Haringey Council

Briefing for:	Overview and Scrutiny Committee

Title:	**"Liberating the NHS" – Department of Health consultation on the future of the NHS**

Purpose of briefing:	To provide the Overview and Scrutiny Committee with a briefing on some of the key issues and commentary from the consultation documents and to inform the Committee of the approach being taken to formulate a response to the Department of Health.

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Appendices	**Appendix 1: Timeline for implementation of NHS White Paper** **Appendix 2: Commentary** ▪ Local Government Information Unit ▪ British Medical Journal ▪ CIVITAS **Appendix : Current and Future structure of the NHS**

1. **Background**
   - The Coalition Government have published a number of consultation documents along with the overarching NHS White Paper (Equity and excellence: Liberating the NHS). These are:

     - Local Democratic Legitimacy in health
     - Commissioning for Patients
     - Regulating Healthcare Providers
     - Transparency in Outcomes

   - These papers set out the Governments long term vision for the National Health Service.

2. **Responding to the consultation**
   - The closing date for responses to the overarching White Paper is 5th October. The closing date for responses to the accompanying consultation papers is 11th October.

   - The Department of Health is asking for responses to be emailed to NHSWhitePaper@dh.gsi.gov.uk.

3. **Haringey Response**
   - Adult Services are coordinating a response on behalf of the Council.
     - The Overview and Scrutiny Committee are inputting into this process as are Children's Services.
   - The Overview and Scrutiny Committee is holding a workshop on 13th September to discuss questions posed in "Local Democratic Legitimacy in Health" and "Commissioning for Patients", in order to inform their input into the Council response.
   - Haringey Local Involvement Network is coordinating a response and are hoping to run two public meetings and conduct a survey in order to inform their response.
   - Discussions are still taking place at a Primary Care Trust level, at present it is envisaged that there may be a response to the consultation by the North Central London Sector.
   - NHS Haringey is running an event for GPs at the end of September in order to discuss the implications for GPs.

Below are some key points from each of the consultation papers.

4. **Equity and Excellence: Liberating the NHS**

   - **The White Paper outlines plans to:**
     - shift the total £80bn worth of commissioning from 152 Primary Care Trusts (PCTS) to new compulsory GP consortia by 2013
     - produce an outcomes framework for health and social care to replace the current targets
     - set up an NHS Commissioning Board in England by 2011. This will commission GPs and specialist services
     - open up health provision to "any willing provider" extending the private provider market

- abolish PCTs from April 2013 and Strategic Health Authorities (SHAs) by 2012/2013
- strengthen local democratic legitimacy of the NHS
- transfer responsibility for public health and local health strategy to local authorities. Local authorities will employ a Joint Director of Public Health appointed with the newly created Public Health Service. A ring-fenced Health Improvement budget will be allocated. The Secretary of State will set national objectives for health improvement
- set up new statutory local authority Health and Well-being Boards by April 2012
- local authorities will get new powers in relation to joining up commissioning of local NHS services including promoting integration and partnership working, leading Joint Strategic Needs Assessments and building partnerships for service change and priorities. These will replace existing statutory health scrutiny functions
- local authorities will progress integration between health and social care
- local authorities will be given the role of co-ordinating health care, social care and health improvement. This function will replace current statutory health scrutiny powers as accountability for co-ordinating change will now rest with Councils rather than the NHS
- National Institute for Health and Clinical Excellence (NICE) will set standards for both health and social care. (NICE will produce 150 standards each with 5 -10 concise quality statements)
- local authorities will retain statutory duty to support patient and public involvement. As a patient voice, HealthWatch will be created as part of the Care Quality Commission (CQC) with local branches, building on the Local Involvement Networks (LINks)
- Monitor, the independent regulator, of NHS foundation trusts will become the financial regulator
- CQC will be the quality regulator and inspect and license providers in conjunction with Monitor
- an expansion of Personal Health Budgets, currently being piloted
- an end to national pay settlements in health

5. Local Democratic Legitimacy in health

Proposals

- Local Authorities to have an enhanced role in health:
  - Leading on JSNAs
  - Supporting local voice and the exercise of patient choice
  - Promoting joined up commissioning of local NHS services, social care and health improvement
  - Leading on local health improvement and prevention activity.

