

# **Liberating the NHS (?) –** The next stage of NHS reform

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## Overview

- > Ambition for reform
- > Key elements of the reforms
- > What does the future hold?

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# NHS Health and Social Care Act

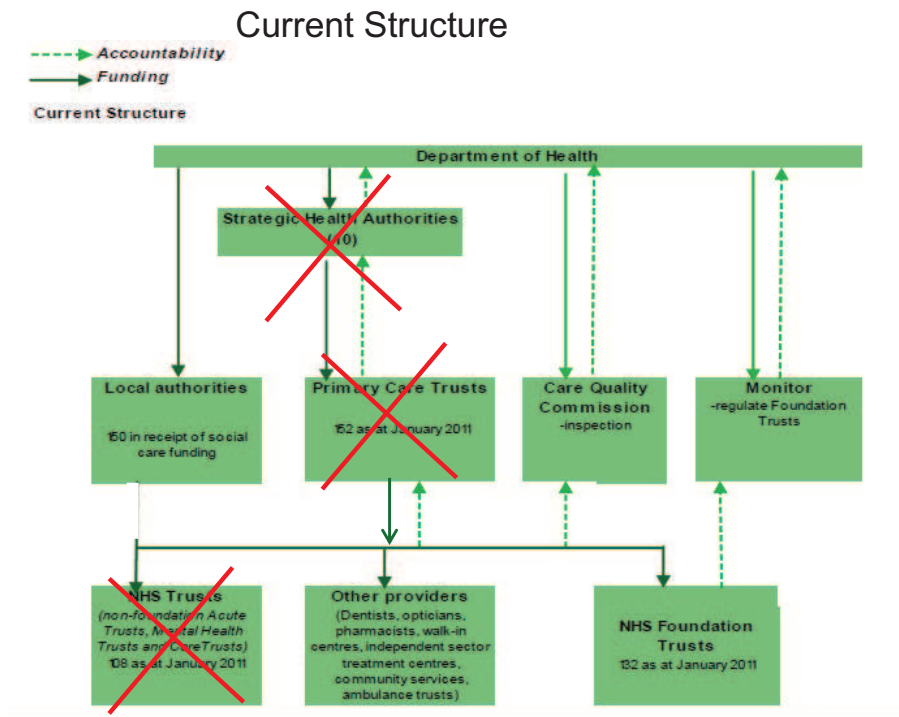


- › The most radical reforms since the inception of the NHS
- › There is continuity with Thatcher, Blair and Darzi
- › But the Act goes much further and faster
- › It was Andrew Lansley's plan with some concessions to the Liberal Democrats

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## The big difference.....



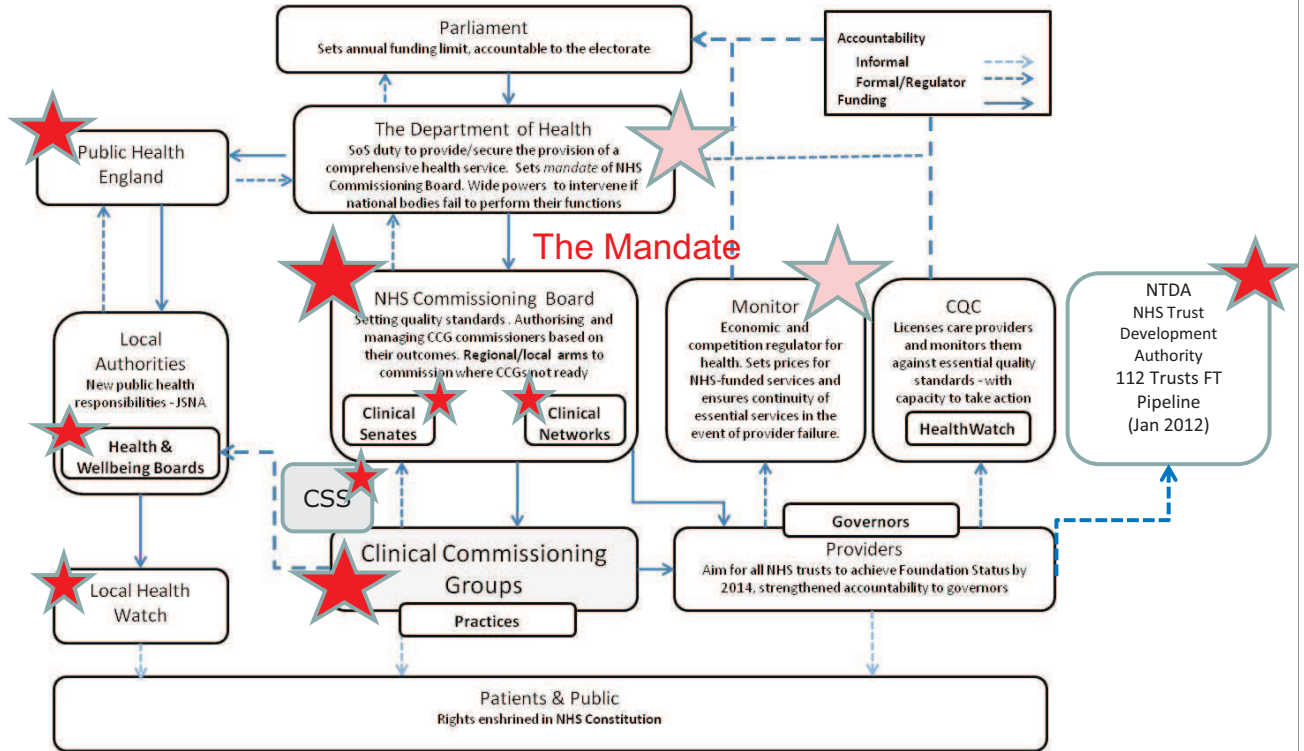
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# New landscape.....



