



NHS White Paper Briefing Equality and Excellence: liberating the NHS

Initial overview and potential early implications for Suppliers to the NHS 15th August 2010

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TRUE WISDOM IS THE ART OF THE QUESTION

Mark Outhwaite
Director
Outhentics Consulting

Contact:
Email: mark.outhwaite@outhentics.com
Phone: +442032399438
Skype: markout

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1. Introduction – and a health warning

- 1.1. This briefing provides an introductory commentary to the NHS White Paper ‘Equality and Excellence: liberating the NHS’¹ published on 12th July 2010. The White Paper applies only to the NHS in England. Administrations in Wales, Scotland and Northern Ireland are not included although they face the same financial challenges as does the NHS in England.
- 1.2. The White Paper follows the Coalition’s Programme for Government² published to frame the negotiated intentions and priorities of the two parties in the coalition agreement.
- 1.3. As part of the process of consultation the Department of Health has released the following consultation papers, designed to help add more detail to the key facets of the proposals:
 - 1.3.1. **Liberating the NHS: commissioning for patients**³ - sets out more detailed proposals for putting General Practice (GP) consortia in charge of commissioning services that best meet the needs of local people, supported and held to account by an independent NHS Commissioning Board for England.
 - 1.3.2. **Transparency in outcomes - a framework for the NHS**⁴ - sets out how the Secretary of State for Health will hold the NHS Commissioning Board to account for delivering better health outcomes, through a national NHS Outcomes Framework.
 - 1.3.3. **Increasing democratic legitimacy in health**⁵ - to seek views on proposals for how patients, locally-elected councillors, local authorities, public health experts and others will work side by side with GP consortia. The consultation outlines proposals to improve health outcomes and ensure that health services meet the needs of people in local areas.
 - 1.3.4. **Liberating the NHS: regulating healthcare providers**⁶ - proposes giving foundation trusts greater freedom so they can focus on improving services and outcomes for patients. It also proposes the introduction of greater competition from ‘any willing provider’ and the necessary regulation frameworks to achieve this.
 - 1.3.5. In addition guidance to the NHS on ‘Managing the Transition’⁷ is also available as is a timeline for implementation⁸.
- 1.4. The aim of the briefing is to give a high-level overview of the proposals and to draw out implications for suppliers to the NHS based on current information. This may well change over time as policy intent meets the hard reality of implementation experience.
- 1.5. There is inevitable ‘smog’ of commentary and opinion that surrounds any White Paper implementation and the growth of a ‘commentariat’ with a range of interests and

¹ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

² <http://programmeforgovernment.hmg.gov.uk/nhs/index.html>

³ http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_117587

⁴ http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_117583

⁵ http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_117586

⁶ http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_117782

⁷ http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_117406.pdf

⁸ http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_117407.pdf

perspectives. Suppliers (anyone indeed) seeking to understand the emerging thinking and substance need to critically appraise sources and should not rely on a single commentator or source. A list of useful sources is provided at the end of this briefing.

2. What are White Papers?

- 2.1. White Papers are statements of government policy intent. They are the precursor to formal legislation to give statutory legitimacy to the government's policies. They provide the framework within which more detailed implementation planning takes place. Consultation on the core aspects of the White Paper usually take place after publication of the White Paper to provide the level of detail required for legislation and to act as the kick-start for moving management into 'implementation mindsets'.
- 2.2. As White Papers tend to lay out frameworks of policy intent they are often seen to be light on the detail of implementation and can be criticised as such. However this is to misunderstand the purpose of the White Paper process. White Papers initiate a period of policy change and resultant service transformation which may last several years (hopefully for a new government one that spans at least two administrations). The final elements of the policy jigsaw may not be given effect for some years depending on the complexity of the change and the readiness of the system for that change.