HealthWatch

- Local Involvement Networks (LINks) will become HealthWatch.
- HealthWatch will undertake the functions of LINks as well as additional functions and responsibilities, matched by additional funding. These include:
  - NHS Complaints advocacy services – the Govt. is proposing that responsibility is devolved to Local Authorities to commission through local or national HealthWatch.
  - Supporting individuals to exercise choice, for example helping them chose a GP practice.
- Local Authorities will:

    - Continue to fund and contract HealthWatch services.
    - Continue to hold them to account for service delivery and value for money.
    - Ensure that the focus of HealthWatch is representative of the local community.
- In the event of under-performance the LA will be able to re-tender the contract.
- HealthWatch will be able to report concerns to HealthWatch England (this will form a statutory part of the Care Quality Commission).

Improving integrated working

- Aims to strengthen integration in a number of ways including:
    - Extending the availability of personal budgets in the NHS and social care, with joint assessments and care planning.
    - Payment systems being used to support joint working, e.g. around hospital readmissions.
    - Freeing up providers for example, the govt is proposing to remove constraints for foundation trusts which could, for example, enable them to expand into social care.
- The Govt believes there is scope for stronger institutional arrangements, within Local Authorities, led by elected members, to support partnership working across health, social care and public health.
- Option of "leav[ing] it up to" NHS Commissioners and Local Authorities as to whether they want to work together and top devise their own local arrangements if they wish or by the establishment of a statutory role (this is the Govt preferred option).

Statutory Health and Wellbeing Boards

- Would have four main functions:
    1. Assess needs of local population and lead JSN
    2. Promote integration and partnership, including around joint commissioning
    3. Support joint commissioning and pooled budget arrangements
    4. Undertake scrutiny role in relation to major service redesign
- Statutory obligation for LA and commissioners to participate as members of the board and act in partnership on the above functions.
- Would have an 'escalation role' e.g. should the Local Children's Safeguarding Board have concerns about local safeguarding arrangements they could raise this with the Health and Wellbeing Board who could in turn escalate to the NHS Commissioning Board should local resolution not be forthcoming.
- Members would include: Leader, social care, NHS Commissioners, patient champions, local govt including DPH, HealthWatch and GP consortia. Would also include representation from NHS Commissioning Board where relevant issues are being discussed. Elected members would decide who chaired the board.

Overview and Scrutiny Function

- Statutory health scrutiny powers would transfer to the Health and Wellbeing Boards.
- Govt believes this would give HealthWatch a stronger formal role as it would have representation on the Health and Wellbeing boards.
- Consultation document notes that "a formal health scrutiny function will continue to be important within the local authority, and the local authority will need to assure itself that it has a process in place to adequately scrutinise the functioning of the health and wellbeing board and health improvement policy decisions" (p13)

Local authority leadership for health improvement

- Local improvement activity would be transferred to Local Authorities once PCTs ceased to exist, along with an, as yet, unspecified resource allocation.
- A National Public Health Service (PHS) will be created to secure the delivery of public health that need to be undertaken at a national level.
- Local Directors of Public Health will be jointly appointed between Local Authorities and the PHS, they will have a ring-fenced budget and will be directly accountable to the LA and, through the PHS, the Secretary of State.
- The Secretary of State, through the PHS, will agree with Local Authorities the local application of national health improvement outcomes.
    - Local authorities will determine how best to secure these outcomes.

