

Liberating the NHS

The right prescription in a cold climate?



The King's Fund response to the 2010 Health White Paper

Summary

The stated aims of the coalition government's White Paper, *Equity and Excellence: Liberating the NHS* (Department of Health 2010a) are putting patients and the public first and improving health care outcomes. While there are elements of continuity with policies that have been implemented over the past 20 years, the scope of the government's proposals, the speed with which they have been developed, and the urgency with which they are being implemented mean that they are much more ambitious than previous reforms.

The King's Fund supports the government's aims but questions whether fundamental reforms are needed at this time. Our review of how far the NHS has progressed towards becoming a 'high-performing health system', published earlier this year (Thorlby and Maybin 2010), concluded that real strides have been made in the past decade in improving performance through investment and reform. While more remains to be done to strengthen the performance of the NHS, the means used need to be proportionate to the problems to be addressed.

Many of the changes set out in the White Paper, such as involving GPs in commissioning and increasing the choices available to patients, have the potential to help to improve performance. However, there are significant risks in making these changes when financial pressures on the NHS are increasing. The case for reorganising the NHS needs to be clear and convincing to justify taking these risks, and this case has not been made.

The coalition agreement published in May stated that there would be no further restructuring of the NHS, yet this is precisely what is happening. Large cuts in management costs and the abolition of primary care trusts and strategic health authorities will make it difficult to ensure there is effective change management in place to support implementation of these proposals.

There will be costs associated with these changes both directly, in the form of redundancy payments and related expenses, and indirectly, via the opportunity costs of taking management time away from the NHS's core business of improving patient care. The proposed changes could also result in less attention being paid to finding the cost-releasing efficiency savings needed to enable the NHS to meet increasing demands for care just at the time when this should be a top priority.

The King's Fund believes that the aims of the government would be better pursued by building on existing arrangements. Among other things, this would mean giving GPs more control over real budgets as they demonstrate their ability to lead on commissioning, progressively streamlining the organisation of the NHS instead of undertaking radical restructuring, ensuring continuity of management and leadership to minimise disruption and instability, and encouraging increased collaboration alongside competition. Ways of adapting the learning from integrated systems should also be explored. A measured approach of this kind would minimise the risks we have identified and increase the chances that the reforms will bring benefits to patients.

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Introduction

In this paper, we set out our response to the broad direction of reform set out in the White Paper, *Equity and Excellence: Liberating the NHS* (Department of Health 2010a). Our response to the White Paper concentrates on the most important elements in these proposals; we will provide further detailed analysis in the responses to the individual consultation documents.

The case for reform

In our review of how far the NHS had come towards being a 'high-performing health system' (Thorlby and Maybin 2010), we concluded that major progress had been made in the past decade in improving the performance of the NHS through investment and reform.

- Waiting times for hospitals have been transformed and there have been improvements too in access to GP services.
- Infant mortality has fallen, and life expectancy is increasing for all social groups.
- Smoking rates are falling, and deaths from cancer and cardiovascular disease have been steadily declining.
- Rates of two of the more common health-care acquired infections have been cut substantially, and there are now more robust systems for collecting and analysing information on adverse events.
- In mental health services, access to specialist early intervention and crisis resolution teams is considered among the best in Europe and has led to reductions in acute admissions.
- There is now far more information available to patients, professionals and the public about how the service performs.

Public satisfaction with the NHS has also risen significantly over the past 25 years. The British Social Attitudes survey in 2008 found that almost 58 per cent of the public were quite or very satisfied with the NHS (up from 35 per cent in 1997) (Appleby and Robertson, forthcoming); 70 per cent of respondents in a MORI poll

agreed that the local NHS is providing a good service and about half of respondents that the NHS is providing a good service nationally (Ipsos MORI 2010). In the 2008 Commonwealth Fund international survey of sicker adults, only 12 per cent of UK respondents said the health care system should be completely rebuilt compared to 33 per cent in the USA, 26 per cent in Germany and 23 per cent in France (Schoen and Osborn 2008). And in the Commonwealth Fund's most recent assessment of the overall performance of the health systems in seven countries, the UK ranked second; on the specific dimensions of efficiency, effectiveness of care and access as a result of charges the UK was ranked first (Davis *et al* 2010).

