

Health System Reforms in NHS England: Context, Culture, Power: A Q&A with Jamie Burn, Research Fellow, Policy Exchange, London UK

TO PROVIDE FURTHER INSIGHTS and prompt additional reflection on the lessons from NHS England's health reforms, The Change Foundation posed the following questions to Jamie Burn, a research fellow with the UK's Policy Exchange who reviewed our case study, *Integrated Health Care in England: Lessons for Ontario* (May 2009).

Q1, THE CHANGE FOUNDATION: What cultural and contextual factors have enabled/hindered change in the English health reforms?

A1, JAMIE BURN: The NHS plan argued that the bureaucratic health service model was out of date¹. A hierarchical system designed to be run from Whitehall created a culture more concerned with procedure than performance, with an over-extended, complex managerial chain that obscured responsibility at service level. Founded in 1948, red tape, outdated systems, old-fashioned demarcations between staff and barriers between services led to unnecessary delays and an aversion to taking initiative, which it was argued stifled service improvement and innovation. This picture is perhaps oversimplified, given the constant clinical innovation displayed in the development of new treatments and services, but clinical autonomy at a micro-level itself frustrates bureaucratic governance, creating a complex system resistant to managerial standardisation and central control. The political orthodoxy held that the NHS was no longer governable, and had become too inefficient to make effective use of scarce resources.

Cultural expectations of the NHS, in the prosperous, service economy of modern Britain, had also changed since its inception. The ethos of public sector paternalism, treating disempowered, impatient patients, was thought behind the times, and a source of growing unrest. Long waiting lists and dirty hospitals were headline news. And the only voice option was through the political system, placing pressure on accountable politicians.

When Labour came into power in 1997, total numbers waiting were at the highest since the NHS was founded in 1948, standing at 1.3 million, and had led to electoral pledges to reduce the backlog.² The system of payment stood accused of penalising success and rewarding failure, with 'over-performance' or low waiting lists resulting in budget cuts and long waiting lists leading to extra funding, to bail out struggling services.³

Extra resources were pledged in the March 2000 Budget settlement, beginning to correct the shortfall in capital assets, staff, equipment and beds, created by chronic under-funding. At that time, expenditure had increased by just 3.6% per capita since 1960, compared with an average of 5.5% in other OECD countries⁴. This comparative funding deficit is partly due to the fact that the Treasury can strictly control resources in

1. NHS (2000) The NHS Plan. London: NHS

2. Harrison, A. and Appleby, J. (2005). The war on waiting For Hospital Treatment. What has Labour achieved and what challenges remain? London: King's Fund.

3. NHS, 2000 *ibid*

4. NHS, 2000 *ibid*

a bureaucratic system, meaning that supply of resources does not necessarily equate to demand. NHS finances were reviewed in the Wanless Report in 2002, which concluded that spending should rise from 7.7% of GDP in 2002/03 to between 10.6% and 12.5% in 2022/23, assuming that the private component of NHS provision would remain at 1.2% GDP. This led Chancellor Gordon Brown to increase spending to 9.4% of GDP by 2007/08⁵.

The budget settlement to substantially increase NHS resources and the 10-year NHS plan for reform allowed for the creation of a uniquely long-term strategy for reforming NHS services, founded upon empowering patients, restructuring incentives for providers and staff, and exploring new ways of working with the private sector⁶. The approach that the government has subsequently taken represents a fully fledged return to the idea of a quasi-market in healthcare, pioneered by the Conservatives in the 1991 Health Service and Community Care Act, which separated the purchaser and provider functions of the NHS, localised purchasing, introduced service level contracting, and allowed limited provider autonomy in service development and the pursuit of contracts. The principle then was that commissioners made a consumption decision on behalf of patients. A relatively large number of contracting authorities were expected to create competition amongst providers, with each contract representing a franchise opportunity to provide for that authority's population, and allowing purchasers to hold the provider accountable for standards in accordance with its terms, and through the possibility of non-renewal.

Ultimately, the competition leverage was low, because it relied on franchising contestability in a low capacity system where the alternative purchasing options were limited and the existing providers had to be protected from destabilisation. This internal market experiment had effectively ended by 1993, with John Major's minority government being unable to continue the reforms in the face of widespread opposition, although the purchaser-provider split was retained.

