

# Is the treatment working?

Progress with the NHS system reform programme



Health

National report

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# Summary

- 1** Since the government announced the NHS system reform programme in 2000 in the *NHS Plan*, the NHS has made significant progress. There are shorter waiting times and the quality of care overall, as measured by the annual health check, has risen. This report examines the impact of the system reform programme on the progress made. It concentrates on some key aspects of the reforms – patient choice, Payment by Results (PbR), practice based commissioning (PBC), foundation trusts (FTs), greater NHS use of the private sector through the introduction of independent sector treatment centres (ISTCs), and the impact that major workforce contractual changes have had on hospital efficiency. It also reviews developments in the commissioning of patient care. Although these are not the only reforms introduced by the government, they are those the government identified to secure devolution of decision making and enable a more market-oriented NHS. The reforms were intended to operate as a package with commissioners and empowered patients able to take advantage of a wide range of provision and more autonomous providers better able to respond to the choices made. Changes in the financial regime would help to support these developments. The broader reform agenda has developed over time with more attention being paid to hospital leadership, clinical engagement and staff understanding, and behavioural issues involved in successful change, but these have not been included in this report.
- 2** The programme is very ambitious, and the significant operational changes it required took time to be implemented. The reforms were not imposed uniformly on a national basis and the programme recognised that different health economies were in differing stages of development. Therefore, a staggered introduction was appropriate to reflect their complexity. However, this has inevitably meant that their impact so far has been more limited than might have otherwise been the case.
- 3** The report is based on fieldwork that was undertaken between May and November 2007. This included: a literature review; national and local data analysis; national workshops in four local health economies; interviews with strategic health authorities (SHAs), primary care trusts (PCTs), FTs, acute trusts,

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health commentators, providers, regulators, commissioners, strategists and independent sector providers. It also draws on other work including major national studies undertaken by the Audit Commission and Healthcare Commission.

- 4 Individual elements of the reform programme have been implemented to different extents in the health economies we visited. This variation is also reflected in other national surveys and reports. While the new workforce contracts and to a certain degree PbR are almost universal across the NHS, patient choice is in reality not always offered; PBC has yet to be fully embedded; less than half of trusts have achieved FT status; and there are few ISTCs.
- 5 Given the controversy that has surrounded the reform programme, its ambition and the scale of the NHS, it is not surprising that more progress has not been made. In fact many health economies have only recently been provided with all the tools and levers for change.
- 6 Nevertheless, despite limited implementation, we found that the reform programme was having a positive effect on the NHS:
  - NHS patients are beginning to benefit from the existence of a diverse range of providers and there is anecdotal evidence that competition is improving services for patients in some areas.
  - The fear of the impact of patient choice, rather than actual choice, appears to be driving a positive change in attitude among providers. Some PCTs can also point successfully to improving services through tendering.
  - The focus that PbR and FT status have placed on improving existing financial management arrangements and encouraging a more business-like approach has provided all NHS providers with incentives to improve.
  - PbR has brought welcome clarity to NHS funding of hospital care for both commissioners and providers and has had some positive impact on trust efficiency and demand management by PCTs.

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# Summary

- 7** However, we also found that the reforms were not yet delivering the desired change:
- Despite the intention to move care out of hospitals and into a primary or community care setting, limited progress appears to have been made. Commissioning and contracting skills are not yet strong enough to drive this agenda, although some PCTs can point to successes. PbR also needs further refinement to facilitate care transfers more effectively.
  - Choice is not offered universally and the infrastructure is still not fully in place to support patient choice that is based on the quality of care provided. The Department of Health (DH) is now improving the information available.
  - On a national level, despite the improved quality of services, FT status does not yet seem to be empowering organisations to deliver innovative models of patient care.
  - The incentives and infrastructure to support PBC are not currently sufficient to engage most GPs in commissioning.
  - At the time of introduction, the new workforce contracts for hospital and community staff were a missed opportunity for change and have so far resulted in higher expenditure, without a proportionate increase in productivity. Nevertheless, the new contracts continue to offer opportunities for change and the full effects may only be seen in the longer term.
- 8** Progress on the implementation of the reform programme has been limited by several factors. These include two major structural reorganisations; under-developed commissioning capacity; and weaknesses in the infrastructure to support and monitor the reforms, particularly in regard to data collection. We also found that many of those who participated in our research did not fully understand the aims of the reform programme, how the individual elements contributed and how they could best be made to work.
- 9** Improving commissioning capacity and capability is critical to the success of the reform programme. Given the 2006 reorganisation, PCTs need time to progress this agenda. More work is needed to strengthen commissioning and without this,

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the reform programme will not provide the necessary balance of power between primary and secondary care. The DH are now placing an increasing emphasis on improving commissioning skills.

- 10** We have identified that service improvement in some areas has been substantially delivered without using the system reforms. Other policies pursued by the government such as waiting list targets, have had a much greater impact. Our fieldwork found that the health economies that had made greater progress in implementing the reforms were not performing at a significantly improved rate when compared with those that had limited reform levers in place. There is some evidence, through the annual health check, that FTs are becoming even stronger organisations when compared with other acute trusts. But it is important to note that they were deliberately selected for foundation status on the strength of their service delivery track record, financial standing and financial management arrangements.
- 11** Many of the reforms have the potential to deliver significant service improvement but need time to bed in, as demonstrated by the implementation of PbR, which has now been largely mainstreamed by the NHS. There has so far been a stronger focus on the supply side (for example, the development of FTs) but greater development of the demand side using patients and commissioning to drive service improvement is now needed. For example, there is evidence that patients will choose alternatives if the choices are real and the relevant information is available. However, the barriers to progress that we have identified will need to be addressed and specific developments related to patient choice, PBC, the quality and convenience of care and efficiency also need to be considered.
- 12** Lord Darzi's review provides an opportunity to take stock of what the reforms have achieved so far and how they might need to develop to contribute to a renewed vision for the NHS. Many of the system reforms have also been developed on an elective, secondary care model, not on primary or community care or mental health models. They have also not focused on managing long term conditions nor specifically addressed health inequalities. His review will also need to address these key issues.

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# Recommendations

Previous reports by the Audit Commission and the Healthcare Commission on PbR, PBC and ISTCs contained a number of relevant recommendations which we have not sought to repeat in this report. The recommendations contained within this report are:

- Stronger working relationships need to be developed within PCTs to engage GPs more effectively in commissioning and particularly PBC. PCTs must adopt a rigorous approach to approving business cases in order to tackle the potential tension for GPs as providers of new community-based services and as commissioners of services for their practice population.
- SHAs, and PCTs as commissioners, will need to have a clear understanding of the planned changes in service provision levels in their areas, across all providers, whether they are ISTCs, NHS trusts or FTs and how this relates to commissioning plans and the funding available. This will help to ensure that the NHS as a whole does not develop capacity that is not required by, or is unaffordable to, PCTs and practice based commissioners.
- To drive up quality and support patient choice, the Information Centre for Health and Social Care should work quickly with the DH, clinicians and patients to define a mandatory national data collection policy by which all organisations providing services to NHS patients must abide. The policy should draw on lessons learned from current data collection and should reflect the information needs of patients, including patient outcomes, and should also be easy to capture. PCTs should drive compliance with this scheme through contracting processes. The statutory provider registration scheme due in 2009/10 should also reinforce this.
- The DH should consider redesigning the GP choice incentive scheme and payment for future years to ensure that those who take up the incentive payments deliver choice to their patients accordingly. In addition, PCTs should manage this payment more robustly through data quality and spot checks. PCTs should also work with GP practices through workshops or sessions to effectively engage GPs in the policy, exploring how choice should be explained to patients.

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- Taxpayers and patients have a reasonable expectation that FTs will not retain large cash balances over prolonged periods. FTs in such a position must set out clearly how they intend to use these balances. Monitor should also consider whether the performance management and regulatory systems for FTs should ensure that where there is such a balance, it is used for the benefit of patients. In order to achieve this, PCTs need to clarify their commissioning intentions on a timely basis.
  - There should be a prolonged moratorium on any further national top-down reorganisation of NHS commissioners. This will enable the benefits of the choice and competition reforms of the NHS to be fully realised.
  - Lord Darzi's review presents an opportunity to clearly communicate and outline the NHS vision for the future. It should clearly demonstrate how the reforms work for patients and how they contribute to the overall vision he sets out.
  - When establishing the new Care Quality Commission, the DH needs to ensure that its terms of reference are wide enough to cover the complete risks and issues throughout the health service, including quality and value for money issues in primary care and community services. As more care is transferred into a primary setting this will be increasingly important.
  - The DH should assess the impact of the current reforms on an ongoing basis. It should also set clear measurable aims and objectives for all major new reform policies and plan a timetabled evaluation strategy in advance of implementation to review the relative success and achievements of these policies.

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# 1 Introduction

This report examines the implementation of key elements of the NHS reform programme, which began following the publication of the *NHS Plan* in 2000 (Ref. 1). The programme accompanied the largest ever sustained investment in the NHS, with net NHS expenditure more than doubling from £43.9 billion in 2000/01 to £90.7 billion in 2007/08 (Ref. 2). The report discusses our findings on the implementation process, how the reforms have interacted with one another and the wider NHS and what the outcomes have been. It assesses the current situation and makes recommendations for the DH and NHS bodies about the continued implementation of the reforms.

The focus of this study is predominantly on the elements of the reform programme that were intended to increase the scope for market-style mechanisms, on both the supply and demand sides, to increase the efficiency and effectiveness of the NHS. We have focused on aspects of commissioning, patient choice, payments between purchaser and provider and diversity of supply. We have also considered how the new workforce contracts have been used to stimulate greater efficiency, but we have not examined their costs as this has been reviewed by other regulators. We have also not reviewed target setting or national information systems development in the NHS, which has been considered by the National Audit Office. Neither have we examined changes to the regulatory landscape nor the impact of the new inspection and assessment system introduced through the creation of the Healthcare Commission, nor the other changes that have been introduced in order to improve the NHS. The focus of this study is, therefore, not on the various components of reform, but only on those most closely linked to the introduction of greater choice and competition. The broader reform agenda has developed over time with more attention being paid to hospital leadership, clinical engagement and staff understanding, and behavioural issues involved in successful change, but this has not been included in the report.

There has been no systematic sustained data collection by the DH designed to monitor the impact of the reforms. For this report, we have relied on routine data sources and interviews with a wide range of staff, both inside and outside the NHS, in a number of different health economies. We have found consistent messages in the quantitative and qualitative information that we have examined. Where we conclude that an element of the reform programme may have had little impact, this is because generally we have found little evidence to show an impact and some evidence to show the absence of an impact.

The remainder of this chapter provides some background to the reform programme and how it aimed to improve patient care.

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## Background to the reform programme

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- 13** The government introduced the current programme of NHS reforms to move away from a centralised NHS toward a devolved health service that gives service-users more choice and control over their healthcare. The reform programme was first outlined in 2000 in *The NHS Plan: A Plan for Investment, a Plan for Reform* (Ref. 1). This set out the core values on which the NHS in England should be based and presented a vision for the future. In this document, the then Prime Minister, Tony Blair, spoke of an aspiration to raise levels of UK spending on healthcare to the average European level (around 9 per cent of Gross Domestic Product).
- 14** In 2001, the Wanless Report assessed the long term resource requirements for the NHS. It concluded that, in order to meet people's expectations and to deliver the highest quality of healthcare over the next 20 years, more resources would need to be devoted to healthcare. However, this increase must be matched by system reform to ensure that the extra funds are used effectively (Ref. 3). In the 2002 budget, the government accepted these recommendations and announced that spending on the NHS would grow by 7.4 per cent a year in real terms over the following five years, the largest ever sustained spending growth in the NHS. When announcing this funding, the then Chancellor of the Exchequer restated the government's message that NHS reform was a precondition of the new resources: the extra investment was not to be wasted on inefficiencies (Ref. 4).
- 15** The reform programme contained in the *NHS Plan* was developed further in *Delivering the NHS Plan* (Ref. 5), published immediately after the 2002 budget announcement. Both documents contained controversial new ideas that challenged traditional ways of working, including greater collaboration with the private sector and the reintroduction of competition. Links between the reforms were not obvious when the *NHS Plan* and subsequent policy documents were published and the reforms were only brought together into a 'system reform programme' some time after their independent conception.
- 16** The drive to increase efficiency has continued and will be of increasing importance as the NHS adapts to the 2007 Spending Review settlement (Ref. 6). This increases NHS funding by 4 per cent in real terms in each of the next three years, in comparison with an average annual real term increase of more than 7 per cent over the previous five years. Public expectations about the healthcare they receive are also continuing to rise. This will add further pressure for savings made in the NHS to be used to fund more and better services.

# 1 Introduction continued

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## Overview of the system reforms

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**17** This report examines five strands of the system reform programme and how these have been, and continue to be, used as levers for change. The five strands are:

- the introduction and establishment of FTs;
- PbR;
- PBC;
- plurality of provision and choice – including the introduction of ISTCs; and
- the new workforce contracts for hospital and community staff – Agenda for Change (AfC) and the new consultant contract.

Throughout the implementation of the reforms, there has been continuing commitment to clearly divide the purchasers and the providers of healthcare and recognition that commissioning capacity and capability needs to be strengthened.

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**18** The creation of FTs aims to give hospitals greater independence and flexibility to respond to patients and commissioners, increasing the potential flexibility of those providers to align more closely with the demands made upon them. PbR underpins the introduction of FTs and patient choice, by directly linking provider payments to the activity that they undertake, allowing the money to follow the patient. It also aims to reward hospitals fairly for the work they do and encourage greater efficiency. PBC seeks to put more purchasing power in the hands of GPs, putting effective demand closer to patients and so making purchasing

decisions more responsive to needs. Plurality of provision and choice are obvious market-style reforms, designed to stimulate competition within the NHS and between it and the publicly funded private sector. The new workforce contracts were less directly focused on market-style reform but contained some elements designed to increase the efficiency of providers.

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**19** These reforms were intended to provide new incentives and tools for the NHS to improve services, increase responsiveness to patients and achieve reductions in health inequalities. The individual reforms were intended to work together, but can be divided into the themes shown in Table 1.

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**20** The individual reforms were implemented over a period of time (Figure 1, overleaf). A staged implementation was important, but has also inevitably limited the impact which the reforms might have had over this period. Such large-scale change would have been difficult for the NHS to implement simultaneously, and there were other practical issues to address. For example, the creation of FTs required a change to primary legislation; many ISTCs needed to be built and staff needed to be recruited; and PbR was rolled out gradually so that NHS organisations had time to implement the necessary systems and to adjust to its financial impact.

**Table 1**

## Aims of the system reform programme

Commissioning reforms	Greater patient choice and involvement in their care	Provider reforms
<b>Aim:</b>	<b>Aim:</b>	<b>Aim:</b>
– to develop commissioning outcomes to achieve better health and well-being, better care and better value for all patients and the public. Benefits would, for example, include fewer unnecessary hospital admissions and more care provided in the community, closer to patients' homes.	– to create more knowledgeable, assertive and influential users of services, which will in turn improve the quality of services and equity of access.	– to create more flexible, responsive and innovative service providers, operating more efficiently and in a more financially stable way.
<b>Policies:</b>	<b>Policies:</b>	<b>Policies:</b>
<ul style="list-style-type: none"> <li>– strengthening the capacity of commissioners and closer involvement with local authorities through, for example, <i>Commissioning a Patient-led NHS</i> and, most recently the development of the <i>World Class Commissioning</i> framework;</li> <li>– introduction of PBC giving more influence to GPs and other primary care professionals;</li> <li>– sanctioning of new approaches such as competitive tendering and external support; and</li> <li>– PbR, through unbundling and the introduction of Healthcare Resource Group version 4 (HRG4),<sup>1</sup> provides incentives for supporting care closer to home.</li> </ul>	<ul style="list-style-type: none"> <li>– patient choice of provider for elective care;</li> <li>– improved information for patients;</li> <li>– PbR to enable funds to follow patient choices; and</li> <li>– greater public and patient involvement.</li> </ul>	<ul style="list-style-type: none"> <li>– FT status, giving greater autonomy from central control and more local accountability;</li> <li>– competition from a wider range of providers, including the independent (private and voluntary) sector;</li> <li>– PbR to drive efficiency by encouraging providers to keep their costs below the tariff, rewarding low cost, efficient providers;</li> <li>– workforce reform to enable more flexible and efficient working and to attract the right calibre of staff in the right numbers; and</li> <li>– regulatory reform, including new systems of performance assessment to help monitor and drive improvement.</li> </ul>

Source: Audit Commission and Healthcare Commission (based on information from the DH)

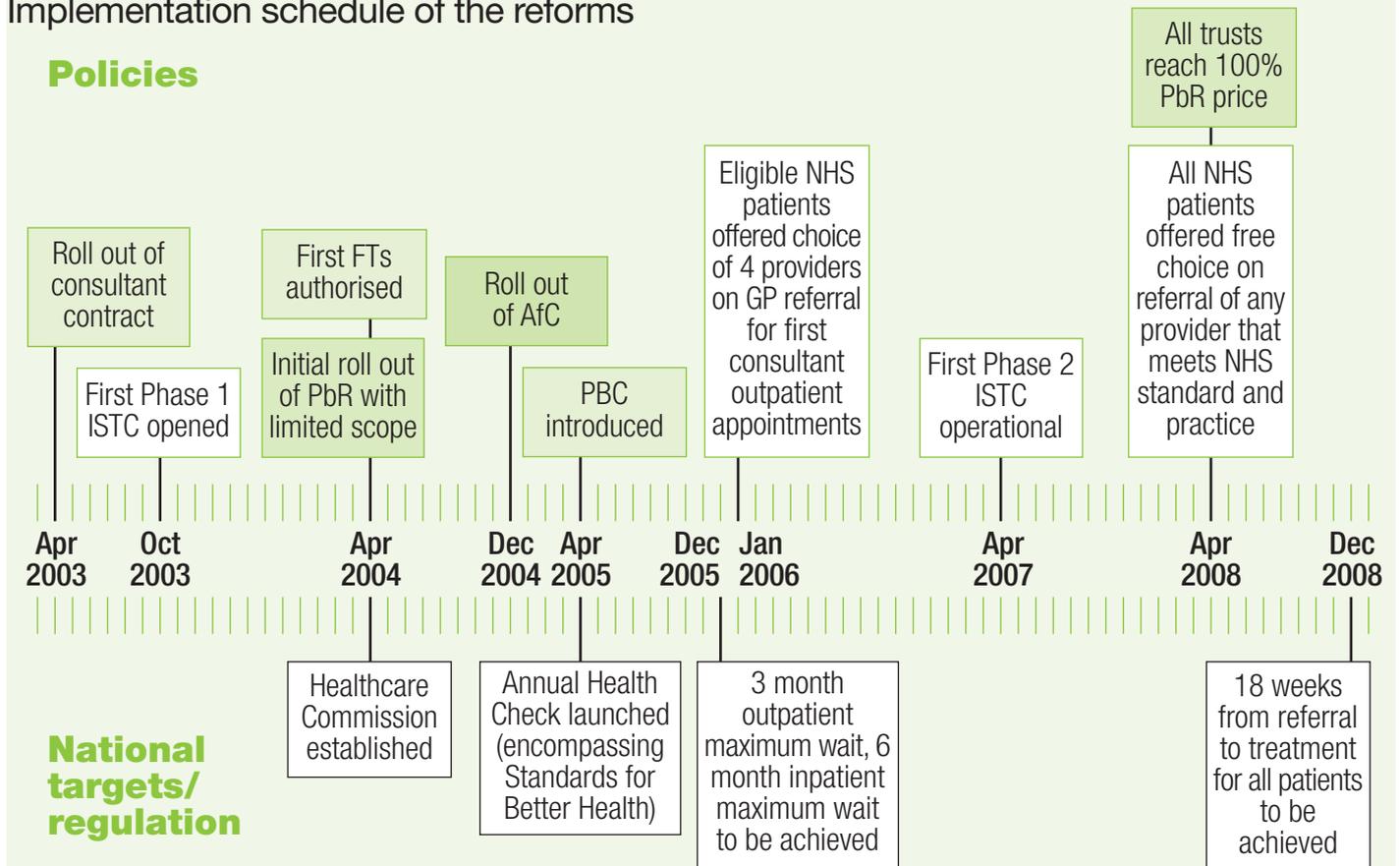
<sup>1</sup> HRGs are standard groupings of clinically similar treatments that use similar levels of healthcare resource. They are underpinned by diagnosis and procedure classification systems such as ICD10 and OPCS, which reflect current clinical activity in the NHS. HRG4 is a major revision of these groupings and was used for the 2006/07 reference cost data collection.

# 1 Introduction continued

**21** The reforms are also interrelated. For example, PbR was important for the FT financial regime and for enabling patient choice. In addition, PbR links with PBC in helping general practices to understand the financial implications of their clinical decision making. It also encourages them to better manage their usage of secondary care.

**22** Progress in implementing the reforms to date varies across health economies and not all the reforms have been fully realised. For example, at the time of publication, only 73 out of 171 acute and specialist trusts are FTs.<sup>1</sup> However, some areas have experienced the reforms to a much greater extent and over a longer period than others. Areas with significant numbers of

**Figure 1**  
Implementation schedule of the reforms



Source: Audit Commission and Healthcare Commission

<sup>1</sup> A further 26 mental health trusts are also now FTs.

first wave FTs, such as South Yorkshire, were early implementers of PbR and AfC, one of the major workforce reforms, and also had one of the first ISTCs. These contrast with other areas, such as Manchester, where progression to foundation status has been relatively slower, as has been the introduction of PbR and other changes. These differences have allowed us to make comparisons to inform our report.

- 23** The reforms support the aspiration to develop a more patient-centred NHS. Box 1 demonstrates how some of the reforms might affect patients using the service.

## Methodology

- 24** To inform the research, we held workshops in Manchester, Peterborough, South Yorkshire and Worcestershire with participants from SHAs, PCTs, acute trusts and FTs to explore their experience of the reforms. Health economies were selected based on their varying progress with reform implementation. In addition to the workshops, which were largely attended by NHS managers, we held structured interviews with hospital clinicians, GPs, non-executive directors, and FT governors. The views of patients were gained through analysis of the results of the DH Choice survey (Ref. 7). We also held a series of interviews with commissioners, providers and strategists based in London. Where necessary, follow-up interviews to further expand on the issues raised at the workshops were held with attendees and other national organisations, including other health regulators; health commentators; and independent sector providers. In total, six SHAs, nine PCTs, six acute trusts and five FTs participated in this part of our research.

### Box 1

#### How the reforms aim to affect patients

Mrs Smith goes to see her GP about a suspected hernia. The GP thinks that she needs to be assessed by a specialist and possibly have surgery. The GP offers Mrs Smith a choice of where she would like to go for her outpatient appointment and also where the treatment might take place. In this instance, Mrs Smith is offered a choice of several providers for the treatment, including an NHS hospital, an ISTC, a private hospital or (for the assessment) a GP with more specialist skills. Her GP provides information on waiting times and infection rates at each provider and this helps Mrs Smith make her decision. All the potential providers meet NHS standards and agree to provide the care for a fixed tariff under PbR: this means that the cost to the NHS is the same wherever Mrs Smith chooses to go for treatment. Mrs Smith does not pay for the treatment, even where it is provided in a non-NHS setting, thus ensuring that the NHS money follows her: so if she chooses to go to the private hospital, they will receive the money for providing her treatment. The workforce reforms have enabled providers to find new ways of working and delivering services, although the quality of the service must meet a set of standards set out by the government.

