DEPARTMENT OF HEALTH WHITE PAPER
Equity and Excellence: Liberating the NHS

Consultation response from the NHS Confederation - 5 October 2010

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1. Overview

1.1 The coalition Government’s white paper *Equity and Excellence – Liberating the NHS*, published in July 2010, sets out a radical vision for the NHS. It proposes a significant structural reorganisation, challenging the location of power and making the move from quasi-markets to full market mechanisms with limited system management. It also sets out major changes to the NHS architecture.

1.2 The NHS Confederation represents 95 per cent of organisations across every part of the NHS. It is therefore uniquely placed to consult with and speak for the health system as a whole. To advise the Government on the reforms, we consulted extensively with our members across the country between July and September 2010. This paper sets out the main points from those discussions, looking separately at the proposed new system and plans for transition.

1.3 Overall, our members are firmly committed to working positively with the Government to ensure its ambitions for the NHS are achieved. They have significant knowledge and experience which they are ready to contribute to making the new system work.

1.4 Our members support the Government’s objectives. Empowering patients is clearly the right thing to do. There are strong arguments for involving clinicians more closely in decisions about the design of care and management of resources. We also see major opportunities to improve the way the NHS works for patients, if the reforms operate effectively.

1.5 However, after analysing the proposed new system, we have identified significant risks, worrying uncertainties and unexploited opportunities. All these need to be addressed if the reforms are to have the best chance of success. In this paper we suggest how the Government might tackle the issues, either by making changes to national policy or by enabling local solutions.

1.6 Our key concerns about the proposed system include:

- **Market mechanisms alone will not be adequate to manage the system**
  There needs to be a way to encourage GP consortia to work together, help providers adjust to changes in demand, make sure patients in unpopular markets receive the services they need, ensure quality, and encourage innovation and change.

- **GP consortia do not appear to be clearly accountable to patients and the public**
  We need clarification on their relationships with member practices, the NHS Commissioning Board and health and well-being boards. These relationships have the potential to be hugely productive, but GPs need to be fully engaged in commissioning, and accountable to the populations and the wider health economies that they serve.
• **Achieving integration for patients requires a whole system approach**
  There is a need to promote better integration between primary and secondary care; and between health, social care and public health. However, some of the incentives and structures in the proposed system could act against the objective of integration. In particular, the omission of any consideration of the role of specialists in the new system could push the different parts of the system further apart. Improving integration will require co-ordinated planning across systems and incentives for commissioners and providers to work together to improve health outcomes.

• **GP consortia need more influence on primary care and health inequalities**
  The proposals do not make the most of the potential of GP consortia to drive health improvements. Giving consortia the power to performance manage primary care and make the tough decisions needed to get the best value for public money could make a big difference in these areas.

• **Overlapping outcomes frameworks for health, public health and social care are needed**
  These frameworks should be developed against a co-ordinated timetable to ensure that the content is consistent and professionals from different sectors are working together to achieve shared outcomes.

1.7 In addition to assessing the design of the new system, our members also examined plans for the transition period. They see this as the area of greatest risk. They believe it will be exceptionally difficult to deliver major structural change and make £20 billion of efficiency savings at the same time. They see potential for failures in the quality of patient care and financial control. We have therefore proposed a ten-point action plan suggesting how the Government might reduce the chances of serious problems.

Our key concerns about the transition period include:

• **GPs need capacity and capability to take over commissioning**
  Commissioning health services is a complex task and GPs will need to quickly develop the capacity and capability to do this effectively. We have major concerns that this will not be possible with 45 per cent management cost reductions.

• **Skills and experience from PCTs are likely to be lost**
  Primary care trusts (PCTs) have built up a wealth of expertise that will be vital to the success of the new consortia. Urgent action is needed to retain good staff and preserve organisational memory.

• **The management burden needs to be reduced from now**
  Strategic health authorities (SHAs) and PCTs have amassed a large number of management responsibilities at the request of the Department of Health, some of which may not be continued in the new system. The Government needs to urgently review which activities it does not wish to continue so that savings can be made immediately.
• **Barriers to trusts achieving foundation trust status may remain**
  The reasons for trusts failing to make the transition to foundation trust status are many and varied. These need to be correctly diagnosed, and solutions found, if the system is to succeed.

• **The scale of the cultural change needed has been underplayed**
  Most of the consultation and documentation focuses on the mechanics of the new system and immediate next steps. However, it is clear that the culture change being proposed is at least as important and, based on health reform elsewhere, will take many years to have an impact. There is insufficient focus on explaining this, which is a hazard given the long-standing view that the Department of Health and ministers run the NHS and should intervene when things go wrong. The NHS itself is also accustomed to a top-down management approach. More needs to be done to explain the shift away from top-down management and to help the public, the NHS, media, and MPs to understand its implications.
2. Consultation with the NHS

2.1 The NHS Confederation consulted extensively with NHS organisations on the white paper between July and September 2010. Our membership includes ambulance trusts, acute and foundation trusts, mental health trusts and primary care trusts, plus a growing number of independent healthcare organisations that deliver services on behalf of the NHS.

2.2 They have contributed to this consultation response in the following ways.

- More than 150 members debated the key challenges and opportunities at two white paper engagement events held in September.
- Our networks have separately engaged with more than 160 of their members through board meetings, events, policy seminars, and telephone conversations and email.
- About 50 members have emailed their views directly to us.
- Our 22-member white paper reference group, drawn from a broad cross-section of our membership, has had direct input at key stages in the development of this response.

2.3 This overall response to the white paper identifies the policy proposals that we feel are particularly welcome, how we think they can be taken forward as quickly as possible. It sets out the risks our members have identified and recommended actions for averting them. It covers the areas of the white paper where the NHS Confederation believes our collective experience and knowledge can have the greatest impact.
3. The NHS Confederation’s response to the white paper

3.1 The NHS Confederation’s response to the Government’s *Equity and excellence: liberating the NHS* white paper sets out our views on:

- effective commissioning arrangements
- creating a dynamic and responsive provider sector
- promoting quality and patient empowerment
- accountability
- public health
- research
- managing the transition.

3.2 In addition, we will publish separate responses to the four detailed consultation documents that accompanied the white paper: transparency in outcomes, increasing democratic legitimacy, commissioning for patients, and regulating healthcare providers.
3.1 Effective commissioning arrangements

3.1.1. The move to strengthen the commissioning arrangements for the NHS, in particular through establishing GP-led commissioning consortia, presents significant opportunities to improve quality, efficiency and value for money in the healthcare system. Developing a policy framework to make the most of these opportunities, while managing some of the tensions and risks that they create, is a challenge. In general, we support the approach of confining policy to the specification of broad frameworks and allowing local organisations to develop solutions that are appropriate to their own circumstances. However, there are some areas where it would be useful to provide some additional detail in primary legislation, regulations or policy guidance.

3.1.2 Greater clarity on the definition of commissioning

The new system appears to give market mechanisms a more important role in shaping the configuration of services. Members are unclear about how far GP consortia will be expected to undertake the strategic planning that may be necessary to make decisions about the configuration of health services, particularly where these will have an impact beyond the scale of a single GP consortium. There are real risks that, with no local system leadership role, commissioning and service delivery could become fragmented. It is essential that there is joint commissioning with social care for mental health. Health and well-being boards could take on some of this system leadership function, but only if they are given the authority to fulfil this responsibility. The extent to which GP consortia are expected to undertake strategic planning, including longer term strategic planning, will have implications in terms of the resources they will need and when they might have to join together to work federally.

