The coalition Government’s health white paper and its associated documents represent one of the most significant reforms of the NHS in its history. It proposes radical changes to where power sits in the system, replaces much of the existing hierarchy and moves from quasi-markets that were often really just managed systems to full-blooded market mechanisms with limited system management. It also represents an attempt to change the nature of political involvement in the detailed management of the system and the way that the NHS is held to account for its performance. Finally, it involves a very large structural reorganisation of the NHS.

About the white paper

The Government's white paper *Equity and excellence: liberating the NHS*, published on 12 July, sets out a radical new vision for the health service in England. It has at its heart three key principles:

- patients at the centre of the NHS
- changing the emphasis of measurement to clinical outcomes
- empowering health professionals, in particular GPs.

The reforms will touch every part of the NHS and have an impact on almost every organisation that delivers NHS care. The Government’s consultation on the white paper runs until 5 October and consultations on its supporting documents run until 11 October.

Read our analysis and have your say

The consultation documents ask a number of detailed questions about the design of the new system and we are working with members to address each of these. However, we would particularly like members’ help to answer two overarching questions.

- Will the design of the new system deliver the improved health outcomes, greater control for patients and improved accountability that the white paper sets out to achieve?

- What are the key steps needed to implement the changes and how can the risks associated with the transition to the new system be managed?

This paper analyses the proposals and highlights key questions where we would appreciate your input under each of the following themes:

- GP commissioning
NHS Commissioning Board
• providers
• economic regulation
• democratic legitimacy
• outcomes.

We also look at the overall system and how the transition will be managed.

We are very keen to hear from members with their views about the issues raised in this document and any additional points you think we may have missed. Please email whitepaper@nhsconfed.org by 24 September with your views. We would also be glad to receive a copy of your organisation’s consultation response.

Our full summary of each of the elements of the reform programme is available at www.nhsconfed.org/healthwhitepaper

Designing the system

GP commissioning
Developing GP commissioning is the centrepiece of the reforms and success will depend on how effectively GPs control finances and address difficult decisions about priorities. This raises a number of design and implementation questions.

Key issues

Capacity and capability
These reforms will place most of the responsibility for managing NHS resources and improving outcomes on GPs working as part of commissioning consortia. While there is a clear rationale for this, consortia will have to develop the capacity, competence and powers necessary to take on these responsibilities and their associated risks. This is a particular concern in the context of the significantly reduced management resource that will be available to the consortia, when compared to that in PCTs. Fundamental to addressing this concern is knowing what the commissioning task for the consortia actually is – what responsibilities they will have, what duties will be placed upon them, what their legal status and operating approach will be and how they will work with the health and well-being boards.

Assurance
We believe some kind of light-touch assurance process will be required to consider whether proposed consortia arrangements will be sufficient to manage the responsibilities and risks involved.

Question: Should there be a consortia assurance process and what should it look like?

Running costs
The white paper documents propose that consortia will have a fixed management allowance, and that all other resources are to be used for directly commissioning patient services. Evidence from US experiments with groups similar to GP consortia suggests that failure to invest in high-quality management is a predictor of failure. If we are moving from a top-down system to one free from political micro-management it does not seem to be appropriate for the Department of Health to specify a management cost cap – particularly in the absence of a clear view of the scope of consortia. Limiting the costs of transactional services, such as invoice settlement, would encourage efficiency in back office services. However, for the leadership and commissioning components GP consortia should...
be able to decide what the correct level of management spending should be.

Motivation to participate
GP consortia will need to take responsibility for improving the quality of primary care provided by their constituent practices. If they are not able to do this effectively, a number of the most significant opportunities for improvement that this reform programme offers may be lost.

Questions: Are there sufficient incentives to generate engagement from GPs, and will they have sufficient powers to do what is required to make the local commissioning system work?
What, if any, contractual (and other) levers will GP consortia require to fulfil this role?

Choice, competition and commercial probity
GP consortia will be allowed to commission services ‘over and above’ core primary care from constituent practices where this offers best value. The white paper also encourages greater integration between primary, secondary and social care. Transparent and, sometimes, independent procurement processes will be required. More clarity and thought seems to be needed about the point at which consortia can take ‘make or buy’ decisions.

