White Paper “Liberating the NHS” consultation response

This is the response of the NHS Alliance to the White Paper issued by Government on 12 July 2010. It deals with that document, and the associated consultation documents set out below.

- Liberating the NHS: regulating healthcare providers
  
- Liberating the NHS: commissioning for patients
  
- Increasing democratic legitimacy in health
  
- Transparency in outcomes: a framework for the NHS
  
- Liberating the NHS: Report of the arms-length bodies review*

*(whilst technically not a consultation document, this was issued as part of the command paper follow up and is considered part of a “set”)

It comprises:

- This document identifying the principal views of the NHS Alliance and identifying those issues which the NHS Alliance sees as key to the successful development of the NHS in the proposed form.
- An appendix which reports the views of the Alliance’s networks from their individual viewpoints. (To follow).
- A Report from four listening events undertaken in association with the Royal College of General Practitioners. This was open to members and non members. (To follow).
- Results of an open web based survey of members and non members. (Already published).

About the NHS Alliance

The NHS Alliance is the only organisation that brings together PCTs with practices, clinicians with managers and board members - and NHS Primary Care with its patients. It is unique in being able to bridge the agenda and work of future GP Commissioning Consortia and PCTs.

It is completely independent of government (and of any particular interest group or political party too) though it is happy to work in partnership with all bodies associated with the NHS providing its values and principles are not compromised.

The NHS Alliance membership and its hardworking national executive are fully multi-professional. No other NHS body has PCT chief executives and other senior managers, doctors and practice managers, nurses, pharmacists and allied health professionals, along with board chairs and members, all working together to improve the health service.

The NHS Alliance champions, supports and represents NHS primary care and all those working in it as a movement committed to a fair and progressive NHS that is free from the traditional tribalism of single interest groups. At the same time, it recognises the value of specialist expertise and its networks allow all groups to benefit from their insights, ideas and experience.
Foreword

Radical change is usually associated with both opportunities and risks. The White Paper “Liberating the NHS” is no exception. For example, there are significant opportunities presented by proposals to harness the energy, invention, and knowledge of primary care clinicians in commissioning. NHS Alliance is equally supportive of proposals that will strengthen both patients’ and community voices in the planning and delivery of healthcare. These are principles that NHS Alliance has advocated for many years and during its listening exercise with members and non members there was 90% support for GP Commissioning Consortia.

There are, inevitably, risks associated with such wide ranging proposals and the NHS Alliance listening exercise has pointed to concerns on several issues of detail, including the pace of change. On the latter, however, the overall view of the NHS Alliance National Executive is “if it were best it were done then it were best done as quickly as possible consistent with effective and successful implementation”.

As for implementation itself, harnessing the commitment and goodwill of GP Practices and potential GPCC leaders will be key. Imaginative and proactive work will be necessary to re-engage the clinical frontline of Primary Care so that it can fully recognise and embrace the current opportunities that result from the White Paper. This is the main task now facing primary care leadership, which must itself now be empowered to deliver the changes independent of traditional central control. The NHS Alliance will play its full part in supporting the NHS to achieve this during the transition period.

The White Paper will only be successful if it can bring about major change of behaviour and culture in the NHS. The risk is that we might simply see changes to the structure and little else, and if this were to be the case then it would mirror many NHS changes of the past.

It is essential that all parts of the transition process, and all future performance management and support have a focus on culture, behaviour and outcomes, and not just system and process. This needs to be so at every level in the system starting with centre, which will need to set an example by reconnecting with the frontline of primary care and becoming itself a demonstration of those cultural changes. That is why NHS Alliance suggests that some of those working in GPCC should sit on the National Commissioning Board as a means of overcoming the disconnections of the past. Otherwise the rhetoric of an NHS “run from the consulting room” could become as hollow as the past rhetoric of a “Primary Care Led NHS”.
The six key themes the NHS Alliance would wish to address are as follows:

1. The balance of power and responsibility between GP Commissioning Consortia (GPCC) and the newly established NHS Commissioning Board (NHSCB).

2. The role of Local Authorities (LAs), and their relationships with, GP Commissioning Consortia, to include issues of democratic legitimacy and the patient/public voice.

3. The balance of power between commissioners and providers. This to include notions of “from registered list to population health” and commissioning as community benefit rooted activity.