Our review highlighted areas in which performance needs to be improved. For example:

- alcohol consumption and related hospital admissions are on the increase, and obesity rates among adults and children are rising
- despite improvements in cancer mortality, we are still performing less well for several cancers than some of our European neighbours
- inequalities in life expectancy between the rich and poor have widened even though life expectancy is increasing for all groups
- the NHS does not yet consistently offer the right support to patients with long-term conditions; given the increases that are forecast in the prevalence of chronic disease and the need to reduce unnecessary hospital admissions, this is a critical area for improvement
- productivity in the service has been declining and there is scope to make savings through reducing lengths of hospital stay, increasing rates of day surgery and using lower-cost drugs.

Against this background of substantial progress in improving performance, albeit with more work to do, the case for radical reform needs to be clear and convincing. The demands of an ageing population, rising public expectations, and the increasing burden of chronic diseases will put more pressure on the NHS at a time when its budget will be more constrained than in the

past. Is the prescription proposed by the government the right one for the colder times that lie ahead, or would it be better to build on existing arrangements and move incrementally to implement the most promising elements in the government's plans?

The broad direction of reform

The government's proposals centre on expanding patient choice and using competition between providers to bring about improvements in performance. While it is clear that ministers have thought carefully about how choice and competition will work in the NHS in future and have developed a comprehensive approach to reform, evidence from the NHS in the past 20 years shows how difficult it is to apply market principles in a publicly funded and politically accountable health care system. Major challenges include:

- providing patients with information on which to make choices and supporting them in so doing
- ensuring that commissioners can negotiate on equal terms with providers
- putting in place appropriate arrangements to regulate the market
- accepting that providers who do not compete successfully may fail, resulting in a reduction in the public's access to services in some circumstances.

The success of the proposals hinges on how the different elements of the health care market relate to each other. While various commentators on the White Paper have focused particularly on the changes to the demand side, the supply side or regulation, the point we would emphasise is that it is the interaction of these changes that will determine their impact. This cannot be planned precisely at the outset, however well thought through the design of the reforms. Much hinges on how the proposals are implemented and this in turn will be influenced by the skills of NHS leaders and the complexity of the changes they are required to make. Also important will be the context in which the changes are made, not least the degree of organisational stability or instability that accompanies the reforms.

What will the changes mean for the NHS?

The White Paper proposes a wide-ranging set of reforms including:

- giving responsibility for commissioning health care to GPs and their practice teams working in consortia
- the creation of an independent NHS Commissioning Board to allocate resources to and oversee GP consortia
- the abolition of strategic health authorities (SHAs) and primary care trusts (PCTs)
- the introduction of an outcomes framework for holding the NHS Commissioning Board to account in place of targets and performance management
- the transfer of public health responsibilities to local authorities
- greater freedoms for providers of health care and an aspiration to see more social enterprises
- the creation of an economic regulator that will set prices, promote competition and ensure service continuity of essential services.

The lack of detail in the White Paper makes it difficult to predict how these changes will play out in practice - a number of outcomes are possible.

Alternative scenarios

Stasis: One scenario is that there will be very little change. GP consortia will in effect look like PCTs but perhaps with more clinical or GP leadership (the Professional Executive Committee in control). They will be performance managed by the National Commissioning Board with regional offices taking on a broadly similar role to that of strategic health authorities. Consortia will reluctantly participate in partnership meetings with the local authority but these for the most part will be talking shops with little real power. They will attempt to manage the activities of member practices, who will distrust those GPs who have gone over to the other side (much as they regard PCTs now). There will be transactional relationships with acute providers, who will carry out the activities they are paid to (and on which they can make a reasonable margin).

