

# The NHS under the coalition government

Part one: NHS reform

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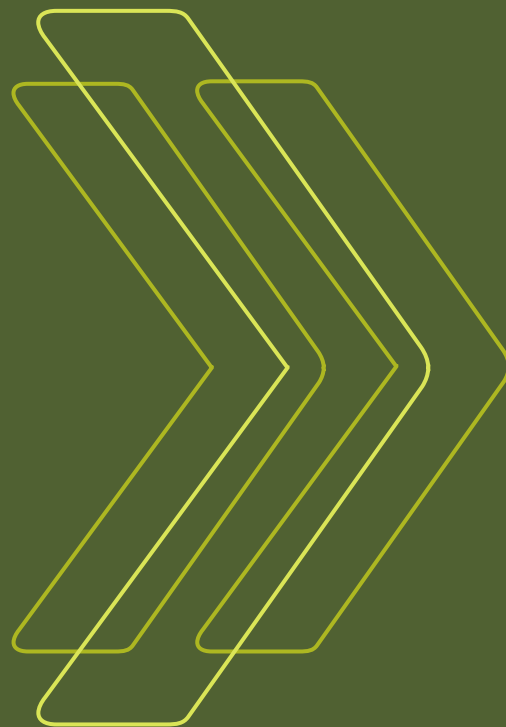
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# 1 Introduction

Historians will not be kind in their assessment of the coalition government's record on NHS reform. The first half of the 2010–15 parliament was taken up with debate on the Health and Social Care Bill, the biggest and most far-reaching legislation in the history of the NHS – designed (largely by the Conservative party in opposition) to extend the role of competition within the NHS and devolve decision-making.

The Bill attracted widespread comment and criticism, including from The King's Fund (Dixon and Ham 2010). It was eventually passed into law only after an unprecedented pause in the legislative process, and extensive amendments following the work of the NHS Future Forum. An unnamed senior government source has recently acknowledged that the decision to promote the Bill was 'a huge strategic error' (Smyth *et al* 2014) and, as we show, its effects were both damaging and distracting.

The second half of the parliament was devoted to limiting the damage caused by the Bill and dealing with the effects of growing financial and service pressures in the NHS. The squeeze on public finances may not have affected the NHS as much as most other public services, but in the context of rising demand from an ageing population, it has struggled both to keep within budget and to hit key targets for patient care. The government responded by redirecting funding to ameliorate the impact of these pressures, amounting to £700 million in 2014/15. It also sought to shift debate away from the technocratic and unpopular changes in the Health and Social Care Act (2012) and towards patient care and how it could be improved. This resulted in a welcome focus on the safety and quality of patient care.

Three people have played a central role in the government's handling of the NHS since 2010. Andrew Lansley, Health Secretary from 2010–12, was responsible for the thinking that lay behind the Bill and for steering it through parliament. As Prime Minister, David Cameron was responsible for appointing Lansley and was later instrumental in initiating a review of the Bill by setting up the NHS Future Forum. He also put his own reputation at risk by promising to keep waiting times for treatment low and to increase the NHS budget in real terms (Ham 2011). Since



September 2012, Jeremy Hunt (Lansley's successor) has taken the lead on damage limitation, studiously ignoring many of the reforms promoted by his predecessor (rarely mentioning competition, for example) and staking his claim as the defender of patients' interests in the wake of the Francis report into failures of care at Mid Staffordshire NHS Foundation Trust.

Hunt's particular passion has been the safety and quality of care delivered in the NHS – a passion he pursued initially by beefing up the role of the Care Quality Commission (CQC) and subsequently by emphasising the need for greater transparency and accountability for performance. Along with Cameron, Hunt was instrumental in appointing Simon Stevens as Chief Executive of NHS England – arguably the fourth important person in this story.

Stevens made his mark in a series of speeches on the NHS shortly after taking up post in April 2014, a precursor to the *NHS Five year forward view* report published later that year. Both Hunt and Stevens focused increasingly on NHS finances as more providers fell into deficit and targets were missed ahead of the 2015 general election.

As partners in the coalition government, the Liberal Democrats' main contribution was to reinforce concerns about Lansley's reforms and to support Hunt's damage limitation efforts. They also led debate about greater integration of health and social care, including championing the Better Care Fund (announced in the 2013 spending review) and mental health. But perhaps their biggest achievement was to secure acceptance of the reforms to long-term care advocated in the Dilnot Commission's report and enshrined in the Care Act 2014 (Clarke 2014). These reforms marked an important step towards greater fairness in the funding of care, and included a commitment of additional spending at a time when the public finances were under pressure, albeit in the next parliament.

Throughout the debate on the Bill, there was continuing controversy about the government's intentions towards the NHS and the long-term impact of its reforms. This debate reached a climax in the final stages of the Health and Social Care Bill's passage through parliament, with critics claiming that its provisions would lead not only to greater marketisation of the NHS but also its privatisation and, ultimately, 'the end of the NHS'. Three years after the enactment of the Bill, it is possible to make an initial assessment as to whether these claims were justified, and what impact the government's policies have had on the NHS overall.



## The structure of this paper

This paper explores the coalition government's record on NHS reform by describing the situation it inherited when it came to power in 2010, the policies it has pursued, and (where available) evidence of their impact. It takes the stated aims of the reforms as the starting point and reviews progress in delivering them. The paper is organised around the six major themes in the government's reform programme, namely:

- commissioning of care
- provision of care by NHS providers
- regulation of the quality of care
- competition and choice
- governance and accountability
- integration of care.

In examining these themes, the paper seeks to answer a number of questions:

- How is commissioning organised and has it delivered any benefits for patients?
- What progress has been made in creating a more diverse provider sector?
- How has regulation of the quality of care changed?
- How has the market in health care evolved and how is it regulated?
- How have the reforms changed governance and accountability?
- What progress has been made in integrating care?

These questions are discussed in depth in the individual sections of the paper but the key findings are drawn together in the overview below. The overview analyses the cumulative impact of the reforms both in relation to the hopes of those who promoted them through parliament and the fears expressed by government critics.



It seeks to shed light on the big questions at the heart of the debate on the Bill as well as exploring the consequences of pursuing such a major programme of reform at a time of unprecedented financial pressure. Readers seeking more detail should refer to the reviews presented in the main part of the paper, which summarise developments in relation to each of the six areas.

Inevitably, given the limited time that has elapsed since the Bill became law and the reforms were implemented (mostly from April 2013), the judgements offered are tentative and may need to be revised as more evidence is gathered over time. Recognising this limitation, this paper should be read as an initial attempt to shed light on health and social care reforms that arguably generated more controversy than any others in the history of the NHS. With the NHS likely to again be one of the key battlegrounds in the forthcoming general election, independent analysis based on available evidence and informed interpretation is particularly important.

The paper does not extend to an analysis of the government's record on performance, as this will be the subject of a separate audit, drawing extensively on quarterly monitoring reports produced by The King's Fund.





## 2 Overview

### The genesis of the reforms

The reforms outlined in the 2010 White Paper, *Equity and excellence: liberating the NHS* (Department of Health 2010a), built on the policies pursued by previous Labour and Conservative governments and sought to go much further by putting into legislation the structures needed to embed a provider market in the NHS. They were also strongly shaped by Andrew Lansley's time as shadow health secretary from 2005–10, with many of the ideas in the White Paper having been foreshadowed in policy papers from that time. At the heart of Lansley's thinking was the need to extend competition and choice within the NHS, drawing on experience of privatising utilities like telecommunications and water. In a seminal speech in 2005, Lansley outlined how lessons from the utilities could be adapted and applied in the NHS, and many of these lessons were incorporated in the reforms introduced by the coalition government (Ham 2011).

Yet, as Nick Timmins showed in his detailed analysis of the genesis of the reforms, Lansley's plan was modified – in some cases substantially – in the days after the 2010 general election as the coalition between the Conservatives and Liberal Democrats was established (Timmins 2012). The process of forming the coalition and agreeing a programme for government resulted in a commitment 'to stop the top-down reorganisations of the NHS that have got in the way of patient care' (HM Government 2014, p 24) and to change the composition of boards of primary care trusts (PCTs) to include a mix of directly elected members and members appointed by local authorities. The latter was a concession to the Liberal Democrats and one that Lansley – who was not involved in shaping the programme for government – was unhappy with.

As Timmins illustrated, Lansley (with support from the Department of Health) circumvented the plans for PCTs by requiring all GPs to be involved in commissioning through what were to become clinical commissioning groups (CCGs). By the time the White Paper had been published, only 60 days after the election, ministers had decided to replace PCTs with CCGs and abolish strategic health authorities (SHAs). The Liberal Democrats' concerns around strengthening



the role of local authorities in the running of the NHS were addressed through proposals to set up local health and wellbeing boards to bring GPs together with councillors. The implication of these decisions was that the NHS would be required to undertake major structural change even though the programme for government – and, indeed, Conservative politicians when in opposition – had promised to avoid this.

Importantly, information asymmetry in Whitehall enabled Lansley's views to prevail. There was no countervailing source of understanding of the NHS elsewhere in Whitehall, the Prime Minister having dismantled expertise built up by Tony Blair and Gordon Brown in No10 as part of his drive to pass back power to departmental ministers. David Cameron's failure to exercise due diligence on the reforms would come back to haunt him.

Timmins' account shows that officials within the Department of Health pointed out to Lansley the risks of embarking on fundamental changes to how the NHS is organised at a time when funding pressures began to bite. But his view was that these risks were worth taking in order to put in place a structure of governance and accountability that would stand the test of time. He was determined to do so through legislation so that a future health secretary could not modify or dilute his reforms by administrative fiat.

As the scale of these changes became apparent, various commentators, including The King's Fund, expressed concerns about their consequences. In a direct response to the White Paper, The King's Fund argued that there were significant risks in implementing the proposed changes at a time of growing financial pressures, adding that 'The case for reorganising the NHS... has not been made' (Dixon and Ham 2010). In place of 'root and branch changes' of the kind proposed, The King's Fund's response argued for an evolutionary approach through 'building on existing arrangements'.

These warnings were underpinned by reference to the experience of high-performing health care organisations around the world. Research into these organisations showed that they rarely gave priority to organisational change and instead adopted quality of care and its improvement as their strategy. In doing so, they supported clinicians to lead work on quality improvement, provided staff with the skills required to improve quality, and aligned incentives in support of these objectives.



The King's Fund's concerns were echoed by Stephen Dorrell, Conservative chair of the House of Commons Health Committee, and by David Nicholson, then Chief Executive of the NHS. In a phrase that was to reverberate throughout debate on the Health and Social Care Bill, Nicholson famously said that the reforms were 'so big you can see them from space'. Nicholson's warnings about the risks inherent in the reforms were set out in a series of letters to leaders in the NHS, in which he pointed out that NHS performance might fall during the transition to the new system.

The main proposals in the White Paper involved:

- giving responsibility for commissioning health care to GPs and their practice teams working in consortia
- creating an independent NHS Commissioning Board to allocate resources to and oversee GP consortia
- abolishing SHAs and PCTs
- introducing an outcomes framework for holding the NHS Commissioning Board to account in place of targets and performance management
- transferring responsibility for public health to local authorities
- giving greater freedom to providers of health care by requiring all trusts to become NHS foundation trusts and creating more social enterprises
- establishing an economic regulator to set prices, promote competition and ensure continuity of essential services.

The lack of detail in the White Paper – a document of only 50 pages – meant there was considerable uncertainty as to how these proposals would work in practice.

A reform programme that was already wide-ranging and complex became even more so as the government made concessions to its critics during debate on the Bill. Particular concerns were expressed about part three of the Bill (the largest section), which contained provisions relating to the role of the economic regulator and the promotion of competition. These provisions were widely interpreted as meaning



that the government wished to open up the NHS to private providers – a view given credence by an article in *The Times* by the head of Monitor, extolling the benefits of choice and competition and invoking the experience of the privatised utilities in an echo of Lansley’s 2005 speech (Smyth 2011).

Senior Liberal Democrats such as Baroness Williams joined other critics of the Bill to question whether fundamental and far-reaching changes of this kind were needed when international surveys showed the NHS to be performing well. Eventually the government responded by setting up the NHS Future Forum during an unprecedented pause in the passage of the legislation, with the aim of seeking the views and concerns of stakeholders. Ministers accepted the Future Forum’s recommendations that the economic regulator should be required to promote integrated care and tackle anti-competitive practices, as opposed to promoting competition, and they took on board most of the other changes it put forward.

As a result, commissioning groups were put on a more formal footing and were required to consult with a wide range of stakeholders. Clinical senates and clinical networks were added to an already complex structure, with the consequence that ‘the overall impact of the Future Forum looked less an assault on bureaucracy than a compounding of it’ (Timmins 2012, p 104). With government sources briefing against Andrew Lansley for having ‘messed up both the communication and the substance of the policy’ (Timmins 2012, p 114), it seemed that the lesser evil was to complicate a set of reforms that had been intended to simplify the organisation of the NHS in order to overcome opposition to them rather than to plough on with a purist vision that risked being rejected.

Although the government’s concessions did not bring an end to pleas to ‘kill the Bill’ – in fact, these pleas intensified for a time – they were sufficient to enable the Bill to pass into law in March 2012 and for attention to shift to the equally uncertain and formidable challenge of implementation. We now turn to how this challenge was handled by summarising the changes made in each of the major areas covered by the reforms.

Implementation of some of the provisions of the Bill began before it was enacted in recognition of the scale of the reforms and the tight timetable adopted by the government. What follows is a summary of the main points that are discussed in more detail in subsequent sections of this paper.