The approach of the Labour government displays policy learning from these arrangements, and in many ways goes further in marketising NHS healthcare. The white paper *Delivering the NHS Plan* announced the introduction of a policy allowing patients to choose the time and place of their elective appointment, and a system of payment by results (PbR) in which providers are paid for the elective services they perform according to a set central tariff⁷. Money follows patient choice, effectively creating a form of a voucher system in which a GP referral for an elective service gives the patient a quasi-voucher that they can cash in with their chosen provider⁸, who then receives payment in accordance with the tariff. The GPs historic role of 'gate-keeper' to the NHS is here used to ensure that only those in need of treatment receive the currency to purchase services, stabilising demand⁹. In this system, rather than competition for a market, where providers compete to win contracts for commissioner populations, the Labour reform programme aimed to create competition within a market, with perpetual competition

5. Glennerster, H. (2003) *Understanding the Finance of Welfare: What Welfare Costs and How to Pay for it*. Bristol: The Policy Press

6. NHS, 2000 *ibid*

7. NHS (2002) *Delivering the NHS Plan: Next steps on investment, next steps on reform*. Norwich: The Stationary Office

8. Glennerster, H. (1997) *Paying for Welfare towards 2000*. 3rd Edition London: Prentice Hall.

9. Barr, N. (2004). *The Economics of the Welfare State*. 4th Edition. New York: Oxford University Press.

for customers, increasing the incentive.

The context is thus that a Labour government, trusted as the founding fathers of the NHS, found themselves in a situation where there was huge dissatisfaction with NHS waiting times and a budgetary shortfall, with a bloated treasury from the economic boom and a huge majority in parliament. That they chose a marketisation policy partly reflects New Labour's ideological thinking under Tony Blair (a pro-choice, pro-market reformist), partly the fact that the funding injection and political background gave them the power to effect the changes in a notoriously conservative and resistant NHS (and they wanted some payback for the investment), and partly it reflects a degree of path dependency from the early Conservative marketisation reforms.

Q2, The Change Foundation: What accounts for the greater willingness to experiment with the NHS in England? Has anyone speculated on this?

A2, JAMIE BURN: What both the Thatcher and Blair governments had in common was a mandate for reform, born out of frustration with the previous regime. And the radical rightwing Thatcher government, against big government and anti-bureaucracy, was always at odds with the principles of a state funded, state provided monolith. They privatised many of the old public services, for example British rail, but the NHS's special status gave it a degree of protection. Nevertheless, creating a quasi-market of autonomous public providers was seen as an acceptable middle-ground.

The White Paper 'Working for Patients' introduced a reform agenda in Britain, splitting the NHS purchaser and provider functions. It aimed to improve value for money, reward efficiency and quality, and encourage responsiveness to patient needs, while maintaining the founding principle of equal access on the basis of need. The theory was that the principles of state provision and equality of access were retained, but purchasing budgets and decision-making were decentralised, creating a potential market for provider competition.

There were significant problems with the system that served to justify reform, although Pollock argues with some justification that perceived failures and the drive for reform have been fuelled by political under-funding¹⁰. The system was under-managed, meaning that although the overall budget was controlled, it was not being controlled effectively at a micro-level, due to widespread ignorance of costs and a lack of incentives to curb wasteful behaviour. Job security in the NHS is high, making negative working practices difficult to eradicate, while there were no explicit rewards for efficient and effective treatment, or customer-focused service¹¹.

Since capital assets were purchased nationally and local districts and services didn't face the costs or stand to profit from their use, they were mismanaged and potential sources of income were lost. There were also perverse incentives in the transfer of resources, with longer waiting lists establishing high need and generating more resources and staff, making them into a form of currency. Where consultants worked part-time and practiced privately, waiting lists also represented a market for their services because go-

10. Pollock, A.M. (2004). *The Privatisation of our Healthcare*. London: Verso

11. Glennerster, 1997 *ibid*

ing private meant you could jump the list, which further distorted incentives.

Ultimately then, the ideological stance and power of the Thatcher government, after a decade spent dismantling the socialist state, and the perceived inefficiency of the system created the conditions to break the taboo of reforming the NHS. The rules of bureaucracy were designed to avoid mistakes and abuse, but tight control of behaviour stifles innovation and makes for a rigid institution, resistant to change¹². And while a hierarchical system should exhibit upward accountability, the scale and complexity of the system meant that national strategy had little influence over the situation on the ground. All of this suggested a need to decentralise control, effect cultural change, and somehow realign institutional objectives and user needs.

Q3, The Change Foundation: How was the transformation to a multi-disciplinary approach where nurses are not so dominated by physicians achieved? What were the battles along the way?

A3, JAMIE BURN: Senior nurses in the NHS are considered in high regard, partly because there was less access to medical school for women of that generation, and high calibre women were attracted instead into the traditionally female profession. In reality, multidisciplinary teams of nurses and doctors was always the norm because the NHS used to be heavily rationed and there are high throughput pressures, although physicians undoubtedly held the authority. The pressures to reduce waiting lists and control costs have led to significant responsibilities being handed to nurses. A more recent pressure has been the introduction of EU working time directives. Traditionally, Junior Doctors worked excessive hours gaining experience and providing a relatively low cost, flexible workforce. Similarly, GPs no longer have responsibility for out-of-hours care, so on the whole far more is being asked of nurses.

