlock it. Participants also thought:

- There seems to be an unstated assumption that system management and strategic planning are not necessary except for economic regulation in relation to competition and the designation of essential services. With the correct regulatory framework, adequate information and intelligent purchasers, markets can drive significant improvements in efficiency, responsiveness and quality. However, it is much less clear that markets are good at solving complex problems such as the configuration of services and so mechanisms or making these decisions may need to be created.
- Trauma, cancer and emergency medicine are composites of other specialties and clinical services and it is probable that the market 'signals' relating to the individual component services will determine who provides them and where they are located and that these will swamp signals in the market for other services of which they are a part.
- It is likely that more change will be driven by provider decision-making and strategy than is currently the case. The less services are subject to additional regulation, the more likely it is that provider-led change will be a key part of the new system.

The impact of new entrants to the market

The reforms assume that new entrants to the market will have a positive impact on improving quality and efficiency and will be an important source of innovation and change. There are good reasons to suppose that this is correct and that where new entrants can gain a foothold they will bring innovative ideas and new service ideas.

Given the financial environment, it will be important that expanding the 'any willing provider' market reduces prices and does so without diluting quality – the evidence suggests that this may be difficult. However, cost and price reductions in similar markets have only been possible because the size of the total market has increased, creating space for new entrants while leaving space for incumbents who must then reduce their costs. For example, the price of mobile phones has fallen dramatically in real terms, but the total size of the market has also expanded enormously, creating space in which new entrants can offer innovation to the market.

The tariff and payment systems

The reforms place a lot of weight on the use of payment mechanisms to drive change and summit participants felt there are lessons to be learnt from using Payment by Results, including:

- There is a limit to the number of objectives it is possible to pursue through pricing signals and, to be effective incentives, tariffs have to be continually adjusted and refined.
- Tariffs have to send clear signals to providers about what they need to do and be sufficiently high powered to make it worth taking the trouble to respond, but, like targets, not so high powered that it leads to 'gaming' or other distortions.

- Fee for item of service tariffs are very effective if the objective is to increase the quantity of what is produced but, for many of the areas where change is required, new forms of tariff will be needed which allow more risk and gain sharing between commissioners and providers.

Accountability

Participants thought that the mechanisms outlined for oversight and accountability may be underpowered, given what they are expected to deliver, and were particularly concerned about whether there will be mechanisms to ensure that quality is maintained and improved, especially if there is to be significant price competition.

Local accountability arrangements contain some interesting manifestations of different policy ideas being put together. At least four, potentially conflicting, theories of legitimacy and power seem to underpin the accountability arrangements. These are illustrated in Figure 1. It is not clear what the impact of this will be on relationships and effectiveness.

Other change drivers

Participants also had concerns about other drivers for change that need strengthening, specifically:

- Whether the failure regime and the reality of being an accountable officer for a GP consortium will create sufficient incentive to invest in high-quality management.
- In common with a number of reform proposals in recent years the white paper contains much more rhetoric than practical measures to empower patients and encourage choice and almost nothing about how shared decision-making will come about.

Figure 1.

	GP consortia	Health and well-being board	National Board	Foundation trust governors
Constituency	Patients (individuals)	Local electorates	National Population	FT members
Source of mandate	Face to face contact with 70 per cent of population	Periodic election and selection	SoS mandate	Election by members
Source of power	Positional & professional	Political	Legal	Representation
World view	Biomedical/ professional	Place/politics	Epidemiological/ technocratic	Provider

In particular there is too little emphasis placed on how patients, supported by patient groups, could become much more active in managing their own care and how they could utilise personal budgets and other more direct forms of control.

- Choice is clearly an important driver of the new system. The current potential for information to shape choices made by patients and the public may have been overestimated, although this certainly will become more powerful over time and the cultural and practical barriers to its widespread adoption may have been underestimated. The solutions for those areas where choice is less powerful or where there needs to be competition for the market

rather than within it perhaps needs further development.

- The drivers to promote greater integration between primary and secondary care and between health and social care are weak and may push the system apart.
- The white paper assumes that there is no need to reform and improve primary care. Participants, including those from GP organisations, felt very strongly that there are big opportunities to bring the best of general practice into some of its less well performing areas, and to make it operate more systematically to exploit economies of scope and scale in ways that have not previously been possible.

