Editorials

The NHS reforms:

are they going to work?

The report from the Future Forum[1] signalled the end of the 'listening exercise' which followed the rushed publication of a series of poorly thought through and naïve proposals for the reform of the UK NHS. Disappointingly, it was hard to discern any really substantive alternative proposals among the widespread criticism. Given the intensely political discussions that were the background to the drafting of the new recommendations, it is not surprising that they came with a sense of anticlimax and compromise, rather than as the blueprint for an exciting future. Less rush, more reflection and better integration are all welcome — but will the proposals really contribute to saving money, doing more for less, and improving health outcomes? Is it realistic to defer, once again, a serious discussion about competitive tendering and co-payments by patients for medical care and medications?

THE EVIDENCE BASE

If the new clinical commissioning groups are going to design and deliver innovative, cost-effective, integrated care, they need the evidence on which to make their plans, rather than merely tinkering with existing arrangements. This means that close working with public health experts and using NHS data sources are urgently required to measure health needs and to determine changes in individual and population health status; already there are squabbles about access to patient data. It also means being able to identify and share best practice, using not only peer-reviewed literature sources but also reports of locally-effective innovations and experiences from other health systems. Traditional health services research methodologies and means of dissemination may not be the best way to approach the evaluation and transfer of good practice, and imaginative methods will need to be devised to do this.

It may be worth asking to what extent a supermarket model of health system management could contribute to cost containment, by looking across the NHS for the 'big ticket' items where savings can be made. These may include centralisation of diagnostic laboratory facilities and re-assessment of community-based venesection and near-patient testing, and procurement of equipment, devices, and diagnostics. Medicines management systems involving practice-linked and community pharmacists could reduce waste, improve concordance and patient outcomes, and avoid expensive hospital admissions for drug side-effects and drug interactions. Building on existing examples of good practice in record linkage and information transfer between primary and secondary care should be as much a priority as the use of patient data in the commissioning process.

INTEGRATED CARE

In the development of effective integrated care, the traditional defences between primary and secondary care will have to be dismantled, and established practice questioned remorselessly. Does the gatekeeper role of GPs always work in the best interest of patients? There is some worrying evidence from a recent European study published in this Journal that 'stronger' gatekeeping is associated with worse cancer outcomes.[2] Are hospital trusts ready for the reality that more care of older patients with complex comorbidities in the community will mean a consequent shift in resources from the hospital to primary care? Shouldn't our enthusiasm for personal continuity of care be tempered by the recognition that it can lead to *folies à deux*, in which problems are allowed to go unrecognised and untreated, and that for some patients multiple primary care providers are preferable? Can't hospital specialists organise themselves to be more accessible for short telephone or electronic advice sessions which could avoid costly referrals?

There is also an important message here for undergraduate medical education and postgraduate training where there needs to be more meaningful exposure to general practice, particularly for those trainees following a specialist career pathway.

EDUCATION AND TRAINING

The modified proposals for reform need to be read alongside the changes that are planned for education and training, following the publication of the ambitiously-titled *Equity and Excellence: Liberating the NHS*.[3] As the demise of the primary care trust approaches, new bodies, to be called Local NHS Education and Training Boards, will be established (in place of the previously-planned and impenetrable Skills Networks). Medical Education England, currently an advisory body with a budget of £5 million, is planned to metamorphose into Health Education England, with an executive role and a budget of £5 billion. As the fates of postgraduate deans and the deaneries are worked out — will they remain within the 'NHS family' as promised or are the arguments to locate many of their functions within the higher education sector simply too strong? — a whole range of new questions will arise about the relationships between the NHS and the universities, and the role of the General Medical Council and the Royal Colleges in medical education.

We are witnessing the biggest reform of health care and medicine in the history of the NHS, taking place against a global background of equally unprecedented instability. We are now faced with the unenviable task of ensuring that the system is sufficiently flexible without destabilising it, identifying what is good and worth preserving, without fossilising it, and ensuring that resources are used wisely and fairly to achieve the best health outcomes we can afford.

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REFERENCES

1. Department of Health. *NHS Future Forum recommendations to Government*. London: DOH, 2011. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127443 (accessed 1 Jul 2011).
2. Rubin G, Vedsted P, Emery J. Improving cancer outcomes: better access to diagnostics in primary care could be critical. *Br J Gen Pract* 2011; **61(586):** 317–318.
3. Department of Health. *Equity and excellence: liberating the NHS*. London: DOH, 2010. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353 (accessed 1 Jul 2011).