6. Commissioning for Patients

Proposals

- The intention is to put GP commissioning on a statutory basis. Every GP practice will be a member of a consortium.
- Most commissioning arrangements to be made by consortia of GP practices which will be made accountable to the proposed NHS Commissioning Board.
- The Govt. envisages that a smaller group of practitioners will lead the consortium.
- Corsortia will be able to employ staff or buy in support from external organisations (including LA, voluntary sector and independent providers) to carry out certain functions, for example to analyse population needs, manage contracts and monitor expenditure and outcomes.

GP consortia will:

- commission the majority of NHS Services on behalf of patients including: elective and rehabilitative care; urgent and emergency care; most community health services; mental health services; and learning disability services.
- Manage allocated budgets from NHS Commissioning Board and deciding how best to use the resources for the needs of their patients (these budgets will be kept separate from GP practice income).
- Work closely with patients and local communities, including through LINks (HealthWatch).
- Determining healthcare needs, including contributing to JSNAs.
- To fulfil effectively their duties in areas such as safeguarding of children.

The **NHS Commissioning Board** will:

- Be an independent statutory authority that provides national leadership.
- Promote patient and public involvement
- Be accountable to the Secretary of State.
- Ensure the development of consortia and hold them to account for outcomes and financial performance
- Allocate and account for NHS resources e.g. calculate practice-level budgets and allocate these resources directly to consortia.
- Develop a commissioning outcomes framework, with support from NICE.

Health and Wellbeing Board

- The proposed new local authority **health and wellbeing boards** would enable consortia alongside other partners to contribute to joint action to promote the health and well-being.

Financial risk

- The principles for managing over and under spends, will be agreed between the NHS Commissioning Board, the DoH and HM Treasury.
- There will also be incentives, including benefits for good financial management.
- The NHS Commissioning Board will have intervention powers in the event of poor financial management.

Transparency and fairness

- The Department of Health proposes that wherever possible services should be commissioned that enable patients to choose from any willing provider.

7. Regulating Healthcare Providers

Freeing providers

- The Government's intention is to focus foundation trusts on improving outcomes and innovate improvements to care for patients' better care. Patients will choose care from the provider they want. The Government will give more freedoms to foundation trusts such as removal of the private income cap to expand private healthcare provision; and some trusts, such as community services, will be able to operate with staff-only membership.

- The consultation also proposes that all NHS trusts must become foundation trusts in three years. In the transition period to the new system, Monitor will continue to apply its current standards to those organisations applying to become Foundation Trusts.

- The legislative framework for trusts will continue to have their unique legal form. They will be regulated in the same way as other providers, whether from the private or voluntary sector. Any surplus will be reinvested or to pay off debts rather than distributed externally.

Economic regulation

- Monitor will be the economic regulator for health and adult social care in England. Its main duty will be to protect the interests of patients and the public and exercise functions in three areas: regulating prices, promoting competition and supporting service continuity. Its statutory remit will be limited to the provision of health and adult social care services.

Licensing

- In the new system, the CQC and Monitor will be jointly responsible for quality assurance, inspection and enforcement. It will be a requirement of Monitor's licence that organisations have gained CQC registration. Monitor will need to license some providers of NHS services for delivering its regulatory functions. This will supersede and replace elements of Monitor's existing authorisation and compliance regime.

- CQC and Monitor will retain separate responsibilities, however both regulators will need to work together to develop streamlined procedures. Monitor's powers to regulate prices and license providers will only cover NHS services. Monitor will be responsible for developing a general licence and special licence conditions (for individual providers in certain cases) for all relevant providers of NHS services. Providers of other care services, including adult social care, would still be required to register with the CQC but would not be required to hold Monitor's licence.

Price regulation and setting

- Monitor will be responsible for setting prices and devising a pricing methodology for NHS-funded services to promote fair competition and drive productivity. This will include price caps for services subject to national tariffs.

- Monitor and the NHS Commissioning Board will need to work closely together in deciding which services should be subject to national tariffs, and in developing appropriate currencies for pricing and payment purposes. Monitor will also need to consult with the Board on its proposed methodology and prices for services under national tariffs, variations to the tariff in individual cases and in relation to some pricing disputes.

