NHS in Transition

Government's agenda for transformation of the Health Service

NHS in Transition

CONTEXT

CURRENT NHS

FUTURE NHS

POSSIBLE ISSUES

Context

- Complex territory
- Ideology
- Beware SPIN!
- Presentation based on info today; changes are likely
- Intended changes are Massive
- Situation in Glos

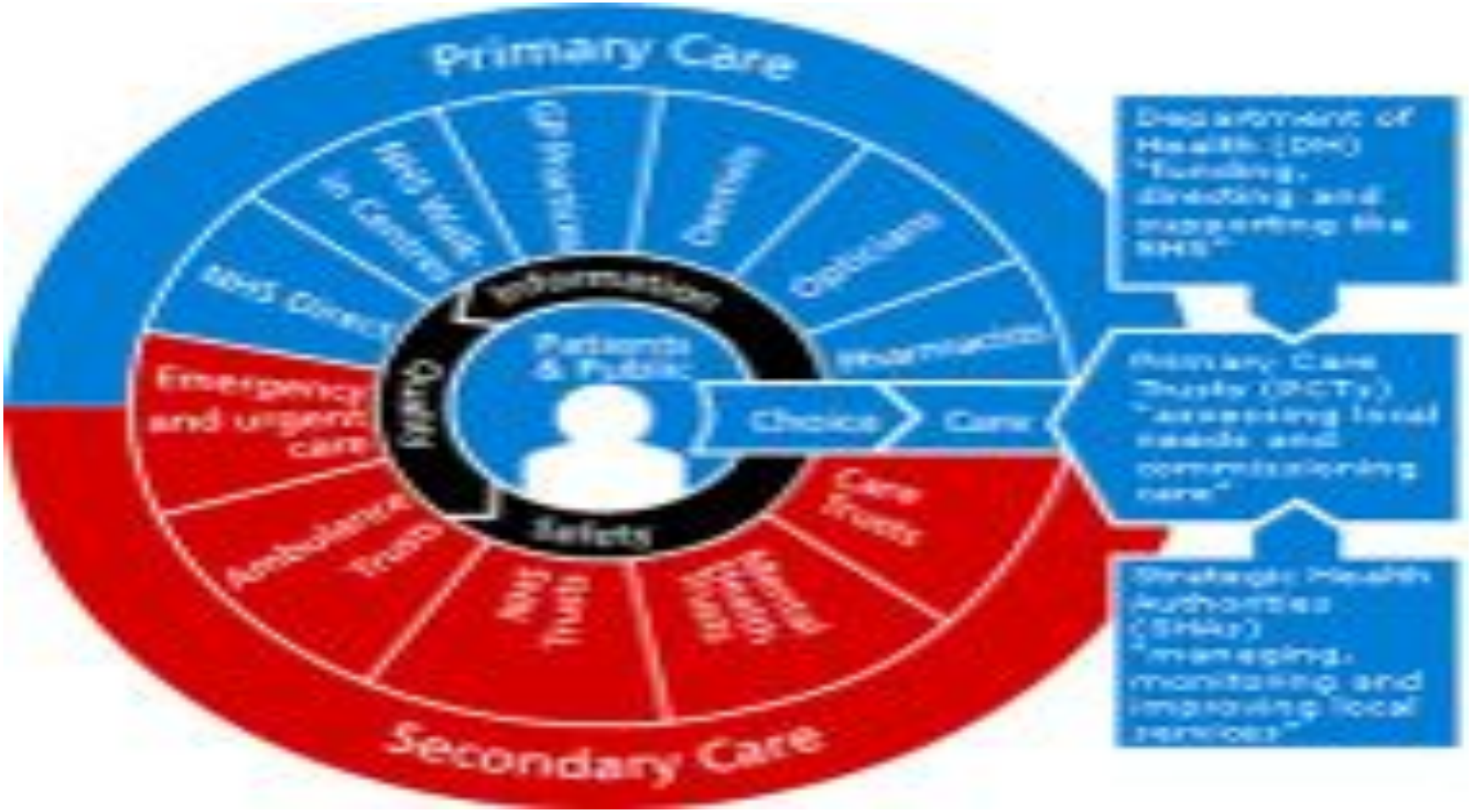
LAYOUT OF PRESENTATION

- **Current NHS**
- **Claimed principles for changes**
- **Future NHS**
  - *** Commissioning**
  - *** Quality, Innovation, Productivity, Prevention.**
  - *** Providers**
  - *** Regulation: Monitor and CQC**
  - *** Public Health and Local Government**