Prior to the reforms being introduced, the opportunity for Mrs Smith to make a choice about where she wanted to be treated would have been limited. In all likelihood, she would have been offered an appointment at her local hospital and a wide range of options would not have been discussed.

Source: Audit Commission and Healthcare Commission

# 1 Introduction continued

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**25** We also drew on available external literature and relevant aspects from parallel studies on clinical engagement in financial management (Ref. 8), PBC (Ref. 9), PbR (Ref. 10) and quality in ISTCs (Ref. 11). To validate our findings we have also analysed the audited accounts, annual health check results and activity<sup>1</sup> and reference cost data.

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**26** The lack of formal monitoring of the reforms means that we have not carried out a comprehensive examination of the reforms in every single part of the NHS. However, a coherent and broadly consistent picture emerges from the evidence available. To a considerable degree, the study highlights the importance of ongoing evaluation of policy programmes, rather than retrospective assessment, as the better way of judging policy reform. In the absence of a comprehensive, built-in monitoring system, the available evidence provides the only basis for our conclusions.

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**27** It should also be noted that many other factors were influencing the NHS at the time of the reform implementation, including targets for shorter waiting times for treatment and the large increase in NHS funding. It is not possible to specifically attribute the effects of each reform on the NHS. A hospital with a shorter waiting time now than in 2005 might have responded to targets, increased capacity with additional funding or improved service efficiency because of greater actual or potential competition from a private sector ISTC. We

have attempted to separate out the impact of different elements by looking at the extent to which there is evidence of their individual effect, for example, patients taking up a choice, through analysis of quantitative data or from our interview programme. However, it remains difficult to provide a definitive case for any one change as the dominant factor when so many elements have been changing simultaneously. Again, this highlights the need for careful ongoing monitoring of major policy changes. Moreover, the broader the programme, the more difficult it is to identify the most effective components of change.

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## Report structure

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**28** The report presents our findings on the NHS reform programme as set out in Table 1. Chapter 2 considers the impact of the reforms on the commissioning process; Chapter 3 examines the impact of patient choice policy; and Chapter 4 reports on the way that care is now provided for NHS patients. The final chapter provides an overview of the effect of the reforms on the whole health system and looks to the future development of the policies.

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<sup>1</sup> Activity data is derived from the Hospital Episode Statistics (HES) data, which records all NHS inpatients and day patients in NHS hospitals.

# 2 | Commissioning patient care

Commissioning is a process that starts with an assessment of a local population's health and social care needs. The local NHS then sets relevant priorities, allocates resources accordingly and negotiates agreements with providers to deliver services to meet these needs. This may include changing the way in which services are delivered, introducing new forms of provision and new service providers. Commissioners aim to get the best value for patients and taxpayers in terms of the best possible health outcomes, including reduced health inequalities, and the optimum healthcare, all within the resources made available by the taxpayer. Strong commissioning is a central component of NHS modernisation and is essential if the reform programme is to be implemented successfully.

This chapter considers the overall objectives of commissioning, the information needed to commission successfully and the tools and incentives that the reform programme offers to increase its effectiveness.

## Background

**29** Commissioning requires PCTs to consider their priorities and how to deliver more and higher quality services within a PCT's individual financial allocation, resulting in population health improvements. National targets and frameworks have been set to encourage uniform delivery of higher quality services, including better access to services. These include, for example, targets for waiting times in accident and emergency (A&E) departments and for elective care, as well as national service frameworks (NSFs) for coronary heart disease, mental health and diabetes. There has also been a general expectation that, wherever possible, care should be delivered outside hospitals, closer to where patients live.

**30** There are three broad areas of commissioning reform:

- developing the commissioning capability and capacity of PCTs;
- engaging clinicians and devolving responsibility to frontline staff through PBC; and
- providing new incentives and tools to promote better commissioning.

## Developing the commissioning capability and capacity of PCTs

**31** The DH has taken several different steps over the years to improve the quality of commissioning in the NHS. Figure 2 (overleaf) shows how local commissioning bodies have changed over the past eight years. In April 1999, 481 primary care groups (PCGs) were created in England, covering populations of approximately 100,000, to hold health budgets

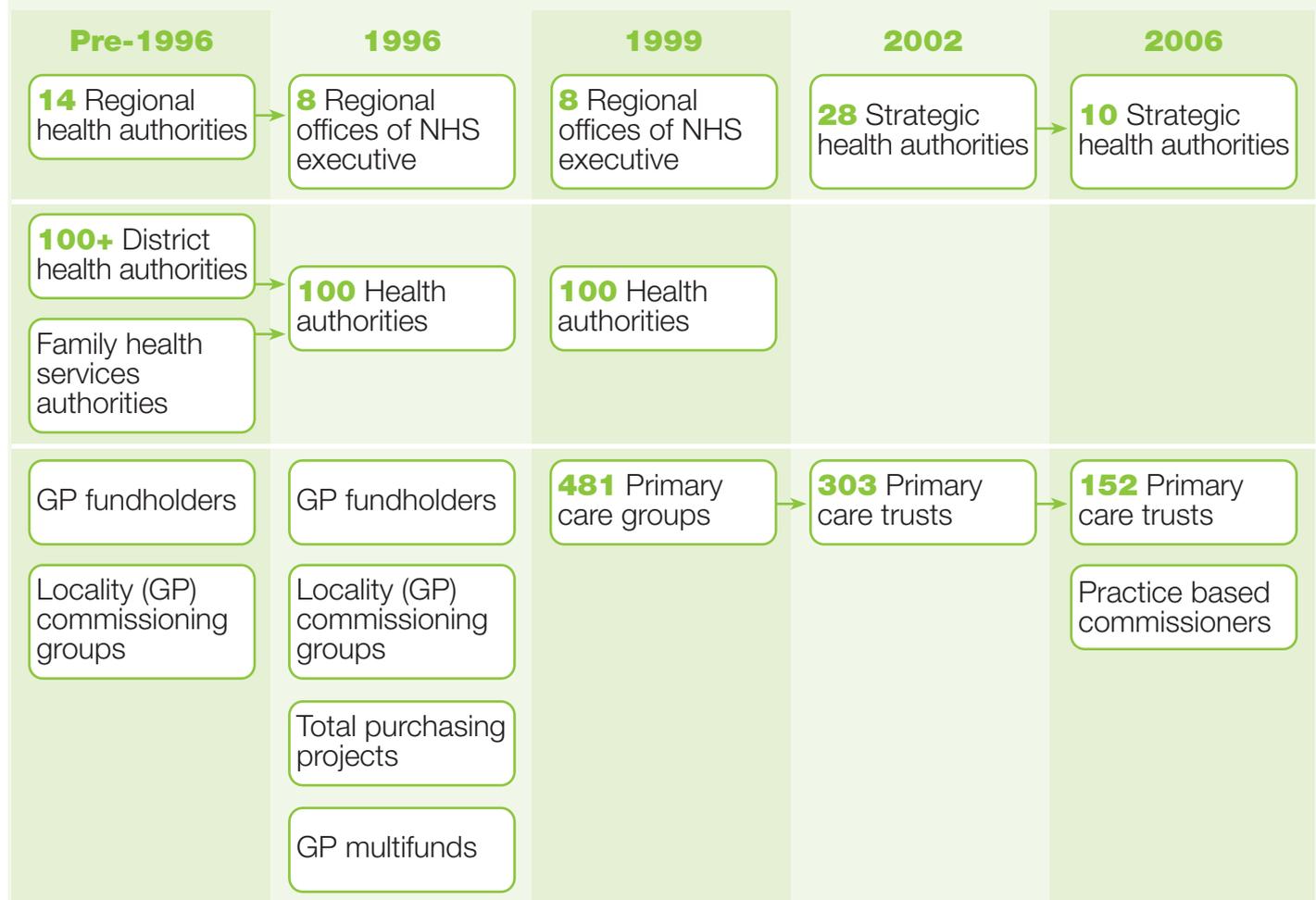
## 2 | Commissioning patient care continued

and commission services for their local population. They acted as sub-committees of just over 100 district health authorities (DHAs), and replaced thousands of GP fundholders and other commissioning arrangements. PCGs were considered to be in the best position to improve local health and the quality of services;

reduce inequalities; advise on the use of a unified budget (which was introduced at the same time and included primary as well as secondary and other care) for the health of the local population; and integrate services through closer partnerships.

**Figure 2**

The changing strategic and commissioning landscape of the NHS



Source: Audit Commission and Healthcare Commission

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**32** Over time, PCGs were encouraged to develop into PCTs, which had the same functions, but were independent of their DHA and were also able to directly provide services; run hospitals and community health services; and employ clinical staff. PCTs were approved in waves, and the first became operational in April 2000. In 2002, DHAs and any remaining PCGs were abolished and replaced by 303 PCTs covering populations of, on average, 170,000. At the same time, 28 SHAs were created to lead the strategic development of the local health service and manage performance, rather than plan and commission services. Some PCTs began working together in larger groups, or clusters, to reduce the transaction costs of contracting and to give them greater purchasing power. In October 2006, many PCTs were formally merged.<sup>I</sup> This led to a reduction in the number of PCTs to 152, with an average population size of over 300,000. At the same time, the number of SHAs was reduced to 10. This reorganisation aimed to facilitate a closer relationship between health, social care and emergency services; to offer an improved and better value service for patients; and to free up more money for frontline services. It also aimed to increase the capacity and capability of individual PCTs, many of which were considered too small to have strong and effective management. These aims followed a familiar theme and echo those of

earlier reconfigurations. The move to larger PCTs has also been matched by greater emphasis on PBC to give more power to frontline staff and a more local flavour to decision making. There are some similarities in the role of the GP in commissioning under PBC when compared with the old system of GP fundholding.

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**33** Each reconfiguration was intended to produce stronger commissioning bodies and hence more effective services in the longer term, as well as reducing management costs. Although the cost of the 2006 PCT and SHA restructuring to the local NHS was at least £192.1 million in 2006/07 (Ref. 12), savings of £90 million have already been achieved in 2006/07 and the NHS is on course to meet its target of £250 million recurrent savings in 2007/08. In addition, the reconfigured PCTs we spoke to felt that they were now stronger organisations, with a greater influence over secondary care, while recognising that their commissioning skills need further development. PCTs are now in a potentially stronger position to utilise and promote the reform levers. In addition, as approximately 70 per cent of PCTs are co-terminous with their local authority counterparts, they are now in a better position to undertake joint strategic needs assessments (JSNA)<sup>II</sup> and commission health and social care services more effectively.

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<sup>I</sup> Following *Commissioning a Patient-led NHS*, DH, March 2006.

<sup>II</sup> The Local Government and Public Involvement in Health Act 2007 requires PCTs and local authorities to produce a JSNA to describe the future health, care and well-being needs of their local community, and the strategic direction of service delivery to meet those needs.

## 2 | Commissioning patient care continued

**34** However, reorganisation has undoubtedly slowed the pace of change of reform and, in each case, temporarily weakened commissioning capacity as management attention has been diverted and new organisations have had to work hard to establish themselves. This can be seen in the greater proportion of lower scores achieved by new PCTs in the Healthcare Commission's 2007 annual health check, including their use of resources scores derived from the Audit Commission's Auditors' Local Evaluation (ALE)<sup>I</sup> judgements. Until the most recent reforms, which are themselves a sign of the potential limitations of earlier structures, the focus on commissioning was less emphatic. Following the 2006 PCT restructure and reform of commissioning roles, the focus has been much stronger. However, as the impact of the 2006 structural reorganisations were still being felt while we were carrying out the fieldwork for this study, it is relatively early to provide an assessment of the current strength of commissioning.

**35** The last two PCT reorganisations have been accompanied by central initiatives to improve and strengthen commissioning. Following the initial creation of PCTs in 2002, the NHS Modernisation Agency<sup>II</sup> rolled out a national initiative to work with every PCT to help them become fit for purpose by providing support

with organisational development. The 2006 reorganisation was accompanied by independent PCT Fitness for Purpose reviews which assessed each PCT, identified gaps (particularly in their financial strategy) and produced action plans. All the newly reconfigured PCTs (70 out of 152), were rated as showing weakness on a range of measures, such as finance, strategy and provider management.

**36** Commissioning capacity and capability is to be strengthened further through the DH-led *World Class Commissioning* initiative. This has identified a series of competencies against which PCTs will be assessed and given support or greater freedom as a result. The overall aim is to improve health outcomes and reduce health inequalities, and ensure that issues requiring a medium to long term focus are not crowded out by short term imperatives.

**37** The DH plans to use an assurance system to drive performance and development, and reward commissioners as they move from their current position towards defined 'world class' standards. This will be managed by SHAs. The DH is also developing a framework to give commissioners access to the tools that they need to drive improvements. Commissioners will be able to identify areas for their own development and select the most appropriate tools for their local circumstances. These tools

<sup>I</sup> The Audit Commission's ALE assesses how well NHS trusts and PCTs manage and use their financial resources and is used to inform the Healthcare Commission's annual assessment of NHS bodies.

<sup>II</sup> The NHS Modernisation Agency was conceived by the NHS Plan (DH, 2000) as part of the focus on patient-centred care, and came into operation in 2001, before disbanding in 2005. It was designed to support the NHS (predominantly local clinicians and managers) and its partner organisations to modernise and redesign local services and improve health outcomes and patient experiences.

may include sharing services and good practice, developing internal resources, or buying in external, independent expertise, for example through the Framework for Securing External Support for Commissioners (FESC).<sup>1</sup>

### Engaging clinicians and devolving responsibility

**38** Commissioning at PCT level can be seen as relatively remote from individual patients and clinicians, particularly since the creation of larger PCTs. As such, it could lack flexibility to drive locally responsive services. It has therefore been seen as important to engage GPs in commissioning. GPs are close to patients and have the scope to design and commission more responsive services for local needs.

**39** PBC is the latest approach to the devolution of power to frontline staff to facilitate better local commissioning, and therefore improved local services. Like its predecessors, it aims to align clinical and financial responsibility. It has many similarities but also important differences when compared with GP fundholding. The aims of the policy and advantages for patients are:

- a better way to manage financial risk;
- a greater choice of treatments;
- an increased range of services provided locally;
- alternatives to hospital admission;

- seamless care between providers; and
- reduced inequalities of outcome.

**40** Under PBC, PCTs continue to be legally responsible for funding and contracting with providers, the overall commissioning strategy and for the implementation of PBC. But, by devolving indicative budgets to general practices that treat and refer patients, GPs and other primary care professionals are encouraged to manage referrals and to commission and redesign services in a way that is more cost-effective and convenient for patients. The Audit Commission's 2007 report, *Putting Commissioning into Practice*, provides detailed information on how the financial management arrangements of PBC are working; the incentives for GP practices to engage with it; and the obstacles to its introduction (Ref. 9).

**41** PBC was first introduced in April 2005. In 2006/07, the DH issued incentive payments to encourage GP engagement with PBC. These are estimated to have cost £98 million in 2006/07 (Ref. 12). According to DH figures, 96 per cent of practices received a payment. However, PCTs in our fieldwork reported that the high uptake of the PBC incentive payment did not reflect the current progress with PBC. *Putting Commissioning into Practice* found that, in reality, PBC was being carried forward by small numbers of enthusiastic practices, often former GP fundholders. A DH survey in March 2008 showed different levels of support

<sup>1</sup> FESC is designed to complement existing frameworks used by the NHS, particularly PCTs, to procure services. For example, to employ external consultancy charged on a day-rate basis or to provide the opportunity for PCTs to partner with independent providers to undertake aspects of the PCT commissioning function.

## 2 | Commissioning patient care continued

for PBC across GP practices: 62 per cent of practices supported the policy, 17 per cent opposed it and 19 per cent had no strong feelings either way (Ref. 13). These figures are not significantly different from the findings of the previous Wave 1 survey. While the payments, along with PCT support, have offered an incentive for some practices to engage, most PCTs in our fieldwork saw PBC as an important vehicle for improving care and making the best use of resources, and were keen to develop it further.

**42** PBC has yet to have a significant effect on the redesign of services and the transfer of care from a secondary to a primary care setting. Where transfer is occurring, it does not appear to be as a direct result of PBC. Trusts in our fieldwork reported that PBC was not yet significantly influencing the levels of activity in their organisations, for example through more effective demand management. While PCTs felt that PBC had been useful as a tool for clinical engagement, it had yet to deliver benefits for patient care. These findings are supported by the DH's GP practice survey in March 2008 (Ref. 13). This revealed that 52 per cent of practices had commissioned no new services as a result of PBC and 30 per cent had commissioned only one or two new services. In addition, only 16 per cent of practices felt that PBC had improved care to date. That said, where PBC was found to be working well, practices were beginning to have a greater understanding of the financial consequences of their clinical decisions.

**43** *Putting Commissioning into Practice* found that many practices were more interested in directly providing, rather than commissioning, new services. As the NHS is an organisation that naturally looks to provide rather than commission care, this focus is perhaps unsurprising. However, there is some frustration among PCTs that GPs are focusing on providing profitable services, rather than on commissioning innovative ways of delivering services or dealing with health inequalities. The incentive for GPs to commission services is weak and this is an area that should be strengthened within PCTs.

**44** Good financial management is critical to the success of PBC. Engagement with, and of, budget holders; a clear understanding of the financial consequences of individual actions; the alignment of resources with strategic objectives; and the provision of timely and relevant information are critical factors in achieving high quality financial management (Ref. 14). Box 2 details the specific factors that we consider to be central to the successful implementation of PBC.

**45** With increased stability and a greater focus on the policy in PCTs, together with the right financial incentives, the outputs from PBC may improve over time. For PBC to achieve its full potential, PCTs will have to improve the level of practice engagement and shared ownership of objectives. They also need to address key points about developing the infrastructure for PBC, particularly the provision of information for practices. If GPs see other practices either delivering better patient care or investing savings made through PBC, then these are likely to stimulate further interest. Peer pressure

and PCT support will also advance the initiative. Lord Darzi's interim report for the NHS review (Ref. 15) and the 2008/09 operating framework (Ref. 16) have also reinforced the centrality of PBC, but more effort, greater shared ownership, training and analytical capacity and improved infrastructure will be required if PBC is to meet its potential.

**46** The available quantitative evidence, fully supported by our interview findings, indicates that the level of genuine GP engagement in PBC is still relatively low. As such PBC is not yet delivering a wide range of more flexible, local services for patients. Where such services are evident, this is partly because GPs wish to take on the provider role for such services.

**Recommendation: Stronger working relationships need to be developed within PCTs to engage GPs more effectively in commissioning and particularly PBC. PCTs must adopt a rigorous approach to approving business cases in order to tackle the potential tension for GPs as providers of new community-based services and as commissioners of services for their practice population.**

## Box 2

### Factors central to success of PBC

- timely provision of robust budgets which are well understood and accepted by the GP practices that commission services;
- regular, accurate and easily understood information that enables GPs to monitor progress;
- training and analytical capacity in GP practices;
- freedom and support for practices to make changes and to generate and use savings for the benefit of their patients;
- good governance arrangements for approving business plans and overcoming any potential conflicts of interest when practices use their commissioning budgets to purchase from themselves; and
- greater shared ownership between PCTs and practices on how resources should be used to support strategic objectives.

Source: Audit Commission, amended from Putting Commissioning into Practice

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## 2 | Commissioning patient care continued

### New incentives and tools to promote better commissioning

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**47** In principle, commissioners have always had a strong incentive to make best use of the funds available to them and to provide cost effective care for their residents. For example, PCTs can limit the number of unnecessary admissions to hospital by securing better primary care, or commission alternative services outside hospital that are more convenient for patients. PCTs have also contributed to NHS improvements through their commissioning activities, for example, by reducing waiting times or enabling patients to be discharged promptly from hospital. However, the reform programme introduced new incentives and tools for PCTs to improve commissioning. These include:

- PbR, which gives PCTs a clear financial incentive to strengthen their commissioning function. For example, negotiating and enforcing balanced contracts, ensuring accurate payments for activity, agreeing demand management strategies and moving care out of hospital into a community setting, where it is the patients' best interest to do so;
- demand management, reinforced, for example, by the provision of data identifying those patients most likely to be at risk of admission to hospital and the introduction of community matrons with a specific remit to provide better care outside hospitals to people with long term conditions; and
- using competitive tendering to secure better value and higher quality service provision.

These changes should, in theory, result in more care being provided outside hospital, fewer unnecessary hospital admissions and greater pressure on providers to improve their services. This chapter indicates that some progress is being made in each of these areas, although the extent to which it is being achieved is variable.

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### Payment by Results

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**48** PbR was introduced in 2003/04 as a single rules-based approach to paying for acute and specialist NHS hospital services. It directly links provider payments to the activity they undertake, thereby allowing money for treatment to follow the patient. Before PbR, NHS trusts relied on locally negotiated block contracts, based on a compromise between provider costs and what commissioners could afford to pay, that were often only tenuously linked to outputs. PbR creates a clear link between volume, the complexity of the activity undertaken, and payment. This enables providers and commissioners to have greater clarity over funding. The aims of PbR are:

- to enable faster access to more appropriate, patient responsive services;
- to drive efficiency;
- to enable a focus on quality; and
- to ensure fairness and transparency of funding.

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**49** The funding transparency that PbR has introduced to the NHS has helped both commissioners and providers plan and operate more effectively. Both can now demonstrate a clearer link between payment and activity. This has led to many trusts reviewing their activities and how they were being funded. For example, we found that one such review identified a number of special clinics that were providing a useful service, but which had not actually been commissioned by the PCT. This situation was reassessed and funding provided for those clinics through a specific funding stream. Trust managers also report that PbR has formalised the process for setting up a new service and that consultants are no longer able to set new services up without a clear funding stream.

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## Demand management

**50** Although PCTs have always been engaged in initiatives to manage demand for hospital activity, also referred to as care and resource utilisation, the introduction of PbR has increased the number of demand management activities and their overall importance. Commissioners need to address the financial risks associated with hospitals being rewarded financially for increasing their activity. The national tariff enables PCTs to move funds more easily when they achieve a reduction in hospital activity. PbR also gives commissioners an incentive to move care from a hospital setting to a more cost-effective community one where appropriate. Previously, block contracts made it difficult to move money out of the hospital if the service was delivered in a new setting, as the hospital could always

demonstrate that it had, at most, incurred only a marginal reduction in costs.

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## Providing care closer to home

**51** Providing care closer to home has been a perennial feature of health policy for successive governments. The *NHS Plan* reaffirmed the direction of policy. The government's white paper *Our Health, Our Care, Our Say* (Ref. 17) further reiterated it and outlined plans to provide more convenient local patient care, outside hospitals and closer to home. The recommendations from Lord Darzi's review are expected to consolidate this. Such a shift in the provision of care would be one of the outcomes of effective commissioning, using the tools and incentives available.