4. The relationship between GP consortia, and GP practices, and also other primary care providers.

5. The roles and potential impact of both the quality regulator and the economic regulator on the commissioning agenda – to include “make or buy” and market development.

6. The transition from the current to the future, to include the role of Primary Care Trusts (PCTs), skills and support to GP Commissioning.
Diagram showing key issues raised by NHSAlliance:
1. The balance of power and responsibility between GP Commissioning Consortia and the newly established NHS Commissioning Board

The primary axis of power in the proposed arrangements is the connection between GP Commissioning Consortia (GPCC), their constituent Practices, other members of the primary care team, with the NHS Commissioning Board (NHSCB). It is important that this relationship is in appropriate balance, which will vary according to circumstances and clinical service.

The culture of the NHS for many years has essentially been one of top down management to a greater or lesser degree. The reforms proposed in this White Paper could either reinforce history, or change it. It will be essential for the NHSCB to have a clear remit, which should be strategic and supportive of GPCC and not directive or worse, behave in a way that substitute’s national judgement for local judgement on key issues. In this sense the NHSAlliance welcomes the commitment that the powers of the NHSCB will be limited by statute. The NHS Alliance looks forward to working with government to flesh out this detail.

The NHS Alliance would go further; it would propose that the NHSCB is formally constituted to include both non executive members and members drawn from GPCC themselves. There may also be a case for introducing, with minimum bureaucracy, a lean “NHS Trustees” organisation which overseas the NHSCB and holds it to account. In any event, the balance between the NHSCB and GPCC should be subject to regular and formal review, using a rigorous methodology.

The NHS Alliance welcomes the government’s focus on outcomes. It should apply that same rigour to organisational change and the NHSCB (and GPCC) should be under a legal duty to demonstrate and report on how they add value to the system. This should be subject to 360 degree feedback to ensure that the system is working as intended and that behaviours are appropriate.

It is particularly important that the detail of the arrangements which propose that the NHSCB hold the contracts for primary care contractors whilst the GPCC have a role in holding contractors to account are worked through to achieve effective arrangements.

The documents propose that the NHSCB will commission directly both specialised services and maternity services. It is right that the commissioning of specialised services should be undertaken at a more centralised level than GPCC, but there will need to be a clear connection between GPCC and those commissioning specialised services for local populations. It is important that the NHSCB is seen and acts, on behalf of GPCC and the local populations they serve. It is of critical importance that GPCC are able to focus and coordinate care for individuals registered with their practices. People with conditions requiring specialised services do not live in a vacuum, nor are those services provided in isolation from other health care. It follows the commissioning and delivery of specialised services must be fully integrated into local health care plans. This requires integrated commissioning led by GPCC.

The NHS Alliance does not believe the case for national commissioning of maternity is made, and proposes that this responsibility should rest with GPCCs.
2. The role of Local Authorities, and their relationships with, GP Commissioning consortia, to include issues of democratic legitimacy and the patient/public voice.

The NHS Alliance welcomes the White Paper’s intent to bring greater clarity to the responsibility for both public health and population healthcare management. It agrees that responsibility for the former should be both a National and Local Authority led function.

The role of GPCC is that of population healthcare management and the current proposed changes should respect the long unrecognised potential of primary care and frontline primary care clinicians (working with their registered population) to have a significant effect on the health of their patient population as providers and commissioners. Realising that potential will require close working between local government and GPCCs as mutually respecting partners. This has previously been the missing link in combined health and local government initiatives that have all too often failed to make sufficient tangible difference in outcomes to patients and communities. The exact nature of this relationship requires much more detail than that which is currently available and the NHS Alliance will seek to support its development in the interests of patient and public health improvement and looks forward to the forthcoming public health white paper.

Local Authorities are to take a key role in health and wellbeing, and to provide hosting arrangements for the Public Health (PH) function. A key challenge set by the White Paper is to move General Practice from a focus on the registered list to population health improvement, and the reduction of health inequalities. There is a risk that the separation of roles from what is seen as the NHS to local government will undermine the very integrated approach that the government seeks to achieve.

Statutory wellbeing and health partnerships will clearly hold the ring but there are then issues about the GPCC, PH, Adult Care, Children’s Trusts and Healthwatch with an overview and scrutiny role. These require further determination to ensure that there are adequate checks and balances in the system to ensure that the patient/client becomes the primary focus.