The NHS plan was introduced after extensive consultation with professional bodies, and sought to respond to throughput and cost pressures by developing the responsibilities of the nursing profession. The government sought to boost staff levels in the NHS with 20,000 extra nurses, in addition to 1,000 more nurse consultants. A new Leadership Centre was established to improve managerial and clinical leadership, and this included the creation of modern matrons with authority over the running of wards. One key driver was the concern over levels of hospital related infections, and it was thought better ward governance with clear responsibilities for ensuring protocols were followed would help to remedy this.

A key reform was to allow nurses to prescribe medicines, taking pressures off junior ward doctors in particular, and better reflecting the level of expertise of experienced nursing staff. The argument was that the creation of National Service Frameworks and organisations such as NICE meant that clear medical guidance would be available so that far more could be undertaken by lower skilled staff, where decision-making is rule-based and does not require expert interpretation. The NHS plan stated that over half of nurses in the NHS would be given the power to prescribe medicines. For a paper on the political machinations that led to this entitlement, see the referenced case study, which discusses the role of the Royal College of Nursing in lobbying for the policy and a subse-

12. Glennerster, 1997 ibid

quent change in legislation.¹³

In primary care, the GP contract introduced reforms to make better use of the skills of other healthcare professionals such as nurses and pharmacists. It also includes opportunities for innovative partnerships between nurses and doctors, so doctors are not necessarily the paymasters, although it is unclear whether this has been widely taken up.¹⁴

There does not appear to be any significant unrest associated with this policy direction. Changes to the working hours of junior doctors and the out-of-hours provision of GPs, throughput pressures, and the context of nurses being held in high esteem meant that this policy was not as disruptive as it would first appear. It also had a sound justification, and was implemented at a time when there was widespread acceptance of reforms that accompanied a much needed influx of resources.

Q4, The Change Foundation: Is the BMA a powerful negotiator in protecting the interests of physicians? Has their influence changed over the years?

A4, JAMIE BURN: The BMA's role in GP and Consultant contract negotiations was significant, and it is generally accepted that these professional groups received extremely good deals. The BMA successfully argued for key priorities, that pay levels should be brought up to reflect the level of clinician/GP expertise, and to more closely mirror the average pay levels of European counterparts. They also successfully lobbied for the responsibility for out-of-hours care to be removed from GPs. The political context for this is that the Labour party had formed an informal coalition with organisations like the BMA while in opposition, as the NHS was a key political battle ground and dissatisfaction with stagnant funding levels was high. They entered into an extensive consultation phase prior to the NHS plan, and recognised that the controversial reform programme they were developing would require doctors to be brought onside. It is widely accepted that the government did not get enough in return for the pay deals. NHS consultants could still perform private practice, and GPs received a significant pay rise despite more favourable working conditions.

"The new (GP)contract delivered a step change in investment in primary care and in practice infrastructure. Spending on primary care increased from £6.1 billion per year to £8 billion by April 2006, a rise of 33 per cent over three years."¹⁵

At the same time, GP 24 hour responsibility was transferred to Primary Care Organisations, which now commission, or in some cases provide, out-of-hours care. This has made General Practice a more attractive profession, but it is an extraordinary concession given the increase in wages. Out-of-hours provision now relies on a multi-professional model, which relies on doctors to a lesser extent. And the negotiation of this clause can be directly attributed to the BMAs representation of GPs in the contract negotiations.

The government did not succeed in its ambition of placating the notoriously powerful medical profession. Many policies since this time have disrupted professions, for example

13. Jones M, Case Report. Nurse prescribing: a case study in policy influence, *Journal of Nursing Management* Volume 12, Issue 4, Pages 266 – 272 2004 Blackwell Publishing Ltd

14. <http://www.gpcontract.co.uk/>

15. <http://www.gpcontract.co.uk/>

the creation of Polyclinics that improve access and compete with GP surgeries, or the policies to introduce Independent Sector provision and patient choice. The source of the opposition is partly the public service ethos and entrenched conservatism of the medical profession, and partly the culture of stringent demands on evidence, protection of their autonomy, and a clear focus on patient safety and quality. The policy community by contrast has sought radical reform and by definition this lacks a clear evidence base. The BMA has consistently lobbied against many aspects of the reform programme. It has been a fierce opponent of many controversial reforms and has galvanised opposition. Former Chairman of the BMA Sir Charles George told me it was ‘an irrelevance’, and dismissed it as ‘government fashion’. This reflects a broader opposition amongst the clinical community. A BMA survey of doctor opinion found that 75% did not think that choice and competition were the way to drive improvements in the NHS¹⁶.

The BMA have also explicitly argued for a return to the old system.¹⁷ However, this has had little impact on the direction of reform, and has arguably led to the BMA being viewed with suspicion by policy makers. Nevertheless, doctors remain a powerful lobby group and their dislike of Patricia Hewitt can be linked to her downfall, while Alan Johnson, the current Secretary of State for Health made it his stated aim to reengage the healthcare community.

