UK health update

June 2006

hlsp institute

In the last few years it has become increasingly difficult to keep abreast of continuous change in the UK health sector. The NHS is often described as being in a state of "permanent revolution", which can make it hard to understand how all the new policies and structural changes are going to work in practice, or to place them in the broader policy context in which they are taking place.

The *UK health update* describes the key developments in UK health and healthcare of the last few months in a concise and user-friendly format, with web links for those wishing to examine the issues in more depth. It is aimed at anyone working in the health and healthcare sectors in the UK and internationally. This first issue has a particular focus on the reorganisation of services that is taking place in each UK country.

The *UK health update* is produced jointly by the HLSP Institute and HLSP's UK Division, and will be issued twice a year. We hope you find it useful.

Peter Greengross, UK Director, HLSP

England - The Modernisation Agenda

Reshuffle and re-emphasis

The Prime Minister, Tony Blair has used the opportunity of the May 2006 Cabinet reshuffle to re-emphasise the key objectives for the NHS over the next four years. In a personal minute to the Secretary of State for Health, Patricia Hewitt, he has underscored the major challenges to the Government, including the need to sustain the momentum in public sector modernisation. His message stresses the five priorities on which the Department of Health should focus:

- Continue improving the range of choice for patients within the NHS;
- Ensure the NHS returns to financial balance;
- Carry on improving access to the NHS by further reducing waiting times;
- Carry through the development of social care policy;
- Advance health improvement policy enabling people to make more healthy choices.

The Prime Minister's minute sets a clear policy framework for the next four years and although some of the priorities are not new, their re-emphasis demonstrates the apparent determination of the Government to carry through the modernisation programme to which it is wedded.[1]

A patient-led service

The government's commitment to a ten year process of NHS reform is now moving into its second phase.[2] The first phase saw increased financial, human and infrastructure resources, and the second, spelt out in the 2004 "NHS Improvement Plan", now looks for even greater reorientation in the way services are delivered, in particular to deliver a "patient led service". In essence, this means ensuring care is made available in the way patients want, rather than in the way that service providers find convenient.

Several policy initiatives are fundamental to changing the way patient services are delivered, including:

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[1] The Prime Minister minute can be read at: www.dh.gov.uk/assetRoot/04/13/50/96/04135096.pdf

[2] For an overview of the modernisation and reform programme, and progress with its delivery, see chapter 5 of the Departmental Report 2006: *The NHS Plan – a plan for investment, a plan for reform* at www.dh.gov.uk/assetRoot/04/13/47/08/04134708.pdf

- **Patient Choice**. This allows patients in need of hospital treatment to choose from a network of hospitals and clinics, including NHS Foundation Trusts and private treatment centres. In order to help patients make an informed choice, data about clinical performance and outcomes will be made increasingly widely available. An ambitious electronic system known as "**Choose and book**" is being rolled out, meaning that patients can book appointments or dates for surgery through an online system in their GP surgery or through other channels, including phone and web-based booking from home.

- **Payment by Results** (PbR). This is intended to provide a transparent, rules-based system for reimbursing NHS Trusts and other providers for the services they offer. Payment is made for each episode of care according to a pre-determined tariff, replacing previous block contracts. All providers receive the same amount from health service funds (albeit adjusted by a "Market Forces Factor"), whatever the provider's true cost of providing a given service. The system is essential if Patient Choice is to be meaningful, on the assumption that providers of popular services will be able to expand and patient needs will be better met.

- **Practice based commissioning** (PbC). Whilst the previous two policies are likely to increase demand for hospital care, PbC represents a constraint. PbC is intended to involve general practitioners in agreeing referral and treatment pathways so as to maximise patient convenience, improve effectiveness and reduce costs. PbC reintroduces the concept of practice-held budgets for patient care (as with fund holding in the 1990s), but this time only with indicative budgets. Subject to Primary Care Trust agreement, however, savings can be ploughed back into a practice.

Alongside these reforms, the roll-out of **Commissioning a patient led NHS** has led to further structural reorganisation. As well as being intended to deliver much of the savings required by the Treasury, through reducing the number of Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs), PCTs are expected to review their role in providing (as opposed to commissioning) healthcare services.

How are these policy initiatives faring?