## Commissioning

All GPs were required to be part of a clinical commissioning group (CCG) and 211 groups became operational in April 2013. CCGs were established after going through an authorisation process and they operated under the aegis of NHS England (the renamed NHS Commissioning Board), which retained responsibility for commissioning primary care provision and specialised services. Around two-thirds of the NHS budget was placed under the control of CCGs, with the remainder held by NHS England.

Commissioning support units were created to undertake some functions on behalf of CCGs and these units were hosted by NHS England. CCGs were also able to draw on support from clinical senates, of which there were 12 in England, and strategic clinical networks covering areas of care such as cancer and cardiovascular disease. These bodies were added to the government's original plans on the advice of the NHS Future Forum to ensure that GPs could access specialist advice.

Funding for public health was transferred from the NHS to local authorities, which became responsible for commissioning public health services for their populations. Local authorities also retained responsibility for commissioning social care for adults and children. Health and wellbeing boards were established under the 2012 Act to link GP commissioners and local authorities and to provide a forum for bringing together commissioning plans.

Changes to the governance of CCGs meant that Andrew Lansley's aim to have GPs in the driving seat of commissioning was only partly realised. The boards of CCGs comprise a range of people from different backgrounds, with GPs in a minority among accountable officers. Recent research has raised questions about whether GPs will be keen to take on leadership roles in CCGs once the current generation of leaders step down ([Holder et al 2015](#)). Restrictions on CCGs' freedom to use their budgets – for example, through top-slicing by NHS England – also bring into question the extent to which they have been liberated by the reforms.

The structure of CCGs has remained largely stable since their establishment at a time when both NHS England and commissioning support units have already been reorganised. Even more importantly, there have been moves to reduce direct commissioning of primary care and specialised services by NHS England in order



to devolve more responsibility for these services to CCGs. These moves reflect increasing recognition that the reforms have seriously fragmented responsibility for commissioning, with population-based budgets formerly controlled by PCTs now split between CCGs, NHS England and local authorities.

Although it is too early to identify any real benefits of the new arrangements for commissioning, there is some optimism in the way in which CCGs are beginning to work more closely with local authorities through health and wellbeing boards. Transferring responsibility for public health to local authorities will potentially allow a broader approach to health improvement. Likewise, some CCGs have begun to test the use of prime contractor and alliance contract models in order to stimulate greater integration of care. These innovations in commissioning hold promise, but they are also challenging to implement (Addicott 2014).

Against these promising developments, NHS England has been slow in establishing its role and was restructured in 2014 to reduce the number of area teams and cut its management costs. Also, the commissioning of specialised services has been problematic, with NHS England's spending on these services considerably over budget. There are uncertainties too about the future of commissioning support units and the extent to which CCGs will choose to use them.

### Provision of care by NHS providers

NHS providers have faced increasing challenges since the 2010 general election both in relation to finance and performance. These challenges have slowed the transition from NHS trusts to foundation trusts, with only 20 new foundation trusts established during this period, bringing the total to 149 at the time of writing (Monitor 2014b). The NHS Trust Development Authority continues to oversee the performance of the remaining 93 NHS trusts and has declared that 12 are unsustainable in their current form.

There are a number of options for these trusts, including being acquired by a foundation trust or a management franchise involving a private sector provider. The acquisition of Barnet and Chase Farm Hospitals NHS Trust by the Royal Free London NHS Foundation Trust is an example of the former, and the award of a contract to Circle to manage Hinchingsbrooke Health Care NHS Trust was an example of the latter. However, in January 2015 Circle announced its intention



to hand management of Hinchingsbrooke back to the NHS following financial pressures and a critical CQC inspection report which resulted in the trust being put into special measures. Further management franchises by private sector providers now seem unlikely, in part because of the significant financial challenges facing the NHS that make franchise arrangements less attractive to non-NHS providers.

The review of alternative organisational models led by David Dalton at the request of Jeremy Hunt outlined a range of options for successful NHS providers to share their expertise with other providers, including the development of chains of providers and integrated care organisations ([Department of Health 2014d](#)). The review emphasised that ‘one size does not fit all’ and described a number of possible models for consideration and adaptation within the NHS. The decision to commission the review was itself an indication of the increasing attention being given to the provision of care in government.

In two cases, the challenges facing providers have resulted in the use of the Trust Special Administrator regime. The first involved South London Healthcare NHS Trust, which was dissolved as of 1 October 2013 because of concerns about the quality of some of its services and longstanding financial problems. The services formerly provided by the trust have been taken on by neighbouring providers.

The second example concerns Mid Staffordshire NHS Foundation Trust, for which a dissolution order was made in October 2014 in the wake of the second Francis report ([The Mid Staffordshire NHS Foundation Trust Public Inquiry 2013](#)) and continuing concerns about the safety of care being delivered at its hospitals. As in the case of South London, the Department of Health provided substantial additional funding to support neighbouring providers to take on services formerly provided by Mid Staffordshire.

The dissolution of trusts and trust mergers present significant challenges to the organisations that acquire services. The experience of the Heart of England NHS Foundation Trust in taking over Good Hope Hospital in 2009 is a good illustration, whereby a well-performing organisation found its performance adversely affected over several years following the acquisition. King’s College Hospital NHS Foundation Trust has run into similar difficulties recently following the acquisition of Princess Royal University Hospital in south London (Barnes 2014a).



The use of the Special Administrator in the cases of South London and Mid Staffordshire was time-consuming and costly, and in South London resulted in a judicial review. These two examples also illustrate that dealing with challenged providers can only be done in the context of the health economies in which they are located. Recent interventions recognise this by focusing not only on providers in difficulty but also their relationships with commissioners and other providers.

Plans to establish a more diverse provider sector have been slow to be realised. Around 40 staff-owned NHS mutuals were established when the former PCTs relinquished responsibility for providing community services, and proposals have been put forward for this option to be available to other NHS providers. Private providers have also won more contracts to deliver NHS services in some areas, although the majority of care continues to be delivered by NHS providers.

Primary care provision continues to be delivered through the long-established model of small practices owned and run by GPs. Many practices are exploring how they can work with other practices in networks and federations or, in some cases, create large practices known as super-partnerships. In a few cases, GPs are employed by NHS foundation trusts.

CCGs will assume more responsibility for commissioning primary medical care from April 2015. Conflicts of interest will need to be handled carefully and it is likely that some GP leaders will choose to focus on primary care provision instead of commissioning through CCGs. This may accentuate the challenges of engaging GPs in the work of CCGs in future.

### Regulation of the quality of care

Many of the challenges faced by providers have concerned the safety and quality of care they deliver. The government has responded by seeking to strengthen how quality of care is regulated through the Care Quality Commission (CQC) and other means. It has also legislated on fundamental standards of care, introduced a new statutory duty of candour, and developed a 'fit and proper persons' test for members of NHS boards.

The CQC has, in effect, been reinvented through the appointment of chief inspectors of hospitals, general practice and adult social care, and the use of specialist





inspections undertaken by large teams of inspectors. Inspections are supported by a new form of intelligent monitoring designed to assess quality of care using routinely available data and anticipate problems before they arise. Services are rated following inspections on a scale ranging from outstanding to inadequate.

There has been a particular focus on NHS providers where data suggest there may be concerns about the quality of care. Following the Francis Inquiry's report into Mid Staffordshire NHS Foundation Trust ([The Mid Staffordshire NHS Foundation Trust Public Inquiry 2013](#)), 14 providers were identified for investigation by the Keogh review, which focused on trusts with higher-than-expected mortality rates. Subsequently, the CQC introduced a special measures regime for trusts where there was evidence that quality of care was at risk.

Regulation of care has received much greater emphasis since Jeremy Hunt became Health Secretary, in part because of the impact of the Francis report. Hunt has argued that the CQC ought to play a role akin to Ofsted's role in education, and many of the changes he has introduced have been designed with that in mind. There have, however, been challenges in developing the new approach to inspections – not least recruiting sufficient people with the requisite experience to constitute specialist inspection teams.

Regulation has become more high profile as less emphasis has been given to competition and choice as a means of reform (*see below*). The result has been that providers are now under intense scrutiny. Research by the Nuffield Trust has documented the pressures placed on leaders within the NHS, which at worst felt punitive and based on attributing blame rather than offering support ([Thorlby et al 2014](#)).

One of the consequences of Jeremy Hunt's focus on the quality of care is that many NHS providers recruited additional nurses and other staff. While this was understandable, it accentuated growing financial pressures in a system where providers were already struggling to balance their budgets. The government responded by redirecting funding into frontline care, but despite this, many providers are still struggling to avoid going into deficit.

The CQC is responsible for regulating adult social care and primary medical services as well as the services delivered by NHS trusts and foundation trusts. Its work regulating general practice is less developed and has run into difficulties



because of errors in the use of data to assess the performance of practices. Critics of the CQC argue that this is symptomatic of the pressures it is under, notwithstanding a substantial increase in its budget and staffing.

### Competition and choice

Part three of the Health and Social Care Act strengthened and made more explicit the role of competition within the NHS and how it would be regulated. The provisions of the Act were elaborated in regulations – known as the section 75 regulations – which attracted criticism for appearing to require commissioners to put services out to tender. Although the government amended the regulations to clarify its intentions, there remains uncertainty within the NHS on when services need to go out to tender, notwithstanding attempts by Monitor to offer guidance on this.

Bearing in mind the range of strongly held views on this issue, it is important to reiterate that the Act did not introduce competition to the NHS. Both the Blair and Brown Labour governments used patient choice and competition as part of their reform programme, including commissioning additional capacity from independent sector treatment centres and using spare capacity in private hospitals to treat NHS patients on waiting lists. They also sought to open up the market in general practice by encouraging for-profit companies to compete with GPs to deliver care.

The coalition government's critics recognised that competition was not new, but were concerned that it would result in much greater privatisation. In fact, this has not happened, even though private providers have been successful in winning contracts to provide services to NHS patients in some areas of care. The evidence shows that spending on non-NHS acute providers has slowed while spending on non-NHS providers of community and mental health services has increased, although the latter is partly due to some NHS provision transferring from PCTs to NHS social enterprises.

Other evidence shows that private providers have been more successful than NHS providers in winning contracts put out to tender, but the value of these contracts is small in relation to the size of the NHS budget. A recent study by the *British Medical Journal* also found that one-third of the contracts to provide NHS clinical services awarded in the year from April 2013 were secured by private providers, but again the value of these contracts was only 5 per cent of the total for those contracts for which financial information was obtained (Iacobucci 2014) Also, the much-vaunted policy



of patients being able to access care from ‘any qualified provider’ has taken a back seat. Overall, the Department of Health’s annual accounts suggest some £10 billion of the total NHS budget of £113 billion is spent on care from non-NHS providers ([Department of Health 2014c](#), p 120), suggesting that claims of widespread privatisation are exaggerated.

Part three of the Act also increased the powers of Monitor, both through rules on tendering and procurement (discussed above) and in conjunction with the Competition and Markets Authority (and its predecessor, the Office of Fair Trading) through oversight of proposed mergers. The first major test case of the latter involved the proposed merger of the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust. After a lengthy and expensive investigation, the proposal was rejected on the grounds that there was not enough evidence that the merger would result in benefits for patients.

Subsequently, other mergers and reconfigurations have been approved, and revised guidance has been issued to help NHS providers prepare their cases in full knowledge of what the regulators expect. This includes giving Monitor a bigger role in assessing proposed mergers before exposing them to full scrutiny by the Competition and Markets Authority. One of the aims of the guidance is to ensure that regulation of the market is proportionate and does not divert scarce funds from the provision of frontline care.

As noted earlier, since Jeremy Hunt replaced Andrew Lansley as Health Secretary, there has been much less emphasis on the role of competition and choice as drivers of performance improvement in the NHS. In a recent interview, Hunt argued that patients were often loyal to local hospitals and some services, like emergency care, were natural monopolies where patient choice was not going to drive change (West 2014b). Despite this, the legacy of the 2012 Act remains, with senior staff at Monitor arguing that competition has a continuing part to play in delivering improvements in patient care (Hazell 2014b).

## Governance and accountability

One of the provisions of the Bill that attracted particular attention was the proposed role of the Health Secretary. Andrew Lansley had wanted to limit the Health Secretary’s accountability for the NHS but met with strong opposition both inside



parliament and outside. The Bill was therefore amended in the House of Lords following detailed discussions brokered by Earl Howe to address critics' concerns.

The reforms altered the governance of the NHS at a national level through the creation of a number of bodies alongside the Department of Health. NHS England was to lead work on commissioning, including allocating resources to CCGs and agreeing an annual mandate with the Health Secretary setting out priorities for the NHS. Although described as a 'lean and expert organisation' in the White Paper, NHS England has accumulated a wide range of responsibilities and at March 2014 employed 15,291 staff ([National Health Service Commissioning Board 2014](#)).

NHS England worked alongside Monitor as the economic regulator, the CQC as the quality regulator, the NHS Trust Development Authority, Public Health England, Health Education England, and the National Institute for Health and Care Excellence (NICE). These arrangements enshrined the separation between commissioners and providers at a national level, and meant that only in the Department of Health was there oversight of the NHS as a whole. The Department cut its staff by 31 per cent between 2011 and 2014 as a consequence of losing some of its functions and refocusing its work on supporting ministers.