**52** Many trusts we interviewed were also planning to transfer some of their services to primary or community care, in consultation with their PCTs. For example, one trust, working at maximum capacity planned to move less complex surgery out of the hospital, so that they could focus on their core work. Another trust was working with their PCT to develop alternative pathways, having recognised that resistance to change may result in lost revenue. However, despite these examples, service redesign currently tends to focus on the services that both the trust and PCT agree should be moved. The point may come where PCTs want to start moving services into primary or community care that trusts want to retain themselves and relationships may therefore change.

## 2 | Commissioning patient care continued

**53** In theory, PbR can provide incentives for PCTs to develop alternative primary and community services where they are more clinically effective and cost-effective. However, as noted in *The Right Result?*, in order for PbR to support care closer to home and to enable much greater flexibility in regard to the location of treatment, the ability to unbundle the tariff into its component parts needs to be strengthened, alongside the creation of a 'setting independent' tariff; a tariff which remains the same regardless of where the patient is treated. At present, making use of indicative tariffs for unbundling, for example for rehabilitation and diagnostic imaging, is challenging, as they are not mandated and require local agreement. HRG4, which is intended to form the basis for the national tariff from 2009/10 at the earliest, will support both unbundling and a tariff which is the same regardless of the setting in which services are delivered. In the meantime, however, progress on delivering care closer to home appears to be slow.

**54** National activity data suggests that there has not so far been a significant transfer of care between the secondary and primary sectors. However, at a local level, many PCTs can point to individual schemes and local progress. Case study 1, previously seen in *The Right Result?*, sets out the approach of Wirral PCT. It has achieved progress through service and pathway redesign, with benefits for patients.

### Case study 1

#### Redesigning the Diabetes care pathway – Wirral PCT

Wirral PCT was established in October 2006, covering a population of approximately 335,000 with a budget of £504 million for 2007/08.

The PCT is keen to take a modernised approach to commissioning and has undertaken initiatives in innovative service redesign in 14 areas across secondary, primary and community care. One such area is diabetes where, before 2004, approximately 70 per cent of services were provided in secondary care, and the remainder in primary care.

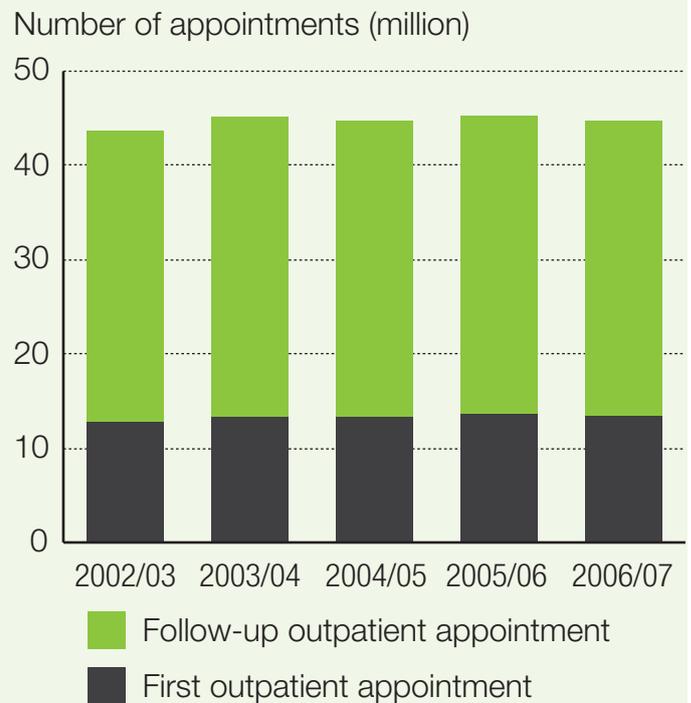
In order to move more diabetes care provision into the primary and community sectors, where appropriate and cost-effective, the PCT has set up a Diabetes Enhanced Service. Protocols and transfer arrangements have been agreed with secondary care and now more than 70 per cent of care is provided in a primary care setting. The Wirral Diabetes Register has been set up. Practice nurses and GPs have been accredited and trained in specialised diabetic care and diabetic technicians have been employed and trained. For example, over 80 per cent of diabetic patients now have regular foot checks. Patients who develop complications are referred to hospital where they will be seen immediately by the Specialist Diabetes Team rather than waiting for a consultant's appointment. Patient education is a key aspect of the programme and has been commended by the National Diabetes Audit.

The benefits have been a reduction in waiting times from three to four months to one to three weeks. By providing the service in this way, the PCT have also been able to make significant savings through PbR.

Source: Audit Commission

**55** Data collected on activity in primary and community care are limited and often of poor quality and this needs to be strengthened if significant volumes of activity are to be transferred. Although the *NHS Plan* stated that, by 2004, consultants that previously worked only in hospitals will be delivering approximately four million outpatient consultations in primary care and community settings, no data is currently collected to monitor this, which is a situation that urgently needs to be addressed. If this target had been met, there should have been a noticeable decrease in the number of outpatient appointments, or at least a change in the rate of growth. However, Figure 3 shows that the number of outpatient<sup>1</sup> appointments has remained constant. This pattern is repeated for early wave FTs, later wave FTs and NHS trusts. The rate of new to follow-up appointments has also remained fairly constant.

**Figure 3**  
The number of hospital outpatient appointments has remained constant



Source: Audit Commission and Healthcare Commission (data from HES)

<sup>1</sup> Outpatient, or ambulatory care, refers to those patients who receive a consultation and/or treatment without being admitted to hospital or requiring an overnight stay.

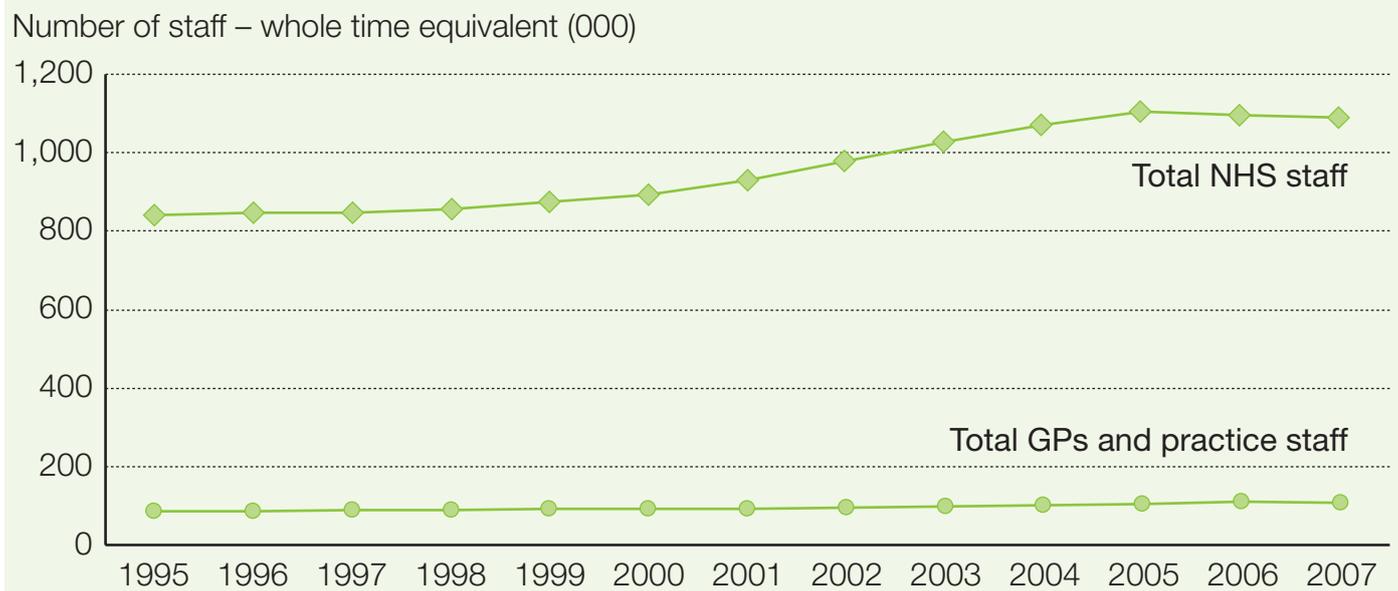
## 2 | Commissioning patient care continued

- 56** The *NHS Plan* also outlined how the range of services offered in primary care would expand and introduced the concept of GPs with a specialist interest (GPwSI). These are GPs who supplement their generalist role by delivering a specialist service, often in areas where there are access problems such as urology or dermatology. They may deliver a clinical service beyond the normal scope of general practice, undertake advanced procedures, or develop services. The *NHS Plan* set a target for 1,000 GPwSIs to be in place by 2004, which has been supported by further policies, such as *Commissioning a Patient-Led NHS* (Ref. 18) and *Our Health, Our Care, Our Say* (Ref. 17). This was met a year early and PCTs report that there are now 1753 working in the NHS.<sup>11</sup> However, the impact that GPwSIs have had on the transfer of care is unclear.
- 57** In addition, while the number of staff in primary care is increasing, it is increasing at a slower rate than in secondary care (Figure 4). If more care was being delivered in a primary care setting, it would be expected that there might be a difference in the relative growth of primary and secondary care staff. While it is possible that some spare capacity to take on additional work existed in primary care, it is unlikely that this alone accounts for the relatively small increase in staff. Once again, a more likely explanation appears to be that the transfer of care is not so far occurring on the scale that was envisaged.
- 58** There are nevertheless a number of practical challenges which may explain the slow rate of transfer. It is not always cost-effective to move care to a primary care setting and there are short term issues if the PCT has to fund the old and new services simultaneously during the transition. Double running costs have been a perennial problem for the NHS but the current expected surplus of £1.8 billion in 2007/08 may provide funds to help ease transitional problems.
- 59** Despite the policy intention to move care closer to home, in our fieldwork it was reported to us that many trusts were planning to expand existing services. As highlighted in *The Right result?*, the operation of PbR provides clear incentives to hospitals to expand their elective activity in particular and thereby their income, with the FT financial regime encouraging greater profitability. However, nationally the picture is less clear, with some trusts planning to reduce activity to take account of successful PCT demand management initiatives.

<sup>11</sup> This figure is taken from the Quarterly Activity Returns that commissioners complete for the DH (correct as at end December 2007).

**Figure 4**

The number of staff in primary care is increasing but at a slower rate than in secondary care



Source: Audit Commission and Healthcare Commission (data from NHS Hospital and Community Staff (HCHS) and General and Personal Medical Services)

**60** Furthermore, our interviews identified concern about the expansion or development of services, which may lead to inappropriate or over-investment in service capacity. In many cases, PCTs felt that they had not been engaged and had conflicting plans to reduce hospital activity. Strong and effective commissioning would mean that it should not be possible or financially viable for a provider to propose spending money to increase activity if this proposal is not backed up by robust

purchasing intentions. Moreover, the rewards of autonomy are matched by the risks of competition and failure inherent in the market-managed environment. There are increasingly effective turnaround processes already in place to help those trusts that are financially challenged. However, the idea of a bankruptcy regime which has been put forward frequently since 2002, could help to impose financial discipline across the board.

## 2 | Commissioning patient care continued

**Recommendation:** SHAs, and PCTs as commissioners, will need to have a clear understanding of the planned changes in service provision levels in their areas, across all providers, whether they are ISTCs, NHS trusts or FTs and how this relates to the funding available and commissioning plans. This will help to ensure that the NHS as a whole does not develop capacity that is not required by, or is unaffordable to, PCTs and practice based commissioners.

### Competitive tendering

**61** There is some evidence that PCTs are using open tendering<sup>1</sup> as an effective tool to commission high quality services that offer the best value for money, particularly when provision is unavailable or does not meet required standards. Bidders for the service may include providers from the public, the private and voluntary sectors. Commissioning through an open tender process generates competition for the market, unlike patient choice (Chapter 3), which generates competition within the market. Case study 2 shows how Wirral PCT (winner of the HSJ Primary Care Organisation of the Year Award 2007) used competitive tendering to secure better genito-urinary medicine services. However, this also shows that competitive tendering can involve significant management time and PCTs should consider this before embarking on this process. The DH's competition policy highlights the role of the commissioner in deciding where to tender (Ref. 19).

### Case Study 2

#### Competition increases quality of services and value for money – Wirral PCT

Wirral PCT was established in October 2006, covering a population of approximately 335,000 with a budget of £504 million for 2007/08. In 2007, the PCT began a process to put the genito-urinary medicine service, which was previously provided by the local FT at a cost of £1.4 million per annum, out to tender.

The PCT used the tender process to improve the service provision to patients, to commission a community-based service and to challenge the value for money of the existing service. The PCT received four bids for providing the service from a range of providers. The tender was awarded to the FT with a revised specification and significantly reduced cost, saving £735,000 over a three year period.

While the PCT recognises that the competitive process has achieved its objective of a better provision of care for patients at lower cost, it should not be understated that the process of going out to tender and subsequently selecting a provider had a significant financial cost to the PCT in terms of diverting management time and opportunity costs.

Source: Audit Commission and Healthcare Commission

<sup>1</sup> Open tendering is the process by which a contract for the provision of services is awarded on an open and competitive basis according to specified criteria or outcomes.

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**62** Once again, while there are examples of local action, we did not find evidence that competitive tendering had a significant impact on a national scale.

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### **Commissioning patient care – Summary**

**While initiatives to improve the quality of commissioning are not in themselves new, some of the levers and incentives available for improvement are. PCTs are responding to improve commissioning and are using some of the tools and incentives that are available. While the initiatives are having some local impact, they are yet to have effect on a national scale. Given that the last PCT reorganisation was in 2006, PCTs need time to progress this agenda. More work is needed to strengthen commissioning and, without this, the reform programme will not succeed.**

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# 3 Patient choice

Choice policy aims to enable patients, in conjunction with their GP, to decide where and how elective care is provided. Previously these decisions have often been made solely by clinicians on the patient's behalf.

This chapter provides information on the aims of choice policy, and comments on both the availability of choice and factors influencing it. While recognising that there are different types of choice, for example, choice of inpatient provider, choice of long term community care provider and even choice of GP, this chapter specifically addresses first referral to elective care only. It also suggests changes that could be made in the future to support the aims of the policy.

## Background

**63** A key component of the government's drive to improve public services is to encourage more knowledgeable, assertive services users to exercise greater choice and control over the services they receive. Choice in healthcare has many aspects. It is widely recognised, for example, that choice of treatment and greater involvement in decision making about their care are very important to patients. The government is pursuing a number of initiatives to encourage greater involvement of patients in their care. Choice policy has now been extended into services for long term conditions and maternity services. Our focus here, however, is on patients being systematically offered a choice of where to be treated at first referral to planned secondary care, which was a major component of the reform programme to introduce greater competition into the NHS. The government expects that, over time, choice will be a significant driver of improvement in provision of services, as the public chooses not to receive services from poor quality providers and competition between providers increases. It also believes

that formalising the arrangements for greater choice would help less well-informed service users who have less ability informally to influence how, where and when their care is provided. PbR is also an enabler of patient choice as it facilitates the movement of funds between providers, based on the individual patient and where treatment is provided. Box 3 outlines the aims of choice policy.

### Box 3 Aims of choice policy

The DH believes that choice will:

- be key to the NHS delivering, responsive, patient centred services;
- help to tackle health inequalities, as poorer sections of society are the strongest supporters of greater choice and information to support choice; and
- offer powerful incentives for providers to improve the quality of their services.

Source: Department of Health

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**64** Choose and Book is considered by the government to be a key component of choice. It is a national service that combines electronic booking with a choice of place, date and time for first outpatient appointment. Under this system, patients are able to choose their initial hospital appointment at their choice of provider, and book it during their GP appointment or later, at a time that is more convenient to them, on the telephone or via the internet. The roll out of Choose and Book began during 2004, but progress has been slower than expected, as the strategy for implementation changed. GP engagement with the system has been limited due to concerns about its reliability and the lack of appropriate technology at the local level to support its implementation. Contrary to the government's expectation, some GPs have chosen not to use it, while some others report that it is difficult to use, which has undermined its impact.

**65** Within the Healthcare Commission's annual health check for 2006/07, a Choose and Book indicator was introduced. PCTs were required to agree a planned trajectory with their respective SHAs for Choose and Book utilisation, with the goal being 90 per cent utilisation by March 2007. This was also one of the key priorities of the 2006/07 *NHS Operating Framework*. Only 11 per cent of PCTs achieved<sup>I</sup> this indicator, while 58 per cent

failed. The remaining 31 per cent of PCTs underachieved on this indicator which would appear to suggest that the challenge of persuading GPs to adopt the new system has been greater than anticipated.

**66** The range of providers available through the choice policy, offered to NHS patients has increased over time. Choice at referral to hospital was introduced in January 2006, offering elective patients the choice of at least four hospitals, or 'suitable alternative providers' (which include independent sector providers).

**67** The *Operating Framework for 2006/07* (Ref. 20) gave a commitment to extending choice, which came into effect in April 2008. This gives elective patients the option of not only choosing from the four or more providers commissioned locally by their PCT, but also from any NHS FT or nationally accredited independent sector providers, where clinically appropriate, and that meet NHS standards and costs as listed on the Extended Choice Network's<sup>II</sup> national menu. This is known as free choice. Some PCTs reported being frustrated by the requirement to offer extended choice and the administration that is required to support it, particularly when patients are situated in rural locations and the level of real choice is limited.

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<sup>I</sup> Performance relating to the Choose and Book indicator is graded in the following way: Achieved: actual performance greater than or equal to 75 per cent of planned performance; Underachieved: actual performance greater than or equal to 55 per cent of planned performance and failed: actual performance less than 55 per cent of planned performance.

<sup>II</sup> The extended choice network, introduced in April 2006, consists of services provided by NHS and alternative, independent sector providers from which NHS patients can choose when referred for treatment by their GP.

## 3 Patient choice continued

**68** Having previously been offered as a referral choice locally, one independent sector provider we interviewed reported being removed from a PCT's choice menu towards the financial year-end. The provider believes this was due to a combination of limited availability of PCT funds and the PCT's flawed belief that the NHS trust was a more cost-effective alternative. Although this situation should no longer arise as a result of the implementation of free choice, PCTs should be monitored carefully. The DH's *Principles and Rules for Cooperation and Competition* (Ref. 19) set out that this practice is unacceptable. SHAs should monitor this situation to ensure that PCTs are offering continuous choice throughout the financial year.

**69** SHAs have a role in ensuring that PCTs offer choice to their patients through routine management of PCT performance. According to the DH, PCTs should be supporting patient choice by:

- allowing patients to choose from any hospital that meets NHS standards and costs;
- working with the local health economy to increase the utilisation of Choose and Book;
- engaging GPs so that they are aware of the benefits of choice and their role in ensuring clinically appropriate choices;
- providing patient information and access to non-clinical support; and
- raising public awareness about choice policy.

**70** The DH has not collected information that enables the precise cost of implementing the choice policy to date to be established. However, it has assessed the additional costs of implementing a free choice of provider from April 2008, over and above the cost associated with a choice of four providers. The DH estimated that the annual economic, environmental and social costs of implementing this free choice ranges between £4.9 million and £43.1 million.<sup>1</sup> There is clearly significant variation in the figures, which reflects uncertainty about some of the assumptions used, such as the cost of patient transport.

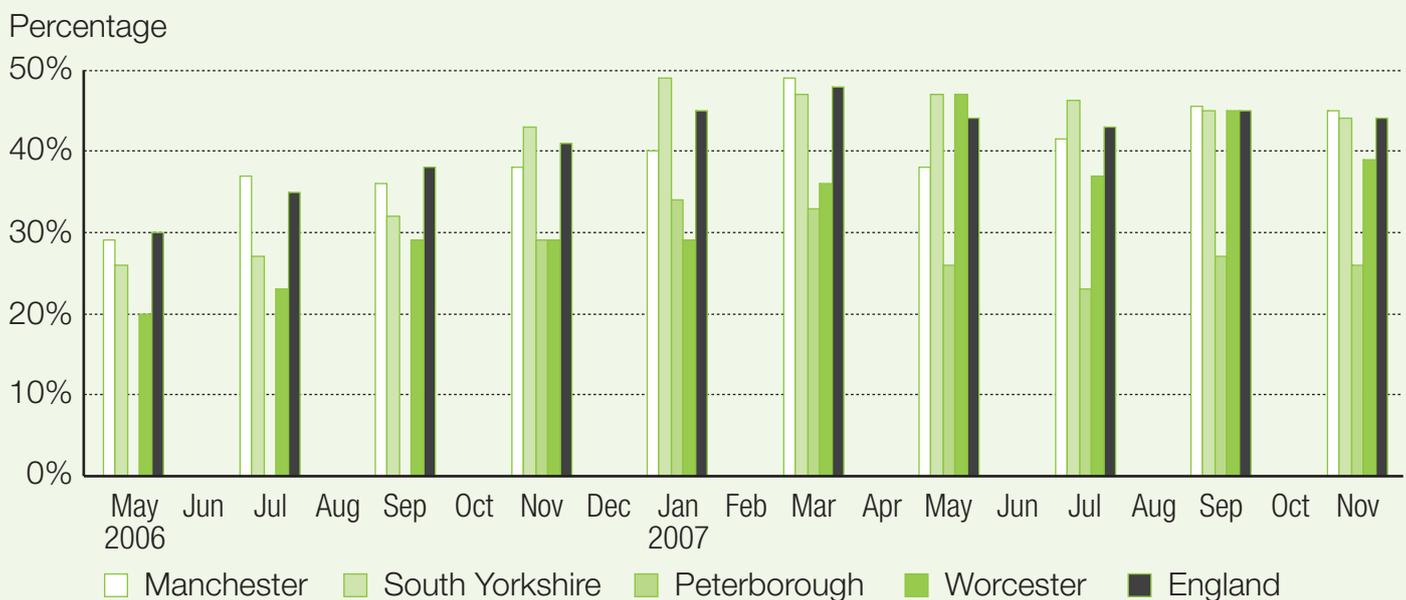
### **Progress on implementing the patient choice policy to date is limited, despite some local enthusiasm**

**71** PCTs support many of the principles of the patient choice policy, including supporting patients to become more involved with their healthcare decisions and using patient choice to improve the quality of their services. However, some difficulties are reported with the policy implementation, and local enthusiasm for taking it forward varies. It is therefore unsurprising that there is variety in the level of choice offered to patients. Figure 5 shows the extent of choice that was offered in the four health economies involved in our study and across England. These results show that the level of choice offered to patients is limited: in November 2007 only 44 per cent of patients in England remembered being offered choice and no PCTs met the 80 per cent target by March

<sup>1</sup> These figures were provided by the DH, based on their Regulatory Impact Assessment regarding the introduction of free choice.

**Figure 5**

There is variation in the level of choice that is offered to patients\*



\*Note: Peterborough data only included from October 2006 following the creation of Peterborough PCT.

Source: Audit Commission and Healthcare Commission (data from National Patient Choice Survey reports, Department of Health).

2007. Although this is disappointing, it does show that some progress has been made over the past year. It may also underestimate the true level of choice, as the DH measure relies on patients remembering an initial conversation with their GP several weeks after it has occurred. However, there is clearly more work to do to ensure that all patients are offered genuine choice and to address any local and regional variations.