The roll-out of **Patient Choice** is controversial.[3] Through **Choose and Book**, patients should now be able to make their referral appointments at times which are convenient for them, using on-line connections via their surgery, but there have been problems with roll out. Apart from technical difficulties with the IT systems, practices have to identify staff and space to assist and enable patients to make on-line bookings, which can be a time consuming process. A recent poll found that half of doctors viewed the system "poor" or fairly poor".[4] At a more theoretical level, some commentators are intrinsically opposed to the idea, because "unpopular hospitals" might be rendered unviable, and more vulnerable members of society would be least likely to benefit from the initiative, which could lead to widening health inequalities.

The roll out of **Payment by Results (PbR)** began in 2004. In 2005/6 it was extended to all NHS Trusts for elective care, and in 2006/7 it will extend further to non-elective care, outpatient and accident and emergency services. By 2008 it is intended that 90% of inpatient, day-case and outpatient activity will be paid for in this way.

Payment by Results is a radical change to funding arrangements and again there has been widespread opposition, including in the national press. Opponents of PbR argue that the system will lead to increased transaction costs, to greater financial instability both for Primary Care Trusts and for providers, and that it might result in "cream skimming" of patients and treatments by providers (i.e. avoiding cases with a high risk of complications).

Whilst many support the fundamental principle of PbR, there are other concerns about the method of fixing the tariff. Publication of the 2006/07 tariff by the Department of Health was delayed at the last minute because of fundamental miscalculations which would have compromised many Trusts' viability. Monitor (the independent regulator of NHS Foundation Trusts) and the NHS Confederation have since recommended that the tariff should be fixed by an independent body.[5]

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[3] Department of Health press release 2006/0205, 31 May 2006.
[4] *GPs dissatisfied with IT system*: http://news.bbc.co.uk/1/hi/health/5028762.stm
[5] *Ensuring payment by results enables system reform* (March 2006): www.monitor-nhsft.gov.uk/

Meanwhile, Patricia Hewitt has approved plans for structural reorganisation proposed under **commissioning a patient-led NHS**. With effect from 1st July 2006, Strategic Health Authorities will be reduced in number from 28 to 10 and ambulance trusts from 29 to 12. Primary Care Trusts (PCTs) will be reduced from 303 to 152 by October 2006. The intention is to give PCTs greater commissioning power, while reducing administration costs.

Meanwhile, the uptake of **practice based commissioning (PbC)** has been slow. Many doctors have complained that they have not received indicative budgets for commissioning, and that data from PCTs are unreliable. The imminent PCT reorganisation may lead to further delays as staff are redeployed and relationships with frontline clinicians are compromised.[6]

Connecting for Health

Choose and Book, mentioned earlier, is one part of the Department of Health's ambitious National Programme for IT (NPfIT), overseen by the newly named arms-length body "Connecting for Health" (CfH). Other elements of the programme include the creation of a national system of electronic patient records, a system for electronic prescribing and a new secure NHS email system. The multi-billion pound programme, one of the most expensive and ambitious of its kind in the world, is at least two years behind schedule and the expected cost has escalated rapidly.[7]

The Government has set aside £2.3 billion centrally over the three years to 2005-06 for the programme. The total value of the contracts awarded to date (covering the seven to ten year programme duration) is £6.2 billion. However, the Department of Health has recently suggested that total costs could rise to £20 billion. Meanwhile, 23 leading IT academics have written an open letter to the Health Select Committee calling for an independent review of the system. The Public Accounts Committee is holding a hearing on 25 June, coinciding with the publication of a National Audit Office report into the project.[8]

Foundation Trusts

Foundation Trusts (FTs) are newly defined "Public Benefit" Corporations. They remain part of the NHS but are constituted on a "mutual" model with greater independence from central control, the ability to raise capital from commercial sources to improve services, and more flexibility to innovate. There are currently 35 Foundation Trusts, with 21 more awaiting authorisation by August. The recent approval of three mental health Foundation Trusts has been hailed as a significant step in the FT programme, as all previous approvals have related to the acute sector.

Monitor's latest progress report published in March highlighted the generally strong financial performance of NHS Foundation Trusts. [9] Between April and December 2005 there was an aggregate deficit amongst FTs of only £9 million on a collective turnover of £5,000 million. Excluding University College London Hospitals, the other 31 FTs had a combined surplus of £20 million - well ahead of their target of £11 million.