We believe that it would be helpful for the Government to provide clarification on the following issues associated with GP consortia as soon as possible:

- confirmation of the functions they will be expected to deliver
- confirmation of the management cost limits they will have to operate within
- a clear accountability framework including the outcome and financial regime they will operate within, a clear failure regime, and clarity about their accountability to health and well-being boards.

We also believe that the Government should provide significant investment in capacity building for GP consortia to ensure that they have a good understanding of the responsibilities resting with GP consortia, and support to develop the skills and knowledge needed to commission health services.

3.1.3 Commissioning at the right level

We can find no convincing reasons why maternity services have been excluded from the scope of GP commissioning. Similarly, there are examples where a more aggregated approach to commissioning would seem to be appropriate that are not mentioned, for example urgent and emergency care. This system could create unhelpful incentives for groups to lobby for their service being taken out of the scope of GP consortia.
We believe a set of clear principles should be developed for determining what will be commissioned nationally or at a local level, and where consortia should consider joining together in shared arrangements or handing over commissioning responsibilities to a specialist agency. These principles could be provided by Government or developed by national representative bodies.

In mental health, the majority of commissioning responsibilities should sit locally in the longer term. However, the Mental Health Network believes the NHS commissioning board should consider commissioning some aspects of specialist offender mental health nationally in the first instance due to the complexity of service delivery and significant unmet needs of this group.

3.1.4 National standards, prioritisation and rationing
We believe that the white paper’s intention to link clinical decision-making with its financial consequences and to encourage all clinicians to take a population viewpoint is an important step. While we have consistently supported local decision-making, the general public clearly expects consistent standards of care across the country. Patients and GP consortia will need clarity on the limitations of local decision-making.

We believe the Government should consider whether it needs to set out in regulations which decisions about quality standards and access to services will be consistent across the country and which will be left to local commissioners to determine. GP consortia will be subject to legal challenge about how they make prioritisation choices and will need to have very clear frameworks for decision-making. This will be particularly important in light of the EU directive on the application of patients’ rights in cross-border healthcare (which clarifies the rules around existing rights for people to receive treatment anywhere in the European Union and have the costs reimbursed by their home country). Implementing the Directive may require the Secretary of State or GP consortia to specify a positive or negative list that explains the offer made to populations.

3.1.5 Taking a population health viewpoint
We believe that GP consortia should have access to public health expertise so they can take a population health viewpoint, in particular, access to epidemiological advice and insight into parts of the population that are either unregistered or invisible to general practice. At present the system architecture set out in the white paper does not explain how this will be provided.

We also believe it will be important for GP consortia and health and well-being boards to work together to ensure those not currently registered with a GP have their needs explicitly addressed in commissioning plans.

3.1.6 Commissioning mental health services
Under the new reforms, GP consortia will be required to commission across the full range of physical and mental health services to promote good outcomes and reduce inequalities. It will therefore be important to establish a
balance between mainstreaming mental health and protecting specialist services for complex and longer term conditions. The design and delivery of integrated care packages and pathways will also be essential to achieve good mental health outcomes.

It will be important to establish what support consortia will need in this area and to explore any alternative support from non-NHS organisations with access to service user, carer and clinical expertise. We believe that GP consortia should work with specialist providers to develop and deliver a capacity-building programme to ensure that GP consortia have the right expertise to commission mental health services.

3.1.7 Geographic considerations
GP consortia will need to build effective working relationships with local authorities, and we believe they should be mindful of this when considering which geographic areas they wish to cover.

We believe the Government should consider moving to a person-based resource allocation formula instead of the current geographic model.

In doing so, we believe the Government should be explicit that funding for the prison population should be allocated to the GP consortia where the prison is located rather than to the area where the prisoner is from. The NHS Commissioning Board should determine whether GP consortia should be asked to take responsibility for commissioning to meet the health needs of offenders.

3.1.8 Management cost limits
While we understand that it is desirable to keep back office services to consortia as lean as possible and free from duplication, we believe that micromanaging expenditure on leadership and management within the consortia is inappropriate. We are concerned that the white paper makes the presumption that management is a cost rather than an investment. This ignores a substantial body of evidence summarised in a recent Nuffield Trust report which summarised its Person-based Resource Allocation project. GP consortia should be held to account for how they spend the totality of their resources.

3.1.9 Risk pool for commissioners
Risk pools are an important part of the system, but we believe the Government needs to prevent proliferation of overlapping risk pools to minimise any instability created in the system by taking significant financial resources out of circulation.

3.1.10 The failure regime
It is not clear what the mechanisms will be for dealing with consortia that consistently fail to provide high-quality outcomes or to manage their financial responsibilities. The balance between a sufficient incentive to avoid failure and creating a major obstacle to participation is a difficult one. The extent to which
there is collective responsibility for the failure is also difficult, particularly where failure may be the result of the action of a relatively small number of practices.

We believe the Government should spell out how it will deal with GP consortia that fail, and ensure that the rewards of success and the consequences of failure are proportionate and significant enough to have an impact on their behaviour.

3.1.11 Performance management of primary care

Our members are concerned about the performance management of primary care, whether the NHS Commissioning Board will be able to do this from a distance and whether it will have the appropriate expertise. Reliance on regulation alone will not be sufficient. Apart from the obvious problem of one national organisation managing more than 8000 separate GP practice contracts, as well as those for dentists, pharmacists and optometrists, the absence of formal performance management responsibility significantly weakens the potential of the consortia to drive improvements in primary care that would complement their commissioning activities.

For GP consortia to be effective, GPs as a profession will need to be motivated to meaningfully engage in commissioning. This does not mean that they will all need to take on leadership roles or ‘macro-commissioning’ tasks such as service or care pathway redesign. Clinical pathways will need to be produced and these should back the difficult decisions which the consortia will need to make on prioritisation of investment or decommissioning of services.

We believe the Government should give the NHS Commissioning Board the power to delegate responsibility for practice performance and contract management of General Medical Services (GMS) contracts to GP consortia where appropriate. The distribution of any performance payments related to commissioning should be the responsibility of the consortia.

3.1.12 Mapping current functions

An important lesson from the creation of PCTs is that there is a danger of burdening the new GP consortia with functions that have no particular fit with their main focus of activity, and clarity is urgently needed on the range of functions which GP consortia will be expected to carry out. Strategic health authorities and primary care trusts have amassed a large number of management responsibilities, many of which will not be continued in the new system. The Government needs to decide which activities it does not wish to continue now so that savings can be made immediately.

In addition, there are many responsibilities currently undertaken by PCTs such as safeguarding and emergency response as well as managing IT systems, premises, second stage complaints, incident reporting, medicines management and GP appraisal, which do not obviously map to any specific part of the new commissioning architecture. Some may go to the NHS Commissioning Board, others to local authorities, and we believe some of these functions can be discontinued. Once this is decided, the Government
needs to ensure that the responsibilities for all parts of the new system are clear and transparent to all.

We believe the Government should carry out an urgent review of the management requirements which the Department of Health has imposed on strategic health authorities and primary care trusts, to ensure that activities that do not add value to the local health economy are stopped so the management burden and spend can be reduced.