A more market-orientated system: In this scenario, competition is exercised on both the provider and commissioning side. Chains of GP consortia align to large private insurance companies, who help them to manage financial and insurance risks associated with their enrolees. Choice of GP in effect becomes choice of commissioner. Rulings by the new economic regulator are powerful in shaping the supply side of care. European Court decisions make it clear that the agreements between providers and commissioners are deemed to be undertakings and therefore subject to competition law. Patients benefit from choice and competition.

An integrated system: In this scenario, commissioning consortia not only develop close relationships with GP federations but also contract with groups of secondary care clinicians who together gradually take on more risk for whole pathways of care. These integrated clinical groups and the consortia develop into integrated delivery systems, with benefits for patients. Links between health and social care are strengthened through maximising use of the flexibilities for pooled budgets. Local authority leadership on public health is strong, and the incentives for the NHS to invest in prevention are aligned.

Disintegration: This is the most pessimistic scenario. The reduced growth in funding and the power of acute providers mean that consortia are unable to control expenditure and lose control of their budgets. Many face losses, some catastrophic. A few consortia make windfall gains, much to the disquiet of the public. Consortia attempt to control demand by requiring prior authorisation for all activity in the acute sector. This reinforces divisions between acute trusts and GPs. Consortia refuse to fund social care services which the local authority can no longer afford and take no interest in public health which they now see as the local authority's business.

Clearly these are extremes and yet they illustrate that the same set of proposals could lead to very different end points depending on the process of implementation and the actions and reactions of those working in the NHS.

Key issues for success

GP-led commissioning

One of the most radical proposals in the White Paper is that general practices should be responsible for health care commissioning. This builds on practice-based commissioning and other attempts to develop primary-care-led commissioning but is much more ambitious in its intention that all practices should be involved and that practices should commission most of the services needed by their registered populations.

While there is a strong case for GPs to play a bigger part in commissioning in order to link clinical and financial decisions more closely to improve care, much will depend on engaging a critical mass of enthusiastic and competent GPs and providing them with sufficient resources to enable them to buy in management support. The skills and capabilities to 'commission' services such as assessing need, using data to analyse utilisation and predict risk, managing financial and insurance risk, involving patients and the public, and monitoring and managing the performance of providers will be essential. These skills need to be valued in the transition and made available to consortia either directly or through commissioning support organisations. The management allowances allocated to consortia must be sufficient to provide GP leaders with high-quality support.

Even if this happens, evidence from previous studies of primary-care-led commissioning (Smith *et al* 2010) suggests that there are some functions that GP commissioners will be neither competent nor motivated to take on. While some of these functions will fall to the National Commissioning Board to perform (see below), others are better undertaken at a local system level. Examples include joint commissioning with local authorities and other partners for services such as learning disabilities and mental health, and the reconfiguration of specialist services like stroke care and trauma services in order to achieve better outcomes.

With primary care trusts and strategic health authorities due to be abolished in 2012/13, it is not clear where responsibility for these functions will sit in future. Without the capacity to undertake local systems leadership, there is a risk that the potential gains

of GP-led commissioning will be outweighed by the inability to take an overview of complex issues that cut across the responsibilities of individual GP consortia, such as the organisation of specialised care and the reconfiguration of acute hospitals. Commissioning consortia may agree to collaborate to fill this gap but there is no certainty that this will happen and even if it does collaboration may take time to develop.

The value of local systems leadership is evident from experience in London, where progress is beginning to be made in improving outcomes through concentrating certain services in fewer hospitals. This has been achieved through the leadership of the strategic health authority and primary care trusts working together across sectors of the capital. The government's decision to put on ice plans to reconfigure services in London is consistent with the aim of devolving responsibility to a local level, but it risks creating a vacuum just at a time when the financial challenges facing the NHS require a strategic approach that uses the expertise of frontline clinicians.