Picturing the future

We asked the participants at the summit to develop scenarios for the next five to seven years as the reforms are implemented. A range of scenarios were generated and two dimensions surfaced as being particularly significant in determining how the NHS will develop:

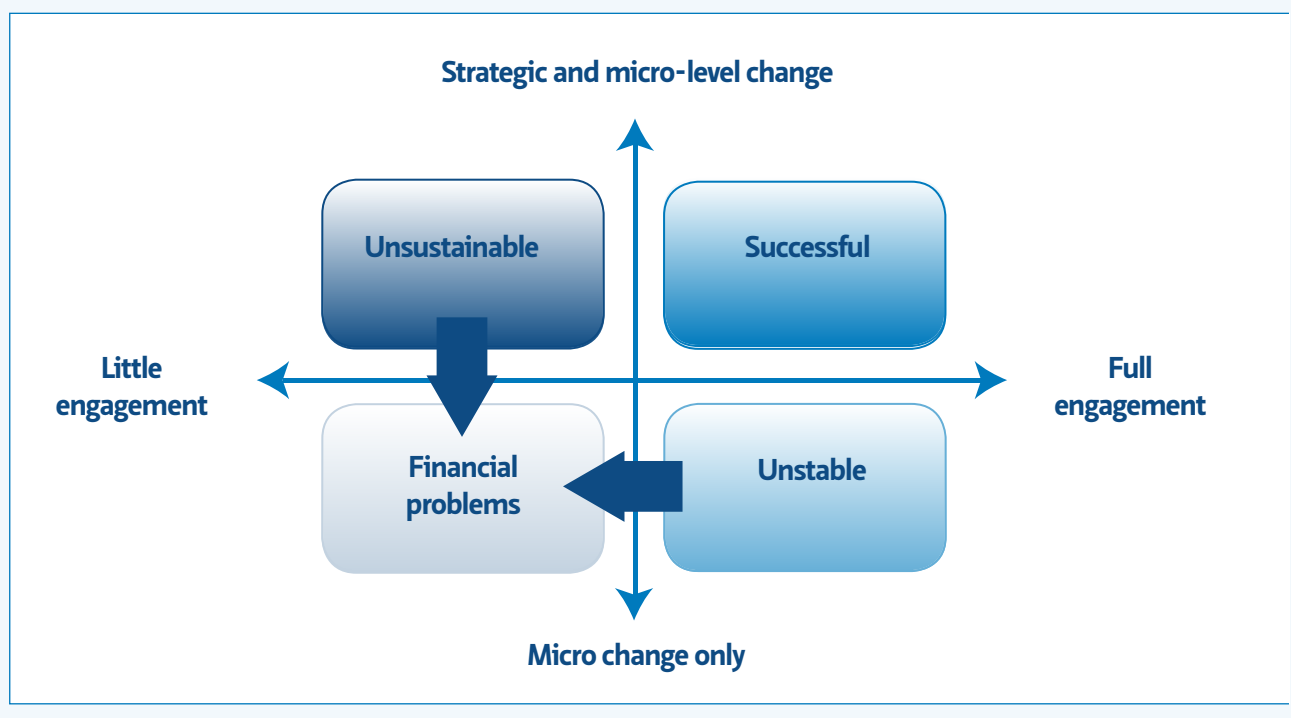
- the extent to which there is effective GP involvement and commissioning i.e. enough GPs involved and who have successful commissioning organisations and support amongst the wider GP body
- how far this and the other change drivers in the system are capable of creating macro-level strategic change as well as more micro-level process and pathway improvement.

Figure 2 sets out what participants thought would be the likely outcomes combining these two dimensions together.

Low engagement and micro-level focus

The participants felt that if there is a low level of GP involvement and those that are involved confine themselves to micro redesign or simply carry on with the current model of commissioning, then the scale of the financial problems in social care and the NHS, growing demand and other pressures will be potentially overwhelming. Widespread financial problems are likely, although possibly not at a sufficient level to encourage providers to exit the market. Providers would be likely to respond by taking the lead on strategy and making decisions about configuration and mergers, where these are permitted. Widespread deficits, sub-optimal performance and longer waiting times are likely to result from this. Such an environment may be very unattractive to new entrants and may be difficult to enter if resources are heavily committed to supporting stranded

Figure 2.



costs in existing providers. There would also be strong pressure to reassert central control to deal with the financial and performance issues and because of the political noise that would undoubtedly be generated by aggressive provider plans to reduce costs. This could create a very bumpy, unpleasant and hazardous period, leaving most of the reforms unimplemented.