## 3 Patient choice continued

**72** Some areas are working hard to address the issue of local variations. NHS North West has consistently been one of the better performing SHAs with regard to the DH patient choice survey. The SHA have several PCT referral management centres, and although individual arrangements by PCT vary, they offer additional support for patients in making their choice and initially there was a definite link between high performing PCTs and the presence of a referral management function. The SHA recognise that using the Choose and Book system to make referrals prompts choice discussions and therefore they encourage referrals to be made in this way where possible. The use of paper referrals which bypass Choose and Book and referral management functions may go some way to explaining why performance in the patient choice survey has shown slower progress than expected. GPs in general have expressed concern, in our study and in other reports, about the time taken in a consultation to work through the Choose and Book IT system with patients and the technical limitations of the system.

**73** NHS East Midlands SHA is also a consistently high performer in the DH's patient choice survey, with 52 per cent of patients remembering that they were offered choice. The SHA attributes this to strong leadership within the SHA and highlights that providing choice is one of the SHA's key aims. The SHA Choice and Choose and Book Programme

Board provides a clear link between the booking and choice options and ensures that there is senior commitment to this agenda in each PCT. However, more work is needed to achieve the 80 per cent operational standard for choice that it has agreed with the DH. Case Study 3 demonstrates the successful implementation of Choose and Book in East Lancashire PCT.

### Factors influencing patient choice

**74** The DH has been recording the factors influencing patient choice since May 2006. Figure 6 (overleaf) shows the top six factors that patients said were important in influencing their choice for provision of care (Ref. 7). Until early 2007, location was the single biggest factor influencing patient choice. This was broadly consistent with findings from the London Patient Choice Project (LPCP)<sup>1</sup> evaluation (Refs. 21, 22, 23, 24 and 25), which found that, patients were less likely to choose a provider with a shorter wait if there was a longer travelling time (Table 2, overleaf). It also found that if the NHS paid travelling expenses (which is only a national policy for low income groups), it made the alternative provider more attractive. The most recently available DH survey (November 2007) found that 76 per cent of patients said that their decisions were influenced by the cleanliness of the hospital. Location however has dropped to sixth position.

<sup>1</sup> The LPCP was established in 2002, with funding from the DH until April 2004. Its aims were to improve waiting times and satisfaction for patients in London; develop a working system and the capacity necessary to support choices made; and provide learning for the national programme. The project was subject to thorough evaluation, covering the following areas: Patient experience (Refs. 21 and 22); Organisational impact (Ref. 23); System wide impact (Ref. 24); and Transport (Ref. 25).

### Case study 3

#### Referral Management Centre – East Lancashire PCT

East Lancashire PCT's referral management centre provides a central hub for GP patient referrals, approximately 90 per cent of which come from Choose and Book. The centre offers administrative support to GPs and non-clinical information to patients.

The centre has a dedicated Choose and Book team that works on a daily basis with GPs to ensure successful implementation of Choose and Book and smooth running of patient referrals. This team works on all aspects of choice and the Choose and Book process.

Once the referral is correctly inputted, a dedicated member of the referral management centre team contacts the patient to offer them their choice providing non-clinical information. The team is driven by the patient experience and offers a personal touch. Team members have a large knowledge base and make a point of knowing all the providers offered on their choice menu, so they can give the information that the patient wants to know, for example car parking and other available facilities. The PCT contracts with the independent sector. However, most of the staff at the referral management centre did not have any experience with private hospitals, and therefore they were sent to contracted independent sector centres to see first hand how they were run, what facilities they had, and what their experience was. This in turn allowed them to provide accurate information to patients enquiring about the independent sector facilities available to them through choice, and how they compared with an NHS hospital.

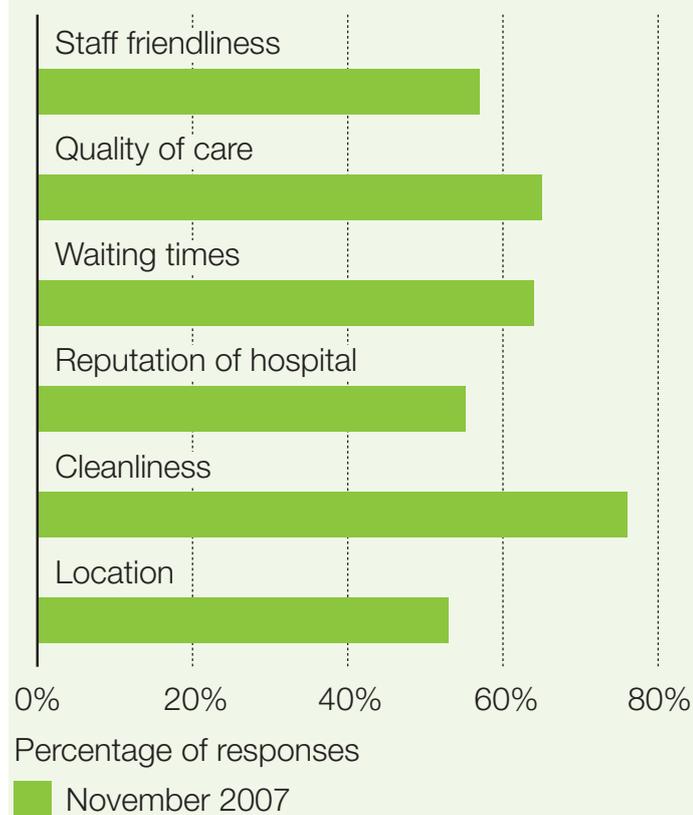
The PCT credits its high levels of patient choice implementation to the hard work and dedication of the team that runs the referral management centre and its efforts in getting GPs engaged from the start in the move towards implementation of Choose and Book.

Source: Audit Commission and Healthcare Commission

# 3 | Patient choice continued

**Figure 6**

The top six factors influencing patient choice for care\*



\*Note: Patients were invited to select, from a list of factors, those they considered most important to them when choosing a hospital.

Source: Audit Commission and Healthcare Commission (data from DH November 2007 patient choice surveys)

**75** The choice policy is intended to encourage patients to choose providers based on a range of indicators such as those that might offer shorter waits, more convenient locations or higher quality care. Factors, such as the success rate for operations and reputation of surgeon were ranked highly in the LPCP survey.

**76** It is important to highlight the different environment in which the LPCP was operating. Under this initiative, only two thirds of patients were eligible to choose and, as in Peterborough (Case Study 4) they were offered choice only after they had already waited over eight months, not at the point of referral. They also had patient care advisors to guide them through the process and to act as a link between the hospital and alternative provider. In addition, given the volume of providers in London, excess travel and location issues were reduced.

**77** In addition to the different target population, the overall difference in findings between the LPCP evaluation and the DH patient choice survey (Figure 6) may reflect that in the DH survey, patients were asked to cite important factors when choosing a hospital for their elective care whereas the LPCP evaluation reviewed the factors influencing both hypothetical and real choice decisions. Given that data are not available on many of the factors listed as most important in the LPCP survey, it is difficult to see how they would have informed decision making. For example, success rates in surgery were the most common factor in the LPCP, but these are not universally available at a local level for most treatments.

**Table 2**

Factors in the London Patient Choice Project that would influence choice of hospital (patients asked before surgery)

Factor	Number	Percentage saying 'very important'
High success rates for operation	1666	86.7%
High standard of cleanliness	1663	86.1%
Good communication between hospitals and GP	1659	82.6%
Reputation of surgeon	1649	77.1%
Follow-up care close to home	1670	74.1%
Reputation of hospital	1644	72.1%
Shorter waiting time	1655	64.5%
UK not abroad	1631	46.2%
Friends and family can easily visit	1626	37.5%
Comfortable journey	1636	36.9%
Not too far from home	1659	36.8%
Free transport	1640	34.0%
Free accommodation for companion	1594	25.2%
NHS hospital	1600	18.5%
Teaching hospital	1516	15.9%
Private hospital	1571	14.8%

Source: Picker Institute (Ref. 21), adapted

## 3 Patient choice continued

**78** Waiting times were listed as a factor for consideration by 64 per cent of patients in the November 2007 DH survey, increasing from 20 per cent in past DH surveys. (Figure 6). This is very similar to the LPCP findings. However, waiting times have fallen significantly over the past few years, and by the end of 2008, the target is to deliver a maximum 18 week patient pathway from GP referral to the start of treatment. This means that patients should see a further reduction in waiting times.

**79** The combined effect of trusts reducing their waiting times to deliver the 18 week referral to treatment target and some PCTs imposing minimum waits for patients should reduce variation in the future. This means that waiting times are likely to have less of an influence on choice. Only if significant local disparities exist between waiting times are patients more likely to exercise choice on this basis.

**80** However, there are often factors that are not recorded by the DH and LPCP surveys such as mortality rates, readmission rates or personal judgements by GPs, which also influence patients' decisions made with regard to choice. Furthermore, patient-reported outcome measurements (PROMs)<sup>1</sup> will soon be available to inform choices made.

**81** Many NHS organisations have a local following which on occasion may be genuinely loyal, but this loyalty may also be a false positive as a direct result of a limited choice of alternatives. Case study 4 shows that the majority of patients chose to go elsewhere for treatment having already waited for six months in Peterborough. However, a significant minority chose not to move but instead wait indefinitely for treatment at their local hospital. This shows that patients will take advantage of those alternative providers where there is a clear difference in the benefits available and information to support that choice. However, it also shows that, even with such differences, a significant minority of patients may have a strong preference for their local provider, either because of its location or their previous experience of using it. Some PCTs reported that such loyalty is observed particularly among older people. We were told during our fieldwork that location becomes even more important if a procedure requires follow-up, because this could involve the patient making several journeys to the provider. The LPCP evaluations found that follow-up care being provided at the local hospital made choosing an alternative provider for surgery more attractive, but this presents challenges for joined-up working between different providers. Many of the structures needed to support this effectively are not in place.

<sup>1</sup> PROMs give an insight into the way patients perceive their health and the impact that, for example, treatments have on their quality of life.

## Case Study 4

### **Patients choosing to remain with their local hospital, even when faced with a lengthy wait – Peterborough PCT**

In February 2007, in response to patients breaching the six month elective orthopaedic waiting time limits at Peterborough and Stamford Hospitals NHS FT (PSHFT), Peterborough PCT set up a small team to offer patients the opportunity of receiving their treatment sooner than could be offered by the Trust.

The PCT team contacted patients as they approached a six month waiting period to let them know that there was still no potential date set for their operation at PSHFT, but that the operation could be provided within the next one to two months at an alternative hospital. Both alternative NHS and private sector hospitals were offered and the PCT provided details about the hospitals to help inform their decision. Choice options were supported by the offer to provide free transport if this was raised as an issue and local aftercare support if needed.

A total number of 927 patients were contacted from March to August 2007. Of these patients, only 587 were offered a choice, since on contact 192 were found to be medically unsuitable to transfer and 148 were already found to have accepted dates to attend their original choice of hospital.

Out of these 587 patients, 61 per cent accepted the offer to transfer to an alternative provider while 39 per cent declined, even though they faced an indefinite wait with their existing provider. The main reasons given for this are discussed below.

Just less than half of the patients who declined to be treated elsewhere were aged 65 or over and the main reasons for doing so were because of issues with transport / visiting; being dependent on others; because they were a carer for a spouse; or because of the relationship already formed with a PSHFT consultant.

In the under 65s, lifestyle choice was more of an issue since these patients wanted to move only when they were able to fit their appointments around work and social commitments. They wanted to exercise more freedom regarding specific dates on which they wanted to receive their operations.

'Other' comprised of a range of reasons given by patients when declining the choices offered. The most frequent reason was that the patient wished to discuss their condition and / or treatment further with the consultant with whom they had been originally listed. The second most frequent reason was around the patient's level of confidence in the quality of care that they would receive.

Source: Audit Commission and Healthcare Commission

# 3 Patient choice continued

## Patient choice has had limited impact on quality of services and patient flows

**82** Quality has started to have an impact on choice, with 65 per cent citing it as an important factor in the November 2007 DH patient choice survey (Figure 6). This figure has risen significantly from 15 per cent in the previous DH surveys. Findings from the LPCP also suggest that quality is important to patients.

**83** Comprehensive information on the performance and quality of providers is often not available to patients, although quality of care is formally assessed for NHS providers in the Healthcare Commission's annual health check and in ad hoc reports on major problems. However, due to the timing of some of these investigations, the problems are likely to have been addressed in part, if not solved, by the time assessments are made public. In addition, assessments are indicators of a whole organisation's performance and not necessarily of a particular service within it which may be of more concern to patients. Patients need additional information to inform their decision making and education on how this information can be used.

**84** Unsurprisingly, given that choice is not universally provided, there is no evidence from our fieldwork that choice policy has so far had a significant impact on patient pathways or that it has led to an improvement in the quality of services offered. We did not find endorsement of choice as a mechanism for changing patient flows. In those trusts or units that are on the cusp of financial stability, a small activity change as a result of choice could have a

significant impact on the viability of a service or of an organisation. In addition, for some patients, a poorly rated provider will still remain the most geographically accessible choice. For example, hospital services in Cornwall and North Devon have been poorly rated by the Healthcare Commission's annual health check for two years in a row, but although there is evidence of some variation in activity, there is no real evidence of a major shift of referrals away from these hospitals. Furthermore, one FT reported that it was working at full capacity and was struggling to bring its waiting times down to meet the 18 week referral to treatment target, while taking on all the patients that chose to be treated there. This had the effect of stalling Choose and Book, as the hospital could then only offer one appointment date, which is counter to booking policy.

**85** Despite evidence from Peterborough and the LPCP evaluation, that in some circumstances a significant proportion of patients will move provider, our fieldwork revealed a widely held view in the NHS that there would never be a large amount of patient movement due to choice, because patients will not utilise it, even if a lot of effort is put into promoting the options available. FTs in our study reported that being on the extended choice menu was not yet attracting more patients to them. PCTs reported that choice tended to impact more on activity under peripheral contracts than on activity under host contracts. The peripheral contracts account for a small amount of the PCT's total activity and are often with organisations that are located outside or near the edge of a PCT boundary. One PCT spoke of a small number of patients that now choose to travel 100 miles for treatment, rather than

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visit a local hospital, and attributed this to family ties, and the new policies that have supported this choice.

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**86** Choice has been shown to influence patient flows under certain circumstances. The LPCP evaluation found that two thirds of patients who were offered the opportunity to go to an alternative hospital chose to do so. In Peterborough, with similar circumstances, they had similar results, although it should be noted that the arrangements for the LPCP and Peterborough were very different from the standard ones currently in place (Paragraph 76). However, services need to remain contestable, in order for the choice mechanism to work, even if few patients decide to exercise choice.

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**87** The trusts we spoke to were also beginning to explore how they could influence patient choice, from signposts at London underground stations to providing a first class service to encourage a return for further treatment. Trusts had also recognised the critical role that GPs played in the choice process and many were holding open days to showcase the trust's services. Providers are positioning themselves for the future and the impact that they feel choice could have. The fear of the impact of choice, rather than actual choice, appears to be driving a change in attitude.

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**88** The DH has recently commissioned a three year academic study<sup>1</sup> to consider how patient choice is likely to impact on the quality of health services. It is important that this considers the views of patients and service users, and not just the general public, which may have a different view about the policy. This research will generate useful information for further policy development.

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### **Further work is needed to strengthen the infrastructure supporting the patient choice policy**

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**89** To maximise its likely impact, several changes need to be made to the supporting infrastructure of the patient choice policy. These include providing better information about providers to patients; ensuring that choice is offered in a consistent manner; and offering GPs sufficient support and incentives to engage in the policy.

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**90** Good quality information is needed to support patient choices about where to receive care; without it choice cannot be used as a tool to tackle health inequalities or to improve quality. The LPCP evaluation found that having data on quality of care was an important factor in whether patients would choose to have treatment at an alternative provider. If the quality of care was worse than the existing provider, or was unknown, patients were less likely to choose to go there.

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<sup>1</sup> The Health Reform Evaluation Programme is funded until March 2010 by the DH and is being coordinated by the London School of Hygiene and Tropical Medicine. The programme's evaluation of the patient choice policy is titled 'How patients choose and how providers respond', and is being led by the King's Fund.

## 3 Patient choice continued

**91** Steps have been taken to develop the information available to patients. For example, since 2006, the DH has produced the *Choosing Your Hospital* booklet,<sup>I</sup> which can be adapted locally to provide patients with information to help inform their decision. The booklet contains a brief summary of services and quality in local hospitals and information on location, parking and public transport. However, despite these steps, the national choice survey and the annual health check shows that the booklet is often not given to patients: 2006/07 data showed that fewer than one in three patients were offered the choice booklet, and this figure had fallen further in DH figures for September 2007 (Ref. 26).

**92** In June 2007, the DH launched the NHS Choices website,<sup>II</sup> at a cost of £3.6 million. It aims to assist patients to make informed and personalised health choices. However, the information it contains is incomplete, and not all organisations list the same information, making it difficult for patients to make true comparisons between providers. For example, some ISTCs and private hospitals do not have data on average length of stay or readmission rates. Similarly, NHS hospitals do not always have data listed for all categories. Moreover, for individual hospitals within one trust, data for each hospital is not presented separately even though there may be significant differences.

**93** However, even if the information on the NHS Choices website were complete, there are further access barriers: 37 per cent of NHS elective patients are over 65<sup>III</sup> and 71 per cent of people aged 65 and over in the UK have never accessed the internet (Ref. 27). The percentage of patients over the age of 65 is likely to be higher for some of the high volume procedures, for example cataracts or hip replacements. Although the number of people who have never accessed the internet is decreasing, the internet should not be relied upon as the only source of information.

**94** There are also challenges for PCTs in providing information about choice in areas where literacy is not high or where English is spoken as a second language. However, these challenges are not unique to choice. Without appropriate support, choice could widen, rather than reduce, inequalities. Information needs to be accessible by all, and to be targeted at all groups, but this has an associated cost.

**95** In July 2006, the Health Select Committee concluded that, without information relating to clinical quality, patients were not offered an informed choice about ISTCs (Ref. 11). The Secretary of State for Health responded in October 2006 and said that the DH recognised the need to provide robust information on clinical quality that is relevant to patients, informs choice and is fair to clinicians and providers (Ref. 28). The DH subsequently established an Information Taskforce to

<sup>I</sup> The *Choosing Your Hospital* Booklet can be obtained from PCTs or GP surgeries.

<sup>II</sup> [www.nhs.uk](http://www.nhs.uk)

<sup>III</sup> Source: HES 2006/07 data

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develop and oversee a work programme to identify indicators of clinical outcomes relevant to patient choice, available either in the short or long term. The Taskforce advised on the first set of indicators for NHS Choices. The task force has since been superseded by the Clinical Information Advisory Group for NHS Choices, which advises the DH on a rolling programme of indicators.

**Recommendation:** To drive up quality and support patient choice, the Information Centre for Health and Social Care should work quickly with the DH, clinicians and patients to define a mandatory national data collection policy by which all organisations providing services to NHS patients must abide. The policy should draw on lessons learned from current data collection and should reflect the information needs of patients, including patient outcomes, and should also be easy to capture. PCTs should drive compliance with this scheme through contracting processes. The statutory provider registration scheme due in 2009/10 should also reinforce this.

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**96** The pace of implementation of the choice policy is slower than expected and challenging. Patients continue to be offered choice without having the information that they feel they need to be able to make a decision. It is already clear from the LPCP that patients wanted more information on follow-up care arrangements; quality of care; qualification and experience of surgeons; operation success rates; standards of hygiene and safety arrangements. From our research we believe that patients would find hospital information more useful if presented by individual procedure, hospital and surgeon. Collating additional information on quality and making it publicly available would also have a wider impact as clinicians, units and hospitals would themselves improve their services accordingly.

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**97** Our research identified that the way that choice is presented to patients is important. Patients need choices presented to them on the basis of fact rather than anecdote or personal GP preference. Some PCTs reported that certain PCT staff did not support all of the choice options (for example, ISTCs) and consequently presented these in a different way. Similarly, where GPs are sceptical about whether the choice policy is beneficial this may have an impact on how choice is offered. In addition, there is still an expectation among some patients that the GP will choose where they should go to receive treatment after considering their condition and issues such as quality and outcomes, thus negating the need for the patient themselves to consider these factors.

## 3 Patient choice continued

**98** GPs need to ensure that it is made explicit during conversations with patients when they are being offered a choice. One PCT said that getting a local NHS clinician to explain the choice available to patients (for example two weeks wait at the ISTC or six months wait at the local hospital) had increased the number of patients choosing to go to the ISTC. DH surveys and data from GPs suggest that often patients do not realise that they have the option of a choice for treatment, or that they have been offered it.

**99** GPs play a crucial role in offering patient choice and in 2006/07 they were offered a time-limited incentive through a directed enhanced service (DES) payment. The first component was paid following written assurances from GP practices that choice would be offered to all eligible patients. The second component was paid if at least 60 per cent of patients agreed that the GP discussed a choice of provider, based on the results of a GP issued survey. A GP practice of 6,000 patients meeting all the requirements would receive £3,048 per year. While this is a relatively small amount in comparison with some other incentives, the total amount paid to GPs across England for offering choice is estimated to be £19.25 million, with 79 per cent of practices receiving the second component.<sup>1</sup> This high level of take-up is not reflected in the patient choice data which are significantly lower. This may be because of the different approaches to surveying patients. However, PCTs may be rewarding some GPs even though they are not

offering choice systematically. PCTs should ensure that the payments being made to practices are appropriate, taking action to reduce or stop payments if choice is not genuinely being offered.

**100** We were unable to find any convincing evidence, from either quantitative or qualitative sources, that incentive payments made by PCTs for GPs to offer choice to patients are delivering value for money. However, a fall in patients being offered choice in May 2007 was linked by the DH to a delay in announcing the rollover of the payment. Since this has been announced, interim figures for the next wave show an increase.

**Recommendation:** The DH should consider redesigning the GP choice incentive scheme and payment for future years to ensure that those who take up the incentive payments deliver choice to their patients accordingly. In addition, PCTs should manage this payment more robustly through data quality and spot checks. PCTs should also work with GP practices through workshops or sessions to effectively engage GPs in the policy, exploring how choice should be explained to patients.

<sup>1</sup> Figures supplied by Department of Health, October 2007.

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## Patient choice – Summary

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There was unanimous agreement from our fieldwork that patients wanted a high quality, local hospital that they could access. However, there was not a universal view that the choice policy would achieve this aim.

We found no evidence that the choice policy was resulting in significant changes for the patient or to patient pathways, suggesting that it was not having the intended impact on quality. The lack of impact on referral pathways is unsurprising at this stage, given the policy's relatively recent implementation; that it is not yet being offered systematically and routinely; and given the lack of information available to patients. More work is needed here, or the policy will certainly not meet expectations.

Despite this apparent lack of progress, providers are currently positioning themselves for the future and the impact that they feel choice could have. The fear of the impact of choice, rather than actual choice, appears to be driving a change in attitude, if not yet in the actual provision of services in ways that can easily be measured. If, over time, patient choice continues to have little impact on activity, providers are likely to stop making these changes.

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# 4 | Provision of care

A key part of the reform process was for the NHS to be transformed from a monopoly provider of NHS services to a health system where different healthcare providers compete to provide comprehensive services to NHS patients. The reforms aimed to increase the capacity in the system and promote competition and innovation, and that this in turn would improve the efficiency, quality and responsiveness of services for the benefit of patients.