Equity
Measures will be needed to ensure that consortia recognise the needs of minorities and patients who are less visible to general practice. Consortia will need to develop the expertise required to commission across the full range of physical and mental health services in order to promote good outcomes and reduce inequalities.

NHS Commissioning Board
The creation of a national commissioning board to hold GP consortia to account is a key step in separating commissioning from providing and removing politicians from the day-to-day running of the NHS. It is not clear whether or not the NHS Commissioning Board (NHSCB) will have sufficient powers in relation to the GP consortia and the regulatory parts of the system, how Parliament holds it to account, and whether the responsibilities assigned to it for directly commissioning services are appropriate.

Who should be accountable to whom for what?
There will be some potentially complex relationships between the commissioning board, the new public health service, GP consortia, HealthWatch and local authorities. How these will work in practice is not yet clear. While it

Key issues
Ensuring the system delivers
The commissioning board will have the task of ensuring the system delivers the improvements/outcomes for which it will be held to account (including reducing inequalities) and maintaining financial balance. It will have to do this without directly performance managing consortia against specific priorities and requirements, and while staying streamlined and ‘lean’.

Question: What safeguards are likely to be most effective in demonstrating transparency and fairness in investment decisions, commissioning services from primary care providers and promoting integration?

Question: How will the commissioning board be able to achieve the task described and manage financial, performance and political risks and potential conflicts of interest?
will be appropriate for the details of partnership arrangements to be determined at a local level, further clarity is required on some of the fundamental issues that will define the relationships between partners.

Deciding what’s in or out
It is not clear if there is a convincing reason for the exclusion of maternity and paediatrics from the remit of GP consortia. There are other services (for example, ‘999’ emergency response and areas of specialised mental health commissioning) where the allocation of responsibility may also need to be considered. We suggest that rather than specifying nationally what services are ‘in’ or ‘out’ of the commissioning consortia at this stage, policymakers should focus on articulating a clear set of principles to help consortia and the commissioning board agree on the most appropriate location for different commissioning activities. This will range from personal budgets and micro commissioning, to consortia, federations of consortia, specialist commissioning groups and the board.

Providers
The intention of the white paper is to build on the existing plural provider market to create a dynamic market system. It is envisaged that all NHS providers will either become social enterprises or become, or be part of, foundation trusts (FTs). The NHS trust model will be repealed. The intention is to take the state out of running (or any detailed involvement in) providers of NHS services and has significant implications for access to capital, the approach to insolvency and failure and – very significantly – the creation of a level playing field between all providers, public and private.

There are a number of proposals to give FTs much greater freedom over income generation, investment, borrowing and governance, which are logical extensions of the existing policy. One consequence of this is a move to a commercial insolvency regime. This is much more than a technical change and there are difficult questions about the continuity of essential services and the more than £30 billion held in assets by FTs and PFI contracts.

The volatile market that providers find themselves in, the need to be able to make radical changes to the cost base, and the removal of the financial brokerage role of the strategic health authority mean that a banking function that is able to make loans for structural readjustment, working capital and investment will be an important part of any future provider system. How best to provide this in a way that is fair, ensures some desired level of stability and conforms to competition law is a significant challenge and this is not dealt with in the white paper.

Key issues
FT status
In moving all trusts to FT status there is a concern that there has not been a very sophisticated approach to understanding the obstacles that some organisations face. It is not clear if the special administration and insolvency regime or takeovers will be sufficient to bring all NHS trusts up to foundation trust status.

Question: If takeovers and the special administration and insolvency regime are not sufficient to ensure that all NHS trusts achieve FT status, what are the solutions for non-FTs?

Level playing field
It is obvious that the new system will require a level playing field and that a rethink is needed on the FT regime for access to capital. The implications of this in terms of policy for other areas, for example pensions, pay, PFI, capital financing, the consequences of
subjecting providers to a commercial insolvency regime and the protection of the State’s stake in FTs are very significant and need detailed consideration.