3.1.13 Strong governance and conflicts of interest
There is general support for a move to a leaner governance structure, but this should not be at the expense of the principles of good governance. Decision-making involving significant sums of public money and services as publicly sensitive as the health service needs to be absolutely robust and defensible. GP consortia will need a clear understanding of the standards of governance that are expected of them, although this need not involve direction as to how to achieve these standards.

There remain significant issues to resolve in relation to the conflict of interest of GPs in acting as both commissioners and providers. It will be important to ensure that competition rules for extended primary care services are not perceived as bureaucratic barriers to change, which could have the effect of reducing clinical engagement in commissioning or deterring innovation and new entrants. Many of the criticisms GPs have made about the current system of practice-based commissioning could continue unless issues with the current system are addressed in the new one. On the other hand, too few safeguards on GP decision-making could lead to concerns from patients and other healthcare organisations about the legitimacy of their decisions. The US found it necessary to pass Federal legislation (the Stark Act) that strictly limits referral to any third party in which the referrer or a member of their family has a direct personal financial interest. An equivalent may be necessary in the NHS but we believe there should also be opportunities for practices to legitimately expand the scope of what they offer.

We believe the Government should put in place an assurance system to make sure that GP consortia establish strong governance arrangements with clear, transparent and robust decision-making to address any conflicts of interest between their roles as commissioners and providers. These governance arrangements should be augmented by a requirement for GP consortia to publish individual practice accounts.

3.1.14 An effective national commissioning board
Commissioning of primary care has been an important function of PCTs and one which has considerably improved the quality of primary care services. We therefore see the role of the NHS Commissioning Board as a very important one and we welcome the proposal to establish a body with a national focus on commissioning. However, it would be highly regrettable if commissioning standards were to deteriorate in the new system and we have concerns that the NHS Commissioning Board may, by default, take on a range of functions...
which mean it will either have to become large and unwieldy or alternatively that it may not have capacity to deliver. We also have concerns about its accountability arrangements, which we examine further in Accountability, section 3.4. The NHS Commissioning Board will retain a very significant commissioning remit and it is important that in exercising this it is subject to the same procurement and competition regimes as the rest of the system.

We would support the NHS Commissioning Board being a small tightly-focused organisation. That said, it must also have the capability and support in place to deal with the scale and complexity of the task.

We believe the Government should ask the NHS Commissioning Board to set out a transparent method by which it will turn NICE recommendations, based on clinical and cost effectiveness, into affordable commissioning criteria.

3.1.15 Oversight of commissioners

It is important that the powers of the new regulator are sufficient both in strength and scope. They need to be applicable to all parts of the NHS system including GP commissioners and the NHS Commissioning Board. It will be necessary to invest time and resource in helping GP commissioners to understand and be ready to discharge their duties as commissioners in relation to choice and competition.
3.2 Creating a dynamic and responsive provider sector

3.2.1 The proposals in the white paper about the regulation of providers represent a far-reaching and fundamental change in the way that NHS providers will operate, with the intention of significantly improving frontline services that patients experience day to day.

The proposals, when implemented, could transform NHS provision from a managed system with some internal competition to a real regulated market on the model of the regulated utilities. In order for this vision to be realised, a major shift in understanding is needed about how providers will operate under regulatory rather than direct government control, with greater variation and fewer constraints on service change.

3.2.2 Price setting

There is a tension in the way the system is currently designed that will require further clarification. From a provider perspective, the pricing system will need to be able to create a sustainable market. Commissioners on the other hand will be primarily concerned with affordability and using pricing to drive productivity.

Price competition is the standard tool in free markets for driving down costs and increasing efficiency. However, economic theory and evidence show that it has particular risks in healthcare markets. Economic theory predicts that price competition is likely to lead to declining quality where (as in healthcare) quality is harder to observe than price. Evidence from price competition in the 1990s internal market and in cost-constrained markets in the US confirms this, with falling prices and reduced quality, particularly in harder-to-observe measures. This tension will need to be resolved in a transparent, rules-based and simple way.

3.2.3 Exit and failure

The design of the failure regime for providers has tended to assume the complete failure of the organisation, but experience tells us this is likely to be a very rare event. Much more frequently, the problem will be that individual services become financially unviable or experience problems with quality or safety. A major problem now, which will become acute as the white paper reforms are implemented, is that while income may fall very quickly as patients choose other hospitals or GP consortia move work around, costs fall much more slowly. Businesses in the commercial sector can respond to a loss of business in several ways: they can acquire additional income from other customers; they can increase the income from their existing customers; they can reduce their costs; and they can improve their products and services and recover their markets.

Additional and increased income is less available in a system with fixed prices and with a fixed pot of money in the market, and reducing costs is difficult because a very large proportion of the price of hospital care represents overhead costs that can not be easily shed. Improving products and services
and recovering markets is the most desirable outcome but it is important that this should not mean that failing hospitals are allowed to take almost unlimited time to effect such improvement. There are also clinical interdependencies between specialties that further constrain the flexibility that providers have to respond to changes in the overall market, and which create a perverse incentive for all providers to continue trading at a loss rather than to exit a specialist area that at least makes a contribution to overhead.

To compensate for this, the Government will need to consider mechanisms that allow for structural readjustment and changes to the consultation machinery.

Structural adjustment: We believe the Government should consider establishing a banking function capable of making long-term loans for restructuring when provider services fail or providers wish to exit a particular market, although it should guard against this becoming a way of propping up unsuccessful organisations. This would allow providers to reduce their costs over time and avoid the danger of stranded capacity within the system with associated high costs and inefficiencies.

Consultation mechanisms: We believe the Government should review the current approach to consultation when provider services fail or providers wish to exit a particular market. The protracted consultation processes currently required do not seem appropriate to a market system where providers will be required to respond rapidly to changes in their environment.

### 3.2.4 Access to capital

There is unfinished business in the design of a viable regime for capital in the NHS. It is not clear that the tariff currently contains a sufficient allowance for providers to develop reserves and/or cash flow that can adequately fund proper replacement and maintenance of their existing capital stock. A second problem may be that regulatory and other requirements, current procurement practice and the construction industry (which is expensive by international standards) combine to make the cost of healthcare buildings disproportionately high. On the other hand, the capital regime also has the potential to distort the market – a major factor in an unlevel playing field – and the new economic regulator will have to address this.

Currently, larger scale projects (any requiring significant capital investment, particularly attached to buildings) are undertaken at the instigation, or certainly with the approval of one or more PCTs and the relevant SHA. While the exact number of GP consortia is not yet known, in practice it will be much harder to muster consensus from multiple consortia, and for many services it will not be possible or appropriate for multiple consortia to enter into contractual obligations to a provider to support investment. If investment is to be made, providers in future must therefore rely on their own assessment of supply, demand and competitive dynamics as in other markets.
3.2.5 **Risk pool for providers**
Risk pools are an important part of the system, but we believe the Government needs to prevent proliferation of overlapping risk pools to minimise any instability created in the system by taking significant financial resources out of circulation.

3.2.6 **Clinical networks**
Some complex services, such as trauma and cancer care, consist of a composite of different services. In these cases, there is a risk that market mechanisms will pull the components of patient care in different directions. This is because the market for the individual components may be stronger than the market for the service as a whole. Other services such as critical care and neonatal care do not have a well-defined market but have high levels of capital investment and heavily fluctuating demand which makes it difficult for individual providers to operate without high levels of collaboration.