Promoting competition

- The NHS Commissioning Board will have a duty to promote patient choice. All patients will have choice and control over their treatment and choice of any willing provider.

- Monitor will have a duty to promote competition. It will have powers to impose remedies and sanctions to address restrictions on competition, through its licensing regime, and through concurrent powers with the Office of Fair Trading (OFT) to enforce key aspects of competition law. Monitor will have powers to enforce competition law and impose sanctions and remedies in relation to providers of health or adult social care services irrespective of whether they are required to hold a licence.

- Monitor will have powers to investigate and remedy complaints regarding commissioners' procurement decisions and other anticompetitive conduct; and to regulate mergers to maintain sufficient competition in the public interest.

Supporting continuity of services

- Consortia of GP practices will commission the vast majority of NHS services for their patients, including elective hospital care, rehabilitative care, urgent and emergency care, most community services, and mental health services. Commissioners will retain primary responsibility for ensuring the continuity of service provision, although Monitor may intervene to ensure continued access to key services in limited circumstances.

- Foundation trusts are not allowed to withdraw 'mandatory services' without Monitor's permission. In the event of special administration Monitor will be responsible for funding arrangements to finance the continued provision of services and they will decide on the best approach, including determining an appropriate approach to risk assessment.

Implications for local authorities

- The consultation document specifically refers to Monitor's role in relation to both health and social care. For example, 'providing equitable access to essential health and adult social care services' and 'making best use of limited NHS and adult social care resources' (3.2). Its strategic remit will be confined to health and adult social care, for example – it will not cover supply of pharmaceuticals. However, the document does not give any examples of how it will exercise its functions over social care, and, in relation to licensing, social care is specifically excluded. The reason given is that there are already mature markets and choice in social care.

8. Transparency in outcomes

- The Government's proposals are based on their belief that, for the past ten years, doctors and nurses have been forced to meet government targets that often did little to improve patients' health. The Government plans to free the NHS to work towards what really matters to patients and clinicians – what actually happens to the patient's health as a result of the treatment and care they receive. They intend to do this by creating an NHS that is transparent about the outcomes it is achieving for patients.

What will the NHS Outcomes Framework do?

- It will motivate service improvements and ensure there is accountability for performance at the most senior levels. It will do this by:
  - helping patients, the public and Parliament understand how well the NHS overall is doing in terms of improving the health outcomes of the patients it treats and cares for.
  - allowing the Secretary of State for Health to hold the new NHS Commissioning **Board to account** for the outcomes it is securing for patients. This new Board will be independent of the Government and responsible for allocating a budget of approximately £80bn to groups of GPs who will then purchase healthcare services to meet the needs of their local populations.
  - having **greater transparency** to drive improvements in what actually happens to patients' health as a result of the treatment and care they receive.

Principles of the NHS Outcomes Framework

- Accountability and transparency.
- Balanced – outcomes will be chosen to look across the whole NHS.
- Internationally comparable – to compare the NHS against other countries.
- Focused on what matters to patients and clinicians.
- Promoting excellence and equality.
- Focused on outcomes that the NHS can influence but working in partnership with other public services where required
- Evolving **over time** – the NHS Outcomes Framework will be based on what we can measure now, but will be updated in coming years.

What will be included in the NHS Outcomes Framework?

- The proposed NHS Outcomes Framework is structured around five very high level outcome domains. **These are intended to cover everything the NHS is there to do**. These five outcome domains are:

Outcome domain:	Underlying principles used to decide on outcome indicators for each domain:	This domain will measure:
1. Preventing people from dying prematurely	• People should not die early where medical intervention could make a difference • Focus on what the NHS can do	Effectiveness