**Question: What are your views on the implications of creating a level playing field?**

**Economic regulation**

The proposal to develop a powerful new economic regulator – Monitor – is a very significant change.

Monitor will have a wide range of competing objectives to manage and very extensive powers to decide on the shape of the system, essential services, market entry, price and competition practice, as well as having duties to promote competition and choice and safeguard patient and taxpayer interests. It will have powers that are currently vested in the Department of Health, strategic health authorities and the Secretary of State for Health to commit other actors’ expenditure and govern their behaviour.

The aim is that the overall system should be much closer to the type of markets found in the regulated utilities than to the constrained quasi-market that has developed in the NHS over the last few years. Competition law will apply, which is one reason why GP consortia will be required to follow procurement rules. Using competition law, rather than principles and rules applied on the basis of patient and taxpayer benefit arguments, is likely to mean revisiting current and proposed transactions and behaviours. For example, unless carefully planned, vertical integration of community service provider arms into acute providers may be ruled to be anti-competitive, as may integrated service models and informal collaboration between different providers or between commissioners and providers. There are arguments for and against a more stringent application of competition law, and it will be important that we gather and reflect the range of views of the membership.

The white paper states that Monitor will set ‘efficient or maximum prices’ for NHS-funded services. This implies that providers will be able to compete more routinely at prices below the tariff. There are existing flexibilities for local agreements but the assumption is that competition is on quality rather than price. Introducing price competition on a more general scale is a significant change of policy. This has benefits in terms of efficiency and innovation and risks in terms of quality and the potential for a reduction in the choices offered or attempts to steer choices in particular directions.

**Key issues**

**Monitor**

Monitor will have wide-ranging powers that will cut across the interests of other actors in the system and sometimes conflict. For example, it will have power to set higher prices for individual providers, committing GP consortia to additional expenditure. It will be responsible for both ensuring service continuity and promoting and regulating competition. There is a question about whether the powers proposed for Monitor may be out of proportion with other parts of the system. The regulations and policy about this and how Monitor will balance its different objectives and take into account the views of the other actors in the system will be very important.

**Question: Are there sufficient safeguards to ensure that the regulator does not have conflicts of interest between its different roles and in balancing the interests of other parts of the system?**
Price vs quality
Understanding the consequences of introducing a regime based on competition law and whether this could undermine one of the white paper’s objectives of creating greater integration is vital.

Question: How can the economic regulation system ensure that price competition does not lead to problems with quality or undermine patient choice?

Balancing cost pressures and resources
It will be very important to understand whether the regulator should balance the resources available for the NHS with the cost pressures faced by providers. This is already an issue with independent pay review bodies where there are similar competing priorities.

Question: Are there issues involved with splitting responsibility for different aspects of price setting between the commissioning board and the regulator and, if so, what are they?

Democratic legitimacy
The white paper makes proposals to strengthen democratic legitimacy within the NHS including creating local health and well-being boards (HWBs) in every upper-tier local authority, and changes to patient and public engagement (PPE) arrangements at local and national levels.

HWBs will have a statutory role to support joint working on health and well-being and are seen as a way of promoting greater integrated working between NHS commissioners and local authorities. These arrangements are expected to replace existing local partnership arrangements and work with the local strategic partnership. The HWBs will also jointly appoint directors of public health to be responsible for health improvement funds within a ringfenced public health budget.

The consultation asks whether upper-tier local authorities should have statutory responsibilities underpinned by statutory powers to support this joint working on health and well-being. It also seeks views on how best to achieve partnership working and integrated commissioning locally. These changes are expected to give local authorities greater influence over NHS commissioning, and also give NHS commissioners influence in relation to health improvement and social care. The Government believes this will create local partnerships which would minimise the potential for disputes. HWBs would have the power to refer decisions to the commissioning board or to the Secretary of State for Health if the area comes under the scope of the commissioning board. However, HWBs’ powers essentially remain just of scrutiny and referral, so it is still an indirect chain of influence and accountability.