The National Commissioning Board

The new National Commissioning Board will: oversee the work of GP commissioners on behalf of the Secretary of State, allocate and account for NHS resources, and commission services that cannot be commissioned by GPs. The Board is designed in part to remove the Secretary of State from detailed management of the NHS, although he or she will still be expected to account to parliament for the overall performance of the NHS. It remains to be seen whether it will be possible to maintain a clear separation between the role of the Board and that of ministers, especially in responding to performance failures.

We also question whether it will be possible for the Board to be the 'lean and expert' body set out in the White Paper in view of the functions that have been defined for it, such as contracting for primary medical care services, dentistry and pharmacy. The role of the Board in assessing the performance of GP commissioners will also be a major responsibility and will require arrangements to be put in place for dealing with commissioner failure and handling deficits should they arise. Although the government is quite rightly determined to streamline the role of national bodies and devolve responsibility to

frontline staff, the need to ensure that GP commissioners are held to account for the use of resources and performance (an issue that the Treasury will be certain to focus on) could act as a centralising influence.

An early test will be the size of the regional offices of the National Commissioning Board. The scale and complexity of the NHS has always required a regional tier of management, and it is hard to see how this can be avoided in future. If regional offices assume many of the staff and functions of strategic health authorities, then this will raise serious questions about the government's commitment to genuinely devolving responsibilities within the NHS – and indeed about the necessity of the planned reorganisation.

Local authorities

The government proposes to strengthen the role of local authorities in health improvement and in ensuring integration of health and social care. There is a real opportunity here to build on the place-based approaches to public services and to extend the role of local authorities in shaping health care locally. The relationship between GP commissioners and health and wellbeing boards will be critical in determining how these issues are played out in practice.

The transfer of responsibility for public health staff and budgets to local authorities is a bold move that may enable more attention to be paid to prevention than has often been the case in the NHS. We would argue strongly that the role of primary care teams and staff working in the community health services in promoting improved health should not be diminished as public health is separated from other health care services. The forthcoming public health White Paper will need to put forward a coherent vision for how public health will be delivered and how GP consortia will be held accountable for health improvement and reducing health inequalities.

By combining increased accountability to local authorities with devolution of budgets to primary care teams, the government is seeking to ensure that both the public and frontline clinicians have a much bigger say in NHS decision-making. The intention seems to be to use public influence and clinical expertise to create pressure for improving how care is delivered rather than focusing on

targets promulgated in Whitehall. Whether this happens depends not only on the motivation and competence of GPs, as discussed above, but also on the willingness of local authorities to take on this role, particularly at a time of huge financial pressure in local government.

Local authorities could fill the vacuum in local systems leadership in the NHS identified above if they can acquire the resources and expertise to do so. The government needs to be clear whether this is the intention behind its plans and if so how it envisages local authorities working with each other and NHS organisations, including GP consortia, in the future.

Providers

Completing the move to foundation trust status for all trusts has potential to bring benefits by creating autonomous organisations more closely engaged with their local communities. Making this happen will not be easy, particularly for NHS trusts that have longstanding performance and financial challenges. There is a particular concentration of such trusts in London, where there will be major obstacles to ensuring that all trusts will become foundation trusts by 2013 (the deadline set out in the White Paper).

If these obstacles are to be overcome, it will be important to ensure there are streamlined arrangements in place for mergers and acquisitions between foundation trusts and NHS trusts. Another option is to franchise the management of NHS trusts to the independent sector, learning from the experience at Hinchingsbrooke Hospital and elsewhere. More radical solutions may also have to be explored, including acute hospitals combining with community health services to create integrated care organisations that might be established either as foundation trusts or another organisational form (this option is being explored in Trafford).

Studies have shown that employee-owned organisations are more productive, have greater staff engagement and are more innovative and we welcome proposals to encourage employee ownership in the NHS. Many NHS organisations that have explored employee ownership have been deterred from so doing by the complexities of the process and the potential loss of valued rights, including access to NHS pensions (Ham and Ellins 2009).