Clinical networks are one solution to these problems and have been a very significant driver of improvement in critical care, cancer and a number of other specialties. They are also a preferred solution for improving trauma outcomes in England. There is strong evidence that in critical care the work of networks has had a significant impact on mortality and other measures of quality.

However, the demise of SHAs and PCTs will remove the funding and governance for networks. Some of the activities of networks could fall foul of the competition regulator’s (Monitor’s) view of the market. The policy framework needs to consider how the benefits of networks can continue in such a way that they are consistent with the principles of the new system.

We believe the Government should ensure that rules on competition do not undermine the effective working of clinical networks and other appropriate inter-provider collaboration. Clinical networks should continue to be used to solve difficult problems currently resting with strategic health authorities and primary care trusts, such as decisions on exceptional cases and responsibility for managing high-cost drugs funds.

3.2.7 **Transactions and franchising**
There is little detail in the white paper and consultation about the ‘pre-failure’ regime for non-FTs. The emphasis seems to be on transactions and franchising. However there is no analysis set out in the consultation paper about the causes of underperformance and members have raised concerns about the evidence of these strategies being successful in the NHS. For some providers, merger might not be appropriate. There is not yet a hospital management franchising market, and the policy would benefit from some piloting.

3.2.8 **Transaction costs**
We support the organic approach to developing the configuration of consortia, but there is a risk that fragmentation and a proliferation of different approaches will increase costs for providers. There is a cost to building and maintaining
relationships, to responding to tenders, to linking information systems, to putting contracts in place and to monitoring and reviewing performance under those contracts. This will rise as the number of commissioners in the system increase. In many instances the reduced scale of procurements may make opportunities unavailable, or limit the potential response to very localised providers.

We believe that GP consortia should simplify contracts and be encouraged to work together to reduce the transaction costs for providers associated with building and maintaining relationships, responding to tenders, linking information systems, putting contracts in place and monitoring and reviewing performance under those contracts.

3.2.9 Market regulation principles
The white paper sets out the roles of Monitor as the economic regulator. It also states that Any Willing Provider will be the default model of the new NHS market. This model has already been developed for elective surgery and will be appropriate for other planned care as markets develop. However, other market models including competition for the market and planned provision of emergency services are also appropriate in many circumstances.

The economic regulator will also be responsible for promoting competition and choice and applying competition law and procurement rules. We welcome a clear rules-based system but the rules should not inhibit cooperation where appropriate, for example in coordinating clinical networks and integrating care pathways.

The remit for the economic regulator should be set carefully to provide clear principles: to allow commissioners the freedom to use different market and planning models where appropriate; and to allow providers to act collectively where this is beneficial for patients and taxpayers and is not aiming to exclude new providers.

3.2.10 Integration
A major objective of any health reform should be to improve the integration of services, but there are significant risks that the proposed reforms could have the opposite effect. A key issue about the development of the NHS in the last 20 years has been the widening gap between specialists and primary care. If these reforms make this division wider, which is a distinct possibility, they will fail to achieve their desired goals.

If the new system is to deliver the outcomes intended, this could mean federations of GP consortia working with hospital specialists; hospitals offering whole pathway models in areas such as rehabilitation, after care, mental healthcare and long-term condition management; and other integrated models that are designed to improve the patient experience and outcomes.

We believe that the Government should consider the following steps to support the development of integrated care for patients:
• review the current incentive structures to encourage hospitals to create more integrated care between primary and secondary care, including mental health, by more readily working with local authority partners as well as healthcare colleagues
• ensure when drafting legislation and regulations that instructions to the competition regulator allow providers to develop integrated patient care solutions
• ensure when drafting legislation and regulations that the obligation to co-operate that is part of the current set of market rules is not lost.

3.2.11 Civil contingency and resilience
As well as operating in a market for elective and ambulatory care, hospitals and ambulance services are expected to provide a safety net of emergency care with medical and surgical inpatient back-up for local populations. Some providers will be expected to be the provider of last resort and will have less freedom to choose particular services to compete for. Clinical interdependencies will mean that this responsibility will tend to be concentrated in a few providers.

When drafting the economic regulation framework we believe the Government should take account of the responsibility that ambulance and acute hospital services have as part of local and national civil contingency operations, requiring coordination and, at times, state control.

3.2.12 Oversight of providers
As Monitor develops its new role as an economic regulator, there is a strong argument that it should divest itself of its function of overseeing the governance of foundation trusts. Increased autonomy is likely to be associated with improvements in governance and strategic management. However, there are some very significant risks in this as providers make the transition from the top-down supervision of the last 60 years to brokerage and other forms of oversight.

Additionally, foundation trusts can hold very significant assets. None of the possible candidates for providing protection and oversight for these assets seems to be without significant drawbacks. One answer would be to retain some of Monitor’s functions in a new body, but this could be difficult alongside Government limits on the number of arm’s-length bodies. For further detailed discussion of this see the response of the Foundation Trust Network to the proposals on economic regulation.
3.3 Promoting quality and patient empowerment

3.3.1 The focus on both quality and the empowerment of patients in the white paper is welcome but has been a familiar theme of policy documents over the last 20 years. The problem has always been how to convert rhetoric into reality. Although the primary goal of the white paper is to put patients at the centre of services, the mechanisms to achieve this do not appear particularly well developed. The third objective of the white paper is to empower professionals. These two objectives are not necessarily complementary, and there are no specific proposals to empower patients beyond the publication of information and a further push in the provision. While both of these are to be welcomed, it is not clear whether, on their own, these mechanisms will be sufficient to achieve the objectives set out in the white paper.

3.3.2 Patient and public voice
The white paper places a clear duty on GP consortia to ensure there is a strong patient and public voice in how they operate and in the development of commissioning strategy, but how this will operate in practice is not clear. The emphasis appears to be on feedback and accountability, which are important, but less so in terms of their influence on the formation of future plans. The HealthWatch arrangements are external to the GP consortia.

We believe insufficient attention is given to the different interests and focus of patients and the public. Patients are most likely to be interested in the design of the services that they use, whereas the general public will tend to focus on overall priorities, access and general standards.

We believe GP consortia should be accountable for identifying and meeting the health interests of minority, excluded and vulnerable groups, particularly those who may be unregistered or invisible to general practice. Health and well-being boards should be responsible for scrutinising this.

3.3.3 Choice of commissioner
Our members are unclear about the extent to which choice of commissioner is intended to play a part in driving improved quality and outcomes. Some further clarity about this would be welcome. There are some strong arguments for patients being able to choose between GP consortia and therefore for patients having a say in situations where practices wish to switch the consortia they belong to. However, for most patients their choice of GP practice will be much more important to them than the commissioning policies of the consortia that they will be joining by default. The ability to change GP consortia is also unlikely to be a viable option for many people due to geography. This means that the power of patient choice to send signals to consortia will be very limited in practice and other methods will be required.