New organisations/bodies



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## Liberating the NHS - Key ideas

- > Choice and competition the main drivers of improvement
- > Level playing field - NHS and private providers
- > Major reform of commissioning structures - "removing bureaucracy"
- > Aligning commissioning with clinical decision making - GPs
- > New home for public health services and new (old) role for local authorities - Health & Wellbeing Boards
- > Greater focus on outcomes - increasing transparency of data on performance
- > Liberating NHS - "duty to promote autonomy" - breaking direct line of accountability from SoS to front line

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# Impact of “the pause” and parliamentary debate

- › SoS explicit duty to promote comprehensive health service
- › Duty of “autonomy” mediated by duty wrt provision of a comprehensive health service
- › Cooperation and Integration - explicit duties
- › Greater scrutiny of Monitor’s application of competition rules
- › Higher profile for health inequalities - access and outcomes
- › More support for patient and public engagement - greater independence for Healthwatch
- › Stronger governance around conflicts of interest in CCGs - to cover members from Commissioning Support Organisations
- › Education and training now explicit concern of CCGs and NHS Commissioning Board

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## The NHS Constitution – new legal force

- 7 overarching principles – comprehensive, available to all on basis need, not ability to pay –partnership, accountability, VFM
- 37 rights and pledges to patients – waiting times and NICE approved drugs
- 10 patient and public responsibilities – health and use of services
- 10 staff rights – pay and conditions, equality and 11 responsibilities – professionalism, development and improvement