Predictions that the Health Secretary would no longer be held to account for the NHS proved wide of the mark. Jeremy Hunt took a close interest in NHS performance – for example, by speaking directly to the leaders of NHS providers that missed politically important targets like the four-hour wait in accident and emergency (A&E). He also met regularly with the leaders of national bodies to ensure that the government's priorities were known and acted on. The government's attachment to targets ran counter to the aspirations of Andrew Lansley and his promise to devolve responsibility for decision-making and reflected increasing concern in government at declining levels of performance within the NHS as the parliament progressed.

At a local level, governance was transformed by the abolition of SHAs and PCTs in 2013 and their replacement by CCGs and NHS England's area and local teams. There was much less change among providers of care, although clinical senates and strategic clinical networks provided new forums through which they could influence developments. Academic health science networks (14 in total) were also established to provide a means for providers to work together at a regional level to support innovation and service change.



The government established Healthwatch England to ensure that the voice and views of patients and the public were not ignored. Healthwatch was to be a national body but also have a presence in local government, and was the latest in a long line of attempts to find a means of avoiding provider dominance in the NHS. Local government was also able to influence the NHS through health and wellbeing boards and growing interest among policy-makers in integrated care, especially as the parliament drew to its close.

As this account indicates, governance and accountability not only changed as a result of the reforms but also became more complex. This was partly because of compromises made during and immediately after the coalition was created and partly because of concessions made by the government during the passage of the Bill through parliament. A set of policies designed to streamline and simplify the organisation of the NHS ended up having the opposite effect. Parliamentarians, among others, were openly and frequently critical of the confused accountabilities created by the Act.

### Integration of care

Integration of care was not an explicit aim of the original reforms but became a core element following the work of the NHS Future Forum in 2011. The Bill was amended to place duties on various organisations to promote integrated care, duties that were reinforced by the Care Act 2014. The Minister of State for Care and Support, Norman Lamb, was particularly prominent in making the case for integrated care, and led development of the Better Care Fund (*see* below) and the programme of integrated care pioneers.

The coalition government perceived health and wellbeing boards as having an important role to play in taking forward integration of health and social care at a local level. However, their membership often did not include some of the organisations and leaders whose involvement was essential for integrated care to succeed. Research by The King's Fund painted a picture of differential development across England, with many health and wellbeing boards initially choosing to focus on issues such as public health rather than integrated care ([Humphries and Galea 2013](#); [Humphries et al 2012](#)).



The establishment of the Better Care Fund in the 2013 spending review, involving almost £4 billion of pooled funds at a national level, helped move integrated care from the margins to the mainstream. Although the Better Care Fund's evolution was heavily criticised by the National Audit Office, its ambitions resonated strongly with CCGs and local authorities who chose to put more resources into the pooled budget than required.

The Better Care Fund was less popular among NHS providers, many of whom feared being placed under even greater pressure as NHS resources were redirected to support joint working between the NHS and local government. At a time when social care funding was being cut, there were concerns that NHS resources transferred into the Better Care Fund would be used to support social care instead of funding the integration of health and social care as intended.

The impact of these policies will only become clear when the Better Care Fund is implemented in 2015/16. Early reports from the Integrated Care and Support Pioneers programme are promising, offering some hope of progress in reducing inappropriate use of hospitals and delivering more care in people's homes. Set against this, it remains to be seen whether CCGs and local authorities can deliver the required reductions in emergency hospital admissions at a time when demand for hospital care is continuing to rise.

The increasing focus on integrated care raised the question of whether competition and integration were mutually exclusive. Monitor addressed this and other questions in guidance for the NHS in which it stated categorically that they were not mutually exclusive although commissioners would need to be mindful of the rules on competition and choice in placing contracts ([Monitor 2014a](#)). Despite this, there remains uncertainty within the NHS on the circumstances in which commissioners are required to test the market in seeking to develop integrated care.

## The end of the NHS?

What then does the balance sheet on NHS reforms look like?

In terms of the big questions raised during debate on the Health and Social Care Bill, the reforms have certainly resulted in greater marketisation in the NHS, but claims of mass privatisation were and are exaggerated. Private providers do play a



part in providing care to NHS patients, as they have always done, and their share of provision of community and mental health services has somewhat increased. Notwithstanding this, NHS providers continue to deliver the vast majority of care to NHS patients, especially in acute hospital services, and there is little evidence that this will change any time soon.

Arguments about privatisation distract from the much more important and damaging impacts of the reforms on how the NHS is organised and the ability of its leaders to deal with rapidly growing financial and service pressures. By taking three years to dismantle the old structures and reassemble them into new ones, the government took scarce time and expertise away from efforts to address these pressures. Although it is not possible to demonstrate a causal relationship with NHS performance, it seems likely that the massive organisational changes that resulted from the reforms contributed to widespread financial distress and failure to hit key targets for patient care.

An example of the distracting and damaging effects of restructuring can be found in the experience of a transformational change programme in the north east of England. A recent evaluation has shown how a programme designed to improve patient care was 'seriously disrupted' by the reforms (Hunter *et al* 2014). Extensive changes in leadership in some of the sites involved in the programme, also evident elsewhere in the NHS as a result of organisational upheaval and redundancies, added to the disruption.

The complexity of the new structures that resulted from the 2012 Act has proved equally damaging. An unwieldy organisation has emerged from debates on the reforms and compromises made along the way in what can best be likened to a Heath Robinson construct. Nowhere has this been more apparent than at the centre of the system, where the leadership previously provided by the Department of Health has been fractured and distributed between several organisations, each overseeing part of the NHS but none responsible for the whole.

Changes to the regulation of provision added to the complexity of the new structures. These changes affected both CQC and Monitor in particular, with their overlapping responsibilities for the quality of care, governance and leadership. Not only were providers put under more pressure as greater emphasis was placed on regulation, but also there were concerns about the impact of reporting requirements and duplication



of roles. This was noted in the Berwick report on patient safety ([National Advisory Group on the Safety of Patients in England 2013](#)), which stated unequivocally that ‘The current regulatory system is bewildering in its complexity and prone to both overlaps and gaps between different agencies. It should be simplified.’

Complexity was also evident in the NHS itself, with responsibility for commissioning shared between NHS England, CCGs and commissioning support units, alongside the new role for local authorities in commissioning public health. Responsibility for providing care continued to be split between NHS foundation trusts (overseen by Monitor) and NHS trusts (overseen by the newly created NHS Trust Development Authority). Care was also provided by a number of NHS mutuals that were established when community services separated from PCTs.

A range of new organisations co-existed with NHS commissioners and providers, including health and wellbeing boards, academic health science networks, clinical senates, and clinical networks – not to forget local education and training boards overseen by Health Education England. *An alternative guide to the new NHS in England* produced by The King’s Fund (2014) attracted huge interest precisely because it offered a comprehensible introduction to what appeared, to many observers, an incomprehensible system. Fear of the effects of further reorganisation inhibited serious discussion of how the new structures might need to be adapted.

One of the consequences of the reforms was to abolish SHAs, which, in the previous structure, were responsible for exercising system leadership in the NHS. This has made it difficult to persuade the large numbers of commissioners and providers in a region or an area to work together to bring about improvements in how care is delivered. At a time when growing pressures on the NHS demanded a response across local systems of care as well as from individual organisations, the absence of a system leader was strongly felt. Andrew Lansley’s intervention in 2010 to bring a halt to work on service reconfiguration in London (because, in his view, it was being driven from the top down instead of from the bottom up) led to the resignation of a high-profile SHA chair, indicating the scale of concern in the NHS.

Given the complexity of this reorganisation of the NHS, it is no surprise that claims about the reforms releasing resources from management costs are contested. Not only were there costs associated with making the changes (including redundancy costs to long-serving and often highly paid managers) but there were also costs





in establishing many new organisations. Additional costs that are difficult to quantify resulted from marketisation of health services, as in negotiations between commissioners and providers, tendering and procurement exercises, and mergers and acquisitions. The opportunity costs of the reforms were as important as these direct costs, especially the way in which NHS leaders at all levels were distracted as they were required to rearrange the deckchairs rather than navigate safely past the iceberg.

More broadly, experience of the reforms to date offers no evidence that the separation between commissioners and providers will be more effective in stimulating improvements in care than was previously the case, nor that competition will bring sufficient benefits to outweigh the transaction costs it entails, though more time is needed to confirm this judgement. This seems to have been accepted in recent statements by Jeremy Hunt (*see above*) and also, implicitly, reflected in the lack of discussion among senior ministers on the role of competition in health care since Andrew Lansley was replaced. Rather than competition, ministers have placed their faith in regulation and, increasingly, in the transparent reporting of information on performance as a means of improving patient care.

Whether this faith is well placed is a moot point, particularly in relation to regulation and the role of the Care Quality Commission in assessing the quality of care. Providers of care are under an increasing regulatory burden in the context of growing financial and service pressures, and at times this has felt more punitive than supportive. While providers must ensure that patient safety and quality of care are their most important priorities, it is not clear that inspection is the best way of achieving this. Frontline clinical teams are the first line of defence against poor care, followed by the boards of NHS organisations. The CQC can only ever support teams and boards in improving quality and ensuring safety and can never substitute for them.

The Berwick report on patient safety, produced at the request of the Prime Minister in response to the Francis Inquiry into Mid Staffordshire NHS Foundation Trust, made this point unequivocally, stating that ‘achieving a vastly safer NHS will depend far more on major cultural change than a new regulatory regime’ ([National Advisory Group on the Safety of Patients in England 2013](#)). Work at The King’s Fund has highlighted the role of leaders in changing cultures and supporting staff to deliver safe and compassionate care ([West et al 2014](#)). The welcome emphasis on patient care in the second half of this parliament should be taken forward by the next



government through a commitment to strengthening leadership and enabling the NHS to become a learning organisation as outlined in the Berwick report.

### Where next?

Taking the longer-term view, the *NHS Five year forward view* published by NHS England (2014f) and other national bodies in October 2014 may well be seen by historians as one of the most important events in health policy under the coalition government. Equally brief as *Liberating the NHS*, the *Five year forward view* served three purposes.

First, it set out a direction for the future of health and care by describing the challenges facing the NHS and the care models needed to tackle these challenges. Second, it made the case for additional funding for the NHS as well as quantifying the ambitious productivity improvements it would need to deliver. And third, it began to describe how national bodies and local leaders would need to behave to implement new care models and improve productivity.

Work on the *Five year forward view* was led by NHS England and was rightly seen as a product of Simon Stevens' thinking. It would be wrong, however, to see the involvement of other national bodies as tokenistic. In a real sense, joint ownership of the document by these bodies signalled an intention to put in place the system leadership needed at the centre to overcome the fracturing of responsibilities that resulted from the reforms. The unanswered question is: can this embryonic system leadership at the centre hold, or will it fall apart?

The same question arises at the local level, where system leadership between commissioners, providers and other partners (such as local authorities) is needed to develop new care models and to tackle growing financial and service pressures. As already noted, the abolition of SHAs has left a vacuum and, in the absence of a designated system leader, it falls to the leaders of the organisations that do exist to fill this vacuum. This is beginning to happen in some areas but is not easy when the current generation of NHS leaders are experienced in leading organisations rather than systems. The conflicting expectations of national bodies may also create barriers to collaboration.

In these circumstances, it would be easy – but wrong – to argue that the way the NHS is organised needs to change to put in place a set of arrangements more likely



to deliver the ambitions set out in the *Five year forward view*. If there is one clear message from the experience of the past five years, it is that politicians of all parties should be wary of ever again embarking on top-down restructuring of the NHS. The clarity of that message needs to be leavened, however, with a recognition that the structures that have been put in place under the coalition government should be modified as opportunities allow.

This is starting to happen as CCGs are given more responsibilities to reduce the fragmentation of commissioning and the provider landscape evolves through mergers, the development of integrated care organisations and systems, and the options outlined in the Dalton review. These developments are not the same as top-down restructuring because they are usually the consequence of local decisions and occur at different times in different places. The *Five year forward view*, as well as the Dalton review, emphasised the need to work towards local solutions in the context of a national framework, and this is where attention now needs to focus.

As this happens, it is important to remember the old adage that form should follow function. The priority for the NHS and its partners must be to turn away from debate about organisational options and focus instead on how services need to change, using the care models in the *Five year forward view* as a starting point. This includes giving priority to public health and prevention as well as treatment services, and working towards greater integration of care. Research by The King's Fund shows that the benefits of integrated care arise from clinical and service integration rather than organisational integration ([Curry and Ham 2010](#)), pointing to the role of alliances and networks of providers in overcoming fragmentation of care.

The coalition government's acceptance of the case for integrated care provides a platform on which to build in the next parliament, despite the huge financial pressures facing local government as well as the NHS. Reforms enshrined in the Care Act 2014 are an important step towards greater fairness in the funding of long-term care. The case for a new health and social care settlement as outlined by the Barker Commission provides a compelling argument for even more fundamental changes, specifically a single health and social care funding system with entitlements to social care aligned much more closely over time with entitlements to health care ([Commission on the Future of Health and Social Care in England 2014](#)). These changes will take several years to implement and will require extra public funding as economic growth and deficit reduction permit.



National bodies should support work on service change and improvement by attending to the physiology of the NHS rather than its anatomy. This means ensuring that incentives, regulation, commissioning and other levers are aligned behind the direction set out in the *NHS five year forward view* (Ham and Murray, forthcoming). Unless national leaders put in place the means to implement new care models, then the five year forward view will gather dust on the shelves. Among other things, much more should be done to enable NHS organisations to reform from within by developing leadership and skills in quality improvement, and supporting innovations in care through academic health science networks and other means.