The NHS Alliance proposes that there should be a statutory duty on both GPCC and local authorities (LAs) to collaborate, but also that there should be specific mechanisms for GPCCs to be involved in the development of local “public health action plans” and agree them formally, with a right of reference to a third party should it prove impossible to reach local agreement. This arbitration role should not be exercised by the NHSCB alone.

Similarly, LAs should have a reciprocal role in the agreement of local commissioning plans, which, once agreed should be binding. Further consultation processes should focus only on implementation arrangements and not the plans themselves. This will be necessary to avoid the potential of disruption caused by local political change.
The NHS Alliance also believes that both local commissioning plans and public health plans should demonstrate the interdependency between them and how both organisations will work together on implementation. Improving the Health of the population should be the key object of GPCC, in partnership with LAs.

Question 34 on the outcomes paper asks “How might we estimate and attribute the relative contributions of the NHS, public health and social care to these potential outcome indicators?” it is of critical importance that this issue is addressed locally and nationally to reflect local circumstances and those areas where there are pooled budgetary arrangements. Whilst this is a legitimate question, it is important to avoid perverse effects of outcome monitoring. In this context, there is considerable potential for this to become a “battleground” and not a “team effort” which will undermine the effective and cost effective delivery of services.

Patients and the public should be fully and appropriately engaged in both the planning, design and delivery of healthcare. This means a population and patient voice at every level in the system together with opportunities for individuals and groups to contribute to decisions about how resources are allocated, how priorities are set, and how care is provided.

At Practice and GPCC level this could be built on Practice Patient Groups, which have already demonstrated, in some cases, the rich potential of frontline clinicians and their patients working together. In some instances, patient groups may also be providers of service and this should be recognised. The NHS Alliance does not consider that the White Paper gives sufficient emphasis to this critical issue.

A key role to be played in this area will be that of HealthWatch. This must be of sufficient independence to represent the public as a consumer of health care but sufficiently integrated into local decision making to avoid confrontation (see 2. above).
3. The balance of power between commissioning and providers. This to include notions of “from registered list to population health” and commissioning as community benefit rooted activity.

At the heart of the reform programme proposed by the White Paper is that the service should become commissioning led and not provider driven. This has been the aspiration of successive governments since 1990. And yet it has not happened.

Future patterns of care design and delivery must change because of developments in patient care, technology, expectations and the financial climate, all demand that. In particular, there needs to be a major shift of services out of hospital wherever safe and appropriate to do so. The NHS Alliance believes that the default assumption should be that services should be based in community/primary care settings unless there is proven good reason for them to be delivered in hospitals. Too often in the past the reverse has been true. To achieve this, there must be an appropriate balance of power between commissioner and provider, with service design being based on collaboration, but ultimately commissioner led.

The NHS Alliance believes that this is not because of a lack of will or competence in commissioners, or at least the best of them (including PCTS), but rather because the system has conspired against them by the over-protection of providers, particularly in secondary care, from the consequences of robust commissioning undertaken on behalf of local communities.

This implies not only the greater involvement of all clinicians, both in primary and secondary care, in commissioning, but system changes, including Payment by Results (PBR) to ensure the removal of perverse incentives. In particular, tariffs must be set as maximum not absolutes to allow for local negotiation; and PBR must measure and reward real outcomes and patient experience, not activity alone. The definition of HRGs, tariff setting, and the use of other levers such as CQUIN, PROMS will require significant review and overhaul so as to enable the commissioner to restore the balance in favour of the patient rather than the provider.

GPCC provide an opportunity to change that, but only if they are not hamstrung by some of the issues identified above. Politicians and the NHSCB must establish the credibility of GPCC by clearly explaining their role to the general public and backing their decisions when supported by appropriate evidence. System redesign will be painful to implement, particularly when coupled with a more constrained economic environment. GPCC must be given the tools to do the job, and government must set the climate in which they are able to succeed. This requires a clear strategy with all parts of the system playing their parts.
4. The relationship between GP consortia, and practices, and also other primary care providers.

GPCC are to be constituted as statutory bodies, or at least on a statutory basis, with the ability to hold budgets and enter into contracts. The NHS Alliance believes that is appropriate and necessary. There should be some flexibility in precise legal form to reflect local preferences but there should be minimum standards and explicit approval of local arrangements by the NHSCB. There is also a need to recognise that GPCC should be reflective of the primary care team locally and not a single discipline alone and their constitution should reflect that.