The encouragement given to any willing provider to deliver services to NHS patients should help to promote innovation, particularly but not exclusively in areas such as health care in people's homes and the community where NHS providers have often been slow to innovate. There will be challenges in making this happen at a time when the organisation of commissioning is being fundamentally changed and resources are much tighter than in the recent past. This underlines the risks involved in destabilising the NHS through restructuring on the scale proposed.

The NHS is and always has been a mixed economy, though not to the same extent as in other health systems that combine public funding with a variety of public, not-for-profit, and private provision. It is not clear whether the reforms will lead to a greater role for the independent and voluntary sector in the provision of care. Regulation and the contractual environment in which these providers operate will be critical to whether this happens. There also needs to be transparency to enable comparison of the performance of all providers of NHS-funded care.

The economic regulator (Monitor)

Monitor's role in licensing providers, promoting competition, setting prices and supporting continuity of services will involve a careful balancing act. The regulator will need to develop its approach as the market in health care matures and to work closely with both the Care Quality Commission and the National Commissioning Board to discharge its new role effectively. The definition of essential services also needs further thought to ensure that Monitor protects the public interest in ensuring access to services where market failure could not be tolerated, eg, in areas of the country where alternative providers of accident and emergency or maternity services are not within 'safe' travel times, while avoiding being seen to subsidise inefficient providers.

There is also a need to protect the public interest by establishing a process for dealing with licensed providers in distress before they fail. If the services are 'essential' the public interest could be better served by early remedial action rather than waiting until the organisation has failed before intervention. These powers could

be given to the new regulator as long as sufficient safeguards were in place to ensure they were able to treat public and private providers fairly. It is not clear what powers the regulator would have unless the private sector is also subject to licensing. We do not believe that strengthening the role of governors in relation to foundation trusts would provide adequate safeguards against the risks associated with distress and failure.

Turning Monitor into a full economic regulator is consistent with the government's ambitions to extend choice and competition in health care. There is a risk that if the economic regulator moves to introduce best practice and 'efficient' tariffs too quickly without taking account of historical capital and deficits then some providers, particularly those with large PFIs, may fail. The establishment of special funding arrangements for essential services that would otherwise be unviable, supported by a risk pool created by contributions by providers, should enable these issues to be tackled. However, this may accentuate the financial pressures on providers as the NHS enters a period of much tighter funding.

Patients

We welcome proposals to expand patient choice, particularly the intention to extend choice beyond choice of provider for elective care into areas such as long-term conditions and mental health and to give patients more choice over treatments. However, we would warn against relying on choice as a key driver to bring about improvements in performance. While it is important to allow patients to leave providers when they have a 'bad' experience, our recent work demonstrates that choice should not be relied on as a means of creating quality competition between them (Dixon *et al* 2010b).

The government is right to recognise the importance of information not only to support choice but as a key driver of improvement in its own right. Recent research suggests that few patients make use of publicly available information on the quality of providers, and many people find it difficult to understand and interpret data about the quality of providers (Dixon *et al* 2010a; Boyce *et al* 2010 forthcoming). In practice,

most patients rely on personal experience and recommendations of GPs, friends and families when choosing where to go for hospital treatment.

If patients are to make more use of publicly available information on the quality of providers, the information needs to be relevant, accessible and presented in a way that patients can understand. Some patients may need support and advice to make sense of their options, particularly choices about treatments. Decision aids can help, but in many cases patients will also benefit from a discussion to enable them to make sense of the information. It will be important to ensure that GPs, who play a key role in supporting choice, first trust and then make use of information about the quality of providers and that clinicians have the skills needed to involve patients effectively in shared decision-making.

Separation of commissioning and provision

Like its predecessor, this government has emphasised the need to make a clear separation between the roles of commissioners and providers to create the conditions for competition. The stated case for doing so hinges on the need for commissioners to concentrate on commissioning, unencumbered by responsibility for service provision, and to avoid commissioners having conflicts of interest in deciding where to place contracts if they are also involved in providing care. This was the argument behind the separation of community services from PCTs, a process which is only now being fully implemented.