The King's Fund put forward many of these arguments in its response to *Liberating the NHS* and they remain as valid today as they were then (Dixon and Ham 2010). The Fund's recent work has shown that there are clear limits to attempts to improve the performance of the NHS through external stimuli like targets and performance management, inspection and regulation and competition and choice (Ham 2014). The next stage of NHS reform needs to act on these insights by drawing on the commitment of the 1.4 million people working in the NHS to perform to the best of their abilities instead of seeking to secure compliance with targets and standards set by others. This is best done by strengthening leadership at all levels and supporting the NHS to develop capabilities for quality and service improvement following the example of high-performing health care organisations around the world.

As the 2015 general election draws nearer, politicians of all parties would do well to reflect on the troubled experience of the coalition government's NHS reforms to avoid history repeating itself. In its response to *Liberating the NHS*, The King's Fund cited Don Berwick's observation of the NHS in warning against the government's reforms, and we do so again to conclude this overview:

*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, as cited in Dixon and Ham 2010)



## 3 Commissioning

- The coalition government's reforms intended to increase clinical engagement in commissioning. Clinical commissioning groups (CCGs) were established as membership organisations led by GPs, though the extent to which member practices are engaged in their work is variable, and sustainability of clinical leadership remains an issue.
- The reforms resulted in fragmentation of commissioning and a loss of population-based commissioning. Attempts are being made to address this through greater use of co-commissioning between CCGs and NHS England in particular.

### What was the situation in 2010?

In 2010, 152 primary care trusts (PCTs) were responsible for commissioning primary, community, mental health, acute and some specialised services. In addition, 10 strategic health authorities (SHAs) provided oversight for the PCTs and were responsible for commissioning particularly specialised services. A number of initiatives had been introduced to improve the quality of commissioning and clinicians' engagement: a 'world class commissioning' programme; practice-based commissioning, which gave GPs virtual budgets to buy health services for their patients; and, in addition, PCTs were required to divest themselves of their remaining community services to ensure a focus on commissioning, with a new procurement framework to give them access to external commissioning support. But despite these initiatives, commissioning continued to be regarded as weak, with the House of Commons Health Committee reporting 'weaknesses due in large part to PCTs' lack of skills, notably poor analysis of data, lack of clinical knowledge and the poor quality of much PCT management. The situation had been made worse by the constant re-organisations and high turnover of staff' ([House of Commons Health Committee 2010](#)).



### What were the key changes proposed by the coalition government?

The main focus of the reforms was to increase clinical leadership in commissioning: the coalition agreement set out the government's intention to 'strengthen the power of GPs as patients' expert guides through the health system by enabling them to commission care on their behalf' (**HM Government 2010**). It proposed that consortia of GPs would commission the majority of services for patients, with PCTs only commissioning residual services and responsible for improving local public health. However, by the time the White Paper *Liberating the NHS* was published, the decision to transfer public health responsibilities to local government meant that PCTs had few remaining functions and so were abolished. The SHA tier was also to be removed, with an NHS Commissioning Board established to provide leadership on commissioning (**Department of Health 2010a**).

The Health and Social Care Act required all GPs to become part of a clinical commissioning group (CCG) and a total of 211 CCGs were established, most taking on commissioning responsibilities in shadow form in the 12 months prior to April 2013. The Act also established the NHS Commissioning Board (now NHS England), which was responsible for commissioning primary care services (to avoid a potential conflict of interest with GP-led CCGs) and some specialised services. The Act also created a new set of responsibilities for the delivery of public health services, with responsibility for commissioning transferred to local authorities and Public Health England, although NHS England retained responsibility for the delivery of many core public health functions such as vaccination. Health and wellbeing boards were established to develop local health and wellbeing strategies; they have the ability to refer CCGs to NHS England if their commissioning plans are not aligned with the local strategy.

Commissioning support units were created to provide specialist commissioning support (for example on contract management, human resources, financial management or procurement), with a view to them becoming autonomous organisations that would 'be fully established, self-sustaining entities in a competitive market' by 2016 (NHS England website). Many of the staff in these units came from former PCTs and SHAs. Clinical senates and strategic clinical networks were also established as part of the new NHS commissioning infrastructure. The 12 clinical senates were intended to provide clinical support and advice on issues that affect a wide geographical region, particularly on complex commissioning decisions that relate to 'whole systems of care'. There are also strategic clinical



networks in each of the 12 NHS England local areas for: cancer; cardiovascular disease (incorporating cardiac, stroke, diabetes and renal disease); maternity and children; and mental health, dementia and neurological conditions.

## What was the impact of the changes in practice?

### Clinical commissioning groups

CCGs were established as a membership model; they are led by GPs and represent all GPs in the catchment area. Mandated membership was intended to ensure that GP involvement was stronger and more consistent than in previous models. Research from the Fund and the Nuffield Trust found that the majority of GPs were at least ‘somewhat’ engaged with the work of their CCG, which was higher than the level of clinical engagement reported in previous forms of commissioning (Holder *et al* 2015). Although the majority felt that CCGs were yet to have a positive impact on the patient experience and quality of care, most GPs viewed them as more effective than PCTs. Despite one merger of three CCGs in the north east, NHS England has indicated that no more mergers will be permitted in the foreseeable future. Economies of scale in running costs and ability to redistribute resources among members has led to a growing number of shared governance structures and in 2014 the government legislated to make it easier for CCGs to work together through joint committees (HM Government 2014). Maintaining a balance between managerial and clinical input is a key challenge for CCGs; managing demands from NHS England, together with the complexity of local collaboration required for commissioning and increasing demand from patients, also presents challenges for making sure all member practices are engaged.

When CCGs were established, less than a quarter of accountable officers (who are responsible for ensuring that CCGs fulfil their duties) were GPs, and around half of CCG board members were GPs (Iacobucci 2012). More recently, concerns have been expressed about leadership in CCGs, with leaders themselves reporting inadequate support and training to do the job. There is also a significant issue about sustainability and succession once the current leaders step down (Holder *et al* 2015).

New federations and networks being developed by GP providers need strong clinical leadership, yet CCGs fear losing clinical leaders to local provider organisations as conflict of interest concerns require GP leaders to choose between retaining a commissioning role or focusing on innovations in provision (Addicott 2014). The



future for some commissioning support units remains uncertain, as some CCGs have begun to bring at least some of their support services in-house. Mergers have reduced the number of support units from 23 to 16, while a 10 per cent cut in CCG running cost budgets in 2015/16 may also affect the nature of the external support they commission.

The 2012 Health and Social Care Act intended to give CCGs more freedom, but their budgets have still been top-sliced and the 2014 Care Act gave back to the Secretary of State powers of direction over finance that had been removed by the 2012 Act. However, some CCGs have begun experimenting with alternative approaches to commissioning and contracting, particularly as a way of driving more integrated care. Models such as prime contracts and alliance contracts are being tested in a number of areas ([Addicott 2014](#)).

### Fragmentation

The changes in responsibility for commissioning – dispersing budgets formerly held by PCTs between CCGs, NHS England and local authorities – mean that there are no longer single population-based budgets for health care. There also are concerns that the changes to commissioning structures have resulted in fragmentation of the commissioning process, particularly for conditions where there are significant issues around co-ordination of care across primary, secondary and tertiary services. Macmillan Cancer Support's publication *Lost in translation* describes problems that have arisen where complex chemotherapy and radiotherapy are commissioned separately from other services (Macmillan Cancer Support 2014). For sexual health services, there are concerns that separating out HIV care from broader genitourinary medicine will leave patients worse off (local authorities are responsible for commissioning certain public health services, including testing and treatment for sexually transmitted infections and HIV testing, whereas CCGs and NHS England both have responsibilities for commissioning other sexual health and HIV services) (Limb 2013).

Despite the introduction of clinical senates, strategic oversight of the commissioning process remains difficult. The House of Commons Health Committee has reported concerns that the transformational changes needed could not be easily implemented because of a lack of coherent strategic oversight ([House of Commons Health Committee 2014d](#)). Recent government statements have attempted to address the issue of





fragmentation. In a statement to the House of Commons, the Secretary of State said that with increased co-commissioning of services, ‘the NHS will... take the first steps towards true population health commissioning with care provided by accountable care organisations’ (Hunt 2014c).

### Commissioning of primary care

Research by The King’s Fund has suggested widespread concern about the capacity of NHS England’s 27 local area teams (to be merged into 15 teams in 2014/15 to reduce running costs by 15 per cent). These teams are responsible for commissioning primary care, among other services. Lack of capacity may mean that primary care commissioners struggle to develop close relationships with individual practices and are forced to rely on data only, with CCGs providing intelligence about performance (Naylor *et al* 2013). In May 2014, NHS England announced plans to allow CCGs to ‘co-commission’ some primary care services with NHS England area teams (NHS England 2014b). The 2012 Act gave CCGs a legal responsibility to support NHS England in improving quality in primary care, and the co-commissioning policy extends this role by giving CCGs the option to take on more formal responsibilities for commissioning primary care. This makes good use of the expertise regarding primary care within CCGs, but does mean that the issue of conflicts of interest will become more pertinent. In December 2014 NHS England issued statutory guidance on managing conflicts of interest for CCGs (NHS England 2014c). Research from The King’s Fund found that CCGs are starting to use their lay members to ensure probity in decision-making processes, bringing in external bodies such as the commissioning support unit to run procurement exercises (Holder *et al* 2015).

### Commissioning of public health

The transfer of some public health teams from the NHS to local authorities has been a significant shift, particularly in terms of developing new cultures and relationships. Analysis of the first year of implementation found that the transfer had allowed public health teams to better engage with local communities and engage on wider determinants of health, although adapting to a local authority culture, with its emphasis on political accountability, had been challenging (Local Government Association 2014; Mansfield 2014; Royal Society for Public Health 2014). NHS England commissions many of the public health services delivered by the NHS



(such as immunisation and screening programmes) on behalf of Public Health England. Until October 2015, it will also commission public health for children up to age five to support investment in this area, particularly the commitments to increase the number of health visitors. In December 2014 the Secretary of State announced that CCGs would also have the option to commission public health services in future ([Hunt 2014b](#)).

### Commissioning of specialised services

There have been problems in the commissioning of some specialised services, for example complex child and adolescent mental health services. The House of Commons Health Committee recently published the results of its inquiry into child and adolescent mental health services in England, finding that ‘NHS England has yet to “take control” of the inpatient commissioning process, with poor planning, lack of co-ordination, and inadequate communication with local providers and commissioners’ ([House of Commons Health Committee 2014a](#)). NHS England also predicts a significant overspend in specialised commissioning in 2014/15, repeating a similar overspend in 2013/14. There have been reports of capacity issues among area teams, which are affecting specialised commissioning (Macmillan Cancer Support 2014); there is also a review under way with plans to engage CCGs in co-commissioning to address overspending and fragmentation (Calkin 2014a), as well as a new tariff to shift more risk to providers. When the new commissioning structures were created, a very broad definition of specialised services was used, with NHS England currently spending £14 billion commissioning a portfolio of around 145 specialised services. However, it estimates that only around 60 services are truly specialised ([NHS England 2014e](#)), and changes are being made to transfer commissioning responsibilities to CCGs or allow co-commissioning between NHS England and CCGs.



## 4 Provision of care by NHS providers

- The coalition government's ambition was that all NHS trusts would become foundation trusts and that the NHS would, in time, become the largest social enterprise sector in the world.
- Use of the Trust Special Administrator regime has been controversial and its powers have been extended to recommend changes across the whole of a local health economy.
- Financial pressures have placed several foundation trusts and NHS trusts into difficulty and many are still dependent on the Department of Health for financial support.
- Some struggling trusts have been buddied with successful ones and new models of provision are being explored, but there is an important gap, in that there is no system-wide leader able to step in when large-scale change is needed.

### What was the situation in 2010?

In 2002, the Labour government had introduced a new governance model under which selected NHS trusts would become foundation trusts, free from direct control by the Secretary of State and with local accountability to members and elected governors. Foundation trusts were created as part of a move towards greater plurality of provision to enable competition and formalise patient choice. NHS acute trusts were originally expected to attain foundation trust status by 2008, but this target was subsequently relaxed, acknowledging that other forms of organisation might be appropriate in some cases. Primary care trusts (PCTs), which had been responsible for providing community services, were in the process of divesting their provider arms from their commissioning functions ([Department of Health 2007a](#)).



## What were the key changes proposed by the coalition government?

The White Paper *Equity and excellence: liberating the NHS* stated the coalition government's ambition to create the largest social enterprise sector in the world by 'increasing the freedoms of foundation trusts and giving NHS staff the opportunity to have a greater say in the future of their organisations, including as employee-led social enterprises' ([Department of Health 2010a](#), p 5). This was in line with the government's wider 'Big Society' approach under which all public services would be opened up to mutualisation. While GP consortia (later clinical commissioning groups) would be GP-led, foundation trusts could be run as employee-led social enterprises, freeing staff 'to use their front-line experience to structure services around what works best for patients' ([Department of Health 2010a](#), p 36). The government committed to separating provision of community services from commissioning by April 2011, moving towards an 'any willing provider' model that would make it easier for new suppliers to enter the market ([Department of Health 2010a](#)). There would be no 'centrally dictated' closures of accident and emergency (A&E) or maternity services ([HM Government 2010](#), p 24). Commissioning by GP consortia would ensure that any redesign of local services would be clinically led ([Department of Health 2010a](#), p 27).