3. Key features of the NHS White Paper

3.1. Core statement of intent:

- 3.1.1. The Government upholds the values and principles of the NHS: of a comprehensive service, available to all, free at the point of use and based on clinical need, not the ability to pay.
- 3.1.2. We will increase health spending in real terms in each year of this Parliament.
- 3.1.3. Our goal is an NHS which achieves results that are amongst the best in the world.
- 3.1.4. We will put patients at the heart of the NHS, through an information revolution and greater choice and control:
- 3.1.5. To achieve our ambition for world-class healthcare outcomes, the service must be focused on outcomes and the quality standards that deliver them. The Government's objectives are to reduce mortality and morbidity, increase safety, and improve patient experience and outcomes for all
- 3.1.6. The Government's reforms will empower professionals and providers, giving them more autonomy and, in return, making them more accountable for the results they achieve, accountable to patients through choice and accountable to the public at local level:
- 3.1.7. The NHS will need to achieve unprecedented efficiency gains, with savings reinvested in front-line services, to meet the current financial challenge and the future costs of

demographic and technological change (up to £20bn of efficiency savings by 2014 to be reinvested)

3.2. Summary highlights:

- 3.2.1. The transfer of over £80bn of NHS funding to groups of GP Practices (Consortia) to commission services for their patients and the abolition by 2012 of the 10 Strategic Health Authorities (SHAs) and 153 Primary Care Trusts (PCTs) who currently act as line of sight for accountability for commissioning. All GP practices will be part of a Consortium. They will have flexibility to form Consortia and use resources in ways that they think will secure the best healthcare and most cost-efficient outcomes for their patients and local community. There is as yet no guidance on the legal form these Consortia might take.
- 3.2.2. Creation of an NHS Commissioning Board for England to hold GP Consortia to account and to support their development. This Board will be independent with its own statutory role with its objectives and plans agreed with the Secretary of State. The NHS Commissioning Board will be accountable to the Department for living within an annual NHS revenue limit, and subject to clear financial rules. The NHS Commissioning Board will allocate resources to GP consortia on the basis of need.
- 3.2.3. Greater freedoms for NHS Trusts with all current providers expected to become (or become part of) Foundation Trusts by 2013 and the removal of a number of central controls including the removal of the private income cap. Trusts will be encouraged to explore different models of ownership including Social Enterprises (owned by staff).
- 3.2.4. Monitor will become the single 'economic regulator' and will be given new powers - to regulate prices, promote competition, and ensure that services for patients are maintained when providers fail. It will sit alongside the Care Quality Commission (CQC), which will continue to regulate quality, to deliver an integrated and streamlined registration and licensing regime.
- 3.2.5. Encouraging market entry of 'any willing provider' to deliver NHS funded services provided they can meet the licensing standards of Monitor. Commissioners will be required to give patients choice of provider.
- 3.2.6. Elected councillors and local authorities will have a strengthened leadership role in ensuring the NHS is responsible and answerable to local communities and that NHS, social care, public health and children's services are joined up. Local strategies for health, social care and health improvement will be co-produced by local authorities and GP consortia to ensure that commissioning is aligned and is undertaken in an accountable way.
- 3.2.7. A new accountability framework to replace those current process and output targets that have no clinical justification, based around patient outcomes and structured around five high-level outcome goals or domains, which are designed to cover all treatment activity for which the NHS is responsible:

- preventing people from dying prematurely
- enhancing the quality of life for people with long-term conditions
- helping people to recover from episodes of ill health or following injury
- ensuring people have a positive experience of care
- treating and caring for people in a safe environment and protecting them from avoidable harm.

3.2.8. The transfer of current local Public Health responsibilities to Local Government control.

3.2.9. The existing Quality, Innovation, Productivity and Prevention (QIPP) initiative will continue with even greater urgency, but with a stronger focus on general practice leadership. The Department will require SHAs and PCTs to have an increased focus on maintaining financial control during the transition period, and they will also be supported in this task by Monitor. The Department will not hesitate to increase financial control arrangements during the transition, wherever that is necessary to maintain financial balance; in such instances, central control will be a necessary precursor to subsequent devolution to GP consortia.

3.3. The key timetable milestones

- 11th October 2010 - closing date for consultation
- October 2010 – Spending review for 2011/12 released
- October 2010 – Public Health White Paper published
- October 2010 – Health Bill published (creates formal legislative framework for the changes)
- April 2011 - NHS Board begins in shadow form, First GP Consortia start work in shadow form.
- April 2012 – SHAs and PCTs abolished; NHS Board and GP Consortia operational; Economic Regulator takes up full powers.

4. What else is happening that is relevant?

4.1. As part of the changes in the wider NHS environment there are some other changes to the landscape that have implications for suppliers.