Commissioning is often described as the 'weak link' within the NHS, and successive governments have struggled to address this. The world class commissioning assurance process was the latest attempt. While primary care trusts valued world class commissioning for the clarity it provided as to what commissioning involves, they found the bureaucratic assurance process burdensome (Naylor and Goodwin 2010).

International experience indicates that other countries face similar challenges and there is no health care system in which commissioning is done consistently well (Ham 2008, Dixon 2010). The reasons include shortages of skills and resources to support commissioning and the inherent complexities

of the health care market compared with other sectors. This suggests that organisations that are only commissioners of services may find it difficult to negotiate on equal terms with providers. To expect GP commissioners to succeed where previous approaches to commissioning have struggled to make a sustained impact would be a triumph of hope over experience.

For many GPs, an important motivation for being involved in commissioning is the opportunity it creates to 'make' as well as 'buy' services to enable more services to be provided closer to home. Rules on procurement and the opening up of the market to any willing provider should not create obstacles to GP commissioners doing this, provided that there is transparency in decision-making. Although concerns have been expressed about the conflicts of interest that may arise from GPs being both commissioners and providers, used in the right way this could be a strength and not a weakness.

Integration

A further question is whether the government is right to promote commissioning from and choice between what could become an increasingly fragmented array of competing public and private providers. An alternative would be to stimulate choice between systems in which responsibility for commissioning and some or all aspects of service provision are integrated. While there are many different kinds of integrated systems, common features include a combined responsibility for commissioning and provision, multispecialty medical practice, the extensive use of information to improve performance, investment in information technology, and aligned incentives that support a focus on prevention, primary care, care closer to home and the use of acute hospitals only when appropriate.

Integrated systems are innovators in the provision of high-quality care, as illustrated by the experience of Geisinger Health System in the United States improving outcomes in the treatment of patients with heart disease. The Chief Executive of Geisinger has emphasised that these innovations occur when the organisation is both the commissioner and provider of care because it is only in these circumstances that incentives align to support quality improvement (Dentzer

2010). Geisinger's experience shows the practical importance of incentive alignment and how integrated systems are able to leverage the benefits of being both commissioners and providers.

The implication for the NHS is that policy-makers should explore how they can adapt the learning from integrated systems in the next stage of reform and should avoid sticking rigidly to a separation of commissioning and provision. This could include supporting GP commissioners to promote integrated forms of provision that overcome barriers between primary and secondary care, between health and social care and between practices themselves.

Collaboration

It will be important to ensure that support is given to providers to collaborate where this is appropriate. Examples include urgent and emergency care, cancer and cardiac care, and care for people with long-term conditions where there needs to be more emphasis on providers working together in networks to share expertise. Health and social care integration also needs to be encouraged for groups such as older people and people with mental health problems. Evidence from both the UK and other countries has shown the benefits of collaboration as measured by health outcomes and other indicators (Ham *et al* 2008).

GP commissioners will have a central role in developing integrated models of care and enabling GPs as providers to forge stronger links with secondary care clinicians and staff working in community health services. Examples include practices working together in federations to share services and expertise and to forge stronger links with staff working in community health services whether employed by the NHS or by the independent sector. This might extend to some hospital-based specialists becoming aligned with integrated providers in the community as models of multispecialty practice are developed.

The case for collaboration in the delivery of high-quality care for people with long-term conditions and for older people who have complex co-morbidities is compelling. Many of these people are frequent users of NHS and social care services who could be supported to live independently if primary care teams worked more

effectively with specialist teams based in hospitals. Integrated service provision has the potential to deliver more care closer to home and avoid the inappropriate use of hospitals as is already being demonstrated in areas like Torbay (Ham 2010).

Implementation

Taken together, the government's proposals will have far-reaching consequences if they are implemented as set out in the White Paper. Recent history illustrates the many challenges that face reforming governments in matching the ambition of policy-making in health with effective implementation (Ham 2009b). These challenges are accentuated by the planned restructuring of the NHS.