The White Paper suggested that the NHS trust legislative model would eventually be repealed and all providers would become foundation trusts by 2014, although the government soon revised this, saying instead that each trust would achieve foundation trust status when 'clinically feasible' ([Department of Health 2011a](#), p 59). NHS trusts that were deemed unviable would merge with another trust or be wound up by the Trust Special Administrator ([Department of Health 2010a](#), p 36).

The government's aim was, and still is, that eventually there would be no difference in the way foundation trusts, voluntary sector providers or private providers are regulated. Until that point, Monitor would retain oversight of foundation trusts and the NHS Trust Development Authority would oversee NHS trusts. The 2014 Care Act created a single failure regime for all NHS trusts and amended the powers of Trust Special Administrators, giving them authority to look at the whole local health economy in their area and not just at failing providers.

Foundation trusts were to be granted greater freedoms; the cap on the amount of income they were able to earn from 'other sources' (including private patients) would be



lifted, and they would be able to merge more easily ([Department of Health 2010a](#), p 36). The government amended the Bill on its passage through parliament. It set the cap on private income at 49 per cent of a trust's income and gave more powers to foundation trust governors, including that any proposed increase in a trust's private patient income of more than 5 per cent must be approved by the governors, and that governors can call any foundation trust director to a meeting in order to request information about the performance of the trust or its directors ([Monitor 2013](#); [Timmins 2012](#)).

### What was the impact of the changes in practice?

There are now 149 foundation trusts – an increase of 20 since 2010, only two of which are community trusts. Community trusts have found it particularly difficult to meet Monitor's financial criteria as they tend to have fewer financial assets than hospital trusts and can be vulnerable to changes to large contracts (Lintern 2013).

The NHS Trust Development Authority had been created as a time-limited organisation to manage NHS trusts that had not attained foundation trust status. But with the government removing its original 2014 deadline, the Authority is still operating, managing the 93 remaining non-foundation trusts in a direct line-management arrangement which mirrors that previously carried out by strategic health authorities (SHAs) on behalf of the Department of Health. The Trust Development Authority monitors trusts' performance against access targets, outcomes metrics, and financial and managerial 'risk ratings'. It stated earlier this year that 12 non-foundation trusts were unsustainable in their current form ([NHS Trust Development Authority 2014c](#)).

There are a number of options for these trusts, including merger with other local trusts or management franchise ([NHS Trust Development Authority 2014c](#)). In 2012, the management of Hinchingsbrooke Health Care NHS Trust was franchised to a private sector operator, Circle, after a competitive procurement process, but in January 2015 Circle announced its intention to hand back management of the trust to the NHS. This followed financial pressures that resulted in Circle making support payments of nearly £5 million, and a critical CQC inspection report which put the trust into special measures. The running of George Eliot Hospital NHS Trust was initially put out to tender after it was deemed financially unsustainable and put into special measures. Private providers Circle and Care UK were among those bidding to run it, as were two neighbouring NHS trusts. However, the NHS Trust Development



Authority ultimately judged that the trust's clinical performance had improved and so halted takeover proceedings (Hazell 2014a).

With growing numbers of NHS providers in deficit or subject to concerns about quality, in February 2014 the Department of Health asked Sir David Dalton to explore ways in which high-performing organisations might help providers in difficulty. The Dalton review set out a number of new organisational forms, including integrated care organisations and hospital chains, and suggested that high-performing organisations taking over challenged trusts should have a period of 'grace' in which their metrics were not affected by those of the lower-performing organisations they had absorbed (Department of Health 2014d). The 11 trusts placed in special measures after the Keogh review have already been buddied with high-performing hospitals that will be rewarded if they improve their partner's performance.

### The failure regime

Foundation trusts are just as likely as NHS trusts to experience performance challenges; 6 of the 11 trusts originally put into special measures were foundation trusts. The Trust Special Administrator role has only been used twice since its inception – at South London Healthcare NHS Trust in 2012 and at Mid Staffordshire NHS Foundation Trust in 2013. It has proved expensive to operate and subject to legal challenges in both instances. The Care Act 2014 amended its powers so that it is able to recommend changes across the whole of a local health economy, and not just for an individual trust. The Act also extended the period of time under which changes must be made, removing obligations that the public must be consulted and that commissioners must support the proposed service changes. These changes create a risk that service reconfiguration could be forced on unwilling providers in areas adjacent to a failing trust without prior public consultation or commissioner support. Neither the foundation trust model nor the Trust Special Administrator regime was designed to deal with the widespread financial difficulties being experienced by NHS providers. This has meant that many have effectively become dependent on the Department of Health for financial support.

The Care Act 2014 created a single failure regime for all trusts, with three main stages: identification, intervention and special administration. The reforms give responsibility for each element to a different body, with the Care Quality Commission (CQC) focusing on identifying quality failings, while the Trust Development Authority and Monitor



are responsible for identifying financial failure and subsequently taking any action required in the case of a failing provider (whether on grounds of clinical or financial performance). The CQC was given new powers to issue warning notices to NHS trusts and foundation trusts. Monitor's powers were also extended to enable it to impose additional conditions on foundation trusts. If it does not succeed in improving either the financial performance of a trust or, since the 2014 Care Act, its clinical performance, then Monitor (for foundation trusts) or the Secretary of State (for NHS trusts) can appoint the Special Administrator to take over the trust's day-to-day running. It would replace the chair and directors of a trust (or the governors of a foundation trust), carrying out the dual role of running the organisation and developing a plan for its future.

### The local health economy

Some pressures on trusts come from other players within the local health economy. For example, a provider struggling to meet demand may be in an area where primary care is weak and referrals are high. Monitor found that in areas where a trust had been issued with a compliance notice, there was often evidence of differences between commissioners and providers ([Murray et al 2014](#)). In tackling performance of individual trusts, it is important that a local health economy is clearly defined, but the abolition of SHAs has left no clear system leader able to step in when large-scale change is required. There is also no evidence base to draw on for those undertaking major clinical reorganisation, either on the best way to provide high-quality services within available budgets or on the positive impact of reconfiguration on finances and clinical services ([Imison et al 2014](#)).

This gap in system leadership has been recognised by the national regulators. There are currently two new models under which it is possible to work across organisations in a local health economy. First, Monitor can now appoint a contingency planning team when the financial situation in a foundation trust is such that it poses a high risk to the provision of essential services. This team works with providers and commissioners alike to look for alternative pathways whereby services can be provided. This model has been used in Mid Staffordshire NHS Foundation Trust, Peterborough and Stamford Hospitals NHS Foundation Trust, and the Queen Elizabeth Hospital, King's Lynn. Second, in February 2014, NHS England, the NHS Trust Development Authority and Monitor started to work together in 11 'financially challenged' local health economies to support providers and commissioners to produce five-year plans ([NHS England 2014g](#)).



The 2012 reorganisation of the NHS perceived providers as independent operators in a market environment. The unforgiving financial environment since 2009 has highlighted the interdependency of different players in the local health economy while also making many financially dependent on the Department of Health.

### Primary care

Primary care providers are also facing financial pressures, and subject to increasing demand from populations with rising levels of chronic disease and higher expectations. New provider models are beginning to emerge in an attempt to meet some of these challenges. Networks or federations of GPs are able to share some of the back-office functions and expertise needed in clinical commissioning; ‘super-partnerships’ operate over several sites where the partners have formally merged while multi-practice organisations operate over several sites but have fewer GP partners than other models and tend to rely on salaried GPs to deliver care (Smith *et al* 2013). This reflects an ongoing trend of larger GP practices: one in seven patients in England is now registered with a practice that has 10 or more doctors (Centre for Workforce Intelligence 2013).

### Staff engagement and mutualism

The government’s ambition was to create the ‘largest and most vibrant social enterprise sector in the world’ (Department of Health 2010a, p 36) in line with the greater role for citizens envisaged as part of the Big Society. Under the right to provide, which was announced in 2011, staff have the right to bid to take over services they deliver. However, foundation trusts, as independent organisations, are under no obligation to grant such rights to their staff (Department of Health 2011b). There are no examples of exclusively employee-led foundation trusts as envisaged in the 2010 White Paper.

Some of the provider arms of PCTs, which were divested under the previous government’s Transforming Community Services programme (Department of Health 2009), have been constituted as mutual models, but the pace of mutualisation has not continued since these initial developments. In 2014, following a review of NHS staff engagement led by Chris Ham, chief executive of The King’s Fund, the government announced a new pathfinder programme under which pioneering foundation trusts and NHS trusts will be supported to explore the benefits of mutualising their services.





## 5 Regulation of the quality of care

- The policy and legislative framework for quality regulation has been significantly altered by the coalition government in response to the findings of the Francis Inquiry.
- New fundamental standards of care include a statutory duty of candour and a ‘fit and proper persons’ test for board members of NHS providers.
- Specialist inspections have been introduced under the auspices of ‘chief inspectors’ (for hospitals, general practice and adult social care).
- There is a new form of ‘intelligent monitoring’ of providers to assess ongoing risks to the quality of care.

### What was the situation in 2010?

From 1997 to 2010, Labour governments set up new systems of inspection and regulation within the NHS via a succession of regulators: from the Commission for Health Improvement (1999–2004) to the Healthcare Commission (2004–9) and finally the Care Quality Commission (CQC) (2009). Each of these bodies used different methods, including routine visits by inspection teams, visits triggered by concerns or analysis of performance data, and self-assessment by NHS organisations using standards developed by the regulator. Systems of published ratings were in place in the period 2001–9 in health care and 2008–10 for social care, but these were subsequently abolished (Nuffield Trust 2013). The CQC was also given responsibility for the regulation of social care and became the first regulatory body responsible for the direct regulation of general practices, although GP inspections did not start until 2014 (Grant and Dirmikis 2014; West 2013; Santry 2008). By 2010, most providers of health and social care in England were legally obliged to register with the CQC. Changes to the regulation of health care professionals were also initiated



as a response to the Shipman inquiry that have changed the national approach to professional regulation. The White Paper *Trust, assurance and safety* (Department of Health 2007b) removed the direct influence of the professions over regulation and required a model of revalidation to be implemented for doctors.

### What were the key changes proposed by the coalition government?

Although quality regulation did not feature initially as a policy priority, the coalition government significantly altered the policy and legislative framework for quality regulation. This was partly in response to the findings of the Francis Inquiry into failures of care at Mid Staffordshire NHS Foundation Trust (*The Mid Staffordshire NHS Foundation Trust Public Inquiry 2013*) although some changes to the regulatory regime had already been initiated after a series of reviews. For example, a 2011 National Audit Office's report on CQC's performance and a report from the House of Commons Health Committee in the same year concluded the regulator's priorities had become 'distorted' by the pressure of its new responsibilities, leading to a 70 per cent reduction in inspections between 2009 and 2011 (Calkin 2011). The 2011–12 Capability Review of the Department of Health expressed concerns about how the regulators would work together (West 2012).

The Francis Inquiry called for a change of direction from an emphasis on planned, routine reviews, to more focused reviews that are triggered by and responsive to concerns based on risk and non-compliance with standards. The Secretary of State for Health, Jeremy Hunt, proposed an independent ratings system for health and social care (Hunt 2012), and commissioned the Nuffield Trust to undertake an independent review of whether 'Ofsted-style' ratings were appropriate for health and social care providers. The report concluded that such ratings could be used to inform the public about quality of care, as well as to improve accountability on the part of providers (Nuffield Trust 2013). As part of its response to the Francis Inquiry report, the government announced 'radical new measures... including Ofsted-style ratings for hospitals and care homes' (Department of Health 2013c).

In response to the Francis Inquiry report, the government initiated two reviews of patient safety. The 2013 Berwick report, *A promise to learn – a commitment to act*, set out a 'zero harm' target for the NHS and reignited the discussion about adequate or safe staffing levels (National Advisory Group on the Safety of Patients in England 2013). The Department of Health also instituted a review led by Sir Bruce Keogh into



14 hospitals across England that displayed a pattern of poor performance, based on their mortality rates (Keogh 2013).

The government's full response to the 290 recommendations made by the Francis Inquiry was published in 2013, and in 2014, the Care Act introduced new fundamental standards of care, including a statutory duty of candour that requires providers to be open and transparent when things have gone wrong. The new regulations include a 'fit and proper persons' test, giving the CQC the power to check that board members of all NHS providers are equipped to fulfil their responsibilities. This shifts accountability onto individuals as well as organisations (Care Quality Commission 2014a). The CQC has also gained new enforcement powers, enabling it to move directly to prosecution without serving a warning notice if it finds providers committing serious breaches of fundamental standards. The government's response also committed to extending revalidation to nurses and midwives.

The new regulatory model requires the CQC to investigate whether the care that is being provided is safe, effective, caring, responsive to people's needs, and well led. Other changes include:

- a new form of 'intelligent monitoring' of providers (Care Quality Commission 2014c) to assess ongoing risks to the quality of care, thereby anticipating services at risk of failing before they do so. The first Intelligent Monitoring report was published in October 2013 based on 150 indicators (Care Quality Commission 2014c)
- greater use of qualitative data drawing on the experience and expertise of clinicians, patients and carers
- specialist inspections under the auspices of 'chief inspectors' (for hospitals, general practice and adult social care), with visits by large teams of experts
- a new form of 'Ofsted-style' performance ratings for individual services and the trust as a whole, from 'outstanding' to 'inadequate' (Department of Health 2013b)
- a new inspection and regulatory model for general practice as a whole.