4.2. The abolition of a number of Arms Length Government bodies created by the previous administration to hold national functions. These include:

4.2.1. NHS Institute for Innovation and Improvement (which also hosted the National Innovation Centre)

4.2.2.National Patient Safety Agency (NPSA)

4.2.3.Health Protection Agency

4.3. The future of NHS Connecting for Health is expected to be published shortly and is likely to see the following:

4.3.1.Connecting for Health being abolished as a brand

4.3.2.CfH responsibilities being transferred to DH Informatics Directorate (Technology Office)

4.3.3.More emphasis on interoperability, shared records and standards with local decision making and procurement within standards.

4.3.4.Significant cuts in central IT funding so less money in the system overall for IT procurement

Commentary

When policy meets financial reality

This government's policy on health has been waiting in the wings for a number of years. Andrew Lansley the current Secretary of State for Public Health was shadow minister for Health in opposition for almost 6 years. However the key policy themes developed during the time in opposition - of decentralisation, giving more power to patients and front-line staff, giving more freedom to NHS Foundation Trusts and increasing competition by encouraging 'any willing provider' run up against the current very tough financial environment. Even with the government's promise to provide real terms increases in spending for the NHS the service will be expected to deliver about £15bn in efficiency savings for reinvestment to meet service pressures over the next three years.

The dilemma is that whilst the policy emphasises decentralisation and greater freedoms, the line of sight of accountability for delivering the savings is being significantly disrupted by the impending abolition of SHAs and PCTs and the transfer of resources to GP consortia. The result will be the development of interim accountability and management controls to meet Treasury requirements that feel the antithesis of decentralised – tightening the grip of central oversight and control to ensure that the disruption of transition does not threaten the achievement of the £15bn. Getting the balance right without significantly 'turning off' GP consortia will need to be finely judged.

Farewell SHAs and PCTs – welcome....?

Whilst SHAs and PCTs are being abolished in 2012 it is highly likely that some form of 'intermediate tier' or 'outpost' will be created on a geographical or territory basis by the NHS Commissioning Board to ensure that its relationships with Consortia are manageable. This may be on the same boundaries as the current SHAs.

The question of who is responsible for commissioning GP Primary Care Services is also unresolved. It would be a conflict of interest for Consortia to commission GP services and those provided by Dentists and Pharmacists in the community. 15 years ago these services were provided by Family Health Services Authorities (FHSAs) which were then abolished. It would be ironic (but not impossible) to see versions of these recreated.

GP Consortia

As yet there is no prescribed form or size, legal or otherwise for GP Consortia. All GPs will be required to be part of a Consortium. Size may well be dictated at the lower end by the ability to manage financial risk – with population coverage of about 130,000 being a lower limit from previous experience. However it is also possible to create pooled risk approaches that support smaller consortia sizes. One approach might well be the creation of ‘Social Enterprises’ to act as the formal commissioning entities for Consortia. A Social Enterprise can take a number of legal forms but the key characteristics are that the entity performs a function to create a ‘social benefit’ and all profits are reinvested and are not distributed. A social enterprise may be owned by its staff for example.

5. What this means for current and potential suppliers

5.1. In the short to medium term the QIPP agenda will continue to predominate. Suppliers must expect:

5.1.1. Increased pressure to cut prices or provide more favourable terms in existing contracts

5.1.2. To be required to demonstrate real clarity of benefit/ROI in relation to local QIPP priorities in new procurements or if they are to retain current relationships. However offerings that are well aligned and demonstrate robust and evidence based ROI are likely to have significant resonance. If the offerings include gain-share type contracts then there will be opportunities for strong partnerships. GP Consortia are likely to be more innovative and agile in considering these types of offerings.

5.1.3. Risk-averse behaviours in regard to new entrants – ‘better the devil we know’.

5.1.4. Slower and more cumbersome procurement processes as customers become more risk averse and key back-office and support staff (including procurement) posts are removed.

5.1.5. To find that there is a greater role for the Office of Government Commerce in national procurement frameworks but the potential for OGC to not fully understand the NHS context for which they are undertaking the procurements thus causing some tension between NHS organisations and the OGC with suppliers possibly caught in the middle.