The costs of restructuring

Proposed changes to the organisation of the NHS will have significant repercussions and could result in less attention being paid to finding the cost-releasing efficiency savings needed if the NHS is going to manage with lower growth (Appleby *et al* 2009, Appleby *et al* 2010). This risk is accentuated by the cuts in management costs that are being implemented and the likelihood that many of the most experienced leaders will leave the NHS. These cuts will come at a cost in terms of redundancy payments and other expenses associated with restructuring, raising serious questions about whether it is realistic to expect the changes to free up £850 million by 2013/14 (Department of Health 2010b), as ministers have argued.

According to one estimate, based on previous NHS experience there may well be additional costs of between £2 billion and £3 billion (Walshe 2010) arising from restructuring. There is also a real possibility that the expected management savings will not materialise, particularly if, as we suggest, the National Commissioning Board has regional offices and if GP consortia employ or work with existing PCT staff. Clarity about the functions and skills that will be required in these new organisations could allow some staff to be transferred rather than being made redundant and then being re-employed at additional expense.

Equally important is the opportunity cost of restructuring in taking time away from the core business

of the NHS – ie, putting patients and the public first and improving quality and outcomes. This seemed to be recognised by the government in the coalition agreement published in May which promised that there would be no further top-down restructuring of the NHS. It is therefore surprising that the White Paper, coming hard on the heels of the agreement, should propose the most radical restructuring of the NHS since its inception.

Leading the transition

Implementation of the reforms will entail a change management programme on a scale rarely seen before in any health care system in the world. Given the challenges in change management, there are many opportunities for things to go wrong, ranging from financial failures (deficits may become more prevalent), performance failures (waiting times may slip) to management failures (the NHS may not be able to retain and motivate managers during the transition).

These risks have been clearly identified by David Nicholson, who wrote to NHS leaders in July warning of the 'significant risk, during this transition period, of a loss of focus on quality, financial and performance discipline as organisations and individuals go through change' (Nicholson 2010). The nature of this advice and the need for it to be issued by the NHS Chief Executive underscores the concerns raised in this paper about whether the White Paper provides the right prescription in this colder climate. If the NHS does lose focus during the transition period, it is difficult to see how the government can press ahead with its plans and adhere to the timetable that has been set out.

Writing a White Paper is much easier than securing its implementation, which relies on excellent leadership and execution over a sustained period of time. Recent history is not encouraging in the lessons that have been learnt about the ability of politicians to successfully lead large-scale change programmes in the NHS (Ham 2009a). General managers have taken responsibility for leadership in previous periods of major reform but on this occasion the government is not only reducing management costs but also is publicly critical of NHS managers as it acts to cut back on bureaucracy, eliminate many quangos, and place power in the hands of GPs and frontline clinicians.

The difficulty this creates is that if GPs and frontline clinicians prove reluctant to rise to the challenge thrown down to them, the loss of experienced leaders may leave a vacuum that will be difficult if not impossible to fill. Failure to recognise the importance of managerial leadership in making change happen is a serious weakness in the government's approach that could yet prove the Achilles' heel of the proposed reforms.

Conclusions

The King's Fund strongly supports the aims of the White Paper: putting patients and the public first, and improving health care outcomes. While there are potential benefits if the reforms are implemented effectively, there are significant risks if they are not.

In view of these risks, we would question whether root and branch changes of this kind are needed to enable the NHS to build on recent progress and to match the performance of the very best health care systems in the world. Evidence from different sources paints a consistent picture of an improving NHS that has addressed many of the challenges it faced a decade ago. With public satisfaction increasing and public concerns declining, it is hard to argue that further major reform is needed. While more remains to be done to improve the performance of the NHS, the means used need to be proportionate to the problems to be addressed.