**NHS**



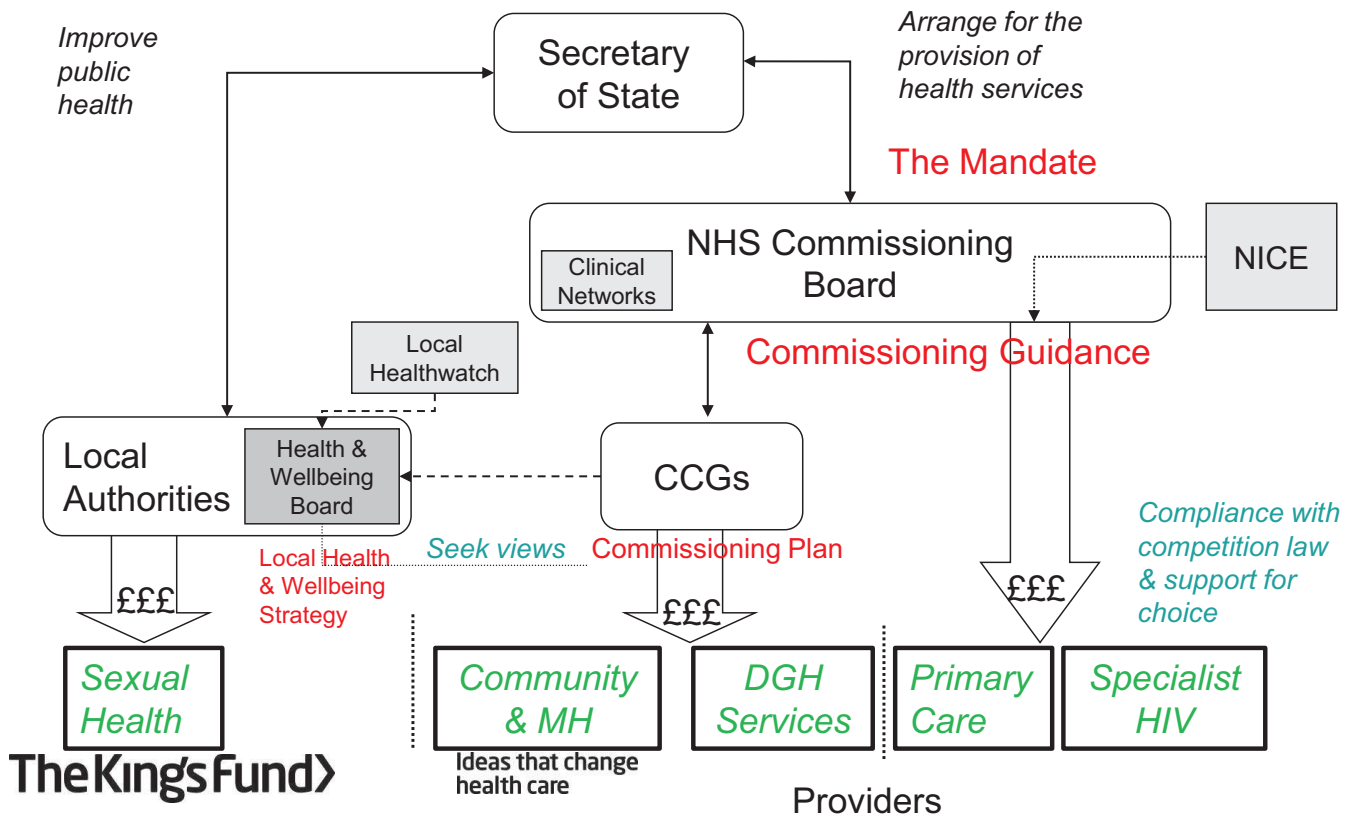
for England  
21 January 2009

Enshrined in statute

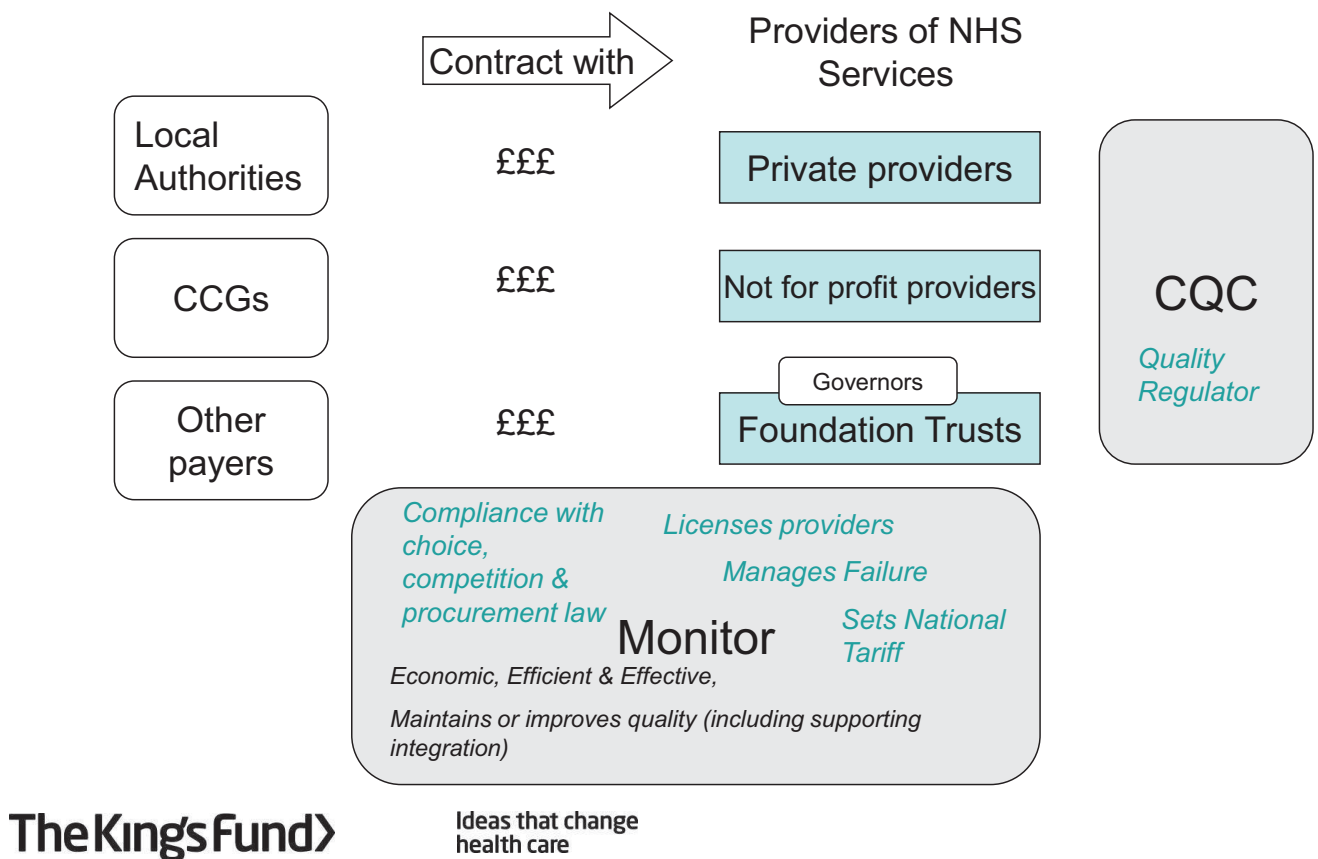
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# New Commissioning Framework