5.1.6. Short term uncertainty about the role of Commercial Support Units (CSUs), Procurement Hubs and Procurement Collaboratives as host organisations are abolished and member organisations come under pressure to balance making savings with investing in development of the CSUs and Hubs. However it is likely that GP Consortia as they emerge will make more use of CSUs.

5.2. Greater freedoms for NHS Foundation Trusts and ‘Any willing provider’ mean that:

- 5.2.1. Successful NHS Foundation Trusts will be strong partners for suppliers and will be looking for relationships that contribute to business expansion as well as value for money.
- 5.2.2. There will be a range of new entrants (any willing provider) into the NHS market providing NHS funded health services. Private companies are not fettered by OJEU procurement requirements. This represents an important entry point for new suppliers looking for entry points to provide goods and services. This landscape is likely to evolve rapidly and suppliers will need to be able to respond quickly as new providers emerge.
- 5.2.3. For suppliers considering providing health services directly to Commissioners the White Paper heralds a wide range of opportunities. However in the current financial environment there will be risks as well – as a supplier would you be willing to consider a ‘gain-share’ (payment by results where the supplier is paid partly from the economic benefits delivered by their service) contract with GP Consortia?
- 5.2.4. The removal of Connecting for Health controls mean that for IT vendors the market will be considerably more open than it has been. However local financial constraints will mean lean ‘pickings’ for most suppliers of larger systems. Smaller ‘lighter’ integration systems that can extend the life of legacy systems, Web 2.0 solutions, and systems designed to support patient pathways – for example Long Term Conditions are all likely to be attractive. GP Consortia will also be looking for management systems.
- 5.3. SHAs and PCTs are about to be abolished (by March 2012 – but will inevitably start to run down sooner with clustering of the remainder to maintain some degree of viability)
 - 5.3.1. If they are current clients then you will need to review your contracts and discuss if they are to be terminated or novated to GP Consortia.
 - 5.3.2. They are unlikely to be interested in any form of new procurement or supplier relationship unless it enables the development of GP consortia or the discharge of their QIPP responsibilities
 - 5.3.3. Substantial cuts in management costs in advance of abolition mean that they will not have funds for procurement.
 - 5.3.4. If you have key contacts within these organisations then you will need to track them around the system as they move to new roles.
 - 5.3.5. You should not waste resource or energy on this client group unless it is to identify the future of current contracts or seek to understand their approach to establishing GP Consortia and how procurement will be managed locally.
- 5.4. The development of GP Consortia represents a significant opportunity for suppliers:
 - 5.4.1. GP Practices are small businesses and at their best can be very entrepreneurial and agile in their decision making. The best Consortia will be valuable clients and partners whose engagement and innovation will enhance your product development – but only

if you have the feedback mechanisms and agility to respond quickly to intelligence and suggestions from clients.

5.4.2. Within Consortia there will usually be GPs who have specific interests and expertise that are in the same 'space' as your offerings. Indeed you may find they are more expert or able to become more expert than your own sales force.

5.4.3. GPs value long term relationships. Suppliers must demonstrate that they understand the General Practice context and are prepared to have a long term relationship. Personalisation and customisation to GP Consortia requirements will be a strong theme in successful relationships between GP Consortia and Suppliers.

5.4.4. Emergent GP Consortia will rapidly find themselves at the centre of increased interest from suppliers, all of whom will be looking to take advantage of the new market opportunities. This could get out of hand and suppliers need to think very carefully how they compete for the limited time of key GPs and how to make their offering stand-out. Shouting more loudly will not work. Suppliers who are SMEs or who can behave like an SME in their relationship with consortia are likely to be more acceptable.

5.4.5. GP Consortia will be subject to Public Procurement rules and OJEU requirements for goods and services. It is likely that GP Consortia will become more committed users of Commercial Support Units (CSUs) and Procurement Collaboratives given the constraints on commissioning and procurement expertise driven by constrained local management costs.

5.4.6. There may be a centrally published list of emergent or shadow GP Consortia but when this list will begin to be compiled is not clear - possibly in April 2011. In the meantime Suppliers will need to use local networks and Google to keep up with developments.

Useful resources:

Health Matters - <http://www.pauldcorrigan.com/Blog/>

The Kings Fund - <http://www.kingsfund.org.uk/>

Civitas - <http://www.civitas.org.uk/nhs/index.php>

Financial Times - <http://www.ft.com/indepth/nhs-reform>