Low engagement with more strategic approaches

Based on previous experience, participants felt that any attempt to deal with the financial pressures by wholesale strategic change without high levels of GP involvement and other types of clinical support will be unachievable. The top left-hand quadrant of the scenario in Figure 2 would therefore appear to be unsustainable and may well rapidly tend towards the bottom-left one where there are serious financial problems. If these happen, the question will be whether they are significant enough to lead to another wave of reforms or whether the system will be able to pull itself into a new and more stable position.

Progress overwhelmed by financial worries and public disquiet

A third scenario in the bottom-right of Figure 2 is where GPs and other clinicians are fully engaged but where their main effort is focused on micro-level change, pathway redesign and other small-scale changes and improvements. Participants felt that, while this approach would undoubtedly have very significant advantages for patients and be very positive in terms of quality, it is not clear that this will be sufficient to create the level of headroom and innovation required to make a step change in the way the system works or, more importantly, deal with the financial challenge. For this reason, although this scenario would have been workable when the policy was originally

designed, it also now appears unstable.

In this scenario the increasing financial problem over the period is likely to lead to GP disengagement if they take the brunt of public dissatisfaction about unpopular local decisions. It seems likely that in the short period in which these scenarios will develop, the expectations of the public and the media that politicians are fully responsible for shortcomings in the NHS or for unpopular decisions taken locally will not have shifted. So while the Secretary of State and Department of Health or the NHS Commissioning Board and Monitor will have few powers to intervene or direct events, there will still be a strong public expectation that they should do something. They will likely find this difficult to resist, leading to further clinical disengagement from the process. In addition, the management infrastructure required to deal with this in the traditional way will have been dismantled by this point or at the very least will require some time and effort to recreate.

Success and progress

Participants felt that the chance of the reforms being successful will be greatly increased if GPs are involved from the outset in organisations that rapidly become effective and are willing to deal with some of the strategic challenges in local health systems. They thought that success will require full participation from secondary care clinicians as well. Exploring this successful picture in more detail, participants thought that the most favourable scenarios would need favourable supporting changes in a number of other areas, including:

- consortia and primary care
- the evolution of commissioning
- provider side issues
- regulation and quality

- patients and the public
- local government and public health
- the Department of Health and politics.

Consortia and primary care

The most positive outcomes will require consortia to make major strides in improving the quality of primary care, in particular systematic approaches to managing long-term conditions and addressing variations in performance. This will be greatly assisted by incentives to create federated GP practices, peer-reviewed, contractual mechanisms to encourage the inclusion of specialists and other clinicians into these and, crucially, delegated power to manage elements of the GMS contract. Participants thought that more scope for new providers of primary care to enter the market would also be beneficial but might be a source of significant conflict.

This inevitably will create some blurring of the line between commissioning and provision but participants viewed this as inevitable and not necessarily undesirable.

The evolution of commissioning

To be effective, consortia will need to develop infrastructure including specialist advice on commissioning in those areas where scale is required or where GPs are less familiar with the clinical issues. Developing commissioning support that offers specialist advice as well as more transactional services would increase the probability of success. These may also be important in providing robust decision-making frameworks for consortia as well as providing a vehicle for more strategic change management. It seems likely that there will be some standardisation of the offer that consortia make to patients to avoid the risk of patients shopping around for treatments not available via the

consortium that their GP belongs to. This seems to undermine the idea that competition between commissioners for patients will be a powerful driver of the change, although competition for practice membership might emerge between consortia.

Our participants thought that, in time, support functions might compete for consortia or practices and might evolve as a way of making competing offers to the public about levels of coverage. They might, particularly if they take over commissioning from some consortia, develop publicly recognisable brands over time.