Then financial and performance management regime for Foundation Trusts is rigorous. Trusts that fail to meet Monitor's targets for financial management are required to implement detailed recovery plans, with the possibility that Monitor will replace the Trust Board. This process has already proved effective at two FTs that had experienced aggregate deficits of £23 million in 2004/5, now reduced to £4 million.

[6] *Latest reorganisation of primary care trust could create planning blight*. BMJ, 27 May 2006.
[7] For more information see the NHS National Programme for IT annual report 2004-05 at www.connectingforhealth.nhs.uk/publications/annual_report_0405.pdf
[8] *Anatomy of a £15bn gamble*, Sunday Times, April 16; *MPs to probe IT fiasco at health service*, The Observer, May 7; for CfH response to the *File on Four* programme on BBC Radio 4, and for more information on NPfIT go to www.connectingforhealth.nhs.uk/
[9] *NHS Foundation Trusts: nine-month report for period 1 April 2005 to 31 December 2005*: www.monitor-nhsft.gov.uk/. Preliminary year-end results for 2005/06 have been published in June on Monitor's website.

Private Finance Initiative (PFI)

The NHS continues to be a heavy user of PFI schemes to refurbish depleted capital facilities. By March 2006, the NHS had commissioned 149 PFI schemes to a total value of £6.5 billion, making it the most active Government Department in this procurement route for new infrastructure projects (the Department of Transport has secured the greatest PFI funding – £21.9 billion), but this is concentrated in only 51 schemes).[10]

In April Patricia Hewitt, the Secretary of State for Health, approved plans for the redevelopment of the Barts and the London NHS Trust involving £1 billion of PFI investment to provide Britain's biggest hospital and the largest Accident and Emergency department in Europe. She also approved a £1 billion of PFI scheme to redevelop hospitals in Birmingham, St Helens, and for Hull and East Yorkshire Hospitals NHS Trust where new oncology and haematology facilities will be provided.

The development and application of PFI in healthcare is the subject of a recent paper published by the HLSP Institute, "The role of the Private Finance Initiative in the delivery of health services in the UK".[11] The paper gives an overview of the drivers for using PFI, its advantages and disadvantages, and lessons learnt so far.

Treatment and Diagnostic Centres

In 2003, the Department of Health announced the roll-out of plans for a network of stand-alone dedicated daycase or short stay ambulatory care centres. They were set up to provide rapidly extra capacity for NHS treatment, thus helping to reduce patient waiting times, offer patients greater diversity and choice of services, and encouraging the adoption of new ways of providing patient care. Over the last few years they have increased rapidly in number, and this is planned to continue.

There is considerable interest in the role of the private sector in this initiative. Private sector companies have been invited to commission and run a number of Independent Sector Treatment Centres (ISTCs), to complement the 44 Independent Treatment Centres (ITCs) already established within the NHS (with another two expected to open later this year). There are now 14 ISTC sites delivering a full service, and three privately run sites delivering an interim service.

At the Health Select Committee in April 2006, Patricia Hewitt stated that ISTCs have introduced a significant element of competition and dynamism into the NHS and that the procurement programme has produced a sharp fall in prices within the independent sector in which, historically, Britain has had the highest prices in the world.[12]

Despite their substantial contribution, ISTCs provide only a small proportion (3%) of elective surgery funded by the NHS. By 2008, the proportion will still only be around seven or eight per cent. The £1.2 billion spent on independent sector treatments will then represent just over 1% of NHS turnover of over £90 billion.[13]

Individuals receiving treatment or undergoing diagnostic tests from ISTCs remain NHS patients throughout their period of care. The same quality standards that apply to the NHS apply to ISTCs. However, there has been considerable criticism of standards of care for certain procedures, including hip replacements. Despite the lack of hard evidence of poor outcomes, Patricia Hewitt has asked the Healthcare Commission to carry out a wide-ranging clinical audit of the programme to date.

Whilst the first phase of treatment centre development mainly provided surgical and therapeutic services, phase two will also offer additional diagnostic capacity. A recent Department of Health report predicts substantial growth in ITC/ISTC usage in future years.[14] It also indicates that new, and some established ITC/ISTCs, will be expected to provide staff training. This is partly intended to ensure that medical and nurse education does not suffer because many "routine" procedures are no longer routinely provided in general hospital settings.