The challenges confronting the government in taking the White Paper forward are partly technical - can the design of the reforms be completed to the point where they are coherent and credible? - and partly political - will ministers have the courage of their convictions and be willing to follow through the logic of the market and allow unsuccessful providers to fail? On this point, it is not clear whether the institutional innovations that have been proposed, such as Monitor and the National Commissioning Board, will insulate politicians from the temptation - and sometimes the imperative - to intervene when things go wrong. The lessons of the past 20 years raise questions as to whether these technical and political challenges can be successfully tackled.

Given that the NHS has more work to do to build on progress, what is the alternative to the road map

laid down in the White Paper? Instead of embarking on massive organisational change, the government could strengthen GP commissioning within the current structures following the example of some of the leading edge PCTs and practice-based commissioning consortia which have put clinicians in leadership roles. Federated groups of practices (in some cases working with clinical colleagues from secondary care) could be allocated real budgets and take on increasing responsibility as they demonstrate the ability to manage this effectively and deliver better value for money. The organisation of the NHS could be progressively streamlined by reducing the size and number of primary care trusts as functions are handed over to federations and clinical consortia through natural evolution rather than a big bang, building on the consolidation that has already started as PCTs reduce management costs.

The government could also capitalise on the increasing interest in integrated care by which we mean both provider integration in GP federations and networks focused on cancer, cardiac and other services, and commissioner and provider integration. Partnership arrangements between the NHS and local authorities could be strengthened, taking forward examples of best practice and encouraging their more widespread adoption. This could include local authorities working in partnership with the NHS on public health and other issues. Competition between providers would be facilitated by all NHS trusts becoming foundation trusts as well as active encouragement of new providers and models such as employee ownership.

Regulation would ensure a nuanced approach. In areas such as primary care, diagnostic services and elective care an all-willing provider market could be promoted in which patients are free to choose (and GPs to refer) to any provider registered with CQC and willing to provide service at tariff in line with national standards. In other areas such as emergency and unplanned care, providers could be designated as preferred providers through a transparent processes of tendering 'for the market' as opposed to competition 'in the market' for individual patients. In areas such as the end-of-life care and the management of patients with complex needs, collaboration between providers (both public and private)

would be encouraged. Patients would be supported to exercise informed choice and this would be as much about the type of care they need as where and when it would be delivered.

If the proposals set out are to be pursued, there are strong arguments for moving quickly to test out how key elements in the White Paper will work in practice and also for evaluating what happens. A good example is GP commissioning, where GPs and managers in some areas are ready to make a start as soon as possible. Supporting GPs and managers in these areas to be early adopters by using 2011/12 as a shadow year for introducing GP commissioning would send out a clear signal that ministers recognise the complexity and ambition of their plans and are willing to mitigate some of the risks associated with these plans through testing and evaluation. The purpose of evaluation would be to inform national implementation by distilling lessons from the early adopters.

As this happens, policy-makers should heed the lessons from high-performing health care organisations around the world. These organisations rarely give priority to organisational change. Rather, they focus relentlessly on ensuring that there is consistency over time in the strategies they pursue and stability in leadership. Specifically, the evidence suggests the need to focus on ensuring that quality of care is the core strategy pursued, clinicians lead work on quality improvement, staff are provided with the skills required to improve quality, and incentives are aligned in support of these objectives. Actions also need to be aligned across organisations with the emphasis placed on whole system thinking and working, not just organisational performance and competition between fragmented providers of care (Ham 2009a).

Don Berwick, recently appointed as head of the Centers for Medicare and Medicaid Services in the Department of Health and Human Services in the United States and one of the most seasoned observers of the NHS, wrote on the 60th anniversary of the NHS:

In good faith and with sound logic, the leaders of the NHS and government have sorted and resorted local, regional and national structures into a continual parade of new aggregates and agencies. Each change made sense, but

the parade doesn't make sense. It drains energy and confidence from the workforce, which learns not to take risks but to hold its breath and wait for the next change. There comes a time, and the time has come, for stability, on the basis of which, paradoxically, productive change becomes easier and faster for the good, smart, committed people of the NHS. (Berwick 2008, p 214)

We endorse this assessment.

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