Following on from the Keogh review (2013) recommendations, a ‘special measures’ regime was also introduced to help trusts improve their services, affecting 11 trusts by July 2014. The measures involve close scrutiny from Monitor (for foundation trusts) or the NHS Trust Development Authority (for NHS trusts), the appointment of an improvement director, and linking with a partner (or ‘buddy’) trust that is performing well in those areas where improvement is needed. In some cases it has also involved changes at board level (Care Quality Commission 2014e). In July 2014, the Secretary of State announced plans to extend the special measures regime to GP practices and providers of adult social care (Campbell 2014).

### What was the impact of the changes in practice?

#### Regulating hospitals

By August 2014, the CQC had inspected 62 acute NHS trusts out of 245 trusts using the new approach. A large-scale evaluation of the new hospital inspection framework was undertaken by Manchester Business School in partnership with The King’s Fund, concluding that it is ‘perhaps the most intensive and in-depth inspection process being used in healthcare regulation internationally’ (Walshe *et al* 2014, p 44). They estimated that each inspection involved between 90 and 320 person-days of fieldwork, as well as substantial time spent preparing for the visit (by inspection staff and hospital staff alike) and reporting on findings (Walshe *et al* 2014).

The evaluation also concluded that inspection reports have been useful in providing the impetus for improvement – mostly by highlighting known issues that need action but also in identifying some new areas for improvement. However, there is a lack of clarity about who is responsible for enforcement of recommended actions after the publication of a ratings report. Furthermore, the system for rating hospitals is largely based on the professional judgement of CQC inspection team members through group consensus-forming processes. While there is some written guidance for inspection teams to follow, it is somewhat limited in scope.

Delivering this new model of regulation has had a huge impact on the CQC’s running costs and staff levels. Between 2011 and 2014, its overall expenditure has increased by almost 50 per cent from £139.1 million to £223 million (Care Quality Commission 2014b, 2011). The new model is highly reliant on large expert inspection



teams, and there may be challenges in maintaining a pool of suitable and willing external inspectors in the longer term. More recently, it has become apparent that the intensity of the CQC's inspection programme for 2014–16 is untenable due to the 'imbalance between the work to be undertaken during 2014/15 and the people available to undertake the work' (Behan *et al* 2014).

### Special measures

Trusts placed in special measures were re-inspected by the CQC one year on, in 2014, with the Chief Inspector of Hospitals concluding that significant progress had been made at 10 of the 11 trusts. Of the original group, only two were recommended to be taken out of special measures completely. In its report, *Special measures: one year on*, the CQC concluded that 'no single factor accounts for the improvements that have been made or for the different pace of change at individual trusts' (Care Quality Commission 2014e, p 2). However, several of the trusts made changes that included:

- recruiting additional nursing and medical staff
- initiatives to improve the flow of patients from admission to discharge
- a greater focus on the quality of care and the governance of quality and safety at board level
- initiatives to engage staff in improving the quality of care.

The CQC inspection teams also observed several other important factors behind the improvements, as follows.

- Strength of leadership: in some trusts, the senior leadership team has not needed to change. However, in others, CQC and Monitor felt that earlier changes at senior level might have led to more rapid improvements.
- Acceptance of the scale of the problems faced: some trusts were already aware of their problems or were open to the findings revealed by the Keogh review, while others were in denial of problems.



- Engagement of staff and a common sense of purpose among senior managers and clinicians when it came to solving problems. In some trusts, a ‘them and us’ culture persists ([Care Quality Commission 2014e](#)).

Recent analyses by Calkin (2014b) and Murray *et al* (2014) found that trusts in special measures are predicting a collective deficit of almost £140 million in 2014/15, with many citing increased expenditure on nursing to improve quality of care as a key factor. This is consistent with the CQC’s review, which found that inadequate ratings on safety and care were often due to low staffing levels ([Care Quality Commission 2014e](#)).

### Adult social care

The CQC is responsible for regulating and inspecting social care, which includes residential care homes, nursing homes and home care services. The Care Act 2014 gave it new oversight responsibilities for the adult care market. This means that from April 2015, the CQC will have to assess the financial sustainability of providers. The intention is not to prevent provider failure but to ensure that local authorities are aware of any risks to the continuity of care.

Since the CQC assumed responsibility for registering all social care providers, it has introduced more rigorous checks for new providers applying to register social care services, covering questions about the premises, environment, and how service users’ needs will be met. It also intends to roll out a more thorough inspection model to the adult social care sector from October 2014, based on the same five domains of quality as the health sector (whether services are safe, effective, caring, responsive to need, and well led), to produce a rating (outstanding, good, requires improvement or inadequate).

### Primary medical services (and other services)

In 2013/14, for the first time, the CQC carried out 1,725 inspections of GP practices, using an intelligent monitoring approach based on a range of evidence about patient care and treatment from surveys and official statistics. It developed a banding system, with 1 being the highest-risk band and 6 being the lowest-risk band ([Care Quality Commission 2014d](#)). Almost one in five GP practices did not meet at least one



of the standards relating to safety. However, it is important to note that the CQC prioritised inspections for those practices where they already had concerns, and so the figure is not representative of GP practices as a whole ([Care Quality Commission 2014f](#)). Also, in early December 2014, the CQC was forced to apologise to hundreds of GPs for giving incorrect patient safety risk assessments. As a result, 60 practices were taken out of the highest-risk bands while four practices were moved into higher-risk bands ([Bloch 2014](#)).



## 6 Competition and choice

- The coalition government emphasised patient choice and competition as a driver of improvement.
- Controversial changes to legislation saw Monitor become the sector-specific economic regulator and confirmed the competition authorities' jurisdiction over mergers and service reconfigurations involving foundation trusts.
- There has been some growth in use of non-NHS providers, particularly in community and mental health services.
- Clinical commissioning groups (CCGs) in particular remain uncertain about procurement rules.

### What was the situation in 2010?

The outgoing Labour government had built on the policies of previous Conservative governments to introduce greater emphasis on patient choice and competition within the NHS, including patient choice for elective care, personal health budgets, and attempts to create a mixed economy of providers. The NHS Constitution enshrined rights around patient choice, and a national tariff was established for many services to enable competition between providers, whether NHS, private or not-for-profit. The Department of Health developed the *Principles and rules for cooperation and competition*, which set out how the developing market should work. It established an advisory board – the Cooperation and Competition Panel – to advise on the application of the principles and rules and to address complaints about anti-competitive practices ([Department of Health 2010b](#)).

### What were the key changes proposed by the coalition government?

The coalition government intended to accelerate patient choice and competition, consistent with a wider belief in competition in public services as a driver of improvement: 'Instead of having to justify why it makes sense to introduce





competition... the state will have to justify why it makes sense to run a monopoly' (Cameron 2011b). The coalition agreement clarified the intention to promote patient choice in the NHS: 'We will give every patient the power to choose any healthcare provider that meets NHS standards, within NHS prices. This includes independent, voluntary and community sector providers' (HM Government 2010). The White Paper *Equity and excellence: liberating the NHS* expanded this approach, stating that: 'Our aim is to free up provision of healthcare, so that in most sectors of care, any willing provider can provide services, giving patients greater choice and ensuring effective competition stimulates innovation and improvements, and increases productivity within a social market' (Department of Health 2010a). The White Paper proposed that Monitor would become the economic regulator for health and social care, with three key functions similar to other utilities regulators: promoting competition, regulating prices and ensuring continuity of services.

The sections of the Health and Social Care Bill that addressed competition were among the most controversial, despite the fact that in the view of some lawyers, the elements that dealt with competition were essentially just codifying what was already applicable to the NHS (Timmins 2012). More than 80 clauses of the Bill were devoted to the new economic regulator and related changes, making it explicit that competition law applied to the NHS; the economic regulator was also charged with 'promoting competition, where appropriate' and given concurrent powers with the Office of Fair Trading (OFT) like other sector regulators. The National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013, which followed on from the Act (sometimes referred to as the 'section 75 regulations'), protect the rights of patients to choose who provides their health care in certain circumstances (HM Government 2013). They also prohibit commissioners from engaging in anti-competitive behaviour unless this is in the interests of health care service users (HM Government 2013). The regulations were widely interpreted as requiring commissioners to put services out to tender, causing significant controversy. The government was forced to withdraw the regulations and re-issue them in amended form.

Following various amendments during the Bill's passage through parliament, the Health and Social Care Act established Monitor as a sector-specific regulator but with powers to promote integrated care as well as to protect patient choice and prevent anti-competitive behaviour. It confirmed the competition authorities'



jurisdiction over mergers and service reconfigurations involving foundation trusts. The Act also enshrined the concept of a fair playing field to ensure that patients can choose services from providers that best meet their needs, including charity or independent sector providers, as long as they meet NHS prices.

### What was the impact of the changes in practice?

A recent report by the Nuffield Trust ([Lafond et al 2014](#)) found that spending on non-NHS providers of acute care had in fact slowed, with primary care trusts (PCTs) spending about £14 million less in 2012/13 in real terms compared with 2011/12. However, spending on non-NHS providers of community and mental health services has continued to rise at a faster rate than spending on NHS providers, partly due to the creation of a number of new independent social enterprises from what were previously PCT provider arms. Nearly one-third of NHS spending on community health services is with non-NHS providers. Spend on independent sector providers of community health services rose by £460 million from 2011/12 to 2012/13, a 4 per cent increase in share. Overall, the Department of Health's annual accounts suggest some £10 billion of the total NHS budget of £113 billion is spent on care from non-NHS providers ([Department of Health 2014c](#), p 220).

A study by the NHS Support Federation, which opposes a competitive market in the NHS, did report an increase in invitations to tender from CCGs, with diagnostics being the most common service tendered. The study found that of 80 contracts awarded, 54 (worth a total of £475 million) went to non-NHS providers, 25 (worth £88 million) went to the NHS, and one was shared ([Davies 2014](#)). Another recent study by the *British Medical Journal* found that one-third of the contracts to provide NHS clinical services awarded in the year from April 2013 were secured by private providers, but the value of these contracts was only five per cent of the total for those contracts for which financial information was obtained (Iacobucci 2014). Despite the original commitment to an 'any qualified provider' approach, interest in this policy among commissioners appears to have waned. The *Health Service Journal* reported findings from data gathered under the Freedom of Information Act, which showed that a minority of CCGs had opened new services up to any qualified provider in 2014/15, and most had no plans to extend the approach in their area. Those that had used any qualified provider did so mainly on marginal areas of spending (Williams 2014).



Despite Monitor's attempts to clarify procurement and tendering rules, CCGs remain uncertain about them, and this is affecting what they do. Research from The King's Fund has confirmed this uncertainty – for example, over whether procurement is obligatory and how the process of procurement works (Addicott 2014). A fifth of respondents to a poll by the *Health Service Journal* also said that their CCG had been formally challenged under new competition rules (West 2014a). However, it should be noted that to date, Monitor has launched just four formal investigations; two involved challenges from private providers, one of which was proved while the other was settled when NHS England entered into a contract with the challenger.

Some large-scale contracts, particularly 'prime provider' contracts, have also attracted attention. Cambridgeshire and Peterborough CCG, for example, is using this model for provision of integrated care services for older people, with a contract value of £800 million; the CCG has identified a preferred bid that is led by an NHS foundation trust. The procurement process for this contract was estimated to have cost the CCG more than £1 million (Illman 2014). Bedfordshire CCG awarded a five-year contract to non-NHS provider Circle as prime contractor, assuming the total risk for musculoskeletal services worth £120 million (6 per cent of the CCG's budget). This contract has generated controversy because a local NHS provider has refused to sign the contract, having seen referrals drop by 30 per cent since the model was introduced (which, as the income from referrals has been used to cross-subsidise its trauma service, is endangering the provision of that service) (Welikala 2014). In Staffordshire, CCGs are seeking bids for a 10-year contract worth £1.2 billion for cancer and end-of-life care, which – although not finalised at the time of writing – looks likely to have significant involvement of private sector providers.

The first and most controversial test of the application of competition law to mergers was when the OFT and Competition Commission (which have themselves merged to form the Competition and Markets Authority) rejected the proposed merger of the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust in 2013. The cost of the merger process to the trusts involved was estimated at £6 million (Calkin 2013). (For more detail see Spencehaye and Dixon (2014)). Monitor and the Competition and Markets Authority have now published additional guidance for trusts, which sets out the



type and level of evidence needed for merger applications, with an emphasis on support in the early stages of discussions to avoid a full review process if possible. The regulators have since approved a variety of other mergers and reconfigurations, including neurosurgery services in north London, a pathology joint venture between two foundation trusts and a private sector firm, and two acquisitions (of Heatherwood and Wexham Park Hospitals NHS Trust by Frimley Park Hospital NHS Foundation Trust, and of Barnet and Chase Farm Hospitals NHS Trust by the Royal Free London NHS Foundation Trust). However, until another merger between trusts with similar geographical restrictions on competition is considered, it will be hard to assess whether the additional guidance and support has had any impact.

Patient choice for a range of services is now enshrined in the NHS Constitution. Data collated by the *Health Service Journal* from the national inpatient survey found that the proportion of patients who said they were offered a choice of provider on referral has fallen slightly since 2010, from 32 per cent to 27 per cent (West 2014c). The spread of performance problems and widespread financial difficulties has reinforced a traditional performance management approach, which is moving away from the Act's vision of independent organisations competing fairly for patients or commissioner contracts. It has recently been reported that a number of large providers plan to restrict referrals outside their immediate geographical catchment area due to fears that increasing demand will damage the trust's ability to meet waiting-time targets (Barnes 2014b).