Outcome domain:	Underlying principles used to decide on outcome indicators for each domain:	This domain will measure:
2. Enhancing the quality of life for people with long-term conditions	• Treating the individual • Functional and episodic outcomes • Meeting the needs of all age groups	
3. Helping people to recover from episodes of ill health or following injury	• Preventing conditions from becoming more serious • Helping people recover from serious illness or injury	Patient experience
4. Ensuring people have a positive experience of care	• Patient experience must be a vital element of the NHS Outcomes Framework • Existing arrangements for collecting patient experience information do not lend themselves well to the requirements of the Framework • It is necessary to measure patient experience now, to drive a step change in improvement • Ensuring that a balanced approach is achieved – so that this work fully supports and complements locally-led innovation and focused improvement activity	
5. Treating & caring for people in a safe environment & protecting them from avoidable harm	• Protecting people from further harm • An open and honest culture • Learning from mistakes	Safety

- Each of the five domains will have:
  - An overarching outcome indicator (or set of indicators) to measure the overall progress of the NHS across the breadth of activity covered by the domain.
  - A small number of specific improvement areas (five or more is suggested) where the evidence suggests better outcomes are possible or areas that are identified as being particularly important to patients.
  - Supporting Quality Standards developed by the National Institute for Health and Clinical Excellence (NICE) to help patients, clinicians and commissioners understand how to deliver better care.

Annex A on page 45 of the consultation report sets out a list of potential indicators for each domain. It is acknowledged that the delivery of outcomes is likely to vary according to geographical area and across different population groups. The framework should not be considered as a performance management tool for NHS providers – **the Care Quality Commission will continue to be responsible for ensuring that providers meet minimum standards and essential levels of quality and safety**.

Appendix 1: Timeline for implementation of NHS White Paper

Timetable for action
The high level timetable below outlines the Government's proposals (subject to Parliamentary approval for legislation)

Commitment	Date
Further publications on: • framework for transition • NHS outcomes framework • commissioning for patients • local democratic legitimacy in health • freeing providers and economic regulation	July 2010
Report of the arm's length bodies review published	Summer 2010
Health Bill introduced in Parliament	Autumn 2010
Further publications on: • vision for adult social care • information strategy • patient choice • a provider-led education and training • review of data returns	By end 2010
Separation of SHAs' commissioning and provider oversight functions	
Public Health White Paper	Late 2010
Commitment Date Introduction of choice for: • care for long-term conditions • diagnostic testing, and post-diagnosis	From 2011
White Paper on social care reform	2011
Choice of consultant-led team	By April 2011
Shadow NHS Commissioning Board established as a special health authority	April 2011
Arrangements to support shadow health and wellbeing partnerships begin to be put in place	
Quality accounts expanded to all providers of NHS care	
Cancer Drug Fund established	
Choice of treatment and provider in some mental health services	From April 2011
Improved outcomes from NHS Outcomes Framework	
Expand validity, collection and use of PROMs	
Develop pathway tariffs for use by commissioners	

Commitment	Date
Quality accounts: nationally comparable information published	June 2011
Report on the funding of long-term care and support	By July 2011
Hospitals required to be open about mistakes	Summer 2011
GP consortia established in shadow form	2011/12
Tariffs: • Adult mental health currencies developed • National currencies introduced for critical care • Further incentives to reduce avoidable readmissions • Best-practice tariffs introduced for interventional radiology, day-case surgery for breast surgery, hernia repairs, and some orthopaedic surgery	2011/12
NHS Outcomes Framework fully implemented	By April 2012
Commitment Date Majority of reforms come into effect: • NHS Commissioning Board fully established • New local authority health and wellbeing boards in place • Limits on the ability of the Secretary of State to micromanage and intervene • Public record of all meetings between the Board and the Secretary of State • Public Health Service in place, with ring-fenced budget and local health improvement led by Directors of Public Health in local authorities • NICE put on a firmer statutory footing • HealthWatch established • Monitor established as economic regulator	April 2012
International Classification of Disease (ICD) 10 clinical diagnosis coding system introduced	From 2012/13
NHS Commissioning Board makes allocations for 2013/14 direct to GP consortia	Autumn 2012
Free choice of GP practice	2012
Formal establishment of all GP consortia	
SHAs are abolished	2012/13
GP consortia hold contracts with providers	April 2013
PCTs are abolished	From April 2013
All NHS trusts become, or are part of, foundation trusts	2013/14
All providers subject to Monitor regulation	
Choice of treatment and provider for patients in the vast majority of NHS-funded services	By 2013/14
Introduction of value-based approach to the way that drug	