Successful consortia will need to develop high-quality working relationships with health and well-being boards and have access to public health expertise to ensure that there is a coherent population health view. This relationship should allow consortia to develop much better joint commissioning of social care, leading in time to the creation of a single strategy in this area. Proposals in the Government's command paper (December 2010) for the health and social care bill on joint health and well-being strategies and a shared outcomes framework for commissioning, public health and social care will be helpful in supporting this.

Developing more personal budgets introduces an interesting uncertainty about exactly what the nature of commissioning for long-term conditions and social care may be in future. It also raises a number of very difficult technical and policy questions. Participants felt there are opportunities to make much more constructive use of patients' own expertise in managing their long-term conditions.

An important risk that will need to be managed is the danger that commissioning becomes fragmented. In the current proposals commissioning is split between at least three different bodies. A second risk is the overuse of fee-for-service payments to providers and micro-management through the over-specification of

incentives. This is likely to undermine attempts to create more integrated care delivery.

A lesson from the past is that commissioners should not be asked to deliver too many diverse objectives at any one time and should be allowed to focus mostly where there are a small number of key problems affecting their local population.

Provider side issues

Participants thought that the development of much more integrated provision offers opportunities to improve the quality and cost-effectiveness of care but the extent to which this is possible in the regulatory framework to be operated by Monitor is not clear.

There was a view that existing NHS providers had in general failed to provide the level of entrepreneurial innovation that had been hoped for. This either needs to change or it will be necessary for new entrants to bring innovation into the system. As with the other scenarios, this requires some of the existing providers to contract to allow some headroom for new entrants if the costs of the system are to be contained. This means that providers will have to have access to strategic finance for restructuring. The attitude politicians and local public take to the changes will also be crucial. The third issue is whether the procurement process that is used for new providers will continue to restrict their ability to offer innovative services.

A key risk in a tight financial environment is that quality could decline in ways that will be difficult to notice. This is a hazard in situations where there is price competition and light touch regulation. A race to the bottom on price has obvious and immediate dangers for quality. The clinical leaders within provider organisations and nationally will have an important role to play here. This leadership could also make a significant contribution to reducing unwanted variation between providers.

Regulation and quality

Regulation has been neglected in much of the analysis of the white paper but participants felt that economic regulation has a crucial role. The attitude the new Monitor takes to the creation of integrated services, proposals for provider mergers or consolidation, clinical networks and other collaborative mechanisms will be crucial. There are hazards in being too rigorous in the application of competition rules and in being too permissive. A pragmatic approach based on patient benefit and one that is open to integration and innovation is needed. Given the very significant powers of the new regulator, there will be a need to address how it gets a public and patient viewpoint to inform its decision-making.

Quality regulation moves to being about baseline assessment and, while this will help to deal with the very worst performing providers in primary and secondary care, quality improvement will be driven by boards, frontline staff, commissioners and the publication of information for patients and the public combined with much more choice. It is not clear whether this package of measures will be sufficient or even if it is it might be re-examined if there is a further quality scandal. A significant uncertainty in this area is what the Francis (Mid Stafford Hospital) Inquiry will recommend and whether this will be consistent with the way the system is emerging.

Participants thought that the changes in the system create some space and an important opportunity for clinical and professional leaders and their national bodies to take a more central role in reducing variation and improving quality.

Patients and the public

Participants thought that there may be some issues about the public's response to some aspects of the new system including variation in

prioritisation decisions and large-scale change of local health systems that are likely to be negative or at the very least action is required to ensure that the way the new system will work is properly understood.

Although participants welcomed increased information and transparency, they were not convinced that the NHS is yet able to use the information that is already available in the best way, and that challenges remain around communicating information about variability and quality to patients. The design of the reform proposals suggests that patients will be most able to influence the shape of health services through contributing to decisions made by GP commissioning consortia, yet the mechanisms for significant patient and public involvement at this point in the system have not been well articulated.

There is much more scope for making imaginative use of patient groups and individual patients as agents of change in this new system.

Local government and public health

To be effective, our participants believe that consortia will need very close relationships with local government. In particular it will be very important that they have access to the expertise of public health professionals to support the decision by providing insight on epidemiology and effectiveness. There is an important role for the new health and well-being boards in providing some of the strategic leadership in this system. However, participants were not clear how this would operate in practice and were particularly concerned about combining scrutiny and strategy making in the role (which has since been reversed).