3.3.4 Shared decision-making
We applaud the adoption of the principle of shared decision-making between GPs and their patients and the responsibility that will be given to the NHS Commissioning Board to champion patient and carer involvement but it is far
from clear what levers they will have to enable this. Most of the mechanisms proposed in the white paper relate to feedback and measurement after care has been delivered which are useful, but do not represent a change in the nature of the relationship between patient and clinician that would usually be understood as shared decision-making. The NHS Commissioning Board will not be able to intervene in what happens in the consulting room, which is where practice needs to change if shared decision-making is to become a reality. One avenue to explore is that there are a range of procedures where it is now possible to argue that the patient has not given informed consent unless they have had access to a range of accredited decision aids, including accounts from previous patients.

We believe the Government should consider which mechanisms it will use to support shared decision-making between healthcare professionals and patients. We support this aim but it is unclear from the white paper consultation document whether there are mechanisms in place to deliver it.

3.3.5 Choice
We agree with the premise in the white paper that patients want to exercise choice. However, we question whether it is a powerful enough mechanism to create the level of change that is required, particularly given the limitations of the power of choice in more rural areas compared with urban ones. The fact that choice might be exercised is undoubtedly a powerful incentive to changing provider behaviour in those specialties where choice operates. In long-term conditions, emergency care and mental health, the exercise of choice operates in a different way from the way it does in elective surgery. The policy framework does not appear to recognise this important difference. Choice needs to be underpinned by far better information about services and the Government’s information strategy will be crucial.

In addition to concerns about price negotiation and quality discussed above, there is a concern that price considerations could work to undermine patient choice. Thought must be given to how this can be avoided. In any event, downward price pressures must be carefully managed via tariff wherever this is appropriate, so that there is not a ‘halfway house’ in which tariff supposedly holds sway but unofficial price competition takes place nonetheless.

3.3.6 Information and outcomes
While welcoming the general principle behind the shift to measuring the NHS through its outcomes, particularly those which relate to people achieving independence in terms of employment and education, we have some concerns about the practical implementation of this. We think that the white paper substantially overestimates the extent to which there is a reliable methodology for measuring outcomes that will be useful to providers, commissioners and patients. It also underestimates the substantial cost of data collection, particularly if it needs to allow for the appropriate risk adjustment of outcomes that will be necessary if these data are to be clinically credible. It is over-optimistic about the extent to which this information will be available in time to be useful to patients and about the evidence that patients
currently use the information that is available. The view that this is simply a problem of poor presentation and accessibility is not supported by the evidence in this area.

We think it is important to be clear that process measures are not being abandoned. It may be difficult to attribute responsibility for outcomes where responsibility is spread between providers, for example the emergency care pathway, and process measures may be needed to understand this. Some process measures are of great value because they allow adverse outcomes to be predicted and intervention to be made much earlier. This is a particular issue in measuring shared decision-making which is itself a process.

3.3.7 Three outcomes frameworks
During our consultation with members, they frequently raised the potential for confusion, duplication and other problems that could arise from the development of three separate outcomes frameworks.

We believe the Government should develop overlapping outcomes frameworks for health, public health and social care against a coordinated timetable to ensure that the content is consistent and professionals from different sectors are working together to achieve shared outcomes.
3.4 Accountability

3.4.1 One of the areas of most significant risk in the new system, and where the development of legislation and regulations will be important, is in providing a clear structure for accountability. In our consultation with members it is probably this aspect of the proposed reforms that has caused most confusion and uncertainty. There are several aspects that will require further clarification and discussion and these are outlined in this section.

3.4.2 Accountability for GP consortia and their member practices

GP consortia will be responsible for billions of pounds of public spending so there must be absolute clarity about how they will be held to account for both their financial performance and the outcomes they are achieving. To date, there has been no detail on the accountability framework.

We believe the accountability framework for GP consortia should make clear the nature of the relationship between the NHS Commissioning Board and GP consortia, what intervention powers exist and when they may be used, and what the consequences of failure and success are for the leadership of the consortia and the practices within it.

3.4.3 Accountability of the NHS Commissioning Board

One of the most significant criticisms of the existing system is that its accountability arrangements are unclear, particularly to Parliament. The NHS Confederation has heard a number of MPs voice disquiet about the difficulty in pinning down who in the current system is responsible for important decisions about priorities, rationing, service configuration or for issues about specific patients.

In the new system, the exact nature of the NHS Commissioning Board’s accountability to Parliament is not clear. While it will be clearly accountable for delivering its mandate and the five main functions specified in the white paper, many of the issues of most concern to local MPs will be the responsibility of consortia, with oversight sitting with health and well-being boards. More clarity is needed about exactly where accountability sits.

We believe the Government should make explicit where in the new system MPs and local councillors should direct enquiries that they are making on behalf of their constituents about healthcare, and who will be expected to respond to these enquiries.

3.4.4 Health and well-being boards

The white paper makes clear that GP consortia will be accountable to the NHS Commissioning Board. However, the accountability framework will also need to clarify what accountability GP consortia will have to local health and well-being boards. The white paper makes clear that health and well-being boards will take on the existing scrutiny powers of local authorities, but it is not clear whether any additional powers will be available to strengthen local democratic accountability. Our members have expressed some concern about the
potential for confusion and conflict of interest in the role of health and well-being boards in terms of how far they are responsible for scrutiny of, and setting strategy with, the consortia.

We believe the Government should clarify what role and authority health and well-being boards will have to scrutinise healthcare, and what roles elected members and local authority officials are expected to play on these boards.

The white paper fails to fully explain what is meant by giving health and well-being boards "influence" over NHS commissioning and it is not clear how these arrangements relate to the existing local strategic partnerships, safeguarding machinery and other systems. The white paper says that local authorities will be able to enable strategic coordination locally and that this will not involve day-to-day interventions in services. This assumes that there is a clear and easily definable distinction between strategy and implementation, which may not always be the case.

We believe that the Government should provide significant investment in capacity building for health and well-being boards to ensure that they have the skills and knowledge needed to scrutinise health and mental health services.

We believe local authorities should work closely with local GP consortia and providers to develop and deliver a capacity building programme to ensure that elected members and local authority officials who will sit on or support health and well-being boards have the right expertise to scrutinise health and mental health services.

We believe health and well-being boards should have overview and scrutiny of commissioning offender health and mental health services and ensuring a joined-up approach across health, local government and criminal justice.

3.4.5 HealthWatch

The white paper promises that HealthWatch England and local HealthWatch will provide a strong and independent consumer voice for patients and the public in relation to the NHS. However, there are fundamental questions about the extent to which they can be truly independent, either nationally or at the local level.

At the national level, HealthWatch England will be part of the Care Quality Commission (CQC), which raises questions about how this function will relate to the CQC risk assessments and its programme of inspections, as well as its existing responsibilities for people detained under the Mental Health Act, particularly in relation to complaints.

We believe HealthWatch England’s independence should be reinforced through appropriate governance and funding arrangements, and the Government should consider whether the CQC is actually the right host because of potential conflicts of interest. For example, a conflict of interest may arise if HealthWatch wishes to criticise the CQC’s handling of a particular individual or group complaint about NHS care.
We believe HealthWatch England should have a consumer panel made up of independently appointed members to inform their work and reinforce their independence.

Locally, mechanisms are needed to ensure that HealthWatch can still provide independent scrutiny of the social care decisions of the local authority, despite being commissioned, funded and held to account for their performance by the local authority. Given the intention that local HealthWatch should build on existing arrangements for Local Involvement Networks (LINks), we assume that existing LINks powers of entry and inspection will be transferred to local HealthWatch.