In addition to its membership, a key mechanism for BMA influence is the British Medical Journal, which is commonly subscribed to by clinicians and GPs alike. This helps to create a common culture amongst medical professionals and gives a forum for arguments against policy changes. The Chairman of the BMA Board of Science and Education holds a joint post of Non Executive Director of the British Medical Journal Publishing Group. The BMJ is a weekly medical journal. It has the highest impact factor of any clinical journal in primary care in the UK, and is received by 70% of all UK GPs. BMJ Clinical Research is the market leader in secondary care with an average issue readership of 69% of all senior grade hospital doctors.¹⁸

Other influential bodies include the Royal Colleges,¹⁹ the NHS Confederation (representing over 95% of NHS organisations and highly influential amongst managers), the NHS Alliance (primary care), and Unison, the largest public sector union.

Q5, The Change Foundation: Has the government been increasingly successful in influencing physician practice by using both carrots and sticks?

A5, Jamie Burn: *“There’s no question that one of the barriers to innovative medicine in the UK is the medical profession. And they’re very, very conservative...I would argue, exceptionally so, to the disadvantage and detriment of their patients.”*²⁰

Generally speaking, NHS clinical culture is extremely resistant to change. Older clinicians

16. BMA News, 03/02/2007

17. BMA (2007) A Rational Way Forward for the NHS in England. [Online] BMA. Available from www.bma.org.uk/ap.nst/content/rationalwayforward [Accessed on 16 May 2007]

18. <http://group.bmj.com/group/advertising/portfolio/bmj-editions>

19. <http://www.medic8.com/BritishRoyalMedicalColleges.htm>

20. Barlow J and Burn J, All Change Please, available at www.policyexchange.org.uk

come in for particular criticism; they were socialised in a heavily rationed system, and the clinical perspective is that patient safety is the paramount concern. They can be won over by quality arguments, but tend to be sceptical about policies aimed at improving efficiency. Vested interests can also play a part in medical decision-making. Healthcare is constantly changing, rendering some professional expertise and practices obsolete, and innovations that move care away from specialists, or require extensive retraining that changes the rules of the game for senior clinicians can stimulate the greatest resistance.

The introduction of general managers at Trust level has done something to threaten clinical autonomy because managers have the authority to make service level changes. However, in practice, managers do not have a clinical background and the culture in NHS organisations is that consultants in particular hold greater authority, which is only really challenged when there is an imperative to meet targets.

There have been a number of factors that have helped to standardise physician practice. The introduction of National Institute for Health and Clinical Excellence (NICE) clinical practice guidelines (CPGs) has introduced clinical standards that physicians are expected to adhere to, unless an individual case merits alternative treatment. In addition, National service frameworks (NSFs) are introduced by the Department of Health. These reflect long term strategies for improving specific areas of care, setting national standards, identifying key interventions and putting in place agreed time scales for implementation. They are often linked to government targets which are used to apply pressure, and Trust performance is assessed according to performance against these targets. This in turn means that physicians are put under pressure to modify their practice in accordance with the target measures, through mechanisms such as clinical audit which assesses doctors against nationally determined criteria.

Consultant contracts were a missed opportunity. They were intended to incentivise consultants to dedicate more time to NHS practice, rewarding those working most intensively or working anti-social hours.²¹ What the government under-estimated was the amount of consultants already doing this. The perceived issue was that too many consultants were spending their time doing private work, so the desire was to create an incentive to spend more time doing NHS work, given that the NHS had gone to the trouble of training them. However, this was based in part on the mistaken assumption that consultants in other regions had the same working practices as those in London. There is a far larger market for private healthcare in London, and arguably a different consultant culture. The result was they ended up spending more money to many consultants for doing the work they were already doing, and little was achieved. There is a good paper by the King's Fund on this showing that there has been little benefit, and that the contract is being loosely interpreted at Trust level.²²

The GP contract is generally viewed more favourably. Implemented in 2004, it made significant changes to the way primary care was delivered, introducing quality incentives and extending the remit of GPs to facilitate the dehospitalisation of services. It was also intended to make General Practice a more attractive profession, because GPs are in high demand and they are increasingly being asked to offer more services and play a role in

21. NHS, 2000 *ibid*

22. Sally Williams, James Buchan (2006) *Assessing the New NHS Consultant Contract: A something for something deal?* The King's Fund

commissioning and managing hospital provision for their patients.²³ The result has been the only genuine payment by results system in the NHS.

General Practice is an area in which the government can clearly realise its ambition to stimulate service improvement through competition. The GP contract gives greater flexibility and autonomy in the delivery of services to encourage experimentation and diversity of provision. Payment for outcomes and other quality measures are intended to provide a stimulus to innovate to achieve this. 90% of patient contact with the NHS does not go beyond their GP, so the argument is that improvements in this area have the greatest impact on patient experience.