Commitment	Date
companies are paid for NHS medicines	
NHS management costs reduced by over 45%	By end 2014
NICE expected to produce 150 quality standards	By July 2015

Appendix 2: Commentary

Local Government Information Unit

- **Equity and Excellence: Liberating the NHS (White Paper) – LGIU Briefing**

The reforms in the white paper are far reaching and very ambitious: they are particularly ambitious in relation to the timetable for implementation of the transfer of commissioning to GPs.

Local government will welcome the commitment in the white paper to linking adult social care, public health and health services at the community level, with a strengthened role for local authorities. The future white paper on public health will clarify whether the vision in the white paper will be translated into reality.

There are obvious risks in undertaking such a profound reorganisation at a time of unprecendented financial pressure, with about £80 billion being handed over to untested GP consortia. The government is clear that the reforms themselves will save billions in management costs, but there is no hard evidence about the scale of savings, given the restructuring will itself be costly in the short and medium term.

The transition period is especially problematic: there will be huge job losses and redeployments, and performance and robust financial management will need to be assured whilst the service is severely disrupted. There are bound to be knock on effects on social care.

……Private sector companies that already work in the health sector have welcomed the opportunities the white paper suggests to support consortia. The BMA has expressed concern at the increased role for the private sector and believe that many GPs will not want to see vastly increased private sector involvement. Local authorities should, perhaps start now to consider how they could themselves provide support services.

….The involvement of GPs in joint strategic needs assessments will be crucial. The new consortia will need to understand the relationship between health and social care and that there are good systems for cross-referral and close working between the two. They will be given powers to make arrangements now covered by S75 of the National Health Act 2006 to work jointly with councils, for example on learning disability and mental health services, but how far will some GPs want to go in, for example, pooling budgets?

There may be practical difficulties, such as boundaries not being co-terminous. A practical but also key policy issue is that richer populations have more GPs per head than poor ones - which was commented on by the recent NAO report on health inequalities. Will the new NHS board be able to influence the distribution of GPs or councils have any powers in relation to this?

……..Clearly, taking on more responsibilities for coordination and promotion requires councils to have the appropriate powers, resources and authority. GPs, particularly, will not be used to working in collaboration. The government will need to give councils the means to take on this role effectively. The transfer of the public health budget will be welcomed, but, again, there are concerns - will there be adequate funding for any additional managerial costs?

The future of health scrutiny is somewhat ambiguous - with the functions outlined replacing the current statutory functions of health overview and scrutiny committees. Will health scrutiny committees be abolished or will they be taking on a wider and different role? Taking on an executive role seems inappropriate and would undermine their accountability role…..”

- **Liberating the NHS – consultations: Transparency in outcomes: a framework for the NHS, and Regulating healthcare providers – LGIU Briefing**

"….some caution is needed about how this framework relates to the work of local authorities and the aims of service integration and health improvement. While it is perfectly appropriate for the NHS, public health and social care to have separate outcomes frameworks covering their core business, without shared outcomes there is a danger of fragmentation. The single Health and Social Care Outcomes and Accountability Framework was a positive development in that it encouraged organisations to jointly own performance outcomes. The consultation on the new framework is extremely NHS focused. While it indicates that 'many' of the outcomes likely to feature in the final framework will require joint work, the potential indicators set out in Annex A are almost exclusively NHS.

A further factor is the role of Communities and Local Government, from where it seems that almost every new announcement signals the demise of red tape and bureaucracy. The abolition of the Comprehensive Area Assessment in June also calls into question the future of cross-public service performance assessment.