The NHS Alliance supports the notion that GPCC should have a key role in developing quality and responsiveness in general practice. Peer pressure is a strong activator of change especially in a system where GP practices are independent contractors and which has shown historically that line management is neither possible nor effective. There must be an appropriate balance of incentives and sanctions to ensure that this happens and this balance is best determined locally wherever possible, not nationally.

The relationship between GPCC and primary care providers, particularly GP Practices, is key to success. Yet the NHSCB will formally hold the contracts of primary care providers. This is fraught with difficulty but can be managed if there is a clear scheme of delegation between the NHSCB and GPCC. In short, the NHSCB should delegate the power to hold providers to account, but retain the responsibility for contractual performance. This in turn requires a model scheme of relationship (rules of engagement) that sets out the relationship between the NHSCB, GPCC and primary care providers. GPCCs should be collectives in the true sense of the word, and not used as local enforcers. Their style should be supportive and developmental and yet they will need clear powers, sanctions and have clear responsibility. These are the key ingredients of the rules of engagement which should avoid confusion and duplication.

It is impossible to entirely separate provision and commissioning at practice level, because the very acts of provision eg referral, prescribing etc, are also commissioning decisions in that they commit resources in a different part of the NHS. Conversely, the commitment of resources (eg prescribing or referral) in the individual patient encounter is often directly related to the quality of care provided. NHS Alliance therefore welcomes the recognition that the quality of primary care itself may become a devolved function (from the Commissioning Board) of GPCC where the GPCC are able and competent and have the right relationship with their member GP practices.

Clearly, the vision in the White Paper is for GPCC to be “make or buy” organisations. This is not different from what a GP does today. For instance, a GP can decide to treat a patients painful knee by giving an injection, or by referring a patient to hospital for an injection to be given (always assuming levels of clinical competence in diagnosis and treatment allow for this). This is of central importance, and the NHS Alliance believes that choices around treatment and referral in primary care are in essence different facets of
clinical judgement. It is for this reason that it is impossible to separate the commissioning and providing function at GP Practice level. It is essential, therefore, that GPs are able to make those effective and efficient decisions at both Practice and GPCC levels (see 5 below). It is crucial that this is handled in an appropriate and transparent manner and in a way that ensures public money is fully accounted for. The NHS Alliance believes that the work of commissioning at GPCC level should be properly funded, but that organisations and individuals should not profit from their commissioning activities.

This will require a careful balance of both financial and performance management arrangements which require further assessment in the light of government intentions which are not clear from the White Paper and the associated consultation documents.

If Liberating the NHS is to achieve its objectives, it must liberate the system, and those working within it, to do things differently for patient benefit: service delivery and integration must be achieved in different ways in the future, and will not be if commissioning of services is hamstrung by bureaucratic and expensive procurement procedures and outdated notions of being able to neatly separate commissioning and provision, particularly at practice level. National model contracts and templates or recognised “due processes” by the National Commissioning Board and transparent contracting processes might all help overcome the current red tape.
5. The roles and potential impact of both the quality regulator and the economic regulator on the commissioning agenda – to include “make or buy” and market development.

The NHS Alliance agrees that there is a key role to be played by Monitor and the Care Quality Commission in regulating the health care system of the future.

These roles need to support a commissioning led health system and not lead it. This means that regulation must be “light touch” and not replace local decision making with national regulation. The regulators therefore will require the input of GPCC to inform their activities and the standards they set for providers. For instance, it should be for GPCC to set affordable standards locally, and not have artificially imposed standards set by CQC.

Similarly, Monitor should be driven by the need for economic regulation to be a means to support local commissioning decisions and be aligned with them. There is a particular need for Monitor’s role in relation to General Practice “licensing” to be clearer: this role must be proportionate to the task involved and not simply replicate the role played with large institutions and corporate providers of care.

This could be achieved in part by both regulators being required to establish commissioning stakeholder boards which would be the key means by which they would be required to reflect commissioning priorities and needs.

To be clear, Monitor must be sensitive to local commissioning arrangements to be sufficiently flexible to allow GPCCs and its constituent practices to reach “make or buy” decisions (see 4 above). The Care Quality Commission (CQC), whilst setting national minimum standards, should avoid doing so in such a way that defeats the judgment of GPCC as to what is affordable locally and to make decisions based on opportunity cost.