The Quality and Outcomes Framework (QOF) directly links GP income to patient care. The more points a practice achieves, the more money it earns. It incorporates measures from patient feedback questionnaires, to encourage patient focus in the delivery and configuration of services. In 2004/05 the average practice score was 91%. This rose to 96% the following year, demonstrating an immediate impact against the measures. Research indicates that more than 8,700 lives will be saved in England over the next five years, as a result of changes that have been made in response to QOF incentives.²⁴

Q6, The Change Foundation: To what extent has authority really been devolved to PCTs from the central government?

A6, Jamie Burn: 85% of the NHS budget is held by PCTs and they have a degree of autonomy in its allocation.²⁵ There are relatively few ring-fenced budgets, and the accountability for service changes is designed to be based on public consultation, as opposed to any formal hierarchical mechanism. That said their performance is closely monitored by SHAs, which are accountable to government for meeting targets. Thus there are strong central pressures on PCTs, some of which are relatively prescriptive, and SHAs are highly motivated to influence PCT decision-making, particularly since they have lost direct leverage over Foundation Trusts.

Whilst PCTs are able to exercise autonomy from government in the configuration of contracts, they are rigorously regulated to ensure they comply with core clinical standards. PCTs are responsible for implementing NICE guidance, which provides the clinical basis for their decision-making and a standardising influence on the quality of care. PCTs have an obligation to demonstrate that NICE guidance is being implemented in their own services, including the independent contractors they commission from. There are defined procedures in place for disseminating guidance, which form the basis of an assurance framework to demonstrate compliance. Where services aren't in compliance, PCTs are required to report the services on a risk register for review by the Clinical Governance Committee.

The Healthcare Commission, the quality and standards regulator for the NHS, investigates whether PCTs and service providers are meeting government core standards. This includes assessing whether NHS organisations have robust standards in place for the

23. <http://www.gpcontract.co.uk/>

24. <http://www.bma.org.uk/ap.nsf/Content/GPcontractandworkload>

25. Boyle S, (2008) The Health System in England, Eurohealth vol. 14, no. 1 pp 1-2

implementation and monitoring of NICE guidance. In particular, explicit reference is made to NICE Guidance in the Clinical and Cost Effectiveness Core Standard (C5) and the the Better Health Safety Core standard (C3).²⁶

The year old World Class Commissioning programme demonstrates the government's commitment to developing decision-making capacity at a local level, whilst also representing a recognition that this aspect of the system is currently deficient. Commissioners play an integral role in leveraging improvements in care. Although the tariff sets prices, it is the Service Level Contracts that specify the range of services to be made available, referral or treatment protocols and relevant performance criteria. Contracts can contain incentives and penalties, and provide an opportunity to specify evidence based practices and an efficient care pathway across different organisations. The ambition is for commissioners to develop local systems of payment by results, but at present this is far from realisation, and block-contracts remain commonplace.²⁷

A key new policy aims to enable greater commissioner leverage in the distribution of funds, in which bonus payments will be made available for incentivising quality and improving outcomes in local priority areas. The Darzi review plans to introduce a new model of financing from 2010/11. The *Commissioning for Quality and Innovation Scheme (CQUIN)* will be introduced to enable PCTs to incentivise the adoption of best practice by overlaying the tariff payments with bonus payments in commissioning contracts. Instead of paying a set tariff uplift across the board, these funds will be diverted to commissioners to address local health priorities.²⁸ Commissioners will be required to collect and monitor provider data to determine who is achieving the best outcomes in priority areas. They can then research the processes that are yielding these outcomes, how these differ from practice in poor performers, and use this knowledge of best practice to set process measures that indicate the required standard of care. The objective will be to clearly disseminate the best practices that come out of this process, and to reward providers financially with bonus payments above the tariff price for implementing improvements.

Q7, The Change Foundation: Do commissioners actually have authority to reallocate funding?

A7, JAMIE BURN: Commissioners are free to enter into contracts with alternative providers, and are responsible for developing a portfolio of services that offers patients a genuine choice and generates competition in the local healthcare economy. However, many areas have pre-existing hospital services that were designed to cater for the entire population, and destabilising hospitals has the potential to cause major problems for the provision of services. Hospitals are often locked into long-term Private Finance Initiatives, which were contracts with the private sector to modernise the hospital estate. While this was achieved, it means that hospitals have less flexibility with their capital assets, and cannot easily decommission services. In addition, contracts held by Trusts with their staff further limit their flexibility in decommissioning services. There is no clear failure regime

26. Information available at <http://www.healthcarecommission.org.uk/guidanceforhealthcarestaff/nhsstaff/annualhealthcheck/annualhealthcheck2007/08/qualityofs/corestandards.cfm>

27. For more information see: <http://www.dh.gov.uk/en/managingyourorganisation/commissioning/worldclasscommissioning/index.htm>

28. Darzi, A (2008) High Quality Care for All: NHS next stage review final report, Department of Health

in place for when hospitals go bust and even if a hospital's services can be covered through alternative arrangements, local ministers are held accountable by the public who are protective over their local services, and there have been instances where PCT decisions have been over-ruled.