….on social care, the main body of this briefing described how the consultation document gives no details on how Monitor might regulate social care in practice. The English Community Care Association has expressed concern that Monitor has little or no experience of adult social care. None of the consultation questions mention adult social care, and the conclusion could be drawn that the DH has not yet considered how these measures might apply."

- **Consultation on local democratic legitimacy in health– LGIU Briefing**

"Local authorities are likely to welcome in principle the proposals that give a greater recognition to their role in tackling the social and economic determinants of health……..

There will no doubt be concern that appropriate resources should be transferred along with responsibilities. Public health is an enormous area of work, impacted on by almost every local government function. Although there has been increasing collaboration in recent years with Directors of Public Health (DsPH), most local authorities have had to struggle with a tiny or non-existent health improvement budget and a small number of isolated staff. If these proposals are implemented, there will need to be some powerful negotiating by local authorities in relation to the transfer of the large public health staff currently managed by DsPH within PCTs. The consultation paper does not mention this issue.

One concern that may arise in relation to the transfer of the health improvement and public health functions to local authorities is that this could give rise to too great a separation from NHS services more generally and possibly lead to a downgrading of public health, prevention and reducing health inequalities in the political agenda – since acute health services by their nature will always demand political and media attention.…….

Local authorities may also be concerned about the proposal to transfer statutory health scrutiny powers to the proposed health and wellbeing boards while retaining the expectation that a separate health scrutiny function will be carried out without those powers. It is generally recognised that health scrutiny has, in many areas, been one of the more successful and influential forms of local authority scrutiny and many health overview and scrutiny committees will not be happy about the loss of their statutory powers and the potential confusion of roles between the proposed health and wellbeing boards and health scrutiny committees.

…….It is also generally recognised that LINks ……. have struggled to make any sort of impact on services. They have never got to grips with their remit in relation to social care and many have spent a considerable proportion of their time and energy in trying to sort out constitutional and relationship issues with their host and the commissioning local authority. The consultation should provide an opportunity for local authorities to reflect on how the LINks structures have operated and to make proposals as to how they could become more effective bodies giving a real voice to health and social care service users."

- **Commissioning for Patients – LGIU Briefing**

The proposals in this consultation document and in the related consultations have significant implications for local authorities, not only in relation to areas of recent close working with the NHS, such as social care and safeguarding, but also in relation to the proposed new local government responsibilities for health improvement and public health. One issue which will no doubt be of considerable concern to local authorities is that of co-terminosity with NHS boundaries…….. The consultation document is at pains to emphasise the government's desire for local flexibility of GP consortia, which means that there will be no real external incentive for commissioning consortia to be aligned geographically to local authority areas.

This means that it will be all the more important for local authorities to make their views known on this issue through their response to the consultation document and other channels, but also to be very proactive in developing relationships with those local GPs who are likely to become leaders within commissioning consortia.

A close working relationship between GPs and local authorities would, in many areas, involve a huge cultural change, since most GPs are not used to the idea of mutual accountability or responsibility with local councils. Nor, despite the consultation document's assertion to the contrary, are most GPs used to thinking in a holistic way about the health and social care needs of whole populations or to thinking of themselves as community leaders……

……Local authorities will no doubt wish to put forward their views on how well health and wellbeing boards could carry out the functions envisaged for them and what support, in terms both of legislation and resources, they might need to do so.

In addition, councils may wish to give their views on the specific roles envisaged for them in this consultation in relation (a) to managing major health service procurement exercises in which local GP practices are bidding and (b) to selling their services to commissioning consortia to provide support with needs population needs assessments or other issues.