It is not clear whether these types of local bodies will be prepared to make some of the necessary but difficult strategic decisions about

the configuration of services. There was also some concern about how consortia will relate to multiple health and well-being boards.

The Department of Health and politics

It was interesting to see the way that the role of the Secretary of State and the Department of Health (DH) evolved in our scenarios. The reforms aim to remove politicians from the day-to-day running of the NHS and that local commissioners will make difficult decisions and providers will be completely outside of direct state control. However, our participants were not convinced that, given the history of the NHS, this new settlement would be perceived or accepted by the public, local and national politicians or the media, and even if it were to be the time required was very significant. Many hospitals are such a large part of the local health system and wider local economy that, if they fail, it will be of great political significance whatever the formal policy says. Likewise, major scandals and quality failures will attract great interest. The history of expectation that politicians get involved in detail and the recent history tells us that it may not be easy to simply draw a line after which ministers and the DH no longer get involved, particularly as the current Secretary of State has been somewhat interventionist. International experience also supports this view.

In previous attempts to shift where power and responsibility is located in the NHS, there has been a tendency for power to accrete at the centre and in regional bodies as ministers, the Treasury and a number of organisations with an interest in central control seek to reassert their influence. The current reforms and proposals to cut DH staff will certainly make recreating power structures more difficult, but participants felt it would be a mistake to underestimate their ability to regenerate.

Issues about implementation

This is the area where participants had most concern. The optimistic scenario we generated had some very demanding conditions that need to be met and it is by no means obvious that these will be achievable within the timescale dictated by the requirement for management cost reductions and efficiency improvements. Trying to do three huge change projects at once in this way and in such a short time is extraordinarily risky.

As one of the participants at the summit reminded us, the lesson of the 1990 reforms is that radical reforms only realise the promise if they are also radically implemented. The attempt to try and create a smooth take-off in the early 1990s, because of the proximity of the general election, took the edge off the reforms. However, the experience of a number of healthcare systems is that poor implementation is a more common cause of the failure of reform than poor design.

Consortia need to get into action more quickly

For any chance of success there needs to be a high level of GP engagement and consortia will need to be ready to take up their role very quickly. There are several reasons for this, the main ones being: to prevent the loss of management talent from PCTs; to ensure that there are robust systems for financial control; and to get to grips with some of the most difficult issues facing the system. There are some areas where this task will be particularly challenging.

Having full engagement and effective organisations, and being ready to address the challenge of major strategic change, require some optimistic assumptions, not because of the time taken to create effective organisations and the fact the progress will inevitably be variable, but because by the time the thinking

and planning to undertake this reshaping has been done it is likely that the financial situation of the NHS will have become very much more difficult. The difficulty is that by the time the necessary thinking has been done it will be inconveniently close to the next general election. The political wisdom is that it is impossible to undertake major strategic change, particularly in hospitals, any closer than two years before an election. As we noted above it is unlikely that a shift in expectations and political culture sufficient to distance politicians from these difficult decisions will have taken place by this point.

Act now to take difficult decisions

It follows from the above that the probability of success will be much greater if the consortia inherit a situation in which some of the most difficult questions about hospital configuration and other measures required to manage the financial challenges have been dealt with. This is much more than simply writing off historic deficits, which will in any case return if the fundamental issues which led to them have not been dealt with (not to mention the inequity and potential for unintended consequences). There has been a presumption that where a number of radical solutions have already been thought through, this has been done in the complete absence of any clinical involvement. This is not the case and in some cases discussions have been going on for over 20 years. To extend these might be an affordable luxury in a time of growth but in the current situation appears to be both risky and unnecessary. There needs to be early action to deal with these issues.

Support for consortia

There will need to be well-developed back-office machinery to support consortia in addressing some of the more difficult strategic questions,

providing them with frameworks for decision-making and prioritisation as well as providing support to those functions where there are some economies of scale. There is a danger that some of the skilled staff required to support these will be lost in the transition process, not least because it may take time for consortia to be sufficiently established to be able to create such machinery. Rapid action is required. Creating well-developed commissioning support arrangements, initially through the clustering of PCTs will help with this, although it will be important to ensure that, where possible, these grow organically in a way that reflects the needs of consortia rather than being driven by the usual top-down change processes.