There is evidence that PCTs do not in practice reallocate funding as a result. A recent survey found that two thirds of primary care trusts failed to decommission any services in 2007/08. It was suggested that many of the decommissioned services reflected the additional capacity PCTs were building into the acute system to hit the 18-week treatment target and their guaranteed volume contracts with the independent sector, thus traditional providers have been relatively unchallenged.²⁹ The Independent sector is increasingly reluctant to enter the NHS because of the favourable conditions for incumbent providers and the low margins available at NHS tariff. So the provider landscape is predominantly unchanged.

Q8, The Change Foundation: Is the principle of subsidiarity (authority to make decisions at the local level unless the objectives of the action can more effectively be achieved through national level decisions) really feasible given the iconic status of the NHS?

A8, JAMIE BURN: In 2003, Shelia Leatherman and Kim Sutherland reviewed England's 10-year quality agenda at its midpoint and described it as "the world's most ambitious, comprehensive, systemic and intentionally funded effort to create predictable and sustainable capacity for improving the quality of a nation's health care system".³⁰ A further five years on, no one could justifiably deny that the past decade has seen an improvement in quality in the NHS. However, given the 10-year time horizon, the generous increase in resources dedicated to healthcare, and the ongoing goodwill on the part of the public, patients and health professionals, there are many who question whether progress has been as marked, as rapid, or as predictable as might have been expected.

One of the problems is that as decision-making is devolved and information is improved, a 'postcode lottery' is becoming increasingly apparent to the public, with examples frequently quoted in the media. The universal, free at the point of use NHS was founded upon the principle of equality, and there is a strong sense amongst the public and healthcare professionals that variations in provision are unacceptable. Pressure from the media, the public and the medical profession mean that the government is strongly motivated to standardise services, and there are certainly tensions between national and local authorities. In addition to variation in the treatments provided, there are also problems with the coordination of care across boundaries (purchaser/provider, health/social care, primary/secondary care), in addition to duplication of effort and territorialism.

Sheila Leatherman argues that the policy conceptualisation in England is strong, but has been let down by a lack of competence in implementation. This stems from the fact that, while in Canada CEO status may be seen as the top of the tree, in England central policy bodies attract more of the talent because that is where the power has traditionally

29. H. Crump 'PCTs failing to decommission services', Health Service Journal, 9/10/08

30. heila Leatherman & Kim Sutherland (2008) Quest for Quality: Refining the NHS reforms, Nuffield Trust

been, and the wages at trust management level are poor.³¹ Moreover, moving responsibility for commissioning from the old Regional Development Agencies (roughly equivalent in size to the current SHAs), to the far smaller PCTs has meant that many of the senior commissioners retired or moved into policy jobs.

However, FT roll-out continues apace and there is a strong policy commitment to create the patient focused, self-improving system initially envisaged.

Q9, The Change Foundation: How does the public relate to PCTs versus the central government? Are PCTs perceived as legitimate and decisive or does the public still hold the central government accountable for PCT decisions?

A9, JAMIE BURN: Section 11 of the Health and Social Care Act of 2001 (now Section 242 of the NHS Act 2006), made public consultation a legal requirement at the level of Primary Care Trusts (PCTs), Strategic Health Authorities (SHAs) and NHS Trusts with regard to the planning and provision of local services and any major decisions that will affect the operation of services.³² The problem is that the public are not sufficiently aware of PCT decision-making processes and accountability is low.

There is no clear guidance as to how effective participation can be achieved; some PCTs have struggled to comply with this requirement and public engagement is generally low.

In December 2006 the Local Government and Public Involvement Bill was introduced into the Commons.³³ This aims to formalise, in legislation, the link between service providers, including local authorities, and local involvement networks (LINKs) at the level of local authorities. Run by local activists and interest groups with independent financial support, LINKs are being set up in most Local Authority areas this year, and will be responsible for actively surveying public opinion and holding local services to account for perceived failings. They have been given powers to request information, which must be provided in a set period of time, can carry out spot checks, produce reports and recommendations with a guaranteed response, and if necessary, they can refer services to the Overview and Scrutiny Committee.³⁴

This is intended to increase public involvement in PCTs and their accountability to public opinion. In the past, the only recourse has been to lobby local politicians, or to pursue legal action. Legal action over funding decisions is relatively commonplace. See for example the Royal National Institute for Blind People's legal action against Oxfordshire PCT.³⁵

Q10, The Change Foundation: How powerful are PCTs in determining physician compensation and working conditions?

