



NHS REFORM

The Coalition Government Proposal

Summary

In July 2010 the Coalition Government published the health white paper '*Equity and Excellence; Liberating the NHS*'. This document highlights the main changes within the proposed reform and opens up the debate on the future role of the voluntary and community sector in response to those changes.

Some of the key changes that will be taking place:

1. GP consortia working with health and other care professionals will be given the responsibility for commissioning the great majority of health services in their local area.
2. NHS Commissioning Boards will replace Strategic Health Authorities and will oversee commissioning performance and quality.
3. Public Health will sit under the Local Authority and will appoint Directors of Public Health who will be accountable to the Local Authority.

Why does the Government want to reform the NHS?

- The Coalition Government believe that the NHS is an essential part of the *Big Society*. The phrase '**no decision about me without me**' is integral to the idea of shared responsibility, particular on the use of resources to deliver effective health services.
- Evidence shows that compared to other countries the NHS scores relatively poorly in achieving some health outcomes and lacks a patient-centred approach to designing services which meet the needs of individuals.

The Health White Paper states that the current system is '*overly bureaucratic and unwieldy*'

What will change?

1. Structure of the NHS

- The role of the NHS will be greatly reduced and become more strategic, with a focus on improving public health, tackling inequalities and reforming adult social care. An independent NHS Commissioning Board will be established and will provide national leadership.
- PCT responsibilities for local health improvement will transfer to local authorities. The local authority will employ a local director of public health jointly appointed

with the public health service. The department will create a ring fenced public health budget. The local director will be responsible for health improvement funds allocated according to relative population health needs.

- Health Watch England will be created as an independent consumer champion within the Care Quality Commission. At national level Health Watch England will provide leadership to local branches and will provide advice to national bodies including the NHS commissioning board.
- Local Involvement Networks (LINks) will be rebranded as local Health Watch. They will be funded by and accountable to local authorities who will have a legal duty to ensure that Health Watch is operating effectively. Councils will have responsibility for commissioning local Health Watch.

2. Commissioning

- Decisions on treatment and care will pass directly to groups of health practitioners (consortium) who will be responsible for around £80 billion of NHS resources per annum. All GPs will be required to join a consortium.
- Each consortium will have to manage financial risk and commission services jointly with the local authorities. The NHS Commissioning Board will be responsible for holding consortia to account for their use of NHS resources.
- The consortia will have a duty to promote equalities, to work in partnership with local authorities and will also have a duty of patient and public involvement.

3. Transition

- PCTs will have a time limited role in supporting the health practitioners to develop their commissioning capacity and to ensure a smooth transition to the new model. It is planned that following the **Health Bill in 2012/13**, GP based consortia will take full financial responsibility from **April 2013** when PCTs will be abolished.
- The NHA Commissioning Board will be fully operational in **April 2012** when Strategic Health Authorities will be abolished. The Board will provide national leadership and guidance on commissioning and will be responsible for assessing the performance and quality of GP consortia commissioning. It will also be responsible for commissioning services that are not commissioned by GP consortia such as GP dentistry and primary ophthalmic services.

Where does the voluntary and community sector sit within the reform?

- Public health will transfer to local authorities and budgets will be ring fenced. New Health and Wellbeing boards will replace Overview and Scrutiny Committees and will be under the local authority. The focus of the Health and Well being Board will be inequalities and partnership working between local statutory and voluntary services.
- Whilst there is recognition that there needs to be more effective relationships between LINK bodies and between LINK, local authorities and PCTs, there needs to be more emphasis on how the voluntary and community centre can contribute to the role of LINK.

Concerns and Challenges

- These changes may expose greater disparity between the wealthier and poorer areas across the country and within localities as performance of consortia may vary from place to place. It is a worry that the National Health Service will become little more than a business based on what is affordable.
- The number of GPs in areas with the greatest health needs has increased in recent years but GP levels, weighted for age and need, are still lower in deprived areas.
- Although spending will increase in real terms each year for the NHS, organisations still need to make efficiency savings of between £15 and £20 billion with cuts of up to 45% in management costs.

For Discussion

- 1 Will the choice of '*any willing provider*' increase opportunities for the voluntary and community sector?
- 2 In what way can the voluntary and community sector make best use of the new NHS cluster arrangement between Kensington and Chelsea, Hammersmith and Fulham and Westminster?
- 3 Whilst there may be opportunities opening up for the voluntary and community sector. Could the impact of less funding result in an unfilled gap of voluntary and community sector providers?
- 4 Will the abolishment of PCT mean less partnership working with the sector?
- 5 How can the sector educate GPs on the diversity of the sector and particular excluded communities?

Ways Forward

- The voluntary and community sector must seek to work in partnership with GPs so that the sector can understand their way of working and they can understand the sectors. This has to be coordinated so that there is a strategic voice coming from the sector.
- Social outcomes and health inequality must align with clinical intervention. GPs and the voluntary and community sector should work closely together to ensure that these outcomes can be addressed.
- Equalities will need to be a key component of GP commissioning, to ensure this happens there must be a wider emphasis on equalities groups that can act as advisory to GP commissioning bodies
- The local sector will have to work closely with the local health watch.

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