

Breakfast briefing - *Equity and Excellence: Liberating the NHS*

1. London Higher held a breakfast briefing on 15 September 2010 to discuss the White Paper *Equity and excellence: Liberating the NHS* and the implications of this for higher education in the capital.
2. The briefing was attended by members of the *Healthcare Education Group* and *London Medicine*. Dr Anna Dixon, Director of Policy, The King's Fund was the guest speaker, providing an analysis of the White Paper and highlighting some of the implications for higher education.
3. This document includes:
 - a. The briefing note, produced by Dr Anna Dixon, distributed to members at the briefing and,
 - b. A summary of the discussion that took place at the briefing.

Briefing note by Anna Dixon Director of Policy, The King's Fund

Key proposals

Objectives: better outcomes and patient centred services

Means: increased clinical engagement, localism, reduced 'bureaucracy', greater transparency and information

Blend of technocratic and political ideas

Technocratic = further refinement of previous market reforms:

- Stronger economic regulator (Monitor + Competition and Cooperation Panel)
- Greater freedoms for FTs and more diverse providers, including social enterprises
- Responsibility for commissioning to GPs - practice based commissioning seen to have 'failed'
- Give patients greater choice including named consultant for elective care
- Changes to tariff to reward quality - accelerate implementation of best practice tariffs

Political = compromises with coalition partners, HM Treasury and wider ideas about 'big society' and smaller public sector

- Abolish PCTs as well as SHAs, cap management costs of GP consortia
- Give greater responsibility to local authorities through establishment of Health and Wellbeing Boards for public health and health improvement, integrating health and social care, and oversight
- GP consortia to have accountable officer and be statutory bodies
- Focus on outcomes not targets

Key risks and issues

- Capacity and motivation of GPs to take on commissioning responsibility
- Lack of system level leadership to manage transition and continue to handle issues across larger geographies, e.g. reconfiguration of major services
- Handling failure of commissioners and providers
- Dual accountabilities and relative power of National Commissioning Board vs local authorities
- Drivers within the system to ensure performance (quality and efficiency)

Implications for HEIs

“It is time to give employers greater autonomy and accountability for planning and developing the workforce, alongside greater professional ownership of the quality of education and training.” 4.3.2

Abolition of SHAs

- Providers will plan and have the funding

Will the incentives be there for providers to invest in training and education or will they try and ‘free-ride’? How to balance the short term vs long term perspectives on workforce requirements?

- Education commissioning will be led by professional bodies

What is the right balance between professional (supply) and provider (demand) influence on the design of training and education? What will this mean for changing skill mix and the relative importance of different professional groups?

- GP consortia and National Commissioning Board will provide oversight of providers plans

Will GP consortia have the skills to provide oversight of providers educational/ workforce plans? How to balance the needs of universities vs professional education commissioners vs providers of NHS care vs funders and commissioners of NHS care

Diversity of providers

- Social enterprises and third sector to play greater role

How will the workforce needs of these providers be ‘heard’ and met? Will these providers be rewarded for providing suitable learning environments?

- Foundation Trusts to be encouraged to diversify (removal of private patient income cap)

As finances become tighter, will these organisations become more selective in who and how they train? Will they use freedoms to change the contracts, pay and conditions of staff? Will they innovate and want to introduce new medical and non medical roles (e.g. physician assistants, sub-consultant medical grade)?

- New community providers and stronger primary care based services if GP consortia reinvest

Do these organisations share the same commitment to staff training? What is needed to reskill the workforce to work in new settings? Will this result in a shift in resources away from the acute sector?

Questions for debate and discussion

Looking ahead to the consultation on the White Paper proposals on education and training how radical might the proposals be?

Will government subsidy of education reduce? Will they remove the limit on educational places and allow private fee-paying students? Will money truly follow the students, with greater competition for students?