A10, JAMIE BURN: Primary Care Trusts (PCTs) can enter into contracts with GP practices

31. Ballantine, J, Forker, J, and Greenwood, M, (March 2008) The Governance of CEO Incentives in English NHS Hospital Trusts, available at SSRN: <http://ssrn.com/abstract=1111534>

32. www.opsi.gov.uk/ACTS/acts2001/10015-b.htm#11

33. www.parliament.the-stationery-office.co.uk/pa/pabills/200607/local_government_and_public_involvement_in_health.htm

34. http://www.dh.gov.uk/en/Managingyourorganisation/PatientAndPublicinvolvement/dh_076366#_1

35. http://www.rnib.org.uk/xpedio/groups/public/documents/publicwebsite/public_pr090707a.hcsp

by negotiating Personal Medical Contracts. These apply to GPs who are directly contracted to the NHS, and are negotiated locally. Most GPs are independent contractors with the government however, and hold General Medical Contracts (GMS) with the government. It is at the discretion of GPs and PCTs which form of contract is used, although all GPs in a PCT should hold the same form of contract.³⁶ PCTs can also enter into Alternative Medical Provider Contracts with the Independent Sector, for example, if there are problems recruiting GPs, or Primary Care Trust Medical Services contracts, if they wish to directly provide services and employ professionals. Extensive information on the terms of these contracts is referenced below.³⁷

Q11, The Change Foundation: Can agreements with provider groups be negotiated locally?

A11, JAMIE BURN: PCTs directly contract acute services from NHS Trusts, NHS Foundation Trusts and Independent Sector providers. There is a standard government template for these contracts, which forms the basis for local negotiations.³⁸

Included in the template are:

- Guidance on the contract
- A standard activity plan template
- A model consortium agreement for PCTs
- Guidance on the consortium agreement
- An impact assessment
- Guidance on the use of Patient-Reported Outcome Measures

Negotiations will include agreed indicative volumes, processes, incentives, and monitoring arrangements, allowing commissioners significant leeway to specify how care should be provided. For example, they can use NICE guidance to form the basis of clinical requirements. They will also set referral protocols to ensure minimal disruption to the patient pathway.

The national contract templates and commissioning expertise are still evolving away from the old practice of 'block contracting', with contractual arrangements seen as a key tool in generating improved healthcare. For example, there may be competition for the volumes that a PCT can offer, giving them greater power to negotiate quality improvements in return for the higher activity and resulting income.

Q12, The Change Foundation: Do PCTs have the authority to limit the number of physician "shingles" in a geographic area? Do physicians have an automatic right to establish a practice irrespective of need in an area?

A12, JAMIE BURN: GP surgeries cannot be set-up without the permission of the local medical committee, although I have been unable to find any policy information on what criteria they apply. General Practices are required to register their patient lists with PCTs.

36. http://www.datadictionary.nhs.uk/data_dictionary/attributes/g/general_or_personal_medical_services_de.asp?shownav=1

37. <http://www.dh.gov.uk/en/Healthcare/Primarycare/Primarycarecontracting/index.htm>

38. The template is available in Annex E to the NHS operating framework for 2008-09; Annex D provides the Principles and Rules of Co-operation and Competition.

They also agree to a geographical catchment area with their PCT, which is the area in which they are obliged to perform house visits. The UK does suffer from a deficit of primary care providers in deprived areas, which was introduced as a policy priority in the government white paper *Our health, our care, our say*,³⁹ which led to a national procurement strategy to boost surgery numbers in understaffed PCTs called the Fairness in Primary Care Procurement Programme⁴⁰. This policy drive was intended to increase the level of GP choice in general, because there is a lack of GP capacity, and often practices have 'closed lists' or only accept patients from their catchment area.

Q13, The Change Foundation: How powerful are PCTs compared to hospitals and other institutions?

A13, JAMIE BURN: There is good deal of animosity between PCTs and service providers in some areas because Primary Care Trusts can have provider arms, and are sometimes accused of restricting patient choice in favour of providing services themselves. Practice Based Commissioners, GP practices with devolved budgets from PCTs, are also allowed to provide services and can undercut the tariff, policies introduced to reduce hospitalisation and encourage care in the community. Hospital Trusts also complain that service innovations such as walk-in centres that they introduce are not supported by commissioners, who tend to control the policy agenda in their local area.

However, major Foundation Trusts are often the only viable provider of many secondary and tertiary services. They have a monopoly on specialist expertise and their budgets often dwarf that of a single PCT. For example, in Newcastle upon Tyne, there is only one hospital Trust in the city, and while there are other Trusts elsewhere, 60% of its business comes from outside of the city. This region (North East England) is comprised of 11 PCTs, and many more PBCs. And because the population of the region is just 3 million, it is the sole provider of many specialist services.