HWBs can also agree joint NHS and social care commissioning for particular services or plan the allocation of place-based budgets. There are particular concerns about how these proposals will affect mental health care and children’s services.

New arrangements for PPE include creation of a national body (HealthWatch England) to sit within the Care Quality Commission (CQC), and local HealthWatch, which will be based on existing Local Involvement Networks (LINks). In addition to LINks’ existing powers and functions, HealthWatch may take on responsibility for complaints, advocacy and promoting choice. Local HealthWatch will have a seat on the HWB and can report concerns to HealthWatch England or the commissioning board. HealthWatch England will have
various reporting and advice functions in relation to the commissioning board, Monitor and the Information Centre, as well as powers to propose investigations to the CQC.

**Key issues**

**Roles and accountabilities**
Many previous attempts at partnership have proved relatively ineffective and the roles and accountabilities of those involved have often got in the way of success. The approach defined in this new system will need to be sufficiently clear and backed up with appropriate powers. There is a danger that the expectations of the different participants in these boards about who holds power will be at odds with each other. Most of this machinery will be designed locally but there needs to be some mechanism for sharing experience and ideas to make this effective.

As the public health budget will be separated from the NHS, it will be necessary for the HWBs, GP commissioners and providers and the public health service to work together to deliver health improvement within the NHS and population-level public health services across multiple GP consortia and local authority boundaries. This will be far from straightforward.

**Outcomes**

The white paper signals a change of emphasis from process measurement to outcomes. The consultation on a new outcomes framework for the NHS is the beginning of an attempt to develop a set of outcome indicators of the overall performance of the NHS. There will eventually be three outcome frameworks covering the NHS, social care and public health.

The framework will be structured around five domains that the NHS should be delivering for patients covering effectiveness, patient experience and safety.

- Preventing people from dying prematurely (effectiveness).
- Enhancing quality of life for people with long-term conditions (effectiveness).
- Helping people to recover from episodes of ill health or following injury (effectiveness).
- Ensuring people have a positive experience of care (patient experience).
- Treating and caring for people in a safe environment and protecting them from avoidable harm (patient safety).

A set of overarching indicators will frame the commissioning board’s responsibilities. These will have a set of improvement areas with indicators used to hold the board to account (by the Secretary of State for Health) and will be supported by clinical standards used to inform commissioning by consortia. This is hugely ambitious and is consistent with the arguments that the NHS Confederation has been making for some years.

**Key issues**

There are three issues which we think the Department of Health needs to consider.

**Cost and burden**

The collection of information for inter-provider comparison is
relatively expensive. Large sample sizes are required to provide reasonable confidence intervals and large data sets are needed to allow risk adjustment. Patient surveys and patient reported outcome measures (PROMs) that are large enough to inform decision making in individual hospital departments need even larger samples. It is possible that this will create a significant new burden. Ways of assessing the costs and benefits of data collection will be required.

Not all process measurement is bad
While the NHS has focused far too much on narrow process measures, some process measures are still required because of the absence of a well-defined outcome, the outcome being too distant and/or the process measures giving an early warning of problems where remedial action could be taken before poor outcomes emerge. Even if process measures disappear at a national level they are likely to continue to be used locally, particularly within provider organisations as they seek to ensure that they deliver their outcome measures.

The scale of the task
Developing robust indicators that will be credible with clinicians and capable of capturing important information on outcomes is a very large task and will require significant investment. Achieving all of this and being able to make meaningful international comparisons is even more challenging.

The overall system
The individual components of the proposed system are complex and new. Understanding how each part works is key, but it is even more important to understand how the different parts work together.

Patient voice and the population viewpoint
The assumption that underpins the reforms is that there is no significant conflict between GP interests and those of patients and that the sum of individual patient preferences provides a reliable population viewpoint. It has little to say about some of the difficult decisions about priorities that GP consortia will need to take. The design of the new system also means that there is significant potential for greater postcode variation in the services that are commissioned as consortia make prioritisation decisions. All of this suggests a need for strong mechanisms for both patient involvement in consortia and public health advice to provide both epidemiology and evidence. It seems that these are underplayed in the white paper.