The changes aim to reward those providers that provide the most efficient, high-quality care, and provide incentives for inefficient providers to improve. The tariff under PbR is based on average costs. It rewards low cost providers and offers incentives for higher cost providers to become more efficient by moving toward the norm. The new workforce contracts also aim to improve efficiency by facilitating new ways of working more efficiently.

This chapter outlines the background to provider reforms and comments on progress against the following themes:

- increasing capacity and plurality of provision in the system, stimulating competition and thereby better services;
- the creation of FTs – autonomous bodies that are accountable to the local population, thereby providing better services; and
- delivering stronger financial management arrangements and greater efficiency through the reform programme.

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## Background

**101** To support the aims of provider reforms and create a more diverse provider base, the government introduced ISTCs and FTs. As discussed in Chapter 2 there has also been a central drive to provide more services at a local level in a primary or community care setting, where it is more cost-effective to do so. This has been reinforced by the introduction of

PBC. The DH has made it clear that commissioners should increase the use of the private sector and voluntary sector more generally when they can provide services that meet NHS standards and offer value for money.

**102** The introduction of private sector diagnostic and treatment centres (DTCs), later to become ISTCs, was outlined in the *NHS Plan* (Ref. 1). ISTCs were designed to increase capacity in the system, separating routine hospital surgery from hospital emergency work to clear waiting lists and introduce some external competition into the system for NHS trusts. Box 4 outlines the core objectives for the ISTC programme. The first contracts were signed in September 2003 and the first ISTC commenced a service in Daventry in October 2003. Some of these contracts have now expired. A second phase of ISTCs was announced in 2005 and the first of those became operational in April 2007. At the time of publication, there are 24 Wave 1 operational ISTCs. Of the 24 Phase 2 contracts that went out to tender, only 7 are in service delivery; 11 were cancelled or terminated; approvals are in place for 3 schemes to proceed to financial close; 3 schemes are being taken forward to completion by the local SHAs; and final proposals are being considered on one further scheme.

**103** The creation of NHS FTs reflects a move from a centrally to a locally managed service and one that is more responsive to patients. The first FTs were created in April 2004 following successful application by existing NHS trusts to Monitor, the FT regulator. The initial aims of FT policy are set out in Box 5, overleaf. After several acute trusts successfully became FTs, the policy developed further and a target was set for all acute, specialist and mental health trusts to have the opportunity to become FTs

by December 2008. In June 2008 there were 99 FTs and 130 acute, specialist and mental health NHS trusts.

#### Box 4

#### The core objectives of the ISTC programme

- to support the NHS in reducing waiting times and achieve the 18-week referral to treatment target;
- to create an independent sector market that delivers value for money;
- to support the shift from secondary to primary care;
- to promote innovative service models;
- to reduce costs of 'spot purchasing';
- to contribute to the long term development of relationships between the independent sector and the NHS in the attainment of local NHS targets; and
- to support choice and contestability.

Source: Department of Health

As at June 2008, there were 73 acute FTs and 26 mental health FTs.

# 4 | Provision of care continued

## Box 5

### Initial aims of FT policy

- to devolve more power and responsibility to the local level, so that NHS hospitals are better able to respond to the needs of patients;
- to bring about improved access to higher quality services for NHS patients by offering an incentive to innovate;
- to devolve accountability to local stakeholders including NHS patients and staff. FTs operate governance arrangements that give local stakeholders and the public opportunities to influence the overall stewardship of the organisation and its strategic development; and
- to support patient choice by increasing the plurality and diversity of providers within the NHS.

Source: Audit Commission, adapted from Department of Health<sup>I</sup>

### Increasing capacity and plurality of provision in the system

**104** Progress with ISTCs has been slower than planned. The *NHS Plan* (Ref. 1) stated that, by 2004, 20 DTCs would be developed, with eight being fully operational, treating approximately 200,000 patients a year. As the ISTC programme developed, the DH expected it to deliver, through Wave 1 from programme

commencement to 2006/07, a total of 216,000 elective episodes (including the ophthalmic chain and the general supplementary contracts). This represents an investment of £463 million. By the end of 2006/07, a total of 160,861 elective episodes of care had been performed in ISTCs. Total spend for Wave 1 of the ISTC programme (from 2003/04 to 2012/13) is projected to be £1.6 billion.<sup>II</sup>

**105** In 2005, the DH stated that independent sector providers would increase their contribution to the care of NHS patients and may provide up to 15 per cent of elective surgical procedures (Ref. 29). Table 3 shows the current level of performance, which shows ISTC activity to be less than 2 per cent of total elective activity. Although the government recently announced a limited increase in the number of ISTCs, they have signalled their intention to move away from centrally-run ISTC contracts and have cancelled some proposals for additional ISTCs because of concerns about over capacity. The government expects that approximately 5 per cent of elective procedures will be performed in ISTCs by the end of next year.<sup>III</sup>

<sup>I</sup> [www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Secondarycare/NHSfoundationtrust/DH\\_4062806](http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Secondarycare/NHSfoundationtrust/DH_4062806)

<sup>II</sup> Figures supplied by the Central Contracts Management Unit, DH, May 2008.

<sup>III</sup> Oral evidence to House of Commons Liaison Committee, 13 December 2007.

**Table 3**

Elective activity performed under contract in ISTCs accounts for a small proportion of the total elective activity in the NHS

Year	ISTC activity*	HES elective activity	ISTC activity as proportion of elective activity
2003/04	3,633	5,544,864	0.07%
2004/05	36,599	5,530,359	0.66%
2005/06	53,388	5,821,062	0.92%
2006/07	67,210	5,590,579	1.20%
2007/08	105,604**	5,900,000***	1.79%

\*Note: This includes the ophthalmic chain and the general supplementary contracts.

\*\*Note: This includes elective activity performed under Phase 2, including renal activities.

\*\*\*Note: AC estimate.

Source: Audit Commission and Healthcare Commission (data from HES)

**106** Although the volume of activity that ISTCs have provided is increasing, it is still relatively low. An analysis of national activity data shows that in 2006/07, ISTCs accounted for 4 per cent of cataract procedures, 7 per cent of hip procedures, and 9 per cent of arthroscopies.<sup>1</sup> Given that the overall proportion of activity carried out in ISTCs is currently small, it is difficult to draw any conclusions about the impact of ISTCs, even at a local level or for specific procedures.

<sup>1</sup> Analysis of HES and ISTC activity data for 2006/07.

## 4 | Provision of care continued

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**107** Some health economies reported that, despite a significant effort from PCTs, their local ISTC was still under-utilised. Some PCTs cited that there was little local appetite for independent sector providers, with the majority of patients choosing to be treated at the local NHS hospital, even if it had longer waits than the ISTC. Another relevant factor was the relationship between the ISTC and the local NHS. Where this was not well-developed, referrals to the ISTC were likely to be lower as GPs are more likely to refer their patients to consultants whom they trust and with whom they have developed a relationship.

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**108** Although appetite for choosing ISTCs can be small, patient satisfaction appears to be high. The Healthcare Commission's report on ISTCs (Ref. 11) found that patients treated at ISTCs were significantly less likely to report negative experiences than those treated in the NHS. This message was repeated by several health economies in this study. While this could partly be attributable to the different casemix represented in the two groups of patients, the Healthcare Commission sought to take this into account as far as possible.

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**109** The Healthcare Commission's review of ISTCs provides some positive assurance about the quality of care provided by ISTCs. Care pathways are designed to meet the needs of patients, and patients rate their care highly. The routine inspections of ISTCs identified that, in general, the centres' processes of care appear to function well. However, there can be occasional difficulties in ensuring that there is a

streamlined process of care where responsibility of care moves from the ISTC to an NHS organisation, and vice versa. This includes the difficulty with the transfer of patient information and difficulties in making arrangements for clinical staff to discuss individual cases. Adequate data did not exist at the time of the Healthcare Commission's review for it to conclude without reservation whether the care provided in ISTCs is different from that provided by the NHS. However, data collection and quality has improved since the publication of the report, including the collection and publication of patient experience information showing that it is comparable to other independent sector and NHS providers.

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**110** Many of the NHS' concerns about the ISTC programme stem from the cost of the programme. The costs to the DH of establishing the first and second phases of the ISTC programme was £146 million at the end of 2006/07.<sup>1</sup>

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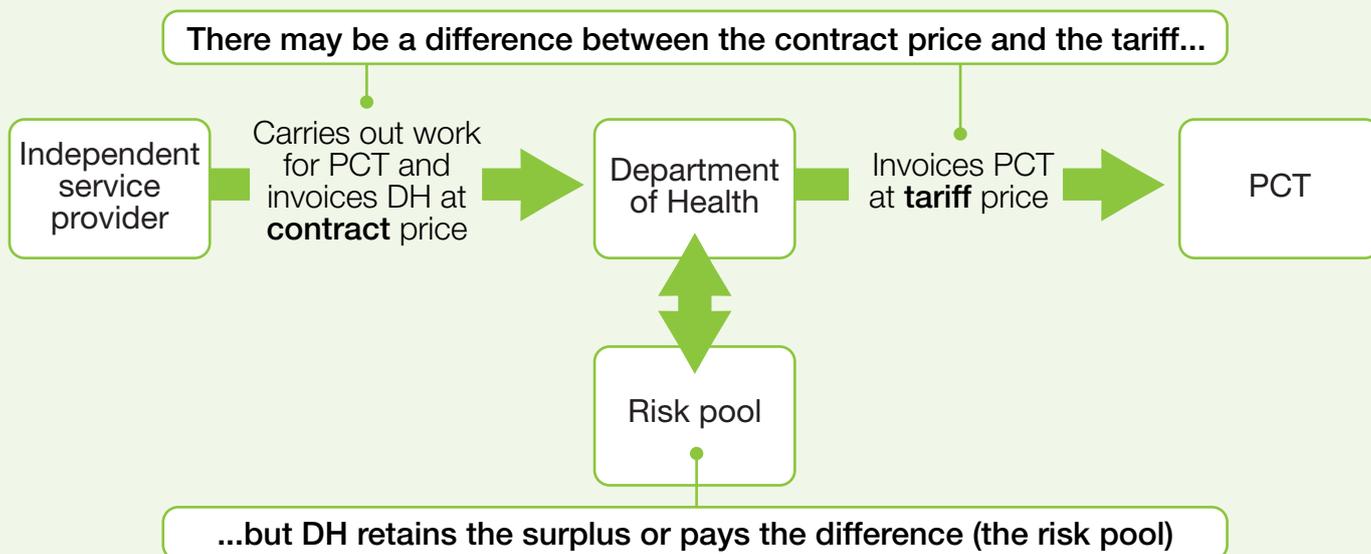
<sup>1</sup> Figures from DH, October 2007.

**111** In addition to these set-up costs, payments to ISTCs were set around 11 per cent higher than the equivalent cost in the NHS, to encourage entry into the market and to cover the cost of new buildings and refurbishments. Moreover, the Wave 1 contracts also provided ISTCs with a guaranteed revenue stream for a period of five years and were structured on a 'Take or Pay' basis, so ISTCs were paid at the guaranteed activity levels, regardless of whether the activity was undertaken. This meant that, where patients were not referred or chose not to be treated at the ISTCs, PCTs who were contractually obliged to pay for activity that did not take place, lost money. The cost of guaranteeing activity that was not performed in ISTCs is classified as

commercially sensitive so cannot be calculated. Without this risk-free agreement, new providers may not have entered the market. However, we found widespread frustration among NHS organisations that ISTCs were paid for activity that was not performed. In response to these concerns, second phase ISTCs were set up on a different basis. ISTCs are still guaranteed a certain proportion of work but, unlike the Wave 1 contracts, this may not be at 100 per cent capacity. In Phase 2 schemes, the PCT pays for actual activity and the DH pays for any shortfall in guaranteed activity (Figure 7). However, while this improves the financial risk for the PCT, the NHS is still paying for guaranteed volume overall, regardless of whether it is used.

**Figure 7**

Phase 2 ISTC payment arrangements



Source: Audit Commission and Healthcare Commission

## 4 | Provision of care continued

**112** There was significant concern in the NHS that the tariff paid to ISTCs does not reflect the casemix.<sup>1</sup> Among our fieldwork sites, there was a belief that the ISTCs have cherry-picked cases and have left the potentially more complicated and expensive cases to the local NHS. This is consistent with the findings of the Healthcare Commission's report on ISTCs which found that the criteria for referral to ISTCs excluded patients with more complex health needs (Ref. 11). As ISTCs lack the complex back-up, like an intensive care unit, selecting the low risk cases for clinical risk management reasons is appropriate, but the concerns expressed were about how much is paid for these lower risk procedures and the financial impact that this has on NHS trusts. In addition, due to the lack of facilities such as intensive care, the costs of any complications resulting in a patient being readmitted as an emergency will be borne by NHS providers, despite the ISTC being the initial service provider.

**113** Some hospitals were beginning to raise these issues with their PCTs, requesting local flexibilities in the national tariff to recognise the situation, even though the existing tariff already allows for casemix complexity. In such a situation, detailed and accurate information needs to be available in order to substantiate the belief that the casemix for particular HRGs had increased in complexity and affected costs in a way that was not recognised by the tariff.

We received no such substantiation. Currently, the information available nationally and at individual trusts may not support such fine tuning. The DH is considering moving to a finer grained tariff of approximately 1400 prices through HRG4, but this is not without its challenges, including the necessity of having robust underlying information.

**114** The impact of ISTCs on other local providers is hard to judge. Our research identified that some health economies felt that the fear of real competition presented by ISTCs had resulted in changes and increases in efficiency. They spoke of how the threat of a private facility and subsequent viability of their hospital or specialty had been a useful tool to engage clinicians and worked with them to deliver change.

**115** We undertook detailed analysis of trust, PCT and ISTC activity data in the four health economies visited in order to better understand changing patient flows. This particularly focused on orthopaedic services for four trusts in potential competition with newly established ISTCs and showed a marked fall in waiting times at the trusts at about the same time as the ISTCs were introduced. The evidence does not enable a causal link to be proved however, particularly as there was strong general pressure to reduce waiting times. Wider national analysis of HES data has shown that there was considerable variation in performance and in the rate of change, whether or not there was an ISTC, and the four

<sup>1</sup> In practice, ISTCS are not paid the PbR tariff. Wave 1 ISTCs are paid 'tariff plus' to stimulate them to enter the market and to cover their capital costs, which guarantees them a payment for activity. Wave 2 ISTCs are guaranteed a certain amount of up-front investment and activity funding. Independent providers that deliver services as part of the Extended Choice Network have been paid tariff x market forces factor per case since 2006/07.

trusts we examined did not perform significantly differently from their peers.

**116** It was also reported in our interviews that ISTCs have had a significant effect on the private sector prices that the NHS has previously paid for ad hoc treatments. Data on spot purchasing arrangements are not collected centrally, however, so it is not possible to say how these prices have changed over time. At least one private sector provider felt that the introduction of ISTCs had had the deliberate effect of making the private sector generally more likely to work for the NHS at, or closer to, PbR tariff rates. That is, ISTCs also meant competition for the private sector and not just the NHS.

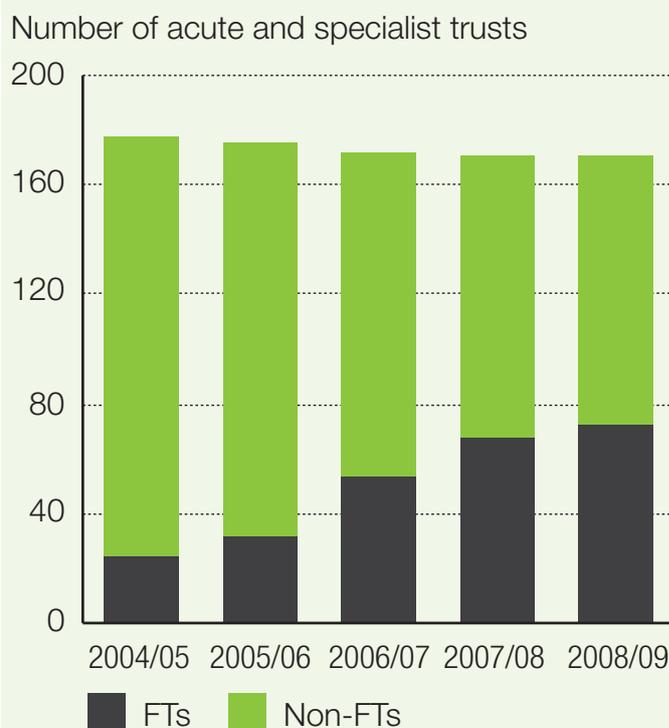
### The creation of FTs – autonomous bodies accountable to the local population

**117** A key aim of the FT policy is to devolve more power and responsibility to the local level, so that NHS hospitals are more able to respond to the needs of patients. The approach aims to give existing NHS trusts more autonomy so that they are able to provide better quality, innovative services for patients. FT status also devolves accountability to local stakeholders, including NHS patients and staff.

**118** The number of FTs has steadily increased and the scope has widened to include mental health, as well acute and specialist trusts. In the future there may also be community services and ambulance FTs (Figure 8). So far there have been fewer successful FT applications to date than anticipated and the government's aspiration to have 100 FTs by December 2007 was not met.

**Figure 8**

The number of FTs is increasing, but the aspiration to have 100 FTs by December 2007 was not met\*



\*Note: 2008/09 figures correct at time of publication (June 2008). Data excludes mental health trusts

Source: Audit Commission and Healthcare Commission

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## 4 | Provision of care continued

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**119** In late 2007, the DH recognised that some trusts would not reach the standard necessary to achieve FT status and that the target of all trusts having the opportunity to become FTs by 2008 would not be achieved. However, it is important that the criteria for the achievement of FT status are maintained, rather than amending them to enable such targets to be met. The DH now intends that, over the next three years, all acute and mental health services will be delivered by FTs, with the implication that there will be more mergers or acquisitions similar to the takeover of Good Hope Hospital in April 2007 by the Heart of England NHS FT, which was accompanied by a reduction and rescheduling of Good Hope's £17 million historic debt.

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**120** Although FTs have greater autonomy than NHS trusts, particularly in terms of the environment in which they operate (for example different performance management arrangements and a different financial regime), there is little difference in the services actually provided. Moreover, although there were advantages for first wave FTs through, for example, a faster transition to generally higher tariff prices, this is no longer the case. PbR now applies equally to NHS trusts and FTs, and the national model contract has been significantly revised. However, Wave 1 FTs are generally still using the old FT contract which requires three years notice to end. This of course means benefits of the new contract will not be available to these PCTs. Nevertheless, the financial regimes for NHS trusts and FTs are much closer – mainly in anticipation of the gradual move of most trusts to FT status.

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**121** FTs in our study welcomed the autonomy that they had to attract and appoint more experienced and able non-executive directors to the board. This gave trusts' management greater challenge, although the Appointments Commission is seeking to secure similar high calibre non-executives to NHS trusts. FTs were also positive about their governance arrangements and the greater connection with the local community, through the governors and the membership. They reported that clinical services are now starting to be planned in discussion with the membership, rather than in isolation. FT governors reported that they felt engaged, had assisted with recent board appointments and had sat on working groups in the FT. However, the extent to which they were informing local priorities was not clear. It was apparent that there can be frustration on both sides where governors seek to get involved in operational issues, which is outside their remit. Our qualitative research did not find significant evidence that FT governors were having a clear and identifiable impact on FT development. Indeed, we identified some instance of confusion of roles between the governors and board of FTs.

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**122** FTs reported other benefits to achieving FT status, including having greater freedom to invest in new services. Monitor, however, has found that FTs are not taking full advantage of their borrowing freedoms and have accessed only £100 million out of £2.5 billion available, partly because many were already undertaking or had recently completed significant capital investments before becoming an FT. However, foundation status has allowed the Christie Hospital NHS FT to reinvest cash balances to take forward plans to build radiotherapy centres in other parts of Greater Manchester and Cheshire – the first network of its kind in the UK. Sheffield Teaching Hospitals NHS FT also highlighted that it had used FTs’ access to capital funds to build a £30 million critical care unit. Although, if this money had not been available, at least part of the sum may have been found from elsewhere as the need for the new unit was vital. FTs also have greater flexibility in workforce issues and are able to move away from the national workforce contracts, although we found no evidence of any having done this to date.

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**123** Despite the fact that their ability to increase their income from private patients is constrained, existing FTs felt that FT status had also created some new opportunities, including the creation of additional services, which have the potential to increase trust income. While the outcomes shown in Case Studies 5 and 6 could have been achieved without FT status, both organisations felt that the space that FT status gave for the organisation to innovate had facilitated them.

### Case study 5

#### **Branching out into new areas: Sheffield Medical Innovation Centre**

The Sheffield Medical Innovation Centre is a collaborative project based in the Faculty of Medicine at the University of Sheffield. Its partners include Sheffield Teaching Hospitals Foundation Trust, NHS Innovations Hub Medipex and Biofusion plc. This unique grouping provides a single portal for collaboration and knowledge transfer between healthcare researchers involved in medically related projects within the University of Sheffield, the pharmaceutical and healthcare industries and the NHS. The Centre was set up from the government’s Higher Education Innovation Fund (HEIF-3) in 2006 and it aims to be self-funding.

When a product is produced that is widely sold, a proportion of the royalties will go back to the FT for investment in improved patient care. The Chief Executive of the FT highlighted another benefit of the collaboration which was the potential boost to the local economy via the creation of new jobs and businesses.

One example of the Centre’s success has been the creation of the spin-out company Aperio Diagnostic Limited which is commercialising intellectual property developed within the FT and the University of Sheffield. Aperio Diagnostic is developing a medical device to detect pre-cancerous cells in the cervix that will lead to faster and more accurate detection, and hence treatment, of patients with cervical cancer.

Source: Audit Commission and Healthcare Commission

## 4 | Provision of care continued

### Case study 6

#### Creating self pay services: Foundation Skin – Harrogate and District NHS FT

Foundation Skin is a clinic based in Harrogate and District NHS FT that offers treatment for PCT-excluded dermatology conditions and runs alongside the dermatology department. It was established when the FT's local PCT stopped providing NHS funding for cosmetic skin treatments.

The clinic provides a range of treatments not ordinarily provided by the NHS or not supported by private insurance companies. All patients are seen by the clinic's dermatologist before undergoing any treatment and where surgery is necessary, it is performed by NHS surgeons in an NHS facility.

Any income generated through Foundation Skin is channelled back into the local NHS service and a donation is also made to the British Skin Foundation to fund research. In 2007/08, the service generated £124,000 income, working towards a breakeven position to contribute to the organisation's activities.

Source: Audit Commission and Healthcare Commission

**124** Monitor also reports that FT status has enabled some trusts to deal more clearly and effectively with financial deficits when they arise (Case Study 7), helped by a rigorous regulatory system. However, FTs are authorised on the basis of the strength of their finances and management and therefore prompt financial turnaround might be expected.