While we support the process of building on existing local arrangements for patient and public engagement, we believe that some key problems associated with the development of LINks must be addressed to ensure the effectiveness of local HealthWatch in providing effective scrutiny of local health and social care commissioning and provision. In particular, local HealthWatch must be representative of the local community and users of services and build effectively on the existing local structures for community and patient involvement.

The proposals for local authorities to commission either the local HealthWatch or HealthWatch England are unlikely to result in services that can guarantee the expertise and knowledge needed for effective complaints advocacy, particularly in complex complaints or in helping people with complex needs. Even with additional funding, local HealthWatch is unlikely to have sufficient public profile or the resources or capability to deliver these functions effectively, and HealthWatch England is similarly likely to be too remote from the local issues to adequately fulfil this role.

We believe the Government should consider using Citizens Advice Bureaux rather than building a parallel system through local LINks which may not have the right expertise or knowledge for delivering complaints advocacy or supporting patient choice. Citizens Advice Bureaux already have a strong high street presence which would facilitate a holistic approach to complaints handling and the exercise of choice by integrating it within a framework of other local public services and access to benefits.
3.5 Public health

3.5.1 The NHS Confederation welcomes the strengthened role of local government in public health, including mental health, given the impact this can have across departments and sectors including education, transport, leisure, housing and economic development. We support giving local authorities the responsibility to facilitate joint working on health and well-being, with statutory powers to underpin this, because this would encourage them to fulfil their public health functions. However, as the health and well-being boards will sit in the upper tier of local government, we believe there should be mechanisms in place for them to be able to hold the lower tier of local authorities to account to implement public health functions within their localities. A clear definition of what public health functions are is required to enable localities to clarify the roles and responsibilities of different parts of the system to improve the health of local populations.

We look forward to commenting on the public health white paper later this year but have set out here our concerns and key recommendations on the public health proposals to date.

3.5.2 Place-based budgets and commissioning

The increased focus on place-based budgeting could support integration and closer joint working between local government and the NHS. However it is not clear how commissioning for some public health services by the GP consortia and the health and well-being board will be organised, particularly as consortia boundaries may not be co-terminous with local authority areas. The NHS has a crucial role to play in the commissioning and delivery of health improvement services across primary, secondary and tertiary care. There are likely to be some practical problems associated with identifying public health activity and spend as the work of many healthcare professionals combines prevention, treatment and long term care that would be difficult to separate and apportion.

The GP consortia will require engagement from public health professionals to support informed commissioning decisions based on the analysis of local population needs.

Local authorities and GP consortia will carry out joint local area assessments of need, and we believe they should be asked to work together to develop and deliver a joined-up health, public health and social care strategy in response.

3.5.3 Workforce

Public health is part of the role of the NHS and local government and the role of the public health workforce across these organisations should be recognised (including GPs, clinicians, and local government staff such as teachers and planners); public health, including mental health, should be everybody’s business. Clarity is required about how the jointly appointed directors of public health will be accountable to a national public health service while responsible for delivering on health improvement locally. It is not clear how much power the centre will have over decisions made locally.
health reform should be based on the principle of subsidiarity to ensure appropriate decisions are made locally and informed by evidence of what works.

3.5.4 Emergency planning

The proposed public health system needs to be flexible enough to respond to local and national emergencies. Previously, intermediary bodies have provided a key function in managing emergencies and the proposed changes might not provide sufficient capacity to manage an emergency at a population level in a given region. Structures to enable the public health functions of localities to work together could provide a solution and strengthen the system. Some aspects of health protection should not have local variation in response, where we already know what should be done, and this should be commissioned and delivered in an integrated manner locally.

3.5.5 Health inequalities

The proposed health premium for health improvement funds will be allocated according to the Joint Strategic Needs Assessments and performance but it is not clear how funding for GP consortia will be allocated to local authorities and how funding for GP consortia will be apportioned. The two systems of resource allocation should be considered jointly alongside the management of place budgets to ensure that health service activity is connected to the health improvement work of local authorities.

We believe GP consortia should have access to public health expertise so they can take a population health viewpoint, in particular access to epidemiological advice and insight into parts of the population that are either unregistered or invisible to general practice. This may mean exploring more creative and proactive ways of meeting the healthcare needs of complex groups such as vulnerable people and offenders with complex mental health needs.

We believe GP consortia and health and well-being boards should work together to ensure that those not currently registered with a GP practice are supported by the system to access health services and their needs are explicitly addressed in commissioning plans.

3.5.6 Children's services

There should be a mechanism to ensure that joint working between health, local government and other local partners such as schools is required so that the different parties responsible for children’s services such as health, social care and education work together and ensure improvements for children’s health and well-being remain a key priority.

3.5.7 Outcomes

Members have frequently raised the potential for confusion, duplication and other problems that could arise from the development of three separate outcomes frameworks. We believe the Government should develop overlapping outcomes frameworks for health, public health and social care.
against a coordinated timetable to ensure that the content is consistent and professionals from different sectors are working together to achieve shared outcomes.
3.6 Research

We support the ambitions for research set out in the white paper. However, it is likely that in the next five to ten years some of the most significant contributions to improvements in quality, effectiveness, efficiency, patient safety and patient experience will also come from health services research into models of service delivery.

Basic science, translational research and other upstream research activity is hugely important but research into how wide-scale change can be achieved and the way that organisations operate will be of equal importance, as will evaluation to provide clarity on what has worked and has not. This means that health services research needs to be treated as equally important to biomedical and clinical research.

We support the goal of improving the UK’s slipping performance in clinical research and in the number of trials carried out and believe the forthcoming revision to the EU Clinical Trials Directive to be an important element in achieving this. Simplifying the system for research approval, ethics committees, research governance, and some of the associated bureaucracy, will have an impact on this.
3.7 Managing the transition – a ten point plan

3.7.1 The white paper and its associated consultation documents pay too little attention to the transition to the proposed new system. Our members see the transitional risks in creating this new system as very significant. The very large scale of organisational, cultural and system changes that these reforms introduced would be challenging in a relatively benign climate. But the risks from the hostile financial environment that the NHS faces are considerable, despite its privileged position of having its financial allocations protected. The two together will make transition exceptionally difficult.

The reforms will require substantial changes in behaviour, new ways of thinking, different approaches to the management of change and the introduction of a suite of unfamiliar and untested policy mechanisms. Much more attention needs to be given to the very real risks to the NHS in the next two to three years. Without this, the entire reform programme is at significant risk.

We believe it is important not to lose sight of the equality, diversity and human rights agenda as we go through the change and that now, more than ever when new systems are being laid down, it is an opportune time to embed this agenda into the fabric of the NHS.

This section sets out what we think are the ten key areas to consider during the transition period:

- providing clarity about GP consortia
- keeping hold of expertise and knowledge
- establishment of consortia
- capability and capacity
- workforce
- management costs
- encouraging GPs to engage quickly
- moving to foundation trust status
- managing expectations
- communications.

3.7.2 Providing clarity about GP consortia

We believe the Government should provide clarification on the following issues associated with GP consortia as soon as possible:

- confirmation of the functions which they will be expected to deliver
• confirmation of the management cost limits they will have to operate within
• a clear accountability framework including the outcome and financial regime they will operate within, a clear failure regime, and clarity about their accountability to health and well-being boards.