Management

The systematic undervaluing of the contribution that management disciplines can make to the commissioning of healthcare is a major source of concern. Participants thought that there was a major task to develop capacity in GP consortia, local authorities and health and well-being boards. There was support for the idea of developing pathfinders for health and well-being boards and local HealthWatch in parallel with those for consortia.

The role of management seems a strange blind spot in the current Government's policy thinking and one which has led to some unpleasant and demotivating language. There is a more immediate task to stop requiring the same level of policy implementation when there is going to be 45 per cent less management resource and when senior management is tied up with organisational restructuring.

Enabling policies

There are a number of critical enabling policies need to be in place which themselves carry some

significant risks. As noted above, the consortia need to be in place quickly. In the spirit of the reforms, to avoid alienating GPs these will need to be created organically rather than by direction. And yet this may well produce delay and some worrying variations in quality and readiness. A way to allow rapid progress and to give assurance that consortia are ready to operate will need to be found in ways that don't constrain innovation and organic development.

Secondly, there will need to be some significant changes to the GP contract to ensure that consortia are appropriately empowered. To do this by negotiation may be costly and will take considerable time, but the risks of imposition, in terms of GP alienation, are also significant. At a minimum, the changes in the contract to support practices taking responsibility and to create the incentives to support this will need to be in place.

Thirdly, there are a number of very significant tasks to do in setting up the economic regulator, NHS Commissioning Board, new tariffs and pricing and new allocation machinery. There is a strong argument for setting up some of these bodies as quickly as possible and tasking them with developing their organisations, business rules and approach rather than letting this be designed by DH officials who will not necessarily be operating this machinery.

Provider side risks

In theory, providers should be the only stable part of the system. However, unresolved issues about provider configurations, the absence of a banking function, the fact that providers' cost structures tend to be much less flexible than those assumed by market theory and a range of other pressures means that providers will also be facing some significant risks. As noted elsewhere, it cannot be assumed that provider failure can simply be dealt with in an administrative and rules-based way

without significant political involvement and embarrassment.

Telling the story

There was general approval among participants for the idea of setting out the complete reform package rather than issuing it in instalments which seemed to be the case with the previous government. The difficulty with this is that it means that it is hard to explain the complex

package and the absence of any compelling story about why the reforms necessary or how they will translate into improved outcomes is of concern. Too much of the discussion of the reforms has been about the technical machinery rather than the cultural and behavioural changes that are required. The absence of any coherent theory of change and an apparent lack of appreciation by politicians of the need to manage the very challenging reform process is an issue of very significant concern.

Conclusions

While participants were able to imagine the reforms being successful, they said it requires that a degree of optimism and a number of demanding conditions will need to be met. Firstly, there are issues about the reforms themselves that will need to be addressed. Secondly, and of much more concern, is the timetable for the dismantling of one system, its replacement with another and the delivery of a number of other very challenging tasks which seems to carry a very high level of risk.

Issues about the design of the reforms

Many of our concerns about the design of the reformed system can be dealt with through a sensible approach to evolving some new ways of working and allowing sufficient space for local healthcare systems to develop answers that are appropriate to them. As long as a flexible and pragmatic approach is taken to economic regulation, the commissioner/provider divide and that patient benefit is the top criterion for making decision, the system should produce many of the results it is aiming for. However, there are a number of areas where further work is required. Most of these are examined above but we have picked out three that require particular attention.

Primary care

The failure of the reforms to address how primary care needs to change will need to be addressed is a concern. It seems strange to tap the talents of leading GPs to rethink the delivery of secondary care while leaving the 80 per cent plus of encounters that most patients experience each day unreformed, unaffected by the principles be applied to the rest of the NHS and with a number of significant issues of quality variation, responsiveness and cost-effectiveness unaddressed.

Integration

Care is required to ensure that the reforms really drive much closer primary and secondary care

integration, particularly over the management of long-term conditions. Integration with social care in both commissioning and provision is an area that the reforms appear to have neglected and yet the opportunities for providing much more cost-effective care and improving the experience of patients are enormous. It should be noted that by integration participants were referring to the nature of the care rather than necessarily to the organisations that deliver it.