Despite these issues, the coalition government's ongoing commitment to patient choice is reflected in the extension of the personal health budgets policy. The 56,000 people who are eligible for NHS Continuing Healthcare now have a right to a personal health budget, and, in October 2014, the Chief Executive of NHS England announced a voluntary Integrated Personal Commissioning programme that will blend health and social care funding for a wider group of individuals (including those with multiple long-term conditions) and allow them to decide how it is used.



## 7 Governance and accountability

- The coalition government's reforms expressed an intention to free the NHS from political micromanagement and increase local accountability.
- There is now a statutory divide between the NHS (as commissioner/allocator of resources) and ministers and the Department of Health, governed by an annual mandate.
- It is not yet clear whether attempts to increase local accountability have been effective.
- The landscape around governance and accountability is complicated, and more work is needed to clarify responsibilities and lines of accountability in practice.

### What was the situation in 2010?

In 2010, the Secretary of State for Health was accountable to parliament for promoting a 'comprehensive health service designed to secure improvement – (a) in the physical and mental health of the people of England, and (b) in the prevention, diagnosis and treatment of illness' (NHS Act 2006). The Secretary of State had general powers of direction over all of the NHS apart from foundation trusts, which were directly accountable to parliament. The Department of Health was the national headquarters of the NHS operating through 10 strategic health authorities (SHAs), which managed the NHS (excluding foundation trusts) throughout England on its behalf. In 1989, the Conservative government had set up an NHS Management Executive (later known as the NHS Executive) to separate responsibility for the operation and management of the NHS from the Department of Health. It was abolished in 2001, although the post of NHS chief executive remained.



## What were the key changes proposed by the coalition government?

The coalition agreement made it clear that the government would ‘stop the top-down reorganisations of the NHS’ and, in line with its commitment to the ‘Big Society’, plan to ‘free NHS staff from political micromanagement, increase democratic participation in the NHS and make the NHS more accountable to the patients that it serves’ (HM Government 2010, p 24). The White Paper *Equity and excellence: liberating the NHS* set out the government’s plans in more detail (Department of Health 2010a). However, the reality was rather different, with arrangements for accountability and governance changing as debate on the reforms intensified. The government responded to criticism of its plans by amending the original proposals; the eventual structure agreed was both complex and, in some respects, quite different from what had been intended.

### Accountability for the NHS

The government had wanted to change the Secretary of State’s accountability for the NHS, consistent with its ambition to promote greater local autonomy for health services. It suggested replacing the Secretary of State’s duty to ‘provide, or secure the provision of, services’ (NHS Act 2006 section 1(2)) with a responsibility to ‘act with a view to securing the provision of services’ (House of Commons 2011). However, after pressure from Labour and Liberal Democrat peers during the Health and Social Care Bill’s passage through the House of Lords, the government amended it to make it clear that the Secretary of State’s duty to ensure a comprehensive service is superior to his duty to ‘promote autonomy’ (Timmins 2012).

### Accountability for commissioning

An independent NHS Commissioning Board (which later became NHS England) would lead on the achievement of health outcomes and quality improvement, allocate resources, and promote patient involvement and choice. It would be ‘a lean and expert organisation free from day-to-day political interference’ (Department of Health 2010a, p 30). Like the NHS Executive in the 1990s, it was intended to put space between ministers and the operational running of the NHS. SHAs would be abolished and the Secretary of State would no longer have powers of direction over local commissioners. Once a year, the Secretary of State and the Department of Health would issue a formal mandate to the NHS Commissioning Board outlining the government’s priorities for the health service. The mandate would be scrutinised



by parliament's House of Commons Health Committee ([Department of Health 2010a](#), p 33). 'Bureaucratic process targets' would be abolished and the NHS would instead be held to account according to evidence-based outcome measures ([Department of Health 2010a](#), p 1 and p 4). Local consortia of GP practices would commission services. This would shift decision-making closer to individual patients.

### Accountability for public health

The Public Health Service (later Public Health England) would take responsibility for the public health functions of the NHS. Locally, responsibility for public health would pass from primary care trusts (PCTs) to local authorities. The Public Health Service and local authorities would jointly appoint local directors of public health. The public health budget would be ring-fenced.

### Accountability for providers

The NHS trust model would be repealed and NHS care would be provided by foundation trusts, accountable directly to parliament and responsible for their own governance and finances. A unit in the Department of Health (later the NHS Trust Development Authority, an arm's-length body) would 'drive progress', focusing on supporting non-foundation trusts to become foundation trusts. Those trusts that were unsustainable would be put under the Trust Special Administrator regime. The role of the Care Quality Commission (CQC) would be strengthened – 'it would have a clearer focus on the essential levels of safety and quality of providers' ([Department of Health 2010a](#)).

Monitor, which had previously had a responsibility only for overseeing foundation trusts, would become a full economic regulator, receiving concurrent powers with what is now the Competition and Markets Authority. It has a role, with NHS England, in price setting for the NHS tariff.

The Bill originally gave Monitor a duty to promote competition 'where appropriate' while regulating 'where necessary'. Opposition to the 'promotion' of competition saw that amended to a duty to 'prevent anti-competitive behaviour' where that would be against the interests of patients, but equally a duty to enable integration where that would improve the quality of services. There is room for debate about how far the amendment changes the original purpose of the Bill.



## Accountability to patients and the public

A new statutory body called Healthwatch England, an operationally independent committee of the CQC, would have responsibility for strengthening the voice of patients. Local branches of Healthwatch would replace Local Involvement Networks (LINKs) and be funded by local authorities. Statutory health and wellbeing boards within local authorities would ‘strengthen the local democratic legitimacy of the NHS’ ([Department of Health 2010a](#)) with responsibility for joining up the commissioning of local NHS services and social care.

## Accountability for staff

The government also proposed the establishment of Health Education England as a ‘special health authority’ to provide national leadership of the training of the clinical workforce and to ensure that there is an adequate supply of staff ([Department of Health 2012](#)). It assumed full statutory responsibilities in April 2013.

## What was the impact of the changes in practice?

For the first time in the history of the NHS, there is now a statutory divide between the NHS as a commissioner/allocator of resources (NHS England) and ministers and the Department of Health. The Department is now a far smaller organisation than it was and the number of permanent staff employed fell by 31 per cent between 2011 and 2014 ([Department of Health 2014c](#), p 189), while NHS England has exceeded the vision for a ‘lean’ body with a staff of 15,291 ([NHS England 2014d](#)). The Health and Social Care Act (2012) intended to bring about a situation whereby the Secretary of State was not involved in the day-to-day running of the NHS, with the annual mandate (from the Department of Health to NHS England) being the limit of their direction of the service.

The mandate itself is structured around an outcomes framework which embodies the Conservative pre-election pledge that process targets – which measure, for example, how long a patient waited rather than the success of their treatment – would be replaced by measurement of health outcomes. This was intended to improve survival rates from cancer, stroke and lung disease ([Cameron 2008](#)).

Setting the mandate has not been straightforward. The first draft was significantly amended after criticism that its objectives were either too wide-ranging or not





measurable ([The King's Fund 2012](#)). On publication of the first mandate, the chair of NHS England revealed that there had been a 'struggle' between NHS England and the Department of Health over its contents, with NHS England concerned that it should not be 'a shopping list' (Barnes 2013). The Secretary of State put the first annual assessment of NHS England's performance before parliament in the summer of 2014. It was a 12-page report in which he commented that 'there was a mixed picture of performance from NHS England in 2013–14' ([Department of Health 2014b](#)).

In spite of the coalition government's initial objections to process targets, they have remained an important part of accountability within the NHS, partly because of the difficulties in holding service providers to account against the high-level outcomes framework. In fact, in 2013, the government introduced a new target under which trusts are fined for every patient who waits more than a year from referral to treatment ([NHS England 2013](#), p 61). The legally binding pledges in the NHS Constitution and the targets (or standards) in the mandate are now collated and published by NHS England rather than the Department of Health. The contradiction in how the Secretary of State could be ultimately accountable to parliament for the performance of the health service while only setting outcome measures became apparent in 2013 when it was reported that the recently appointed Jeremy Hunt had been contacting chief executives of trusts that were failing to meet accident and emergency targets (Clover and Barnes 2013). Jeremy Hunt directly intervened again in August 2014, announcing that there would be a 'managed breach' of the target that patients must be treated within 18 weeks from referral by a GP to a specialist ([Department of Health 2014e](#)).

Local accountability was an important part of the government's original vision for the health service. Initially, the intention was to make PCTs more accountable to local communities. When clinical commissioning groups (CCGs) were created, they were mandated to have a lay member on the board with accountability for patient and public engagement. CCGs have a statutory duty to involve patients and the public in their decision-making; recent research with stakeholders found high levels of CCG engagement with local Healthwatch and patient engagement groups, which represents an improvement on the situation before CCGs were established ([Ipsos MORI 2014](#)). Local Healthwatch groups and health and wellbeing boards were also intended to strengthen local accountability, but it is not clear whether they have enough powers or are sufficiently well established to perform this role effectively.



CCGs are accountable to NHS England and undergo an annual assessment based on an assurance framework that is still being developed. Because of this, NHS England acknowledges that the assurance framework will change over time ([NHS England 2014a](#)). Some have predicted that there is a potential for the old command and control relationship between the Department and Health and PCTs to be replicated in interactions between NHS England and CCGs, as ways of working are brought with staff from one institution to another ([Maybin et al 2011](#)).

The proposed Public Health Service was eventually constituted as Public Health England, an executive agency of the Department of Health, which fulfils the Secretary of State's statutory duty to protect health and address inequalities. However, many observers feel that its status is unclear ([Buck 2014](#)). A report by the House of Commons Health Committee argued that there is not sufficient separation between Public Health England and the Department of Health, stating an 'urgent need' for the relationship to be clarified so that Public Health England would be truly independent of government and able to 'speak truth to power' (House of Commons Health Committee 2014e).

Monitor and the CQC are both non-departmental public bodies, accountable to parliament (usually via appearing in front of the House of Commons Health Committee and Public Accounts Committee). They each have a sponsor in the Department of Health, and the Secretary of State can ultimately reallocate their functions if the two organisations fail to perform properly. In line with the intentions of the NHS Act, Monitor has accrued more powers. Between 2011 and 2014, the number of staff employed and its spending on core running costs have both more than trebled ([National Audit Office 2014a](#), pp 15–16). The role of the CQC is discussed in more depth in the section on quality regulation (*see* Section 5).

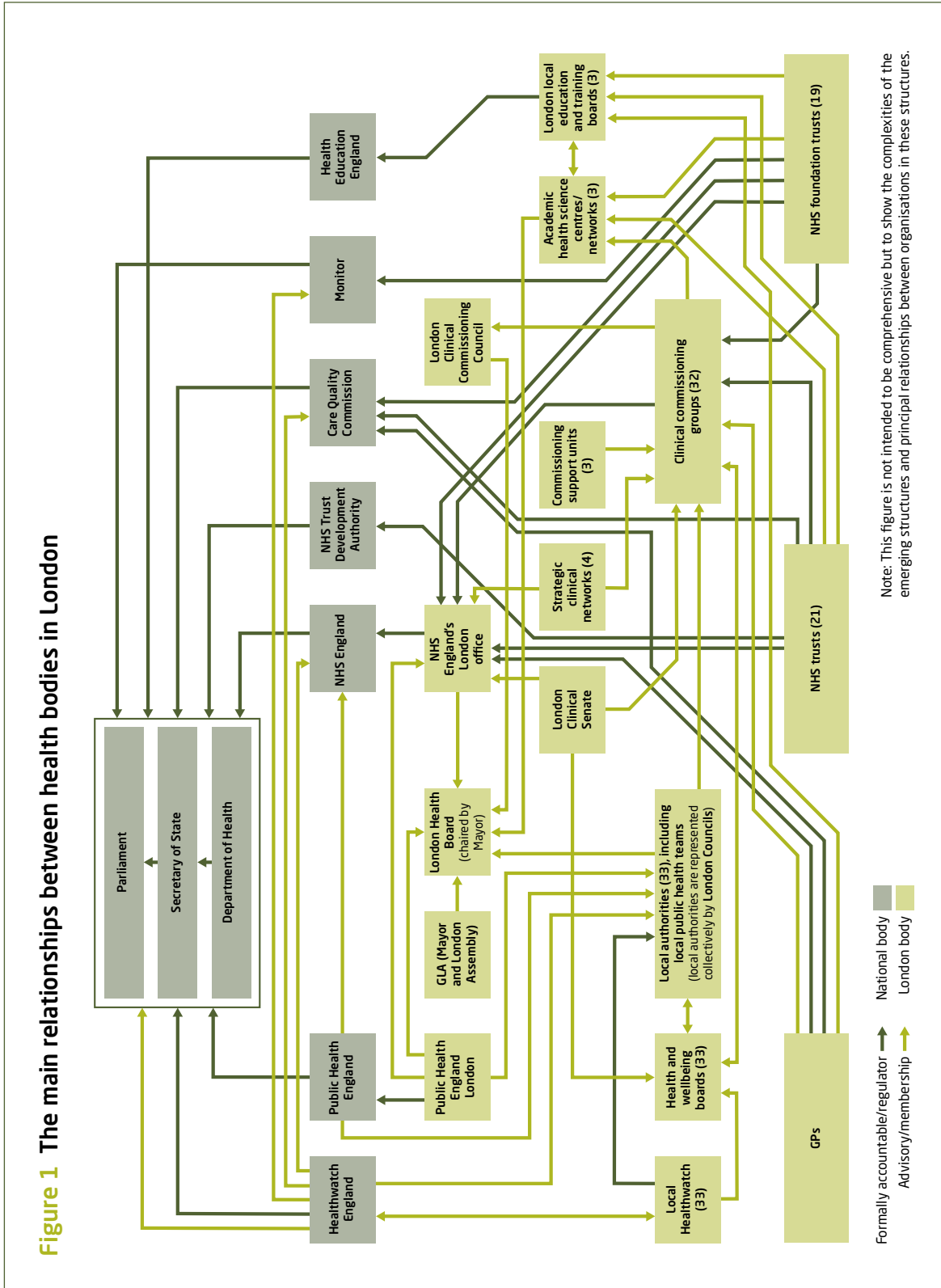
Despite the government's attempts to clarify accountability arrangements ([Department of Health 2014a](#); [House of Commons Public Administration Select Committee 2014](#)), the landscape around governance and accountability is complicated. Figure 1 illustrates the complexities of relationships between health bodies in London alone. Commenting on the £95.6 billion that NHS England is responsible for, the chair of the Public Administration Select Committee has said that 'it is simply not acceptable that there is no clarity or clear accountability for that kind of public expenditure' ([House of Commons Public Administration Select Committee 2014](#)). Those working in the system are also confused by it; senior foundation trust staff expressed



confusion and concern as to how Monitor would work with NHS England and the NHS Trust Development Authority ([National Audit Office 2014a](#)). However, there is increasing collaboration between the national organisations, which have attempted to clarify their overlapping duties through a series of partnership agreements ([NHS Trust Development Authority 2014a, 2014b](#)). When NHS England published its *Five year forward view* for the NHS, in October 2014, it did so in conjunction with the CQC, Monitor and the NHS Trust Development Authority, as well as Public Health England and Health Education England ([NHS England 2014f](#)). Publication of the *NHS five year forward view* was also the first significant indication that NHS England was using its semi-independent status to act as the voice of the NHS in negotiation with the government.