Minority groups and vulnerable patients
We know that people with learning disabilities and mental health problems often do not get the service they should from the NHS. There are also groups in the population who are not in regular contact with primary care or may not even be registered, such as prisoners, drug users, the homeless and travellers. The arrangements for making sure that these people get appropriate attention need to be very robust. Further work is required in this area.

Choice of commissioner
The proposals provide some choice of commissioning group for patients but the impact of this in sending a clear market signal to commissioning groups will be weak. Unless commissioning groups clearly articulate what they offer that is different, it is not clear how patients will be able to choose other than on the basis of the quality of the practice they register with, and this will be about their quality as a provider not as a commissioner. It may be necessary for commissioning groups to become more transparent in stating what they offer and, in particular, areas they have chosen not to commission if the European Directive on Patient Mobility is enacted.
Mechanisms
There are some concerns as to the extent to which there is sufficient choice to drive change and the potential for overly prescriptive national standards to stifle innovation.

**Question:** Does the proposed combination of regulation, market incentives, transparency, choice, GP commissioning incentives, national standards, regulation and other change mechanisms provide sufficient impetus for change?

Managing large scale change
There appears to be an assumption in the white paper that large scale change will be more of an emergent process than the result of the sort of large scale planning exercises which have been a feature of the NHS. The question is whether this will be adequate for dealing with the scale of the financial and efficiency challenge facing the NHS, workforce pressures, and the changes that GP consortia will make. Together, these will create a pressure for large scale change in hospital services. National standards may also drive providers and commissioners to reshape services. It is not clear how large scale change will come about in this new system. A significant issue is that dynamic markets rely on easy entry and exit and providers that can rapidly respond to changes in the environment. The high ratio of fixed costs to total costs and the lack of alternative income sources for many acute hospitals mean that there are difficulties in making rapid large scale changes in response to shifts in patient choice and GP commissioning.

It is generally easier to increase income than to reduce costs. Mechanisms to allow providers to reshape their services over time will be necessary. The consultation regime will need attention. At the moment it is designed on the premise that decisions are generally initiated by commissioners. Increasingly in this new system, decisions to exit a service will be taken by a provider on commercial or safety grounds – neither of which are very amenable to a long consultation process.

Workforce
The white paper will have both an immediate and a longer-term impact on the NHS workforce. For staff in PCTs and SHAs there will be immediate transitional issues as functions transfer to new bodies. In the longer term, the move to a more competitive system with a wider range of providers will create pressure to develop more flexible employment and reward models.

The white paper states that following the central pay freeze employers will have scope for greater local pay determination. This is expected to build on existing national contract frameworks. The drive for efficiency savings will impact on staffing levels and, in particular, on management costs. Future tariff arrangements will also act as a catalyst for productivity improvements.

The shift of services outside of hospital means that more staff are likely to be employed in community settings and community services will complete their transition to operating as separate provider functions.

The “any willing provider“ policy will expand the use of non NHS providers and existing frameworks for staff transfer will need to be reviewed to support this. There will also be experimentation with models of employee ownership in “social enterprises”.

**Question:** What do you see as the major implications of the white paper on your workforce?
Integration
One of the ambitions of the white paper is to create much more integration between primary and secondary care and between health and social care.

Questions: Are the mechanisms for facilitating integration sufficiently powerful?
Are there obstacles from other elements of the system – such as competition regulation, procurement and tariff payments – to overcome?

Accountability
Accountability will have to be clear. However, there appear to be a number of dotted lines in the design of the system. Ambiguity and room for manoeuvre might be helpful in developing the relationship between GP groups and the health and well-being boards but could be an issue if problems of delivery arise. The nature of the relationship between the commissioning board and the GP consortia is not well defined, nor is the exact nature of what it will mean to be an accountable officer in a GP group.

Conflicting objectives and roles
A number of elements of the system create potential problems with conflicts of objectives and roles. More work is needed on the mechanisms for dealing with these.

Question: What would you say are the main conflicts that will need to be addressed?