Patients

The opportunity to harness patient groups' expertise and ability to provide support, the potential for patients to support each other in the management of long-term conditions, and for providers to engage individual patients much more has not been taken in the radical way that the rhetoric of reforms suggest. Patient groups should be given the space to come forward with how they can support some of the changes that are required.

Participants were very clear that the reforms could produce some very beneficial effects for patients and population health. Some design changes are required and strengthening of some of the components may be necessary, but there was no requirement for a major rethinking of the system that is being proposed. However, to operate effectively a number of optimistic assumptions need to be made about the speed of progress, the level of GP engagement, the extent to which strategic decisions to reshape the system will be taken and how far providers will be able to respond to this. The fact that the reforms are being implemented during a very difficult period mean that the risks usually associated with a change programme of this scale are even greater than normal. The temptation is for the system to exert a high level of top-down control in driving the reforms. The risks of doing this are that GPs will be quickly alienated, the existing system replicates itself, and the NHS is less liberated than it was before. The risks of organic and evolutionary change are that it may

take too long, have results which are too patchy, and will result in a loss of financial control.

The need for realism

Perhaps above all there is a need to be realistic about what should be expected from the reforms.

The reform programme will start to deliver improved quality and efficiency in the short to medium term but most of these will need to be achieved using more traditional techniques. The reforms have to be seen as more about what needs to be done in phase two of the battle to improve efficiency when the conventional methods have been exhausted.

It is likely that GP commissioning will produce some early improvements in care, especially in

the areas where GPs have particular problems, but experience from healthcare associated infections and waiting times tells us that public opinion tends to lag performance by at least two years. So, little credit may be earned for this.

Major culture change takes a long time and almost always longer than is expected. This is true inside the NHS but will also be true of public and media attitudes to issues that seem to call for political intervention and an end to postcode variation.

Change drivers that excite policy analysts and economists can prove to be underpowered when used in the field.

Key lessons that repeated health reforms have failed to learn is not to over-promise, take more care about identifying the risks and have a plan to mitigate them.

Reducing the risks – implications for policy-makers

1. **Create a compelling narrative about why the reforms matter in order to engage patients, the public and staff in the enterprise.** This is key when you consider the scale and complexity of the changes as well as the challenging financial environment. This might be better if it were not created by Government, but it is needed.
2. **Address the significant cultural and behavioural changes required and develop capacity and capability.** GPs will retain their role as patient advocates with a focus on individuals, but will also need a population viewpoint to take decisions in areas like rationing and reconfiguration. Some help can be provided by external agencies. There are similar challenges for local government and providers. The professions have the opportunity to take a leadership role in helping to lead improvement and identify where change is needed.
3. **Recognise that low GP involvement is among the biggest threats to success.** The NHS in some areas could be overwhelmed by demand if GP involvement is low or if consortia either carry on with the current model of commissioning or confine themselves to micro issues.
4. **Ensure hospitals operating in a market-based system can reconfigure services and organise multi-faceted specialist care.** Markets work best when suppliers can quickly adjust costs or what they supply, but this can be difficult in the NHS where many services are inter-dependent. Measures to make this easier are required.
5. **Realise the benefits of the market in terms of improving quality and efficiency by creating space for new entrants.** This will not happen naturally when, as in the case of the NHS, the size of the total market is not increasing. Closure of existing services will be necessary.
6. **Learn the lessons of the past when driving change through payment mechanisms such as the NHS tariff.** This means pursuing a limited number of objectives, continually adjusting and refining the approach, and ensuring tariffs send clear signals that are worth responding to.
7. **Clarify weak arrangements for oversight and accountability, particularly those relating to the quality of care.** New accountability arrangements contain potential for misunderstanding and conflict – this at a time when the financial environment will put pressure on quality.
8. **Carry out further work in three areas:**
 - The reforms ignore the need to improve primary care, in particular in relation to enabling the best GP practices to help those in less well performing areas.
 - There is a need to integrate primary and secondary care, as well as health and social care, but the reforms may not achieve this and could push them further apart.
 - There are insufficient practical measures to empower patients, encourage choice, and bolster shared decision-making – despite strong rhetoric in this area.
9. **Help the new relationship between GP consortia and local government to work.** Consortia will need access to public health professionals. Health and well-being boards will need to help provide strategic leadership. These are new bodies so building relationships will not be easy.
10. **Recognise that removing politicians from the day-to-day running of the NHS may prove difficult.** Local commissioners will be making difficult decisions and providers will be outside state control. History suggests politicians will struggle to resist pressure to intervene.
11. **Address the biggest risk: transition.** This means: getting consortia into action more quickly; acting now on long-standing hospital reconfigurations; ensuring well-developed back-office support for consortia; avoiding devaluing those driving change; and setting up as soon as possible new bodies such as the economic regulator and NHS Commissioning Board.
12. **Be realistic and recognise that the reforms will take some time to deliver.** GP commissioning is likely to produce some early results but big improvements will take time and it will take even longer for the public to recognise them.