- **British Medical Journal Editorial -** 14th July 2010

"…….The impact of the reforms will depend crucially on answers to four questions. Firstly, how effective will general practitioners be in commissioning care, assuming they are willing to do so? Attempts to introduce market principles into the NHS in the past 20 years have foundered on the weaknesses of commissioning, and much hinges on general practitioners being more successful this time round. Although evidence suggests that primary care led commissioning can bring benefits, it is a triumph of hope over experience to expect all general practitioners to take complete responsibility for commissioning.

Secondly, will the government follow through the logic of its reforms and allow unsuccessful providers to fail? The impact of competition hinges on the possibility of market exit being real, but politicians have been reluctant in the past to accept a reduction

in the public's access to services. How they respond when hospitals run into difficulty will provide an early test of their resolve.

Thirdly, can changes to the anatomy of the NHS be implemented without taking attention away from the need to find up to £20bn (€24bn; $30bn) from the NHS budget through increased efficiency? Despite the promise in the Coalition Agreement published in May not to embark on top-down structural changes, that is precisely what is happening, and the effects of major organisational upheaval will be felt for three years. This creates a real danger that experienced leaders will be distracted from work on identifying ways to improve productivity just at the time when a single minded focus on this work is needed.

Fourthly, will the government give priority to supporting collaboration and service integration as well as promoting competition? Collaboration is especially important in areas such as urgent care and the provision of high quality cancer and cardiac services, where better outcomes depend on services being planned and provided in networks. General practitioners must also work more closely with hospital based specialists in clinically integrated groups to improve care for people with long term conditions. Recent NHS reforms have neglected the need for organisations to collaborate across local systems of care, and the capacity to do so in the proposed arrangements must be strengthened.

The government's changes owe a great deal to the secretary of state for health, Andrew Lansley, and the ideas he developed in opposition. Unlike many of his predecessors, Lansley came into office as a man with a plan and has moved rapidly to turn his plan into proposals for legislation. The support of the prime minister has been sufficient to overcome concerns in the Treasury about how general practitioner commissioners will be held to account. The proposed abolition of strategic health authorities and primary care trusts will leave a vacuum in the organisation of the NHS, and it is questionable whether local authorities can fill the void. On this matter, the government's visceral dislike of managers has trumped thoughtful analysis of what is needed and may yet prove to be an Achilles' heel in the plan……"

- **CIVITAS**

James Gubb, director of the health unit at independent social policy think-tank Civitas said:

"'The Secretary of State for Health, Andrew Lansley, should be congratulated on moves to introduce greater competition in the NHS by granting extra freedoms to foundation trusts, expanding choice for patients and supporting a genuine 'social market' through the introduction of meaningful competition law.

Recent evidence on the impact of the competition that already exists in the NHS suggests this is the right course of action to drive value in tight financial times.

However, moves to transfer responsibility for commissioning from PCTs to GPs universally and at such a rapid pace must be cause for concern.

What is proposed represents a huge structural change. The reality is that considerable resources will need to be devoted to the restructuring by: creating new organisations; laying people off in PCTs and recruiting new staff at GP consortia; working out the right blend of risk and reward for GP consortia; creating new accountability frameworks; and implementing new formulas for distributing resources.

All will take time, distract attention, and carry significant risks if got wrong. Evidence from past restructuring of commissioning in the NHS in 2006 suggests a dip in performance of at least one year is likely, which would be ruinous for the NHS's goal of making £20 billion efficiency savings by 2014.

It is also unlikely that it will cut management costs by 45%; with potentially as many as 500 commissioning organisations replacing 152, transaction costs, for one, will almost certainly increase. Many people, too, will end up re-applying for their old jobs in the new structures.

To complement moves on the provider side, instead of effectively eradicating PCTs, the coalition government should focus attention on developing PCT's commissioning skills and getting behind them as vigorous, impartial, purchasers of care, able to exert pressure on providers to improve, or to switch services where necessary to new innovative ones (NHS or non-NHS) without fear of backlash. The goal of increasing clinical involvement in commissioning is vital to this, but would be better achieved working through existing structures.'"

Appendix 3: Current and Future structure of the NHS – BBC website