In particular, the government should ensure that regulation does not become a self fulfilling industry and that Monitor should avoid “one size fits all” decisions which place the requirement of regulation or market development before service needs locally.

This is not to suggest that there should not be nationally driven minimum standards, but rather that such minimum standards are just that – minima, and that they are driven by commissioners acting on behalf of local communities and ensuring that patient and public views are taken into account when arriving at decisions as the nature of services to be secured.
6. The transition from the current to the future, to include the role of PCTs, skills and support to GP Commissioning

The NHS Alliance believes that the key to successful implementation of the reform programme set out in the White Paper is local empowerment, local decision making and flexibility in both detail and timescale that reflects local circumstances.

Some will say that the transition is too fast, others that it is too slow. That is an oversimplification of the reality that in some parts of the country putative GPCCs will be ready to assume responsibility for commissioning no and in the very near future, and in others, will require more development support and time to be in that position. The NHS Alliance believes that there should be sufficient flexibility within the proposed timetable to accommodate both the fast movers and those who require a more considered timescale.

It will be absolutely necessary to manage the transition in an orderly way, and due regard must be given to the maintenance of PCT functions during this period (especially when budgets will be hard pressed), but a “one size fits all” approach will not maximise the opportunities. This means that where GPCCs are ready, willing and able, they must be given full budgetary responsibility and the necessary management resource as soon as possible.

The smoothness of transition will depend upon positive relationships between PCTs and their nascent GPCC and, in the spirit of the reforms these, should be centrally coordinated but not directed. This calls for concerted work to create productive transitional plans between GPCC and PCTs and for them to learn from the experiences and outcomes of others. NHS Alliance, as the organisation bridging both, is already providing transitional support and is well placed to extend this work.

Performance management of change should move from absolutes to progress made. Short term inventories of PCT responsibilities should be identified and locally agreed programmes for transition should be set. Government is eager for change and rightly so. So are many in the NHS. The current system does not work as well as it should. Yet a single change programme that thrusts power and responsibility on those who are unwilling (for whatever reason) or not ready is a recipe for failure. What is needed is a flexible and negotiated organisational development programme, not inflexible nationally prescribed change management for its own sake.

In the majority of cases, if and where PCTs have failed to deliver in the past, it is because the system has not allowed them to do so. The considerable skills of those currently working in PCTs must not be lost to the NHS which will require careful transition planning at a local level. PCTs have a key role to play in this transition period. Their skills and experience should be valued and their contribution to the future ensured where this is
appropriate. For instance, their ability to morph into independent businesses, perhaps of social enterprises should be supported and invested in.

The NHSAlliance considers that current PEC Chairs, reflecting both clinical and organisational knowledge, have a particularly important role in the transition period. In many ways, they represent both the commissioners of now and the future and their contribution must be recognised and valued. This contribution includes, but is not limited to, the need to maintain clinical governance and a quality focus during a period of fundamental change.

Similarly, GPCC need clear organisational and personal development plans which will allow them to flourish and succeed. This needs leadership, management and technical functions to be developed. A National support programme should be developed. In its content this may be similar to the World Class Commissioning Programme but with a difference – it should not be used as a performance tool to chastise commissioners, but rather one which enables them to achieve excellence in service delivery that reflects local needs, and wants within limited resources. The delivery of such a programme should make best use of resources, talents and organisations that are already available and avoid a centralised “one size fits all” process of delivery that has often characterised previous attempts to modernise the NHS.
Conclusions

*Radical change is usually associated with both opportunities and risks. The White Paper “Liberating the NHS” is no exception. For example, there are significant opportunities presented by proposals to harness the energy, invention, and knowledge of primary care clinicians in commissioning and the proposals that will strengthen both patients’ and community voices in the planning and delivery of healthcare.*

The values of partnership must not be replaced with adversarialism, and the empowerment of local communities and those who serve them (for the avoidance of doubt GPCC) must not be subject to top down centralism which for too long has characterised the NHS.

*Of course, there must be accountability mechanisms, checks and balances, with regulation playing an important role, but system design must be weighted in favour of those who choose to take on the commissioning responsibility. The aim should be to create, a clinically commissioning led system that builds on team working and partnership with providers with a clear outcome – improved health through efficient and effective health care, and action on the wider determinants of health.*