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[10] See www.hm-treasury.gov.uk/documents/public_private_partnerships/ppp_pfi_stats.cfm
[11] Available at www.hlspinstitute.org/files/project/86709/HealthPFI.pdf
[12] *Minutes of Evidence before Select Health Committee*, 26 April 2006: www.publications.parliament.uk/pa/cm200506/cmselect/cmhealth/uc934-iv/uc93402.htm
[13] Department of Health press release 2006/0157 (26 April 2006)
[14] *Independent Sector Treatment Centres*: www.dh.gov.uk/assetRoot/04/12/91/08/04129108.pdf

Returning to financial balance

In 2000 the Prime Minister promised to bring health spending up to European levels. However, despite an unprecedented 7% annual real increase in the NHS budget over the last six years, the deficit remains high. The latest unaudited figures have confirmed that NHS Trusts ran up deficits totalling £1.27 billion in 2005/06 (with a net deficit of £512 million when NHS organisations in surplus are included)[15]. Large numbers of NHS posts are under threat, and the debate in both the national media and the specialised press has become heated.

How big is the problem? With such significant increases in allocations, there seems to be no reason why the financial resources in many parts of the service should be overcommitted. A recent analysis in the British Medical Journal reviews the possible causes of the current problems. It suggests that spending controls were overridden as politicians and managers concentrated on activity targets and service delivery. Lack of control was most evident with respect to pay negotiations, contracting arrangements and the role of the National Institute for Health and Clinical Excellence (NICE) in drug cost control. The analysis implies that unexpected increases in salaries without concomitant improvements in efficiency probably had the greatest impact on resources. A recent King's Fund report, based on evidence from the Department of Health, suggests that the new consultants' contract cost £90 million more to implement than was planned. According to the report, the increased costs have put considerable pressure on hospital budgets and have contributed to the size of deficits faced by some trusts.

Minor adjustment – major correction? Professor John Appleby of the King's Fund believes that the debt crisis is more widespread than ministers claim. Most parts of the service are financially stretched, and a minority of Trusts are reporting significant overspends requiring radical responses including reductions in staff headcounts. The precise numbers are unclear, but the political opposition states that more than 20,000 posts are at risk. Although the Secretary of State for Health, Patricia Hewitt, has rebutted this claim, the total number announced is now mounting through the thousands. These figures should be set against the growth in staff numbers of some 300,000 since 1997, and it is possible that many reductions in headcounts will be achieved through natural wastage (high turnover) or reduced use of agency staff. Nonetheless, staff losses have provoked a predictable political outcry and an angry response from staff.

Meanwhile, the government has continued to take a bullish stance on service targets. The Prime Minister has reiterated the importance of achieving the eighteen week target for the time between GP referral and treatment starting and similar goals, while also conducting further rounds of major structural reorganisation. These are aimed at enabling financial stability as much as better service delivery, but not all commentators favour further change, believing it better to focus effort on more effective management in the existing structure.

Good performers. The Department of Health has repeatedly stressed that the net deficit represents only 0.8% of the NHS budget and that two thirds of the deficit is accounted for by only 10% of Trusts. Similarly, whilst problems with financial management have beset many parts of the service, there are exceptions. Neighbouring SHAs have reported very different out-turns (North West Thames overspent by £50m, North East Thames generated a small surplus). The Greater Manchester Strategic Health Authority (SHA) announced a year end surplus having inherited a £70 million debt four years ago.[16]

Mental Health Bill withdrawn

The Government's attempt to introduce a new Mental Health Act was finally abandoned in March 2006. The draft bill provided for compulsory detention of people who had committed no crime but who had been identified as being a potential risk to others. The proposed reform was triggered by a high profile murder case in 1996 committed by a man with a dangerous personality disorder, but who could not be legally detained. Ostensibly because of pressure on parliamentary time, the about-turn was at

[15] *Chief Executive's Report to the NHS*, June 2006: www.dh.gov.uk/assetRoot/04/13/58/40/04135840.pdf
[16] *Seven years of feast, seven years of famine: boom to bust in the NHS?* A. Maynard and A. Street, BMJ 15 April 2006; *Assessing the new NHS consultant contract - a something for something deal?* S. Williams and J. Buchan, May 2006: www.kingsfund.org.uk/resources/publications/assessing_the.html; *NHS faces job cuts as financial crisis deepens.* BMJ 1 April 2006 www.bmj.com; *Health chiefs' £40m surplus*, Manchester Evening News, 28 March 2006.

least partly due to the relentless opposition of many mental health professional staff, carers and representative bodies over the eight years of its gestation. Objections extended from opposition to proposed compulsory treatment orders, to issues of equity of care for black and ethnic minorities.