3.7.3 Keeping hold of expertise and knowledge
It will be important for GP consortia to have access to expert commissioning support. Much of this expertise is currently within the existing PCTs. We believe the Government should put in place, as a matter of urgency, an effective human resources framework to ensure that we do not lose important skills and expertise during the transition period, since it will be difficult and expensive to rebuild it.

Preserving relationships that have been developed over time will be important. These have often been at the heart of the successes PCTs have achieved. We believe GP consortia and primary care trusts should work together at a local level to preserve the organisational memory, archives and information that will help GP consortia to understand the context they are working in, understand previous commitments and identify opportunities for error that need to be avoided.

3.7.4 Establishment of consortia
We believe the Government should provide clarification on the process for signing off the establishment of GP consortia, and set out an assurance process which is light touch but robust enough to ensure that the consortia formed will function effectively.

We support the absence of absolute guidance on size of consortia as there is no evidence of any one size of commissioning organisation being optimal. We believe GP consortia should take account of the following factors when determining their configuration: clinical flows, critical mass to influence provider organisations, management and leadership capacity, and the need to build effective working relationships with local authorities. The solution to different commissioning tasks requiring differing scales of operation is to allow federal solutions.

3.7.5 Capability and capacity
There is general consensus about the need for a very substantial investment in capability and capacity building for GPs and any other clinicians who will be involved in the leadership of the new consortia. We believe the Government should provide significant investment in capacity building for GP consortia and health and well-being boards to ensure that they have the skills and knowledge needed to commission and scrutinise health and mental health services.

While many have extensive experience there is agreement that stepping up from the activities of practice based commissioning groups to hold population health management creates new demands. Capability and capacity development for leaders will be very important but ordinary GPs who may not
be very involved in the work of the consortia will also need to improve their understanding and skills. There are a range of important public health skills that many GPs understand but which will need to be further developed.

3.7.6 Workforce
We look forward to the consultation paper on workforce development and education commissioning. The changes envisaged in the white paper will raise issues around the application of the transfer and undertakings, and these need to be explored further.

Our members were clear about the importance of drawing on the expertise and experience of all healthcare professionals, including secondary care clinicians, nurses, managers, therapists and pharmacists, as well as GPs, to make the new system work.

3.7.7 Management costs
We support scrutiny of management costs as part of the wider NHS productivity drive, and we believe the Government should carry out an urgent review of the management requirements which the Department of Health has imposed on strategic health authorities and primary care trusts to ensure that activities that do not add value to the local health economy are stopped so the management burden and spend can be reduced.

However it will be important that the proposed system has sufficient management resource to work effectively. Separate to the white paper, we have concerns that delivering the proposed 45 per cent (and higher in some places) management savings requirement could leave the overall commissioning system seriously under-managed which would be counter-productive. Applying these cost savings to the provider side of PCTs seems to be causing some significant problems for trusts being asked to take over community services. This may lead to some organisations wishing to withdraw from taking services over from PCTs.

3.7.8 Encouraging GPs to engage quickly
We believe the Government should clarify that GP consortia will inherit both contractual commitments and the financial position from primary care trusts to encourage GPs to engage in current decision-making at a time when it is critical that they should become involved.

3.7.9 Moving to foundation trust status
The consultation sets out the abolition of the NHS trust model in 2013 as a final deadline for the creation of an all-FT, social enterprise or independent sector market. Deadlines for FT status in the past have not succeeded in solving the barriers to FT status for non-FTs. There are doubts among providers and commissioners as to whether this objective will be achieved this time unless there is a convincing strategy for solving the reasons for trusts not becoming FTs. We believe there is a need for transparent diagnostic processes to analyse the barriers to FT status – including inherited debts,
large public financial initiative schemes and local health economy issues – and pilots of potential solutions.

The potential conflict of a strategy based on acquisition and merger with an emphasis on competition is not discussed in the white paper consultation documents. Furthermore, it is not clear why independent providers should volunteer to take over systemically failing organisations, even with a large incentive, or how the policy will respond if, as is their right as independent organisations, they refuse to do so.

3.7.10 Managing expectations
The expectation of the public, patient groups, media and other stakeholders is that national government and the Secretary of State will act to deal with problems in individual providers, intervene to deal with variation and respond to public outcry about specific, often detailed issues, relating even to individual patients. These are powers that the Secretary Of State does not technically have at the moment. The public are also very concerned about postcode variation.

We believe the Government should take a leadership role in supporting the cultural change needed for the public, patient groups, media and other stakeholders to understand the new NHS system and what can be expected from the health service in future.

3.7.11 Communications
As with any major organisational transition, it is important for the Government to communicate effectively both with those affected and those responsible for implementing the changes. With this in mind, the debate about reform should not take place against a backdrop of anti-managerial rhetoric. In providing effective and good quality services to patients, management is an essential investment, not just a cost.

Any transition programme needs to recognise the good work that people have done under the previous structure. The Government should acknowledge the contribution and progress made by the existing PCTs, which still have responsibility for the control of finances and delivery at present. To do this will send a positive message to those who are set to take over these responsibilities: potential leaders of GP consortia should not think that that they will be the next in line for criticism when tough decisions are needed and difficult change has to be managed. Everything possible must be done to ensure that morale is kept as high as possible during what is likely to be a very challenging period for many NHS employees.
4. Summary of NHS Confederation recommendations

4.1 Ensuring GP commissioning is effective

a) GP consortia should have access to public health expertise so they can take a population health viewpoint, in particular access to epidemiological advice and insight into parts of the population that are either unregistered or invisible to general practice.

b) GP consortia should consider the need to build effective working relationships with local authorities when considering which geographic areas they wish to cover.

c) A set of clear principles should be developed for determining what will be commissioned nationally or at a local level and where consortia should consider joining together in shared arrangements or handing over commissioning responsibilities to a specialist agency. These principles could be provided by Government or developed by national representative bodies.

d) The Government should consider whether it needs to set out in regulations which decisions about quality standards and access to services will be consistent across the country and which will be left to local commissioners to determine. This will be particularly important in light of the EU directive on the application of patients’ rights in cross-border healthcare.

e) The Government should provide clarification on the following issues associated with GP consortia as soon as possible:
   • confirmation of the functions which they will be expected to deliver
   • confirmation of the management cost limits they will have to operate within
   • a clear accountability framework including the outcome and financial regime they will operate within, a clear failure regime, and clarity about their accountability to health and well-being boards.

f) The Government should spell out how it will deal with GP consortia that fail, and ensure that the rewards of success and the consequences of failure are proportionate and significant enough to have an impact on their behaviour.

g) The Government needs to prevent proliferation of overlapping risk pools to minimise any instability created in the system by taking significant financial resources out of circulation.

h) The Government should give the commissioning board the power to delegate responsibility for practice performance and contract management of General Medical Services contracts to GP consortia where appropriate.

i) Strategic health authorities and primary care trusts have amassed a large number of management responsibilities, many of which will not be continued in the new system. The Government needs to decide which activities it does not wish to continue now so that savings can be made immediately.

j) The Government should consider moving to a person-based resource allocation formula instead of the current geographic model.

k) The Government should be explicit that funding for the prison population should be allocated to GP consortia where the prison is located rather than to the area where the prisoner is from, and the commissioning board should determine whether GP consortia should be asked to take responsibility for commissioning to meet the health needs of offenders.
l) The Government should put in place an assurance system to make sure that GP consortia establish strong governance arrangements with clear, transparent and robust decision-making to address any conflicts of interest between their roles as commissioners and providers. These governance arrangements should be augmented by a requirement for GP consortia to publish individual practice accounts.

m) The Government should ask the commissioning board to set out a transparent method by which it will turn NICE’s recommendations, which are based on clinical and cost-effectiveness, into affordable commissioning criteria for GP consortia.

n) The Government should make explicit where in the new system MPs and local councillors should direct enquiries that they are making on behalf of their constituents about healthcare, and who will be expected to respond to these enquiries.

o) The Government should provide significant investment in capacity building for GP consortia and to ensure that they have the skills and knowledge needed to commission health services.

p) GP consortia should work with specialist providers to develop and deliver a capacity building programme to ensure that GP consortia have the right expertise to commission and mental health services.

q) GP consortia will need to invest time and resource in making sure commissioners understand and are ready to discharge their duties in relation to choice and competition.