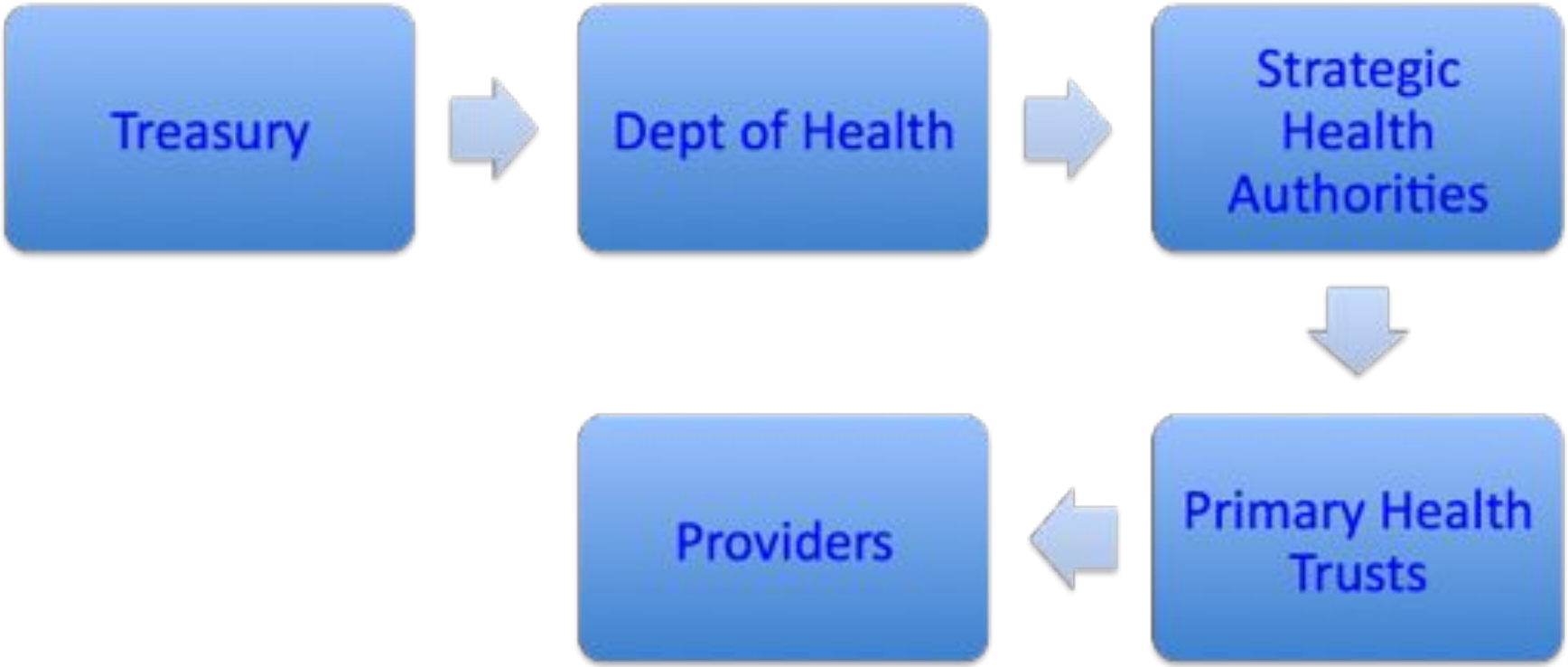
Current NHS structure

- Primary care - 37,000 GPs, 21,000 dentists, pharmacists and optometrists
- Secondary care - 1,600 acute hospitals, mental hospitals and specialist centres
- Other agencies such as NICE – National Institute for Health and Clinical Excellence, and NIII -National Institute for Innovation and Improvement

CURRENT NHS


Primary Care
Secondary Care
Information
Safety
Patients & Public
Choice
Care
Emergency and urgent care
Ambulance trusts
Acute trusts
Mental health trusts
Care trusts
NHS Direct
NHS Walk-in Centres
Dentists
Opticians
Pharmacists
Department of Health (DH) "funding, directing and overseeing the NHS"
Primary Care Trusts (PCTs) "assessing local needs and commissioning care"
Strategic Health Authorities (SHAs) "managing, monitoring and improving local services"

Current NHS – flow of cash



CLAIMED PRINCIPLES FOR CHANGES

- putting patients at the centre of the NHS
- changing the emphasis to clinical outcomes
- shifting power from the centre into the hands of healthcare professionals, in particular GPs

COMMISSIONING

- Commissioning now = £80 billion /year
- Currently commissioning is by 152 PCTs
- In future *NEW* GP Consortia responsible for Commissioning
- Consortia will be authorised by the *NEW* NHS Commissioning Board
- This board will have wide ranging powers
- Consortia will legally take responsibility for their budgets from April 2013 – PCTs will be abolished
- GPs will decide on size and make-up of Consortia

QIPP – Quality, Innovation, Productivity, Prevention

Overall costs for Health Services continue to rise due to

- people living longer
- increasing medical technology and
- pharmacological improvements
- increasing expectations by public

NHS must save c. £20 billion over next five years for these costs alone

QIPP

- ongoing productivity improvements at about 5% per annum essential
- QIPP is based on several years intensive research, and has been running up to speed.
- From now on it will receive considerable attention
- It requires major changes in NHS culture and will be a challenge for personnel and for all current practices

PROVIDERS

- Any Willing Provider will allow the involvement of Private Healthcare, and ‘not for profit’ Organisations
- All NHS Providers to be Foundation Trusts by 2014
- Community Services [Local Authorities] to be separate entities from NHS
- Significant expansion of Social Enterprise model

REGULATION

- Twin regulators
- 1. Monitor - similar to Ofgem or Ofwat - will become the Economic regulator.
  - license providers
  - regulate prices
  - promote competition
  - support service continuity
- Will manage the failure regime for Providers
- 2. Care quality Commission – health and social care regulator - [continues]

Public Health

- local authorities to assume responsibility of local public health improvements
- Public Health England, a department within the Department of Health, to be set up to bring together all health protection and improvement functions into one body
- the budget for public health to be ring fenced from within the overall NHS budget.

POSSIBLE ISSUES

- The functioning of the GP Commissioning system
- Change in public's views of GPs
- The impact of competitive environment
- Maintaining an effective ongoing clinical service during the change period - over perhaps four years.
- Possibly more heterogeneous service – geographically, and in varieties of providers