The existing act, which dates back to 1983, will therefore be amended, particularly in relation to supervised community treatment, professional roles, nearest relative responsibilities, definition of mental disorder, criteria for detention, and the Mental Health Review Tribunal. The legislative timetable for revisions has not been announced yet.

Private firm to run GP services

The NHS has signed the first government-brokered deal allowing a private company to run traditional GP services. The deal aims to fill gaps in service provision, and similar other contracts are close to agreement. Controversy has already arisen over whether doctors and nurses will be "poached" from the NHS and over the role of private contractors in delivering primary care, although GPs have always been contracted as independent practitioners with the NHS.

Wales

The devolved government of Wales is following a different path of NHS reform. It has rejected the concepts of greater private sector involvement, autonomous foundation hospitals, and the creation of diagnostic and treatment centres. The emphasis is on local NHS bodies and local authorities working together to meet local needs, and on health prevention and promotion. Many of the underlying issues are, however, similar to those facing the rest of the UK: the Welsh NHS is facing a mounting financial crisis and has had to cut back some patient services, and waiting lists remain a grave concern. The burden of ill health, a legacy of Wales' heavy industry, is also a major problem.

Strategy

The Welsh Assembly's strategy for achieving a "world class service" by 2015 is outlined in the 2005 document "Designed for Life". The strategy will be achieved through a series of three-year cycles: 2005/08: Redesigning care; 2008/11: Delivering higher standards; and 2011/14: Ensuring full engagement.

"Designed for Life" spells out the need for the further development of performance management as a key enabler of change, with a framework of standards ensuring high quality across all services. To this end a **Delivery and Support Unit (DSU)** was established in December 2005. Its aim is to assist Trusts and Local Health Boards achieve national priorities, and to embed a culture of performance and delivery throughout NHS Wales.

Local boards

In 2003 the five Welsh health authorities were replaced by 22 health boards, in order to better integrate health and social care. The boards share boundaries with local authorities and are expected to work closely with the councils. They remain controversial - many opponents continue to argue that they are over-bureaucratic and are diverting resources from frontline services.

Hospital reorganisation

In March this year, plans for a massive reorganisation of hospitals serving one million people across mid and west Wales were unveiled. One of the most controversial proposals would see the closure of two hospitals in Haverfordwest and Carmarthen, making way for a new "super hospital" based between the towns. Predictably, the announcement provoked angry reactions from local communities. They argue that patients' needs are not being considered and that an urbanizing, metropolitan English model is being imposed on communities across Wales.

Financial crisis

A recent study by the auditor general found that in addition to £82 million of historical debt, the NHS in Wales was overspent by £32 million last year. In contrast, local health boards are predicting an overall surplus of £4m. The report questions whether there have been effective links between the "strategic direction" of the NHS and the implementation of local plans. The report recommends that an "all-Wales analysis" is carried out, examining how well NHS finances are managed.[17]

[17] *Auditor's warning on NHS finances* http://news.bbc.co.uk/1/hi/wales/4900758.stm; Auditor General for Wales, *Is the NHS in Wales Managing within its Available Resources?*

Scotland

Implementing "Delivering for Health"

As in other parts of the United Kingdom, the Scottish Health Service is facing up to change. The policy direction has been set by last year's review "Building a Health Service Fit for the Future" (known as the Kerr report)[18], and by the Executive's response "Delivering for Health".[19] As in England, the NHS budget has nearly doubled from £4.6 billion in 1999 to £8.8 billion in 2005.

"Delivering for health" describes the action needed to make the changes envisaged in the Kerr report, and sets them alongside the Health Department's existing initiatives and future plans. In February 2006 specific guidance was published on tasks and timetables that would carry forward the change agenda. Three task groups have been established: a Delivery Group focusing on performance management issues; a Primary and Community Care Group; and a Health Care Policy and Strategy Group.