Appendix: Leeds Castle summit participants

- Dr Frank Atherton, president, Association of Directors of Public Health
- Mr John Bewick, director of commissioning development, NHS South West
- Ms Susan Biddle, joint head of programmes, Healthy Communities, Local Government Association
- Mr John Black, president, Royal College of Surgeons
- Mr Stephen Bubb, chief executive, Association of Chief Executives of Voluntary Organisations
- Mr Jonathan Carr-Brown, managing director, NHS Choices
- Ms Vicki Chapman, director of representational and political activities, British Medical Association
- Prof Angela Coulter, non-executive director, Nuffield Orthopaedic Centre NHS Trust
- Ms Helen Crump, senior policy and research officer, NHS Confederation
- Baroness Julia Cumberlege CBE DL
- Prof Lindsey Davies, president, Faculty of Public Health
- Dr Jennifer Dixon, director, Nuffield Trust
- Mr Nigel Edwards, acting chief executive, NHS Confederation
- Dr Jonathan Fielden, chief medical officer, Royal Berkshire NHS Foundation Trust
- Mr Liam Hughes, national adviser, Healthy Communities, Local Government Association
- Mr Paul Jenkins, chief executive, Rethink
- Dr Johnny Marshall, chairman, National Association of Primary Care
- Mr Hugo Mascie-Taylor, medical director, NHS Confederation
- Prof Nigel Mathers, vice chair of council, Royal College of General Practitioners
- Mr Andy McKeon, managing director of health, Audit Commission
- Dr Martin McShane, director of strategic planning and health outcomes, NHS Lincolnshire
- Dr Linda J Patterson OBE MB FRCP, clinical vice president, Royal College of Physicians
- Dr Mark Porter, deputy chair of consultants committee, British Medical Association
- Mr David Stout, director, Primary Care Trust Network, NHS Confederation
- Mr Jeremy Taylor, chief executive, National Voices
- Ms Elizabeth Wade, senior policy manager - commissioning, NHS Confederation
- Ms Jo Webber, director, Ambulance Services Network, and deputy policy director, NHS Confederation

Liberating the NHS. What might happen?

The Government's health reform proposals, announced in July 2010, undoubtedly represent the biggest shake-up of the NHS in its history. Radical changes to where power sits in the system are proposed, along with a very different hierarchy and a move to full-blooded market mechanisms with limited, if any, system management. The Government also proposes having a much lighter touch itself in managing both the system and the way the NHS is held to account for its performance.

The Government confirmed its intention to press ahead with the reforms in December 2010 and went some way to addressing our concerns, including

making progress on establishing the NHS Commissioning Board and a more realistic timescale for making the necessary efficiency savings. However, we hope that much more detail will be ironed out in the Health and Social Care Bill.

This report sets out the key points from the discussions at the November summit and what we see as the outstanding issues that the Health and Social Care Bill must address as it enters Parliament. We end by setting out 12 points for policy-makers to bear in mind to minimise the risks associated with moving to a new system.

Alternative formats can be requested from:

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

© The NHS Confederation 2011. The use of this publication is covered by the conditions of Creative Commons Attribution-Non-Commercial-No Derivative Works License: www.creativecommons.org/licenses/by-nc-nd/2.0/uk

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

ISBN: 978-1-85947-189-0 Stock code: BOK60040

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