Summary note of breakfast briefing

4. Anna Dixon provided an analysis of the White Paper *Equity and excellence: Liberating the NHS*. Points made in addition to Anna Dixon's briefing note were:
 - a. The White Paper introduced significant changes, more so than was expected.
 - b. These changes are to be implemented in a period of significantly lower growth in funding; and there will have to be huge increases in productivity if there are not to be cuts in services.
 - c. The White Paper introduces a drive for localisation and greater competition.
 - d. Practice based commissioning has not been enthusiastically embraced by the majority of GPs, and where this has led to changes they have often been small scale and not at a level of re-designing services.
 - e. PCTs and SHAs have been powerful and instrumental in managing the NHS; it is not certain how the system will be managed once they have been abolished.

In discussion the following points were raised.

5. The Department of Health has published a transition timeline for implementing the White Paper. This sees the publication of the paper on education and training possibly delayed from October 2010 until January 2011.
6. The White Paper introduces the concept of plurality of providers (Foundation Trusts and GP consortia). How will workforce planning be managed across this plurality? How will local and national workforce requirements be managed in this environment?
7. Traditionally London has over-produced healthcare workers at a local level, although not at a national level. If workforce planning were to sit locally this would put London at significant risk of losing students and funding.
8. Medical Education England is responsible for medicine, dentistry, pharmacy and healthcare scientists. Will a new body be created for nursing, midwifery and the allied health professions?
9. How will the current education and training subsidy be deployed? It could be quite devolved. There could be an argument for some education and training to be commissioned centrally. The 'how much' of what is commissioned could be market driven.
10. Is the responsibility for commissioning undergraduate nursing, midwifery and allied health professions likely to move to HEFCE? This is presently uncertain. If not, the long term could see HEFCE as the university regulator and no longer responsible for distributing funds.
11. Are the proposals in the White Paper based on a model used elsewhere? Other countries have plurality of provision, and a competition regulator, for example the Netherlands. It is likely they have an intermediary body responsible for education commissioning and that student numbers are not controlled in the same way as in the UK. However giving responsibility of such significant funding to primary care seems to be unique.
12. How do you ensure there is a critical mass of GPs enthusiastic about taking on the responsibility of commissioning? There are already some GPs using a consortia model, it is hoped that they will act as the vanguard and others will learn from their experiences, but it is unclear whether this will happen as envisaged.

13. How many GPs need to be in a consortium? Many commentators have suggested there would be 'around 500' (i.e. around about the same size as PBC clusters), but the Secretary of State has not committed to a number as yet. Several consortia could share a joint back office. This would mean that there would not need to be a large number of GP leaders to implement this change.
14. Is there an agenda to move commissioning and healthcare providers into the private sector? If so, when would the private sector move into healthcare education? There are no overt plans to privatise NHS assets. However the Further and Higher Education Act 1992 is being revisited and one option being explored is the plurality of healthcare education providers e.g., the introduction of private institutions.
15. How much is known about how the NHS will work when all the recommendations in the White Paper are implemented? It is proposed that the new system will be up and running by 2013, although it seems the end product is not clear (perhaps deliberately so). The driving principle is to improve health outcomes but factors such as funding or political fallout could interfere with both the timetable and the end product.
16. How much room is there to influence the next stage of the White Paper? It seems there should be room to influence the detail, but not the bigger picture.
17. How does the White Paper influence the process in London of introducing medical and dental education commissioning? There is still a desire to have the commissioner and provider split, however the process for introducing this might be slowed down.
18. To understand what might happen in healthcare education it is sensible to look at other areas of higher education. This would suggest that it is likely that the market will be opened up. Feedback from the Universities UK Annual Conference suggests that changes in HE will include:
 - a. Research conducted at some HEIs, not all; creating teaching only HEIs
 - b. The introduction of graduate contributions
 - c. The inclusion of private providers
 - d. Expansion of apprenticeships
 - e. In the case of market failure institutions will no longer be supported
 - f. Emphasis on shared services.
19. Key points to convey to David Willets on behalf of London universities include:
 - a. Making a stronger link between the Department of Health and Department of Business Innovation and Skills on the matter of healthcare education.
 - b. Universities want to engage with government in the development of plans for change.
 - c. The importance of maintaining teaching and research links in institutions teaching healthcare subjects.