But while the Kerr report reflected the consensus in Scotland that the NHS needed to change, the question of how it should change is still being discussed. A debate on the future needs of the National Health Service took place on 18th May.[20]

Much of the debate focused on the most contentious issue – attempts at rationalisation. While boards are trying to achieve this through amalgamation and centralisation, patients want to retain their familiar local facilities. Some MPs blamed "lazy" health boards for using the Kerr report (which did not provide a detailed framework for implementation) as an excuse for centralisation. There was clear agreement that to deliver the type of health care that Kerr envisaged, Scotland must move away from an emphasis on hospital care, towards delivering care to people through improving health across the board. The recent smoking ban can be viewed as an important step in this direction.

Recruitment drive

In March, an advertising campaign was launched to encourage people to consider a career in the NHS in Scotland. £1 million were set aside by the Scottish Executive for this fresh recruitment drive - but controversy was caused late in May when a delegation from the Scottish Executive and cash-strapped NHS health boards travelled to the United States to hire 20 physicians' assistants.

Scotland faces an acute shortage of consultants. The US-trained assistants are being recruited for a two-year pilot scheme to help hospital doctors and general practitioners. If the scheme is successful, it will spread across the country. However, opposition politicians and health campaigners have accused the executive of wasting money attempting to provide medical care on the cheap, and of putting patients' lives at risk.

The news came just days after a change in immigration rules, under which many doctors from overseas who trained and worked in the UK are facing possible deportation. It has been claimed that the new immigration rules could hit of 13 % of Scotland's health workforce.[21]

Smoking ban

The Smoking, Health and Social Care (Scotland) Act 2005, restricting smoking in public places, came into force on 26th March. Despite fears that the change in law would provoke a major backlash, the new regulations appear to have been implemented without any significant problems. The law in Scotland now corresponds to that in many other countries and is set to play a part in the ongoing battle to reduce the health hazards of both active and passive smoking.

[18] The report can be read at www.scotland.gov.uk/Publications/2005/05/23141307/13104
[19] Available at www.scotland.gov.uk/Publications/2005/11/02102635/26356
[20] www.scottish.parliament.uk/business/officialReports/meetingsParliament/or-06/sor0518-01.htm
[21] *Anger as NHS pays to recruit US medics*. The Observer, 28 May.

Northern Ireland

Trust and Health Board reconfiguration

In November 2005 the then Health Minister Shaun Woodward announced “the biggest ever reform to health and social services in Northern Ireland”. Reconfiguration of Northern Ireland Health Services is now firmly under way, and in practice it means:

- a reduced Government Department;
- a single Strategic Health and Social Services Authority to replace the four existing Health and Social Services Boards;
- a reduction from eighteen to five Trusts;
- the creation of seven local commissioning bodies involving patients, GPs and other health care professionals;
- a Patient and Client Council to replace the existing four Health and Social Services Councils.

The restructuring, which will retain the separation of commissioning and provider functions, is intended to streamline management arrangements and enable patients to drive demand in the service. In this sense, the proposals reflect changes in other parts of the UK.

Introduction of the new arrangements is being coordinated by a Reconfiguration Programme Board. Legislation to create the Strategic Health and Social Services Authority and to sanction related structural changes is unlikely before the autumn of 2007. This will lead to the Authority, the Patient and Client Council and Local Commissioning Groups becoming fully operational in April 2008.

In the meantime, the Chief Executive (Designate), together with a Steering Group, will begin developing the roles and responsibilities of the new Authority. The appointment of new Trust Chief Executives will take place, leading to more detailed planning for the amalgamation and reconfiguration of the existing Trust structures. This process can go ahead without legislation and should lead to an orderly dissolution of existing Trusts and the start of operation of their successors in April 2007.

Although the number of Trusts has been decided, details about their configuration still have to be agreed. Consultation on all these issues is still under way, doubtless adding to uncertainties among staff, as with the reduction in the number of Trusts and other bodies it is inevitable that there will also be a diminished number of posts. A Public Service Commission will advise on the transfer of staff to new organisations. Handling these issues, particularly where there is the possibility of compulsory redundancies, will be a major challenge.

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The HLSP institute aims to inform debate and policy on global health issues and national health systems in order to reduce inequalities in health