Managing risk
There is significant potential for there to be a number of different risk reserves in this system. A larger number of consortia will mean more volatility and there is also a requirement for risk pooling to manage risk on the provider side. This has the potential to create precisely the outcome that the system is trying to avoid. A common risk pool would reduce the overall level of risk reserves required.

Secretary of State’s powers
The lesson of previous reforms is that if the intention is to remove politicians from the day-to-day operation of the service then there needs to be a legal framework to support this. The commissioning board cannot be independent if it is subject to frequent intervention and can have its mandate changed regularly. Safeguards to prevent this will need to be built into the Bill. This is a particular issue for reconfiguration, where it may make sense for the Secretary of State to be bound by the IRP and commissioning board and to only be involved where they fail to agree.

Transition
Difficult questions remain about the transition to the new system. The questions about financial control and maintaining quality standards are well rehearsed. The risks that PCTs lose their best staff and become demotivated – not least because of the very negative way they have been presented – are also obvious. But there are other important risks which need to be managed and a set of important implementation issues which require attention.

Movement to FT status
The reasons for some trusts failing to achieve foundation trust status may not be fully understood and there are issues about what to do in those cases where the problem requires major reconfiguration or other major change.

Question: Should the current Monitor compliance regime be retained for a transitional period to manage the risk while a number of new FTs are formed?

Unravelling the current system of financial subsidies
Despite a move to much greater financial transparency there is
still an issue with financial subsidies. With PCTs and SHAs gone and the introduction of a level playing field, the current system of subsidies will have to cease and there will be significant short-term problems in some areas as a result.

**Forming consortia and capability building**
There are over 900 practice-based commissioning (PBC) groups and it is likely that this will need to change. Some practices may wish to change their allegiance and there will be some realignment and merger. Building new organisations and equipping them with the skills, infrastructure and capability they will need is a significant task.

**Continuity of existing relationships**
The disruption of existing relationships between providers and commissioners will be an issue for many trusts and a particular challenge for new providers, national organisations offering local services, third sector and independent sector providers. These providers will form an important part of the new system but may have their existing markets disrupted in the short term.

**Organisational memory**
One key lesson arising from previous changes is the danger of a loss of organisational memory. Even if GP consortia do not want to employ ex-PCT staff from their own area they will need to ensure that they preserve the information about key decisions, deals and plans from the PCTs.

**Moving to a new resource allocation formula and fair shares**
Allocations based on practices, and with changes in the way that deprivation is treated, will lead to a change in the allocation of the formula. The fragmentation of allocations will produce much more variation in terms of the distance from target for individual consortia. Rapid movement to target has very significant risks but handing over below-target budgets to consortia may be difficult. In an environment with very little growth, it may be necessary to take money away from over-target areas rather than just wait for differential growth to equalise allocations. This also has major risks.

**PCT and SHA functions**
There are a large number of functions that PCTs and SHAs undertake that may not fit well with GP consortia. Some of these can be transferred to the public health service, the independent board or local authorities, or, in some cases, might cease. However, we believe consortia will need their own access to public health advice – particularly for prevention strategies, epidemiology and the assessment of evidence. How resources can be split between different bodies needing access to scarce expertise in these areas requires some thought. Continuing care, medicines management and similar PCT functions might also fit with the consortia. There are a large number of these and careful planning of where they go and ensuring that they are properly funded will be important. The future of some functions, such as the responsible officer role (dealing with doctor’s revalidation and fitness to practise), LIFT (Local Improvement Finance Trust) and infection control, is less obvious.
Help shape our response on your behalf

The analysis and questions in this document represent the start of our thinking about how to respond to the white paper consultation. We are consulting with members through a number of events and forums to feed into our response. Your responses to this document will help us to provide the weight and detail needed for a fully representative response.

The questions we have highlighted are those where we believe your help will have the greatest impact but we encourage you to respond to any aspect of the consultation and this paper. Please email whitepaper@nhsconfed.org by 24 September to give us time to formulate our full response.

www.nhsconfed.org/healthwhitepaper

The NHS Confederation

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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.

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