**125** However, an important test is whether the autonomy that accompanies FT status results in higher quality services being provided. Although FTs tend to be higher performers in the quality of service ratings in the annual health check, there is no significant evidence yet that FTs are delivering higher quality of care as a result of their status. FTs generally started from a better financial position. The great majority of current FTs were also scoring highly on quality of service before the introduction of FT status. This changed with the new assessment system but the response does not appear to depend appreciably on when FT status was obtained. Analysis of the Healthcare Commission's annual health check quality of service scores found no clear indication that FTs improved their quality of service at the time they achieved their FT status. The changes in the scoring system in 2005/6 (the introduction of the annual health check to replace star ratings) meant that a large proportion of current FTs suffered a reduction in their score from the highest level, so it is difficult to disentangle any effect of FT status from the change in scores.

## Case study 7

### FT status facilitates financial turnaround – University College London Hospitals NHS FT

University College London Hospitals (UCLH) became an FT in July 2004. In 2005 the Trust began to commission the new University College Hospital, thereby incurring additional double running costs during the transfer period as well as a substantial loss of income due to the non-availability of clinical services. Through Monitor's quarterly reporting process the Trust reported that its financial performance was off plan in early August 2005. Over the following couple of months, the trust's performance deteriorated rapidly indicating that the trust was now facing a significant financial deficit and possibly liquidity issues.

Monitor suggested that a turnaround team be appointed to the FT and required that monthly meetings occurred to discuss progress towards financial balance. A recovery plan was developed and subsequently approved by the Board. Throughout the process the Trust had regular contact and dialogue with Monitor.

The Trust maintained that the key objective was to recover the patient activity lost during the transfer of services to the new hospital. Specific measures that were put in place to tackle the deficit included:

- appointment of high quality professional advisors;
- appointment of a full-time turnaround director;
- changes in the management reporting structure;
- clinical buy-in to operational efficiency plans;
  - reduction in temporary staff;
  - increased efficiency in clinics;
  - improved theatre utilisation;
  - increase in day case rates;
  - increased clinical activity;
- reduction in the workforce over two years
- identification of procurement savings; and
- improved property utilisation.

The FT reversed the annual overspend trend through 2005/06 and 2006/07 and has achieved a surplus position in 2007/08 (subject to audit).

Source: Audit Commission and Healthcare Commission

## 4 | Provision of care continued

**126** Both FTs and non-FTs have increased their overall activity levels between 2003/04 to 2006/07, although the increase was greater for FTs by almost 3 per cent. For FTs, this increase has been steady, although slightly higher in 2005/06, possibly as a reaction to PbR, which was introduced in 2004. FTs experienced activity growth for all types of care, with the exception of non-elective short-stay admissions. However, between 2004/05 and 2006/07, the increase in activity was greater in FTs for all types of care, including non-elective short-stay admissions. Therefore, second and third wave FTs have seen the highest level of activity growth of the three groups over this period, and this has been more noticeable since 2004/05.

**127** The rates of patients being readmitted as an emergency are increasing, and 83 per cent of PCTs show an increase in hospital readmission rates between 2003/04 and 2006/07. This could indicate that providers are discharging patients early to reduce costs or to maintain throughput to deliver on waiting times. Nine out of ten trusts with the highest increases over the period are all NHS trusts. This may reflect the fact that FTs, and PCTs with more experience of PbR and dealing with their local FTs, have been able to address this issue more effectively, for example, through monitoring and enforcing readmission targets.

**128** Between 2003/04 and 2006/07, FTs have continued to be lower cost providers, and their relative cost position has been less subject to change than other trusts. However, FTs were authorised partly on the basis of their efficiency, and it should not be surprising that the majority are still relatively more efficient than the average NHS trust.

### **Delivering greater efficiency, clinical engagement in business matters and stronger financial management arrangements through the reform programme**

**129** Stronger financial management arrangements and greater efficiency are key aims of the reform programme. FT status has introduced a more rigorous financial regime. The system now also aims to reward the most efficient care providers, and incentivises inefficient providers to improve. PbR supports this by rewarding low cost, efficient providers and offers incentives for higher cost providers to become more efficient by reducing their costs towards the norm on which the tariff is based. Introducing contestability in the system aims to drive further improvement as complacency is challenged. The new workforce contracts also aim to improve efficiency by facilitating new ways of working and providing incentives for existing staff to participate in service redesign.

**130** Our research identified that undergoing the FT application process has made a significant difference to the internal processes of both successful and unsuccessful applicants. The health economies felt that FT application has led to a better understanding of both the current trust business and how the organisation would function in the future. Legally binding contracts, which cannot be broken by either side, force NHS organisations to operate in a more business-like way.

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**131** The Audit Commission's report *The Right Result?* (Ref. 10) assessed the impact that PbR has had on efficiency. It concluded that PbR has had some positive effect on increasing the number of elective day case admissions and, possibly, on contributing to a reduction in the length of stay of elective inpatients. However, the report found that PbR had contributed to, rather than driven, these changes. A wider analysis of length of stay and reference costs suggests that the impact of PbR on overall efficiency is questionable. Capacity constraints, limitations in the underpinning infrastructure of PbR, such as information systems, and initial instability in the tariff, may all explain why PbR has not had more impact in this area. Its impact may be more pronounced now that the transition period, which smoothed the financial impact from local to national prices, has been completed.

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**132** This contrasts with the Health Economics Research Unit (HERU) report's findings (Ref. 30) that there has been an increase in both elective and non-elective activity due to the introduction of PbR and that unit costs, as measured by length of stay, have fallen more quickly where PbR was implemented, due to efficiency gains. However, HERU's conclusions are based primarily on comparisons between England and Scotland, which may not be valid given the extent of the differences in healthcare provision and health policy implementation between the two countries. *The Right Result?* also found that there was no evidence of PbR having a significant impact on emergency admissions, nor on it adversely affecting the quality of care, as previously discussed.

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**133** PbR has also proved to be a useful mechanism for engaging clinicians in financial management decisions and business matters in general. At PCT level, where PBC is the primary lever for engaging primary care clinicians, PbR provides an important platform for clinical engagement in both primary, but mainly secondary, care. Clinicians need to be able to see the financial effect of their clinical decision making. In many cases, providing trust clinicians with information about the nature and costs of their activity has improved the understanding of the link between clinical and financial decisions. PbR has also clarified where NHS trusts are making a profit or loss, for example, through service-line management (which is discussed later in this chapter) and patient level costing, and has helped clinicians engage more in discussions about use of resources and financial management.

## 4 | Provision of care continued

**134** One clinical director we interviewed commented that PbR enabled him to plan necessary changes in the genito-urinary service to ensure that access targets were met. He was able to estimate the unit's income, based on planned activity, and take appropriate steps to increase capacity, for example by employing additional staff. He observed that other genito-urinary clinics in trusts that were not operating under PbR at the time could not expand in this way, because their PCTs would not release the money to fund the additional capacity.

**135** Another clinical director we interviewed felt that FT status and the implementation of PbR led to increased financial awareness across their whole department, highlighting that there are now discussions about whether it is better to use the funds to provide an expensive drug treatment for one patient or employ an additional nurse. This is the kind of decision that might, in the past, have been taken only by management rather than in conjunction with clinicians. Issues such as these were also highlighted in the Audit Commission's report, *A Prescription for Partnership: Engaging Clinicians in Financial Management* (Ref. 8).

**136** Despite the positive effect that PbR has had, further work is needed for full clinical engagement. Much of the data collected at a local level to inform PbR are not in a form to which clinicians can relate. Clinical teams are often more interested in income per patient for their service-line, related to procedure and length of stay, rather than the information that clinical coding currently generates. Many GPs and clinicians would also prefer PbR to be

outcome-based using measures that are more sophisticated than simple mortality data. Trusts and PCTs need to ensure that clinicians receive data that they find relevant and useful if they are to remain engaged.

**137** These developments have been brought together through service-line management (SLM), an approach which has been introduced, piloted and disseminated in the NHS by Monitor. SLM helps an organisation to understand the combined view of resources, costs and income, and hence profit and loss, by business unit or service-line rather than at trust level. Having the information at this level is making organisations think about the services they provide. In this way, managers and clinicians can make more effective decisions about growing or reducing services on the basis of efficiency and profitability, where cross-subsidisation is required or where services might be better provided outside the hospital setting. One of the trusts in our study that was well advanced with SLM, had identified services that were operating at a loss, even after efficiencies had been made. The trust subsequently decided to stop one of them because it was not a core service and felt that it should therefore not be subsidised by other specialties. PbR has certainly encouraged the trust to adopt a more comprehensive and thorough SLM approach.

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**138** Robust activity and cost information is a fundamental building block of PbR and financial management. There has therefore been a growing drive for trusts to introduce patient level costing. This enables a deeper understanding of service profitability and opportunities for addressing trust inefficiencies, using information about individual patients' resource use. This is particularly critical for those seeking to maximise profitability or undertake a major service change. Patient level costing gives an improved understanding of cost drivers and enables greater transparency and accuracy, which is a powerful method for engaging clinicians by allowing costs to be presented in a meaningful way.

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**139** FTs generally perform as well or better than NHS trusts in the annual health check's use of resources, but the mechanism that is used is not directly comparable. Recent research by the University of York concluded that the FT policy had not made a significant difference to FTs' financial management, attributing the improved financial performance down to long term trends (Ref. 31).

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**140** In the three years that FTs have been operational, their cash surplus<sup>1</sup> has increased to £1.5 billion as at the end of the first six months of 2007/08 and is expected to continue to rise. This represents about 38 days of operating expenses (Ref. 32), and is an increase of approximately £0.6 billion from the end of 2006/07 (Figure 9, overleaf). In addition, FTs have access to approximately £900 million of unused overdraft facilities. FTs are set up as independent bodies and are free to retain any surpluses they generate. FTs are also motivated to generate a reasonable surplus to achieve a low risk rating with Monitor and to be able to borrow monies for investment.

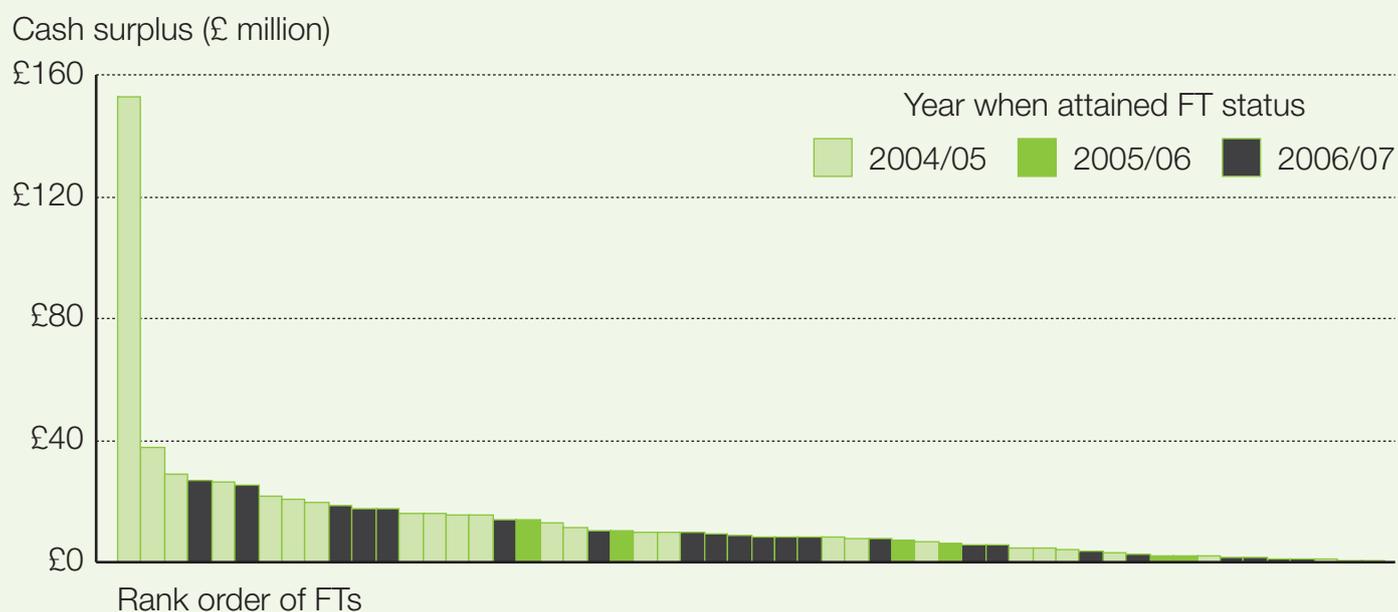
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<sup>1</sup> Cash surplus is the cash at the bank and in hand, as reported on the balance sheet, minus any bank overdrafts.

## 4 | Provision of care continued

**Figure 9**

### FT cash surplus (2006/07)



Source: Audit Commission and Healthcare Commission (data from FT accounts)

**141** There is a clear link between income growth and FT status (Figure 10). This is unsurprising given that the FT application is built upon financial viability. The early FTs were, historically, low cost trusts, and stood to gain income under PbR through a higher national tariff than local prices. They also had a faster transition than other trusts to the new higher prices.

However, increasing income is a contributing factor to both FT and non-FT surpluses. Of the 11 acute and specialist trusts that made over 45 per cent income gain between 2003/04 and 2006/07, just under half are FTs. One NHS trust, now an FT, made almost 60 per cent income gain over this period, and only one trust made a loss.

For the purposes of this analysis, FTs are those that achieved FT status as of 31 March 2007. Taking into account trusts that achieved FT status in 2007/08, one more of these top 11 income gainers is now an FT.

**Figure 10**

Percentage change in income growth for trusts 2003/04 – 2006/07



Source: Audit Commission and Healthcare Commission (data from Trust accounts and FT accounts)

**142** Income growth overall has been a significant contributor to the FT net surplus before exceptional items,<sup>1</sup> which in 2006/07 amounted to £134.4 million, and their cash surplus, which amounted to £995 million. Efficiency gains have also contributed to their improved financial position.

<sup>1</sup> Net surplus is the excess of income over expenditure. Exceptional items includes the effects of impairments and profits on disposals of fixed assets.

## 4 | Provision of care continued

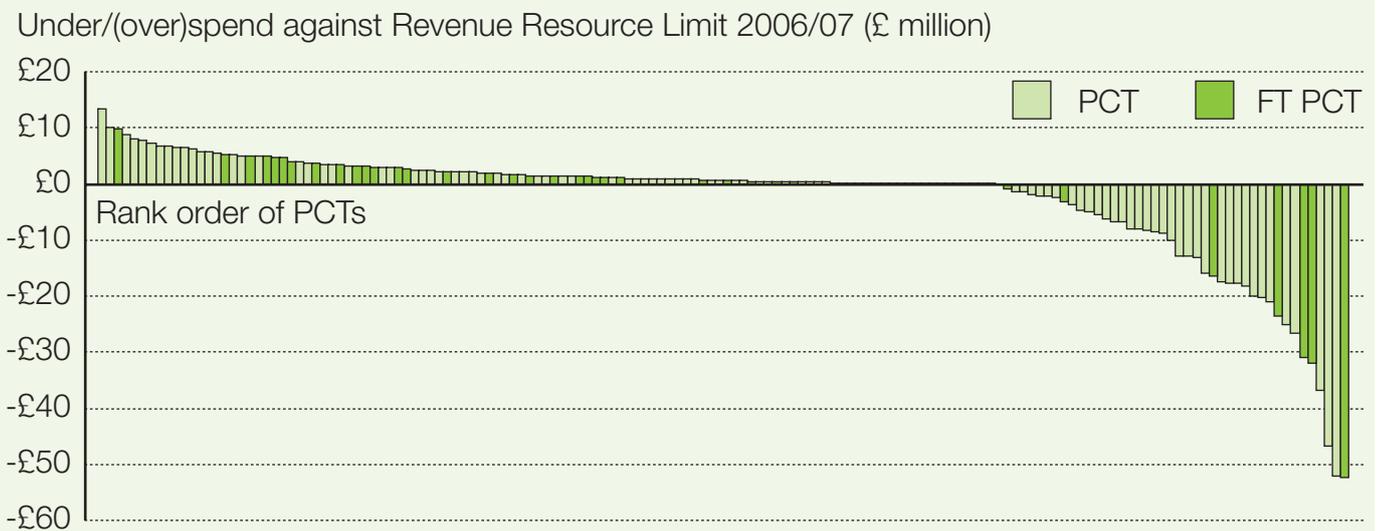
**143** Monitor noted in its review of the first six months of the 2007/08 financial year that: ‘NHS foundation trusts must [...] take full advantage of their financial freedoms, such as the use of cash resources, for the creation of better environments for patients and staff, and the development of innovative new services’ (Ref. 32). FTs have been successful in generating surpluses. However, there is clearly an issue with the size of unused but available funds for FTs. Some FTs said that they felt unable to invest in services due to a lack of clarity about future commissioning intentions. Other FTs wanted to build up funds to cope with the anticipated decrease in the growth of health funding from 2008/09 and uncertainty around the national tariff. Some have also only recently moved to FT status. With the improving financial position of the NHS overall, large surpluses may also disincentivise innovation and the achievement of further efficiency gains. To ensure that money is spent on patient care, PCTs need to be clearer about their future plans and FTs need to engage in these discussions, despite their concerns over the lack clarity about PCT commissioning intentions following the 2006 PCT reorganisation.

**Recommendation:** Taxpayers and patients have a reasonable expectation that FTs will not retain large cash balances over prolonged periods. FTs in such a position must set out clearly how they intend to use these balances. Monitor should also consider whether the performance management and regulatory systems for FTs should ensure that where there is such a balance, it is used for the benefit of patients. In order to achieve this, PCTs need to clarify their commissioning intentions on a timely basis.

**144** Some NHS organisations interviewed for our research claimed that the aggressive provision of services by FTs, that is over-provision without due reference to demand, PCT spending or plans, had led to an overspend at their host PCT. Although FTs have increased their income more quickly than non-FTs, we found no relationship between those PCTs predominantly commissioning with an FT and their overspend (Figure 11).

**Figure 11**

PCTs who commission over 50 per cent of work from FTs are no more likely to overspend than other PCTs



Source: Audit Commission and Healthcare Commission (data from PCT accounts)

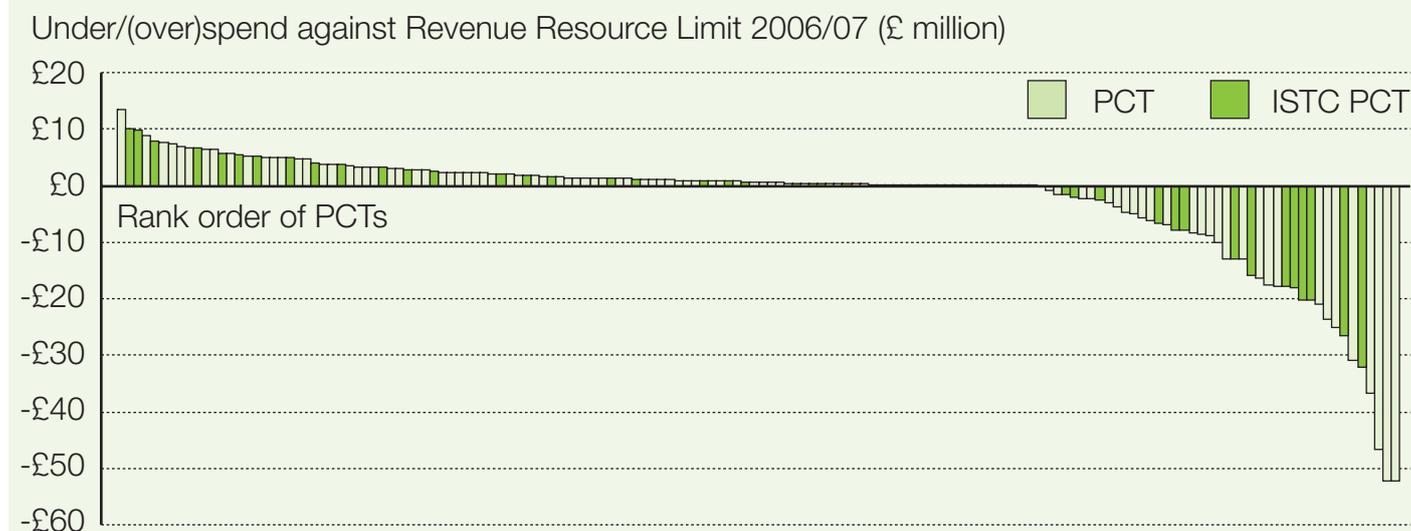
**145** Health economies were still very concerned about the effect that the ISTC programme has had on the local NHS, particularly that the contracts that already exist would cause PCTs to overspend or face financial difficulty. However, our analysis shows no relationship between contracting with an ISTC and PCT overspend<sup>1</sup> (Figure 12, overleaf). The concern of health economies on a national level appears to be unfounded, but the situation may vary locally. Strong capacity planning will reduce the risk of overspend and managers' fears about the impact of ISTCs may reflect a lack of local engagement in the planning process.

<sup>1</sup> PCT defined as contracting with a PCT if geographically close to the ISTC.

## 4 | Provision of care continued

**Figure 12**

There appears to be no relationship between contracting with an ISTC and PCT overspend



Source: Audit Commission and Healthcare Commission (data from PCT accounts)

### Workforce contracts as a tool to improve efficiency

**146** In 2000, the *NHS Plan* (Ref. 1) identified the biggest constraint that the NHS faced as a shortage of doctors, nurses and other health professionals. In response, the government set ambitious targets for the numbers of staff needed and the new contracts were designed to tackle some of these problems. The new contracts aim to ensure that the NHS has flexible, efficient working practices and a well paid and high quality workforce that will support a patient focused NHS.

**147** After lengthy negotiation between the DH and the trade unions, the consultant contract was introduced in 2003. AfC, the contract for most of the other directly employed NHS staff groups, was rolled out nationally from December 2004. A new GP contract was also introduced in April 2004 but our research concentrated on those for hospital and community staff. Our findings on implementation of the new consultant and AfC tell a familiar story and repeated some of the main messages in the National Audit Office's recent report (Ref. 33).

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**148** Overall, the consultant contract and AfC were perceived as a missed opportunity for change. NHS organisations spoke of an unnecessarily rushed implementation, leading to a focus on the administrative aspects of the contract without utilising the levers for change. On the whole, organisations did not individually determine what their overall objectives of the contracts should be and what they wanted them to deliver. This means that where service redesign had occurred on a large scale, this was due to other initiatives and any contractual changes had simply followed on.

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**149** However, there have been some benefits since the introduction of the new hospital contracts. NHS bodies felt that the consultant contract had created greater transparency. Clinical directors are able to plan services more effectively because they know the consultants' schedules and they can ensure that they undertake activities that contribute to the trust's key objectives. There is increased awareness that job plans are important.

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**150** Peterborough and Stamford Hospitals NHS FT reported that no clinical excellence awards were paid to clinical directors who failed to provide appraisals for consultants. AfC was also highlighted by some trusts as a useful tool for pre-empting a large number of anticipated equal pay claims under the old contracts. Prior to the introduction of AfC, the NHS was bracing itself for a range of equal pay claims. Many of these were resolved by AfC although for the remainder it provides a clear footing for

payment comparisons. As a result, its final net cost might be smaller than would otherwise appear.

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**151** Organisations are now starting to think about how to get the best out of the contracts. For example, Sheffield Teaching Hospitals NHS FT is using the flexibility that exists in the new consultant contract to negotiate an annualised hours arrangement; on average, consultants will work the same total number of sessions, but the sessions will not be evenly distributed each week. This flexible approach enables the trust to respond effectively to peaks and troughs in activity.