4.2 Creating a dynamic and responsive provider sector

a) The Government should consider establishing a banking function capable of making long-term loans for restructuring when provider services fail or providers wish to exit a particular market. This would allow providers to reduce their costs over time and avoid the danger of stranded capacity within the system with associated high costs and inefficiencies.

b) The Government should review the current approach to consultation when provider services fail or providers wish to exit a particular market. The protracted consultation processes currently required do not seem appropriate to a market system where providers will be required to respond rapidly to changes in their environment.

c) The Government should ensure that rules on competition do not undermine the effective working of clinical networks and other appropriate inter-provider collaboration. Clinical networks should continue to be used to solve difficult problems currently resting with strategic health authorities and primary care trusts, such as decisions on exceptional cases and responsibility for managing high-cost drugs funds.

d) GP consortia should simplify contracts and be encouraged to work together to reduce the transaction costs for providers associated with building and maintaining relationships, responding to tenders, linking information systems, putting contracts in place and monitoring and reviewing performance under those contracts.
e) The Government should review the current incentive structures to encourage hospitals to create more integrated care between primary and secondary care.

f) The Government should ensure when drafting legislation and regulations that instructions to the competition regulator (Monitor) allow providers to develop integrated patient care solutions.

g) The Government should ensure when drafting legislation and regulations that the obligation to co-operate that is part of the current set of market rules is not lost.

h) The Government should take account of the responsibility that ambulance and acute hospital services have as part of local and national civil contingency operations requiring coordination and, at times, state control when drafting the economic regulation framework.

i) The Government needs to prevent proliferation of overlapping risk pools to minimise any instability created in the system by taking significant financial resources out of circulation.

4.3 Promoting quality and patient empowerment

a) The Government should consider which mechanisms it will use to support shared decision-making between healthcare professionals and patients. We support this aim but it is unclear from the white paper consultation document whether there are mechanisms in place to deliver it.

b) The Government should develop the outcomes frameworks for health, public health and social care against a coordinated timetable to ensure that the content is consistent and professionals from different sectors are working together to achieve shared outcomes.

c) We believe GP consortia should be accountable for identifying and meeting the health interests of minority, excluded and vulnerable groups, particularly those who may be unregistered or invisible to general practice. Health and well-being boards should be responsible for scrutinising this.

4.4 Accountability

a) The accountability framework for GP consortia should make clear the nature of the relationship between the NHS Commissioning Board and GP consortia, what intervention powers exist and when they may be used, and what the consequences of failure and success are for the leadership of the consortia and the practices within it.

b) The Government should clarify what role and authority will be given to health and well-being boards to scrutinise healthcare, and what roles elected members and local authority officials are expected to play on these boards.

c) The Government should provide significant investment in capacity building for health and well-being boards to ensure that they have the skills and knowledge needed to scrutinise health and mental health services.

d) Local authorities should work closely with local GP consortia and providers to develop and deliver a capacity-building programme to ensure that elected members and local authority officials who will sit on or support health and well-
being boards have the right expertise to scrutinise health and mental health services.
e) Health and well-being boards should have overview and scrutiny of commissioning offender health and mental health services and ensuring a joined-up approach across health, local government and criminal justice.
f) HealthWatch England's independence should be reinforced through appropriate governance and funding arrangements, and the Government should consider whether the Care Quality Commission is the right host due to conflicts of interest.
g) HealthWatch England should have a consumer panel made up of independently appointed members to inform their work and reinforce their independence.
h) The Government should consider using Citizens Advice Bureaux, rather than building a parallel system through local LINks which may not have the right expertise or knowledge for delivering complaints advocacy or supporting patient choice. Citizens Advice Bureaux already have a strong high street presence which would facilitate a holistic approach to complaints handling and the exercise of choice by integrating it within a framework of other local public services and access to benefits.

4.5 Public health

a) GP consortia should have access to public health expertise so they can take a population health viewpoint, in particular access to epidemiological advice and insight into parts of the population that are either unregistered or invisible to general practice.
b) Local authorities and GP consortia will carry out joint local area assessments of need, and they should be asked to work together to develop and deliver a joined-up health, public health and social care strategy in response.
c) GP consortia and health and well-being boards should work together to ensure that those not currently registered with a GP practice are supported by the system to access health services and their needs are explicitly addressed in commissioning plans.

4.6 Managing the transition

a) The Government should provide clarification on the following issues associated with GP consortia as soon as possible:
   • confirmation of the functions which they will be expected to deliver
   • confirmation of the management cost limits they will have to operate within
   • a clear accountability framework including the outcome and financial regime they will operate within, a clear failure regime, and clarity about their accountability to health and well-being boards.
b) The Government should put in place as a matter of urgency an effective human resources framework to ensure that we do not lose important skills and expertise during the transition period, since it will be difficult and expensive to rebuild it.
c) GP consortia and primary care trusts should work together at a local level to preserve the organisational memory, archives and information that will help GP consortia to understand the context they are working in, understand previous commitments and identify opportunities for error that need to be avoided.

d) The Government should provide clarification on the process for signing off the establishment of GP consortia, and set out an assurance process which is light touch but robust enough to ensure that the consortia formed will function effectively.

e) GP consortia should take account of the following factors when determining their configuration: clinical flows, critical mass to influence provider organisations, management and leadership capacity, and the need to build effective working relationships with local authorities.

f) The Government should provide significant investment in capacity building for GP consortia and health and well-being boards to ensure that they have the skills and knowledge needed to commission and scrutinise health and mental health services.

g) The Government should carry out an urgent review of the management requirements which the Department of Health has imposed on strategic health authorities and primary care trusts, to ensure that activities that do not add value to the local health economy are stopped so the management burden and spend can be reduced.

h) The Government should clarify that GP consortia will inherit both contractual commitments and the financial position from primary care trusts, to encourage GPs to engage in current decision-making at a time when it is critical that they should become involved.

i) The Government should set up a transparent diagnostic process to analyse the barriers to foundation trust status for some trusts – including inherited debts, large public financial initiative schemes and local health economy issues – and pilot potential solutions.

j) The Government should take a leadership role in supporting the cultural change needed for the public, patient groups, media and other stakeholders to understand the new NHS system and what can be expected from the health service in future.
The NHS Confederation

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% 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.

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