# New Provider Framework



## Some Key Issues

- › There are major risks in the transition – as evidenced in the risk register
- › Restructuring is a distraction from key task of addressing the financial challenges while safeguarding and improving quality
- › Operational pressures are increasing and financial pressures could drive provider failure & greater not less central control - NB FT Pipeline
- › Major developmental challenge for GP commissioners - will all rise to it?
- › NHS has lost a locus for regional planning and leadership - replaced by complex lines of accountability

## What does the future hold?



## Scenario 1: Stasis

- › GP commissioning groups resemble PCTs but with more clinical leadership
- › NHS Commissioning Board drawn into a performance management role over CCGs, with “Field Forces” akin to SHAs
- › Weak links between GP commissioning groups and LAs
- › CCG leaders distant from other GPs
- › Relationships between CCGs and providers are mainly transactional

## Scenario 2: Market-orientated system

- › Competition both on commissioning and provider side
- › Chains of CCGs align to large private insurance companies
- › Choice of GP becomes choice of commissioner
- › Rulings by Monitor are powerful in shaping the supply side
- › European Court rules that agreements between providers and commissioners must be subject to competition law

## Scenario 3: Integrated system

- › CCGs develop close relationships with GP provider federations & also groups of secondary care clinicians
- › Evolution into integrated delivery systems
- › Strong links between health & social care, with use of pooled budgets
- › Strong LA leadership on public health

## Scenario 4: Disintegration

- › CCGs unable to control expenditure. Many face losses, some catastrophic
- › A few CCGs make windfall gains
- › Growing divisions between primary and secondary care as CCGs attempt to control demand by requiring prior authorisation for all referrals
- › CCGs refuse to fund social care services and take little interest in public health



# 2010 Simulation - Key Messages

- › Could be major catalyst change - dynamism and energy – with support for shared clinical vision of more integrated model of care, but will they be allowed to deliver it?
- › The scale of the CCG development challenge – number of “blind spots” - with vacuum of support ultimately filled by NCB
- › Risk that behaviours from the old system simply transferred to the new – NHSCB adopting SHA role – The Daisy syndrome
- › Uncertainty about system rules and leadership – collaboration or competition?
- › Who trumps who – NHSCB, Monitor, CQC?
- › What trumps what – Money, competition, quality?

## Yes Minister?



## Conclusion

- › There are major risks in the transition
- › The outcome is highly uncertain
- › The opportunities
  - Clinical leadership and engagement
  - Removing the “dead hand” of the bureaucracy
  - Disruptive innovation
- › The risks
  - Fragmentation and confusion
  - Service financial and quality failure
  - Clinical and staff disengagement

## Resources

- › A collection of King’s Fund materials on the Health and Social Care Act and Bill:

[http://www.kingsfund.org.uk/current\\_projects/the\\_health\\_and\\_social\\_care\\_bill/](http://www.kingsfund.org.uk/current_projects/the_health_and_social_care_bill/)

Questions?

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