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**152** Despite these benefits, there is little evidence to suggest that the new consultant contract and AfC have been a lever for increased efficiency or productivity. When announcing the new contracts, the government was clear that, in return for better pay, NHS staff must increase productivity and accept new ways of working (Ref. 34), such as, nurse consultants. This was particularly important given the scale of the increase: the new consultant contract has cost the NHS over £250 million a year and AfC cost between £1 billion and £1.8 billion each year since implementation.<sup>1</sup>

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<sup>1</sup> Figures from the DH.

## 4 | Provision of care continued

**153** Some organisations we interviewed reported that the scale of the overall increase in funding made it very difficult to increase productivity by an equivalent amount. There was a local perception that productivity had not improved; managers consistently reported that few, if any, gains in productivity had come from the consultant contract and AfC. Despite the government's intentions, our analysis of reference cost and accounts data show that the amount of output per pound spent decreased between 2003/04 and 2005/06 (that is, unit costs increased), caused almost entirely by the increase in staff wages. Although there are several different measures of NHS productivity, the Office of National Statistics (Ref. 35) also found that productivity has fallen by 2 per cent a year on average over the period 2001 to 2005<sup>I</sup> as growth in healthcare outputs has been lower than growth in inputs.

**154** The impact that these contracts have had on improving staff numbers is unclear. Much of the staff increase was met in advance of the new contracts being introduced. For example, the *NHS Plan* target to recruit an extra 20,000 nurses was met in 2002, two years early, and well in advance of AfC being rolled out in December 2004. There were other initiatives outside pay and other contract issues that may have had a greater impact on recruitment and retention (for example an increase in training

places, international recruitment, flexible working and return to work schemes). In addition, despite generous pay settlements, NHS staff job satisfaction<sup>II</sup> in the acute sector has not increased; it has in fact declined from 72 per cent in 2003 to 68 per cent in 2007.<sup>III</sup> This may be because, among other things, subsequent pay awards were seen as attempts to claw back some of the financial increases. Figure 4 shows that NHS staff numbers have been rising since 1995, particularly from 1999 onwards. Also, recently, more general financial restraint has reduced other resources and activity and this has lowered morale even at a time of higher pay. Unfortunately, it is not possible to measure the alleged 'recruitment crisis' that might have occurred without the new contracts.

**155** The full effects of the new workforce contracts for hospital and community staff may only be seen over a longer period of time. The new contracts will potentially enable increased productivity and the development of new ways of working.

<sup>I</sup> With quality adjustment for output.

<sup>II</sup> This is based on a staff satisfaction level regarding various aspects of their job, such as the recognition received for good work and how well their work is valued by the trust.

<sup>III</sup> Figures from National survey of NHS staff 2003, Healthcare Commission, July 2004 and National survey of NHS staff 2007, Healthcare Commission, April 2008.

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## Provision of care – Summary

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Plurality of provision has occurred since the advent of the system reform programme, although the change has been slower than expected. NHS patients are beginning to benefit from the existence of a diverse range of providers and anecdotally we found that competition, and particularly the fear of competition, may be leading to some service improvements.

In FTs, the DH has succeeded in creating more autonomous, locally accountable bodies. The FT concept has driven change more quickly in NHS organisations and improved financial control, including for those organisations that are still preparing for FT status. The freedom and flexibilities of FT status give frontline healthcare professionals and local managers the incentive to improve services and innovate in response to the needs of their patients and local populations. However, the changes resulting from this are not striking. We found no evidence of significant innovation in our research for this study or from the detailed service reviews undertaken by the Healthcare Commission. Annual health check data suggest that FTs are generally higher performers, but they started from a better position in terms of service delivery, efficiency and financial standing.

The FT regime has resulted in trusts improving their financial management arrangements. As noted, their financial standing also improved with income growth being a significant contributor. There is no consistent evidence that FT income growth, as well as efficiency gains have been achieved at the expense of PCTs overspending. As highlighted in *The Right Result?* PbR has encouraged growth in day case activity and the reduction of length of stay for elective inpatients, but otherwise has had little direct impact so far on improving efficiency. The new workforce contracts for hospital and community staff have not yet led to improvements in efficiency or productivity, nor is it clear that they have resulted in increased staff numbers.

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# 5 | The reforms as a package and the future

While earlier chapters consider the individual strands of the reform programme, this chapter considers the overall effect of the set of reforms that aimed to introduce more market choice and competition into the NHS. It explores the inter-relations between the strands of reform and identifies certain prerequisites for them to be successful.

The chapter sets out:

- the overall impact of the reform elements included in the study;
- barriers to progress; and
- our conclusions.

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## The overall impact of choice and competition reforms

**156** Since the reform programme was announced in the *NHS Plan*, the NHS has made significant progress. Funding and staff numbers have increased significantly; there has been an increase in quality, as reported in the Healthcare Commission's annual health check; financial management has improved, as identified through the Audit Commission's ALE; waiting times for A&E and for elective care have reduced; and, for example, cancer pathways have been reformed, among other improvements. However, it is difficult to attribute any of these changes to the system reform programme. The evidence is limited and not systematic and where we have found evidence, it does not suggest that the choice and competition elements of the reforms are having the greatest impact. Although not the subject of this report, NHS funding increases and other drivers for change, including targets, such as the four hour wait target for A&E, regulation, NSFs, National Institute for Health and Clinical Excellence (NICE) guidance and,

more recently, the push to achieve financial balance following the deficit of £547 million in 2005/06, are perceived by those working in the health service to have had much more of an impact (Ref. 12).

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**157** The reforms were intended to work as a package, with commissioners and empowered patients able to take advantage of a wide range of provisions and more autonomous providers better able to respond to the choices made. Changes in the financial regime would help to support these developments. The reforms were not implemented uniformly on a national basis. Where change was implemented nationally, such as PbR, there was a strong case for it. In other areas, the reform programme had been able to recognise that different health economies were in differing stages of development. However, from the available quantitative and qualitative evidence, health economies that implemented many of the reforms earlier do not appear to have a significant advantage. Our fieldwork found that those health economies that were advanced with implementing the system reforms were not

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performing at a significantly higher rate than those that had limited reform levers in place. We also found that, where there is evidence, for example through the annual health check, of better services being delivered, this relates, at least in part, to the fact that the organisations involved have performed well historically. For example, the highest performing trusts tend to be the early wave FTs, but these were, by definition, the highest performing trusts before their FT application. The role that FT status has played in maintaining the level of performance is not clear, but we have not found consistent and widespread evidence that it alone has led to substantial and significant improvement. In addition, the health economies selected as early achievers of 18 week referral to treatment targets<sup>1</sup> represent a range of stages in system reform implementation, suggesting that the reforms are not a prerequisite for meeting access targets.

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**158** Aspects of the choice and competition elements of the reform programme were considered controversial among certain groups when they were first introduced. Given this, and the practicalities of implementing major developments on the ground, it is not surprising that more progress has not so far been made. Table 4, overleaf, summarises our findings on the five strands of the reform programme and the progress that has been made to date.

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<sup>1</sup> Thirteen early achiever local health communities consisting of 14 acute trusts were launched in February 2007. Early achievement was defined as delivery of 18 week pathways for a minimum of 90 per cent for admitted patients and 95 per cent for non-admitted patients by December 2007.

# 5 | The reforms as a package and the future continued

**Table 4**  
Summary of progress against system reform aims

Progress with implementation of reform policy	Aims	Have the aims been met yet?
<b>FTs</b> – 73 out of 171 acute and specialist trusts are FTs (a further 26 mental health trusts are FTs)	Stronger finances, greater efficiency	FTs started from a good financial position and have improved further. Income growth has been a significant contributor to the increasing surplus. Efficiency savings have also been made. FT application process has helped non-FTs improve financial management and financial stability.
	Service improvement	FTs perform well, but they started from a better position than other trusts. Impact on any improvement is unclear.
	Patient responsive services	Role of FT governors and membership is still developing.
	Increased independence for providers	FT status allows autonomy and use of cash balances to deliver service improvements.
<b>PbR</b> – Implementation by acute and specialist trusts, where the policy has been largely mainstreamed. Little implementation beyond the acute sector. By April 2008, all acute trusts reached 100% PbR price and purchasing parity adjustment phased out for all PCTs.	Fairness and transparency of funding	There is now a clear link between activity, income and expenditure, removing the need for much local price negotiation.
	Efficiency	Day cases have increased and lengths of stay have fallen, particularly for elective inpatients. Where changes have occurred, PbR seems to have reinforced rather than driven change.
	Faster access to more appropriate, patient responsive services	Increase in overall activity, but particularly short-stay activity such as day cases and non-elective short-stay admissions. However, other policies will have also contributed to these changes. PbR has encouraged PCTs to focus on demand management.
	Increased focus on quality	Not a primary driver in changes in quality to date, although, while emergency readmissions are increasing, there is no evidence that PbR has resulted in a negative impact on quality overall. Rewarding quality is likely to be a focus in the future.
<b>PBC</b> – Limited progress.	Better services closer to patients	PBC has only had a limited impact on service redesign to date.
	Better use of resources to purchase services for patients	PBC has only had a limited impact on commissioning of services to date.
	Reduced inequalities of outcome	There is potential to deliver this if PBC moves forward.

**Table 4** continued

Progress with implementation of reform policy	Aims	Have the aims been met yet?
<b>Plurality and patient choice</b> – Limited introduction of ISTCs. Variable availability of patient choice.	Greater choice of provider for patients	Greater choice is available for most patients.
	Stimulating competition	The fear of new providers has stimulated some change.
	Improvement in quality	Information does not yet exist to enable patients to make a decision based on quality of outcome or to determine whether quality has improved as a result of patient choice.
	Increasing capacity	ISTC programme has increased capacity but progress has been slower than expected.
	Tackling health inequalities	No evidence that choice or ISTCs have reduced health inequalities.
<b>Workforce contracts</b> – Fully implemented.	Flexible workforce	Mixed progress has been made. The contracts have introduced some flexibility, but implementation has alienated some staff.
	Delivering different services in new and better ways	Contracts have supported but not driven service redesign.
	Increased productivity	The new hospital contracts resulted in an increase in costs without an associated increase in productivity.
	Improvements in quality of care	Measures of quality did not improve significantly after introduction of new contracts, although it would be difficult to attribute any change to this.
	Resolving recruitment and retention issues	Problems were largely solved in advance of new contract implementation.

Source: Audit Commission and Healthcare Commission

# 5 | The reforms as a package and the future continued

## Barriers to progress

**159** We found that progress in implementing the reform programme in organisations has been limited by the following factors:

- structural reorganisation;
- commissioning capacity;
- infrastructure to support the reforms;
- cultural factors; and
- communication and engagement.

## Frequent structural reorganisation

**160** Earlier chapters discuss how the local NHS has been subject to frequent reconfiguration both at SHA and PCT level. This has had a detrimental effect on the implementation of many of the NHS reforms, particularly PBC, choice and, at least in the short term, commissioning capacity and capability. Unsurprisingly, the PCTs reconfigured in 2006 tended to perform least well in 2006/07 on both use of resources and quality of services in the annual health check. We found that the latest round of PCT reorganisation in October 2006 resulted in a short term loss of organisational memory, particularly as reconfiguration occurred half-way through the contracting year. It also stalled PBC implementation, and has made trusts cautious about commissioning intentions and therefore about developing services. However, these short term disadvantages should be outweighed by the longer-term gains. The mergers appear to have strengthened relationships between PCTs and local

authorities and positive steps have been made, such as some PCTs now being co-located in council offices and, for example, joint appointments of directors of public health. PCTs also considered themselves to be potentially stronger organisations. Collaboration across the newly merged PCTs together with the greater coterminosity with local authorities which has resulted, has meant sharing of expertise as well as strengthening commissioning capacity and power. Trusts also report that they prefer negotiating with fewer PCTs. Such positive results should achieve even more when combined with a period of organisational stability.

**Recommendation:** There should be a prolonged moratorium on any further national top-down reorganisation of NHS commissioners. This will enable the benefits of the choice and competition reforms of the NHS to be fully realised.

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## Commissioning capacity

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**161** Strong commissioning is a central component of NHS modernisation and is essential if the reform programme is to be implemented successfully. However, our fieldwork found that organisational capacity still needs developing and that there is an imbalance between commissioners and providers in the experience and skills required to work in a more business-like NHS. Trusts tended to be in a stronger position, particularly given that they had been affected less by the recent reorganisations. PCTs need to develop their commissioning, business and legal acumen to match the capability and capacity of provider trusts, particularly early FTs. PCTs should identify gaps in capacity and develop those required to operate in the new environment, in line with the emerging *World Class Commissioning* competencies. SHAs should offer PCTs support in doing so.

**162** The imbalance between commissioners and providers is apparent in the way that new services are being developed. Many trusts are planning for an expansion in activity, even though there is a drive to move more care out of a hospital setting. This runs the risk that services will be simultaneously developed in different organisations, leading to potential over capacity in the NHS and subsequent waste and inefficiencies. In some cases, PCTs have not been engaged and may have conflicting plans to manage demand by reducing hospital activity. In a health economy with a strong commissioner, it would not be possible or financially viable for a provider to spend money to increase future activity in these areas.

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**163** FTs are not subject to performance management by SHAs. There is therefore no longer any regional or central oversight to ensure that commissioner and provider plans are based on similar, sound assumptions. Previously, the SHA would have sought to manage this, particularly if some activity expansion was in similar clinical areas; however SHAs no longer have the power to do this where FTs are involved. Monitor's programme ensures that FTs make realistic plans, as failure to meet planned income levels and generate cash surpluses can result in higher risk ratings and ultimately intervention. However, the key is good local communication and for PCTs to have sound service and financial plans that can inform and lead provider decisions. Medium-term financial planning has been weak in the NHS (Ref. 36), particularly among commissioners as demonstrated in the PCT fitness for purpose reviews last year and in the ALE results. There will be an opportunity to refresh plans following the announcement of the PCT resource allocations for 2009/10-2010/11, expected in summer 2008.

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## Infrastructure to support the reforms

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**164** Previous chapters explain how the implementation of PBC, patient choice and FT status has been slower than anticipated. Progress with implementing the reform programme has been hindered by the appropriate infrastructure not being in place to support it.

# 5 | The reforms as a package and the future continued

**165** There have been significant delays in the roll out of electronic patient records as part of the National Programme for IT, *Connecting for Health*. Many of the organisations involved in our research were frustrated with the pace of implementation for *Connecting for Health* and that its structure, at times, was perceived neither to match local needs nor offer an improvement to existing systems. Even PbR, the most fully implemented reform, has been hampered by a lack of supporting infrastructure, for example, in the provision of data. For example, as stated in *The Right Result?* (Ref. 10), the timeliness and quality of data available to PCTs through the secondary uses service (SUS)<sup>1</sup> for monitoring contracts and making payments under them need significant improvement.

**166** The necessary infrastructure is also not yet in place to enable choice to reach its full potential. The national roll out of Choose and Book, the electronic booking appointments system, was delayed. This has limited the choice that patients had over access to outpatient appointments. In addition, the NHS Choices website only went live in July 2007; the information it contains is still incomplete; and not all patients will have access to this medium. Chapter 3 explains how choice policy is being hampered by the lack of necessary information on patient care, although the DH are now addressing this. PBC is also yet to deliver significant change and the slow progress can be attributed at least in part to underdeveloped budgeting, data collection and information sharing and governance processes.

## Cultural factors

**167** During our fieldwork we observed that local health economies were nervous about making decisions that would change the *status quo*. There was concern from both commissioners and providers about the impact that significant movement of care from secondary to primary providers would have on the long term viability of smaller hospitals. For some organisations, even a small loss of caseload could affect the feasibility of a service. An example was given of a successful GPwSI in dermatology, whose work led to the local hospital service becoming close to unviable, even though the GPwSI relied on them for certain referrals.

**168** Anxiety also surrounded the introduction of new Independent Clinical Assessment, Treatment and Support Services (ICATS), which are provided by the independent sector. GPs can refer to ICATS centres to enable patients who require triage, diagnostic tests, treatments or therapies to be treated more quickly, as an alternative to traditional hospital outpatient services. In one area, the PCT has planned for two thirds of referrals to go through the ICATS centre. However there are local concerns about the impact on acute outpatient appointments and service viability, if this planned activity is met, but the PCT was not clear how this was to be handled locally. Commissioners and providers are also concerned that ISTCs and ICATS will threaten the viability of existing NHS organisations that they, in turn, rely on for some services.

<sup>1</sup> SUS is the NHS's main source of activity data, which will be the definitive source of data for payment under PbR from 2009.

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**169** In addition, not all providers are committed to the principle of developing out of hospital services when it is likely to reduce their income, unless there is an obvious benefit, such as helping to achieve the 18 week target. The DH 2008/09 Operating Framework (Ref. 16) makes clear that, from April 2008, organisations should cooperate when it is in the best interests of patients. If the NHS is to function as an integrated service, rather than a fragmented one, it is essential that local NHS bodies have a clear perspective of what is in the best interest of patients, and are able to work together to develop and achieve this vision. Although this could be seen to be in conflict with the autonomous nature of FTs, providers should not be so focused on increasing their service-line and profitability that they neglect the overall interests of patients, for example by not participating in a scheme to increase the convenience of care by moving the service out of a secondary care setting, where appropriate. Where collaboration is limited, PCTs need to be innovative to offer incentives for providers to participate.

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**170** While PCTs and practice based commissioners are right to consider the impact of commissioning new services and changing care pathways on existing services upon which they rely, giving the highest priority to maintaining the position of the existing local provider may restrict the progress that might otherwise be made.

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## Communication and engagement

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**171** While the general intention of the reform programme is evident, there has not been a clear vision that directs all policy initiatives to a well-understood objective. This has adversely affected progress. Links between the reforms were not obvious when the *NHS Plan* and subsequent policy documents were published and the reforms were only brought together into a 'system reform programme' some time after their independent conception. This gives the impression that many of the links were a post hoc rationalisation. The rationale for development of the individual reforms is not clear to both clinical and non-clinical managers.

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**172** It is particularly important to understand how the reforms interact, given that some of them challenge NHS culture. Some staff, including NHS managers, are still not clear how to manage the tension between collaboration, which is often in the best interest of the patient, and competition, which can also lead to improvements for patients.

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**173** There was also ambiguity surrounding the timescale for implementation. When announcing the reform programme, the *NHS Plan* (Ref. 1) was clear that expanding and reforming the NHS would take time. However, the subsequent messages were not always so clear and consistent, giving staff and the public a perception that change would happen quickly, leading to anxiety among NHS staff. In reality, change has been implemented relatively slowly and the impact, particularly on patient care, has been even slower to materialise.

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## 5 | The reforms as a package and the future continued

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**174** Staff engagement is crucial if the reforms are to be delivered successfully. Engagement has been a common theme in many previous Audit Commission and Healthcare Commission reports. Once again we found that clinical engagement in financial and business matters specifically was crucial for successful delivery of all the reforms. Some respondents reported that there was not a clear framework to link the reforms together or describe how they fit into the aims of the NHS and work as an integrated whole for patients. Being clear about the rationale for change and taking organisations and staff along with it are prerequisites for any successful change programme.

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**175** At the same time, participants in our research felt that some of the recent progress that had been made regarding broader clinician engagement, through initiatives like PbR and PBC, was damaged through the poor central handling of the medical training application service. This was particularly true where a new system designed to administer training allocation resulted in disarray, with doctors claiming that some of the most qualified and experienced doctors were left with no training contract. There was also some dissatisfaction about the way that the new workforce contracts were introduced.

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**176** Some of the incentives designed to engage staff in the reform programme have had limited success, such as PBC. In this case, payments have secured the take-up of indicative budgets but have not resulted in widespread engagement and support.

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**177** A need for central government and local NHS managers to re-establish staff engagement was reflected in our interview findings. The DH has recognised this by giving more attention to the hospital leadership, clinical engagement and staff understanding, and behavioural issues for successful change. The wide-ranging NHS review, taken forward by Lord Darzi, has sought to re-establish engagement across all staff groups. It also plans to develop a new ten year strategy for the NHS to update the position outlined in the *NHS Plan*. Many managers in our fieldwork indicated that they would welcome such a vision.

**Recommendation:** Lord Darzi's review presents an opportunity to clearly communicate and outline the NHS vision for the future. It should clearly demonstrate how the reforms work for patients and how they contribute to the overall vision he sets out.

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## Conclusions

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**178** As the reforms have been implemented in stages (Figure 1) it is still relatively early to assess their combined effects. This is particularly the case given that many of the reforms are not yet fully realised and that the existence of other pressures like the annual health check, hygiene audits, waiting times and other targets and the management of financial deficits have clearly affected service delivery. In addition, other initiatives such as the NHS Modernisation Agency's *Ten High Impact Changes* (Ref. 37), which identified areas for improvement, have also been integrated into NHS structures relatively recently. As a result, organisations have had to focus on a number of challenges and initiatives as well as the reforms. Nevertheless, service improvement to date has largely been achieved without system reform.

**179** There is potential for the reforms to deliver positive change in the future. Clinicians we spoke to as part of our fieldwork felt that much of the reform in service delivery will come from within organisations or specialties, and not from the external environment. However, organisations do not operate in a vacuum. There is no doubt that the external environment and the opportunities and incentives it provides will have some effect on service delivery.

**180** The reforms will need further time to fully integrate, particularly in reconfigured PCTs. The barriers we have identified above also need to be addressed if the reforms are to be successful. Further developments may also be needed if the aim of more empowered patients receiving higher quality, more convenient services, provided more efficiently is to be achieved.

**181** The infrastructure and the information to support patient choice, are only just being put into place. Even so, the information available needs to be extended to cover the quality of clinical care and patient experience of individual services and units. This will become more important as waiting times reduce. Patients' appetites for such information also need to be stimulated. However, given that patient choice is having a limited impact on the quality of elective care to date, so far as we can identify, and given that patients have very little outcome data on healthcare providers, there needs – at least for the foreseeable future – to be a much greater focus on commissioning, contracting and regulatory processes for elective as well as non-elective care to really drive improvement. Choice alone does not appear to be strong enough to deliver this change.

**182** There also needs to be plurality of provision for patient choice to be effective. Anecdotally, the fear of competition has had some impact, although we have found it hard to demonstrate this conclusively through data analysis. Some PCTs have certainly found actual competition through competitive tendering to have been effective.

# 5 | The reforms as a package and the future continued

**183** The impact of the independent sector as an NHS provider is slowly increasing, but should be monitored closely in the coming years. The central ISTC capacity planning process set the programme in motion, but the interests of the DH, SHAs and PCTs in establishing ISTCs did not always align and incorrect planning assumptions were common. This affected local buy-in to the schemes and utilisation. Where independent sector provision developed through a locally-run initiative, it appeared to have greater support.

**184** Further large-scale entry of the independent sector to the market at this stage seems unlikely, given that the government has announced that there will not be another centrally procured ISTC scheme, and that the second phase programme will be scaled back significantly. Without central assistance with set-up costs, significant further expansion is not expected. When the 18 week target is met, there may also be extra capacity in the NHS system, and independent sector capacity may not be as critical. Competition and choice will rest for a large part on competition between NHS providers in secondary and primary care. It will also depend upon PCTs' increasing willingness and ability to tender for services in order to secure improvement.