As well as being complex and confusing, current arrangements for governance and accountability have left a vacuum in the system at a local level through the abolition of SHAs. Commissioners and providers in different areas are seeking to fill this vacuum in various ways. Their efforts are not helped by sometimes conflicting expectations of national bodies. The absence of system leadership is keenly felt at a time of growing financial and service pressures and when transformational change is needed.

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## 8 Integration of care

- While not originally a major part of coalition reforms, integrated care emerged as an explicit priority policy, with organisations given various duties to promote integrated care.
- Health and wellbeing boards were created to provide a vehicle for collaboration, although their impact has been variable.
- The Better Care Fund created a pooled budget with the intention of driving increased integration (particularly between health and social care) and an ambitious reduction in emergency admissions.

### What was the situation in 2010?

Supporting the closer integration of health services, and health and social care services, has been a broad aim for policy-makers for a number of years. From 1997 to 2010, successive Labour governments used legislation to try to overcome service fragmentation and encourage the development of integrated care. During this time, they introduced greater flexibility to allow health and social care commissioners to pool budgets and transfer resources from one commissioner to another. They also enabled the joint provision of health and social care services by a single organisation and Care Trusts were introduced to further support the closer integration of services, although relatively few were actually set up. Emphasis was placed on increased personalisation of services, particularly for people with long-term conditions.

Apart from a small number of notable exceptions (*see, for example, [Thistlethwaite 2011](#)*), these policy initiatives were not matched by a widespread shift towards the delivery of integrated care at scale across the country. In 2009, the Labour government set up a two-year Integrated Care pilot in 16 sites to test different models of care, with some positive but generally mixed results (RAND Europe and Ernst & Young 2012).



## What were the key changes proposed by the coalition government?

### Legislation

Integrated care was not originally a major part of the coalition government's plans for NHS reform. Yet after the Health and Social Care Bill's troubled passage from White Paper through to law via the work of the NHS Future Forum, integrated care emerged as an explicit policy priority, prompting a number of amendments to the Health and Social Care Act 2012. Newly formed and existing organisations were given various duties to promote integrated care, and health and wellbeing boards were created to provide a vehicle for collaboration between local organisations. The Care Act 2014 also outlines a duty for local authorities to promote integrated working.

Health and wellbeing boards – formally local government committees, and made up of representatives from local authorities, clinical commissioning groups (CCGs) and local Healthwatch organisations, along with other members appointed at the discretion of local areas – were presented as a core part of the government's vision for enabling whole system working ([Cameron 2011a](#)). Boards were tasked with assessing the needs of their local population, developing a joint health and wellbeing strategy to offer a strategic framework for local commissioning decisions, and promoting greater integration of services – for example, through encouraging joint commissioning and the use of pooled budgets.

In an effort to balance the role of competition with the need for integration between local services, a duty was placed on Monitor to enable the provision of integrated care where it will benefit patients. The then Secretary of State for Health, Andrew Lansley, told the House of Commons Health Committee that Monitor's role in supporting integration should 'trump' its role in promoting competition where appropriate in the health service ([House of Commons Health Committee 2011](#)).

### Pooling budgets and the Better Care Fund

In the 2013 spending round, the government announced a new pooled fund of £3.8 billion to try to encourage health and social care organisations to work together more effectively to co-ordinate local services. This was first called the Integration Transformation Fund, and then the Better Care Fund.



The Better Care Fund built on initial commitments made by the coalition in the 2010 spending review. These included £1 billion to be set aside from the NHS budget to fund new ways of delivering integrated services between health and social care and an increase in the Personal Social Services grant from the NHS budget to local authorities (although this should be seen within the context of large cuts to local authority budgets). It also included the reformulation of the previous government's Total Place pilots with new Community Budgets to pool local funds for families with complex needs (HM Treasury 2010), which were followed by Whole Place Community Budgets the following year.

While the Better Care Fund is a new initiative, it contains no new money – only reallocations of existing funds and transfers from the NHS budget, including a new transfer of £1.9 billion from CCGs. Based on central guidance, local areas have been tasked with developing plans for how their allocations will be spent to meet a set of national conditions (including better data-sharing and seven-day working) and performance indicators such as reducing avoidable emergency hospital admissions and delayed transfers of care. After being approved locally by health and wellbeing boards, plans have been submitted (and resubmitted) to NHS England, to be implemented in April 2015.

In the original formulation of the Better Care Fund, £1 billion was planned to be set aside for staged payments to local areas based on their performance in meeting these national conditions and indicators. However, in July 2014, the pay-for-performance element of the Better Care Fund was revised to focus solely on local targets for reducing emergency hospital admissions. Under the new rules, if local areas fail to meet their targets – with just over a 3 per cent reduction assumed across the country – this part of the Fund will stay in the NHS (National Audit Office 2014b).

### **Integration pioneers**

Alongside the Better Care Fund, 14 areas in England were selected in November 2013 as exemplar sites to demonstrate innovative approaches to delivering integrated care – framed as 'pioneers' rather than the 'pilots' established under the previous government.

The pioneers were selected on the strength and ambition of their plans for co-ordinating services between local organisations, and have received support



from national bodies to take their plans forward. They are expected to disseminate lessons from their integration efforts to support wider adoption, while national organisations have pledged to address any barriers to integration that emerge from the programme ([Department of Health 2013a](#)) – although these barriers are well known and have been documented elsewhere ([Goodwin \*et al\* 2011](#)).

In October 2014, the Minister for Care and Support, Norman Lamb, announced an extension of the programme, with 10 new pioneer sites. In a speech later that month, he said ‘many successive governments have tried to introduce integration, but we are introducing it’ ([Lamb 2014](#)).

### What was the impact of the changes in practice?

Assessing the impact of these changes to deliver integrated care is difficult – not least because efforts to develop integrated services often take a number of years, and transformation from fragmented to integrated care is rarely linear ([Bardsley \*et al\* 2013](#); [Ham and Walsh 2013](#)). In addition, the coalition reforms have often had conflicting results for local areas seeking to integrate services; while some changes have explicitly aimed to support integration, others – particularly changes to the structure of the system – have pulled in the opposite direction.

While the creation of health and wellbeing boards was widely welcomed, their impact and influence has been variable, and generally limited ([Humphries and Galea 2013](#); [Humphries \*et al\* 2012](#)). Boards have shown few signs of being able to provide the collective leadership needed to tackle the urgent issues facing their local systems, and have often chosen to prioritise other issues ahead of promoting integrated care ([Humphries and Galea 2013](#)). There is also no robust evidence on how well Monitor is doing in its balancing act of promoting integration (first) and competition (second) – and the relationship between these duties remains ambiguous.

The impact of the Better Care Fund will not be known until local plans have been implemented in 2015/16. So far, plans from 146 out of 151 local areas have been approved by NHS England, projecting savings of around £500 million for the NHS and a reduction of just over 3 per cent in emergency admissions ([Hunt 2014a](#)). Despite this optimism, the assumption that local integration plans will reduce hospital admissions accordingly in a short space of time is not supported by evidence or recent experience. Since 2008, the average trend increase in





emergency admissions has been 1.6 per cent a year and evidence that these increases can be quickly reversed is difficult to find (Purdy *et al* 2012). Expectations for the Better Care Fund's impact are therefore very ambitious.

At the same time, there is no doubt that the Better Care Fund has facilitated closer working (albeit mandated) between communities tasked with developing joint plans for integration – particularly commissioners, who have collectively boosted the Fund from £3.8 billion to around £5.3 billion through local top-ups. In Sheffield, for example, health and social care commissioners have pooled around £280 million, up from the £41 million requirement specified by the Fund (Furness and Fowler 2014). A number of areas have also begun to explore new ways of commissioning and contracting to support the development of more integrated services – many using flexibilities created by the previous Labour government – and there is growing interest in the role of new organisational models in delivering more integrated services for defined population groups (Addicott 2014; Addicott and Ham 2014).

More broadly, communities in a number of parts of the country have begun or continued their efforts to develop integrated health and social care teams and new models of care to better co-ordinate local services, particularly for older people and those with complex needs. This includes work in Northumbria to develop integrated services between hospitals, general practices, community and adult social care services and other partner organisations (Naylor *et al* forthcoming), building on a long history of local partnership working. A number of pioneer sites have reported progress in co-ordinating services for their local populations, although like many others, their efforts to do so have often been under way for a number of years (House of Commons Health Committee 2014b; House of Commons Health Committee 2014c).

Despite the coalition reforms designed to explicitly support joint working, a number of policy barriers to integrated care have persisted since 2010. They include:

- payment systems that reward organisational activity rather than collective outcomes
- fragmented commissioning arrangements, both within the NHS and across the NHS and social care



- regulation that focuses too heavily on organisational performance rather than system performance
- the lack of a single outcomes framework to promote joint accountability for integrated care.

In some cases, these barriers have been reinforced by the coalition's reform agenda. In particular, the fragmentation of commissioning responsibilities (described in Section 3) created by the Health and Social Care Act 2012 has meant that population budgets are widely dispersed across the health and care system, making it difficult to align incentives across different providers of care. In 2014, the House of Commons Health Committee argued that existing fragmented commissioning structures 'significantly inhibit the growth of truly integrated services' (House of Commons Health Committee 2014e).



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Chris has advised the World Health Organization and the World Bank and has served as a consultant on health care reform to governments in a number of countries. He is an honorary fellow of the Royal College of Physicians of London and of the Royal College of General Practitioners, and a companion of the Institute of Healthcare Management. He is a founder fellow of the Academy of Medical Sciences.

Chris was a governor and then a non-executive director of the Heart of England NHS Foundation Trust between 2007 and 2010. He has also served as a governor of the Canadian Health Services Research Foundation and the Health Foundation and as a member of the advisory board of the Institute of Health Services and Policy Research of the Canadian Institutes of Health Research.

Chris is the author of 20 books and numerous articles about health policy and management. He is currently emeritus professor at the University of Birmingham and an honorary professor at the London School of Hygiene & Tropical Medicine. He was awarded a CBE in 2004 and an honorary doctorate by the University of Kent in 2012. He was appointed Deputy Lieutenant of the West Midlands in 2013.

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Hugh was also seconded from PwC to work on Sir John Oldham's Independent Commission on whole-person care, which reported to the Labour party at the beginning of 2014. The Commission looked at how health and care services can be more closely aligned to deliver integrated services meeting the whole of people's needs.



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As politicians and the public gear up for the general election in May 2015, how will the coalition government be judged on its NHS reforms?

*The NHS under the coalition government* argues that the 2010–15 parliament has been a parliament of two halves for the NHS. The first half was dominated by debate about the Health and Social Care Bill which was intended to devolve decision-making and extend competition and choice in the NHS. The second half was taken up with limiting the damage caused by the Bill and giving priority to patient safety and the quality of care.

This report concludes that the:

- coalition government's reforms have resulted in greater marketisation of the NHS but claims of mass privatisation are exaggerated
- reforms have resulted in top-down reorganisation of the NHS and this has been distracting and damaging
- new systems of governance and accountability resulting from the reforms are complex and confusing
- absence of system leadership is increasingly problematic when the NHS needs to undertake major service changes
- Care Act 2014 has created a legal framework for introducing a fairer system of funding of long-term care.

The report argues that the next government should continue the emphasis on patient safety and quality of care but with less emphasis on regulation and more on supporting NHS leaders and staff to improve care. It also welcomes the *NHS five year forward view* which sets out the future direction for the NHS and the new care models required.

While top-down reorganisations must be avoided, evolutionary and bottom-up changes to the organisation of the NHS should be made to reduce the complexity and confusion of the structures introduced by the coalition government.

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