**185** The capacity of the reforms to improve the quality of care depends on improving commissioning capacity and capability and also on the information made available for patients. Even if patients did not make much use of such information, clinicians and NHS managers would inevitably compare and contrast their own performance. Changes could also be made to the system so that high

quality procedures and high quality outcomes are rewarded. We found significant frustration in the NHS that PbR in its current form does not reward higher than average quality procedures or outcomes. *The Right Result?* (Ref. 10) suggests that a separate payment be made outside the tariff to reward quality. One example is the NHS in the North West Advancing Quality Programme which will make use of financial payments to incentivise improvements in the quality of care, across the SHA in cooperation with both providers and commissioners. This initiative needs careful evaluation.

**186** FTs also need to take further steps to improve the quality of their services, making greater use of the cash surpluses available to them. Their performance has generally been better than that of other trusts, although they started from a higher base position. Nevertheless, the logic of FT status was that greater autonomy and stronger local accountability would lead to better, more responsive services. That now needs to be demonstrated across the sector. Stronger commissioning will help, but regulation may also have a part to play.

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**187** PCTs have made progress in developing more convenient locally based services but a significant shift from secondary to primary care has yet to take place. There has been extra investment in primary care. In 2002, PCTs controlled 75 per cent of the budget, but they now control over 80 per cent. Spending in primary care has increased at a greater rate than in secondary care; from 2003/04 to 2006/07, the absolute increase in expenditure on primary care was 42 per cent compared with an increase of 16 per cent for secondary care. However, a large proportion of this increase in spending on primary care is attributable to the new General Medical Services (GMS) contract.<sup>I</sup> This contract was underpinned by a three year deal that increased the resources available from £5 billion in 2002/03 to £6.9 billion in 2005/06.<sup>II</sup>

**188** PBC is the most likely vehicle for delivering more local services, but it has been slow to develop. Moreover, PbR also needs to develop to enable funds to move more easily into primary care when part of a patient's care is provided there. If such service developments do take place on a larger scale, there are some issues that the DH will need to address. For example, it is not yet clear how clinical governance and accreditation issues will operate in small primary care organisations that do not have a hospital's infrastructure.

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**189** Also, as data are not currently collected centrally on primary or community care activity, there is concern that a move to primary care may appear to change overall activity, for example decreasing the number of day cases carried out. This could lead to existing targets apparently not being met and generate a skewed set of national data, with some cases lost in primary care. Therefore, there is a case for amending current national targets in order to reflect the impact of new policies regarding the flow of activity from secondary to primary care.

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**190** PCTs will also need to monitor activity and outcomes more carefully, as part of the Quality and Outcomes Framework (QOF).<sup>III</sup> Performance will also need to be managed to a much greater extent than previously. Currently, the lack of such processes makes it difficult to know if primary and community care have high quality services that offer value for money.

**Recommendation:** When establishing the new Care Quality Commission, the DH needs to ensure that its terms of reference are wide enough to cover the complete risks and issues throughout the health service, including quality and value for money issues in primary care and community services. As more care is transferred into a primary setting this will be increasingly important.

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<sup>I</sup> The new GMS contract is a framework for providing individual funding to GP practices which came into effect on 1 April 2004.

<sup>II</sup> Source: DH, October 2007.

<sup>III</sup> The QOF was introduced as part of the new GP contract and is a system of standards, assessments and incentives relating to the quality of care delivered by GPs

# 5 | The reforms as a package and the future continued

**191** The reforms have currently had little direct impact on efficiency, most likely reinforcing already positive trends rather than driving them. PbR appears to have had some impact on day cases and possibly on lengths of stay, particularly for elective inpatients, but overall its impact has not been significant. Now that it is the norm across the majority of the NHS, it should deliver more. We believe that its impact on efficiency would be greater if prices were based on the most efficient and effective practice, that is 'normative pricing'. An impact would also be made by stronger commissioning based on rigorous review of business cases for alternative methods of care outside hospital.

**192** Lord Darzi's review provides an opportunity to take stock of what the reforms have achieved so far and how they might need to develop to contribute to a renewed vision for the NHS. Many of the system reforms have also been developed on an elective, secondary care model; not one based on primary, community or mental health care, or one that focuses on managing long term conditions. The review will also need to address these issues.

**193** Finally, there are lessons for the DH to learn for future policy development. The specific aims of the individual elements of the reform programme were not readily available and this made it difficult to assess the success of the reform programme. Given the ambitious nature of the programme and the large scale changes it proposed, it would have been prudent for the DH to have clear measurable aims for such major policies from the outset. At present, the outcomes from the reforms are unclear and the total cost of implementation and running costs are not known. It is therefore difficult to

comment on whether the policies offer value for money and this is an important tool for engaging NHS staff, patients and taxpayers.

**194** It is promising to note that the DH has now commissioned some research to evaluate the reform programme. In future, the evaluation process of large policy changes should be considered before the policy is implemented. Greater prominence should also have been given to existing research, for example the evaluation of the LPCP, which correctly identified many of the issues that are currently hampering choice policy. The use of pilots to test ideas before they are rolled out nationally, for example, by drawing on the emerging lessons from NHS in the North West Advancing Quality Programme and *World Class Commissioning*, or the Humber region's test of the PbR tariff in mental health, for example, might also be a useful tool for future initiatives. This would help to identify potential skills shortages and give organisations time to develop them.

**195** Our study as a whole has highlighted the lack of consistent and effective data collection to identify the most effective elements of the reforms and provide rapid post implementation assessment.

**Recommendation:** The DH should assess the impact of the current reforms on an ongoing basis. It should also set clear measurable aims and objectives for all major new reform policies and plan a timetabled evaluation strategy in advance of implementation to review the relative success and achievements of these policies.

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# Appendix 1 | NHS organisations interviewed for the study

## **Strategic health authorities**

NHS East of England  
NHS London  
NHS North West  
NHS South East Coast  
NHS West Midlands  
NHS Yorkshire and the Humber

## **PCTs**

Barnsley PCT  
Croydon PCT  
Doncaster PCT  
Lambeth PCT  
Manchester PCT  
Peterborough PCT  
Rotherham PCT  
Sheffield PCT  
Worcestershire PCT

## **Acute NHS trusts**

Central Manchester and Manchester Children's University Hospitals NHS Trust  
East Kent Hospitals NHS Trust  
Medway NHS Hospitals Trust  
Pennine Acute Hospitals NHS Trust  
St George's Healthcare NHS Trust  
Worcester Acute Hospitals NHS Trust

## **FTs**

Christie Hospital NHS FT  
Guy's and St Thomas' NHS FT  
Peterborough and Stamford Hospitals NHS FT  
Rotherham NHS FT  
Sheffield Teaching Hospitals NHS FT

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# Appendix 2 | Overview of NHS bodies included in this study

The NHS in England is divided into ten SHAs, which were established in July 2006. These organisations are responsible for managing and setting the strategic direction of the NHS locally, ensure that local systems operate effectively and deliver improved performance, and provide support for organisational and workforce development. They are the key link between the NHS and the DH.

Within each SHA area the following types of NHS bodies each have their own roles and responsibilities:

**Acute trusts** – Hospitals are managed by NHS trusts (acute trusts) that ensure that hospitals provide high-quality healthcare and spend their money efficiently. PCTs commission (purchase) hospital services on behalf of patients. Services include emergency and planned treatments, where patients can be inpatients, day patients or outpatients. There are currently 171 acute and specialist trusts in the NHS (including FTs).

**Foundation trusts** – A new type of trust with more financial and operational freedom to run their services than other NHS trusts and reduced central government involvement. They clearly illustrate the shift of decision making power to frontline staff and their local communities. FTs remain within the NHS and its performance inspection system but are not performance managed by SHAs, and instead fall under the auspices of the FT regulator, Monitor. The first NHS FTs were established in April 2004. There are currently 99 FTs in the NHS (including mental health trusts).

**Primary care trusts** – Primary care refers to the first contact a patient has with the healthcare system, before being referred elsewhere. It includes, for example, GPs or other practice staff, general dental practitioners, opticians or pharmacists. Primary care services are managed by a local PCT. PCTs lead their local health system, developing and delivering their functions through effective partnerships with GPs, local authorities, the local population and the full range of different types of providers. They hold providers to account through commissioning and contracting a comprehensive and equitable range of high quality responsive and efficient services, within allocated resources. They also directly provide services where this gives best value. PCTs control over 80 per cent of the total NHS budget. In October 2006 the local NHS was reorganised and the number of PCTs reduced from 303 to 152 to ensure a closer relationship between health, social care and emergency services.

There are also mental health trusts and ambulance trusts. However, these are not covered in this report.

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# Appendix 3 | Glossary

## **18 week referral to treatment target**

The 18 week target is a government set target for the NHS. The aim is to create an 18 week patient pathway from GP referral to the start of treatment for each NHS patient. This is a key objective for the NHS, and aimed to be achieved by the end of 2008.

## **Agenda for Change (AfC)**

AfC is the pay system for the majority of directly employed NHS staff. The system was reached in November 2003 and rolled out national in December 2004. It promotes a fairer pay system that pays staff on the basis of the job they are doing. Doctors, dentists and some very senior managers are the only exceptions to the system.

## **Annual health check**

The Healthcare Commission's annual health check assesses and rates the performance of each NHS trust, PCT and FT in England each financial year. It scores performance on a wide range of areas including quality of services, including safety of patients, cleanliness and waiting times, and how well finances are managed. There are two ratings: one for quality of services and another for use of resources.

## **Auditors' Local Evaluation (ALE)**

ALE assesses how well NHS trusts and PCTs manage and use their financial resources. It involves auditors making scored judgements on the five key areas of:

- financial reporting;
- financial management;
- financial standing;
- internal control; and
- value for money.

On the basis of these five areas an overall score is calculated. This overall use of resources score is included within the Healthcare Commission's annual health check.

## **Comprehensive Area Assessment (CAA)**

CAA is the new approach to local public service regulation. It will provide the first independent assessment of the prospects for local areas and the quality of life for people living there. CAA will cover issues like reducing inequalities in health and education, increasing the availability of affordable housing, reducing the fear of crime, improving educational achievement, attracting investment and reducing each area's carbon footprint.

CAA is being developed and delivered jointly by the Audit Commission, Commission for Social Care Inspection, Healthcare Commission, HM Inspectorate of Constabulary, HM Inspectorate of Prisons, HM Inspectorate of Probation and Ofsted, and will formally begin in April 2009.

**Commissioning**

This is the process whereby PCTs assess the health and social care needs of their local population; set relevant priorities, allocating resources accordingly; and negotiate agreements with providers (NHS, private and voluntary) to deliver services to meet these needs.

**Directed Enhanced Services (DES)**

DES exist as part of the new GP contract. An additional one year DES payment was introduced as an incentive payment in 2006/07 to encourage GP practices and other allied healthcare professionals to participate in PBC. The PBC DES was made up of two components. The first component entitled practices to 95 pence per registered patient in recognition of the need to support them with the development and implementation of locally agreed plans. If through a process of review PCTs determined that practices had delivered the objectives set out in the plan, they were entitled to component two. Component two was a minimum of 95 pence per registered patient, which had to be reinvested in practice activity for the benefit of patients locally.

**Department of Health (DH)**

The DH is the government department responsible for improving the health and wellbeing of the people of England. It sets national standards and shapes the direction of the NHS and social care services, as well as promotes healthier living.

**Elective patient**

An elective patient refers to a patient that receives treatment that has been planned.

**Extended choice network**

The extended choice network provides a 'national menu' of NHS and alternative providers across England. NHS patients, when referred for treatment by their GP, can choose a place of treatment from this menu. Alternative providers include ISTCs and additional independent sector hospitals that have been approved by the DH.

**Foundation trust (FT)**

NHS FTs are a new type of NHS hospital. The first wave of FTs was introduced in April 2004. FTs are free from central government control and SHA performance management.

**GPs with a specialist interest (GPwSI)**

GPwSI were developed from the government's aims to provide more services in a primary care setting. GPs are encouraged to take up and provide a specialist interest service to increase the accessibility and range of services in the community.

**Gross Domestic Product (GDP)**

GDP is the total value of all goods and services produced in the economy. It equals gross national product minus income from abroad.

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### **Healthcare Resource Group (HRG)**

HRGs are standard groupings of clinically similar treatments that use similar levels of healthcare resource. They are underpinned by diagnosis and procedure classification systems such as ICD10 and OPCS, which reflect current clinical activity performed in the NHS. Each HRG has an assigned price. HRGs are grouped into 19 chapters, which relate to an area of medicine, for example the nervous system, mental health, and obstetrics and neonatal care.

### **Healthcare Resource Group version 4 (HRG4)**

HRG4 is the new version of the HRG classification system, which has not yet been introduced. It will improve differentiation between routine and complex care, extend the areas covered by the classification and help to facilitate the funding of the services provided out of the hospital setting.

### **Health Select Committee**

The Health Select Committee is appointed by the House of Commons to examine the expenditure, administration and policy of the DH and its associated bodies. The Committee has a maximum of 11 members and unless discharged remain on the Committee until the next dissolution of Parliament. The current Health Select Committee was appointed on 13 July 2005.

### **Hospital Episodes Statistics (HES)**

HES is the national database that records the care provided by NHS hospitals to NHS inpatients and day patients. HES is the data source for a wide range of healthcare analysis for the NHS, government and many other organisations and individuals.

### **Independent Clinical Assessment, Treatment and Support Services (ICATS)**

ICATS are an alternative to traditional hospital outpatient services and offer outpatient assessment, diagnostics and therapies for a range of specialist services, following GP referral. They are fully funded by the NHS, but are provided by the independent sector. They have been designed to improve services for patients by reducing waiting times and providing more diagnostic and therapeutic services directly to GPs in order to help meet the 18 week referral to treatment target and extend choice.

### **Independent Sector Treatment Centres (ISTCs)**

ISTCs are treatment centres operated and owned by the independent sector, such as BUPA and Netcare. These centres provide NHS standard healthcare to NHS patients at no cost to the patients. They perform routine operations, procedures, and diagnostic services. ISTCs were mainly introduced to alleviate the pressure on waiting lists at NHS hospitals and facilitate greater competition in the NHS.

### **Market Forces Factor (MFF)**

MFF is the method used to adjust allocations to health authorities for unavoidable variations in healthcare costs in different parts of the country. Such variations include staff, land and building costs. MFF evens out the purchasing power between PCTs. MFF performs an important function under PbR by allowing

adjustments to tariff payments to providers to account for unavoidable cost differences in delivering services. MFF has a number of limitations, and the DH plans to keep the approach under review.

### **Monitor**

Monitor is an independent regulator that authorises and regulates NHS FTs. It was established in January 2004 by the government. Its main powers are to authorise and grant FT status to acute trusts that meet the application requirements; to monitor and regulate the performance of FTs; and to ensure they comply with its terms of authorisation.

### **National Institute for Health and Clinical Excellence (NICE)**

NICE is an independent organisation responsible for producing national guidance in three areas of health:

- public health – guidance on the promotion of good health and the prevention of ill health for those working in the NHS, local authorities and the wider public and voluntary sector;
- health technologies – guidance on the use of new and existing medicines, treatments and procedures within the NHS; and
- clinical practice – guidance on best clinical practice.

### **Outpatient**

Outpatient care refers to those patients who receive a consultation and/or treatment without being admitted to hospital or requiring an overnight stay.

### **Patient level information and costing**

Patient level costing records the actual resources used by a patient by calculating the actual costs an organisation incurs in providing a service. It is a more direct and sophisticated approach than allocating costs on a top-down basis. It is based on the actual interactions and events related to individual patients and the associated costs, for example theatre and nursing costs.

### **Payment by Results (PbR)**

PbR was introduced in 2003/04 as a single rules-based approach to paying for acute and specialist hospital services in the NHS. It was intended to improve the fairness and transparency of hospital payments and to stimulate provider activity and efficiency. Rather than relying on locally negotiated contracts based on local prices and with a tenuous link to outputs, providers are paid for the number and type of patients treated, in accordance with national rules and a national tariff.

### **Practice based commissioning (PBC)**

PBC is a system reform policy that aims to give more commissioning responsibilities to GP practices in England. It is argued that GPs are better able to understand the needs of their patients, and are therefore better able to decide what services are needed for their local population. Under PBC, GP practices are to be given their own indicative budgets with which they can commission health services for their patients.

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### **Primary care trust (PCT)**

PCTs are the bodies responsible for assessing the need for local healthcare provision, planning and commissioning health services and improving health. There are currently 152 PCTs.

### **Quality Outcomes Framework (QOF)**

The QOF is a system for payment of GPs. It was introduced as part of the new GP contract in April 2004. It rewards GPs for implementing good practice by measuring practice achievement against a range of clinically evidence based indicators and against a range of indicators covering practice organisation and management. Practices score points according to their level of achievement against these indicators. Payment to practices is calculated by the level of points achieved.

### **Secondary Uses Service (SUS)**

SUS aims to provide a single, consistent source of patient level data and support additional analysis for management and clinical purposes, other than direct clinical care. It provides information about provider activity (as submitted by trusts and verified by PCTs) and casemix, grouped by HRG, and applies the national tariff under PbR in accordance with national guidance.

### **Service-line management**

Service-line management takes a combined view of resources, costs and income, and hence profit and loss, by service-line or specialty within a trust. The management of finances is devolved to specific business units. This requires integrated ownership of clinical, operational and financial objectives and outcomes.

### **Service-line reporting**

Service-line reporting measures a trust's profitability by each of its service-lines, rather than just at an aggregated level for the whole trust. This allows clinicians and managers to understand the overall actual profitability of their service, what drives profitability, or what impact different decisions have on profitability. NHS FTs are organised around a portfolio of services, each with their own distinct set of patients, medical conditions treated and clinical leaders. In business terms, the service-line is the natural 'business unit' of the hospital.

### **Strategic health authorities (SHAs)**

SHAs are regional bodies that are responsible for strategic leadership, organisational and workforce development and ensuring local health bodies (PCTs and NHS trusts) operate effectively and deliver improved performance. There are currently ten SHAs.

### **Unbundling**

This refers to unbundling of the PbR tariff into separate components and payment for packages of care, based on patient pathways. It offers flexibility in moving care out of the hospital setting.

# Appendix 4 | References

- 1 HM Government, *The NHS Plan: A Plan for Investment, a Plan for Reform*, HMSO, July 2000.
- 2 Health Select Committee, *Public Expenditure on Health and Social Services 2006*.
- 3 Derek Wanless, *Securing our Long Term Health: Taking a Long Term View*, HM Treasury, April 2002.
- 4 HM Government, *Budget 2002, The Strength to Make Long Term Decisions: Investing in an Enterprising, Fairer Britain*, TSO, April 2002.
- 5 HM Government, *Delivering the NHS Plan: Next Steps on Investment, Next Steps on Reform*, HMSO, April 2002.
- 6 HM Treasury, *Meeting the Aspirations of the British People, Pre-budget Report and Comprehensive Spending Review*, HM Treasury, 2007.
- 7 Department of Health, *Report of the National Patient Choice Survey, England – November 2007*, Department of Health, April 2008.
- 8 Audit Commission, *A Prescription for Partnership: Engaging Clinicians in Financial Management*, Audit Commission, December 2007.
- 9 Audit Commission, *Putting Commissioning into Practice: Implementing Practice Based Commissioning through Good Financial Management*, Audit Commission, November 2007.
- 10 Audit Commission, *The Right Result? Payment by Results 2003-07*, Audit Commission, February 2008.
- 11 Healthcare Commission, *Independent Sector Treatment Centres: A Review of the Quality of Care*, Healthcare Commission, July 2007.
- 12 Audit Commission, *Review of the NHS Financial Year 2006/07*, Audit Commission, October 2007.
- 13 Department of Health, *Practice Based Commissioning, GP practice survey: Wave 3 (January-March 2008)*, Department of Health, April 2008.
- 14 Audit Commission, *World Class Financial Management*, Audit Commission, November 2005.
- 15 Department of Health, *Our NHS, Our future: NHS Next Stage Review Interim Report*, Department of Health, October 2004.
- 16 Department of Health, *The Operating Framework for the NHS in England 2008/09*, Department of Health, December 2007.
- 17 Department of Health, *Our Health Our Care Our Say: A New Direction for Community Services*, Department of Health, January 2006.

- 
- 18 Department of Health, *Commissioning a Patient-led NHS*, Department of Health, July 2005.
  - 19 Department of Health, *Principles and Rules for Cooperation and Collaboration*, Department of Health, December 2007.
  - 20 Department of Health, *The NHS in England: The Operating Framework for 2006/7*, Department of Health, January 2006.
  - 21 A Coulter, N le Maistre, L Henderson, *Patients' Experience of Choosing where to Undergo Surgical Treatment, Evaluation of London Patient Choice Scheme*, Picker Institute, July 2004.
  - 22 A. Burge, N. Devlin, J. Appleby, C. Rohr, J. Grant, *A Model of Patients' Choices of Hospital from Stated and Revealed Preference Choice Data, London Patient Choice Project Evaluation*, Rand Europe, The King's Fund, City University London, 2005.
  - 23 E. Ferlie, G. Freeman, J. McDonnell, C Petsoulas, S. Rundle-Smith, *NHS London Patient Choice Project Evaluation, Organisational Process Strand*, Royal Holloway, University of London, Imperial College London, June 2005.
  - 24 D. Dawson, R. Jacobs, S. Martin, P. Smith, *Evaluation of the London Patient Choice Project: System Wide Impacts*, University of York, September 2004.
  - 25 Operational Research in Health Ltd., *London Patient Choice Project, Study of Transport in Choice*, Operational Research in Health Ltd., April 2004.
  - 26 Department of Health, *Report of the National Patient Choice Survey, England – September 2007*, February 2008, Department of Health.
  - 27 National Statistics, *First Release: Internet Access, Households and Individuals 2007*, National Statistics 2007.
  - 28 Department of Health, *The Government's Response to the Health Committee's Report on Independent Treatment Centres*, HMSO, October 2006.
  - 29 Department of Health, *ISTC Wave 1 Manual*, Department of Health, February 2005.
  - 30 *National Evaluation of Payment by Results – Report to the Department of Health*, Health Economics Research Unit, University of Aberdeen; Office of Health Economics; Department of Economic Studies, University of Dundee; and University of Melbourne, 2007.
  - 31 University of York, *Health Policy Matters*, University of York, September 2007.
  - 32 Monitor, *NHS Foundation Trusts: Review of Six Months to 30 September 2007*, Monitor, December 2007.

- 33 National Audit Office, *NHS Pay Modernisation: New Contracts for General Practice Services in England*, The Stationery Office, February 2008.
- 34 HM Treasury, *Steering a Steady Course: Delivering Stability, Enterprise and Fairness in an Uncertain World*, HM Treasury, 2002.
- 35 Office of National Statistics, *Public Service Productivity, Health Care: Summary*, Office of National Statistics, January 2008.
- 36 Audit Commission, *Improving Medium-term Financial Planning: Practical Guide for PCTs*, Audit Commission, March 2008.
- 37 NHS Modernisation Agency, *10 High Impact Changes for Service Improvement and Delivery*, NHS Modernisation Agency, September 2004.



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