This situation has arisen, in theory, because it enables PCTs to switch providers without destabilising a hospital and damaging provision, but this lacks a coherent rationale in areas where there is no alternative. It is only really practical to have a choice of specialist services in London, which has 31 PCTs and numerous hospital Trusts. Another reason for the distribution (and variation in size) of PCTs is that they broadly conform to the boundaries of Local Authorities, which separately commission social care services. In many case, health service patients will need continued care, such as in a nursing home, and so the two authorities were made to coincide, without being fully integrated because while healthcare is state provided in the UK, social care is not necessarily, causing an artificial boundary.

Q14, The Change Foundation: Is there a real option not to purchase services from a major practice or institution?

A14, JAMIE BURN: In addition to the GP contract freeing primary care providers to enter into alternative service provision agreements, the government has attempted to secure market entry for the Independent sector with regard to diagnostic and elective services,

39. Our health, our care, our say: A new direction for community services (2006) Department of Health

40. http://www.dh.gov.uk/en/procurementandproposals/tenders/informationaboutprocess/DH_073435

to provide a genuine alternative to hospital provision and greater competition for PCT contracts and patient choice.

Allowing NHS hospitals to go bankrupt is highly sensitive, and the services they provide can only be allowed to recede if there is a readily available alternative, so that provision isn't damaged. The use of small treatment centres with a single focus as the vehicle for private provision reduces the costs of entry and exit, adding flexibility relative to the start-up costs of entire hospitals, and to some extent separating an elective service market from other services less amenable to marketisation.

In 2004, the DH, under Secretary of State John Reid, anticipated that the IS could carry out up to 15% of elective procedures per annum for NHS patients, equating to 1.1 million procedures⁴¹. However, the national procurement fell some way short of these levels. Wave 1 of the ISTC programme was announced in October 2002, with contracts for 171,000 procedures per year, over 5 years from the commencement of services⁴², costing £1.7 billion⁴³. The government initially selected 7 private companies, from 147 expressions of interest⁴⁴, to run 24 ISTCs, with two British and 5 from Canada, South Africa and the USA. Centres were located on new or refurbished NHS premises, and in 2 mobile ophthalmology units⁴⁵. The first phase 1 contracts were signed in September 2003, with the first ISTC commencing service in Daventry in October 2003. The number commissioned will subsequently grow to 31 phase 1 ISTCs⁴⁶, identified as phase 1 procurements because of the different arrangements in phase 2. The DH estimated that phase 1 ISTCs had a market share of 250,000 procedures per year, prior to phase 2 commissioning, 3% of total elective surgery provision⁴⁷. However, evidence collected by Leys, Player and Pollock states that of the 880,000 procedures contracted to phase 1 ISTCs, only 114,000 had been performed by the end of 2006, which demonstrates that PCTs were failing to refer enough patients despite the fact that the terms of the ISTC contracts guaranteed a minimum income.

Despite admitting that the first wave had over-subscribed capacity in some areas under wave 1, the government committed a set amount of £550 million per year for a second wave of procurement, amid allegations that local authorities were being pressurised into further commissioning contracts⁴⁸. Under phase 2, the government spent a further £2.75 billion on elective procedures, including an Extended Choice Network of independent sector providers delivering procedures to patients choosing referral, on an ad hoc basis. Although initially comprised of 24 schemes, SoS Patricia Hewitt cancelled 7

41. Department of Health (2004b) NHS Improvement Plan — Putting People at the Heart of Public Services. London: HMSO.

42. Commercial Directorate (2005) ISTC Manual. London: CD

43. Healthcare Commission (2006). The Healthcare Commission's submission to the Health Committee inquiry into independent sector treatment centres. London:HC.

44. Health Committee, 2006 *ibid*

45. UNISON (2005). Operating for Profits: An examination of the UK government's policy of promoting "Independent Sector Treatment Centres". London: UNISON.

46. Department of Health (2006e) The NHS in England: the operating framework for 2007/08. London: HMSO

47. Sally Ruane (2006) independent Sector treatment centres, Health Matters

48. Health Committee, 2006 *ibid*

at an early stage⁴⁹, because no suitable locations could be found⁵⁰. There are no plans for a third wave, and further market expansion will be left to local commissioners, who have been slow to engage in any significant IS procurements⁵¹. The second wave of the ISTC programme was scaled back when Gordon Brown took office, with only 6 of the contracts having been signed off, as of July 2007⁵².

The problem that ISTCs have is that they provide a relatively small number of procedures and need a large catchment area to supply them with sufficient referrals. In their written evidence to the Health Committee, several members of the NHS Alliance from PCTs complained at the geographical isolation of ISTCs⁵³, presumably located to be central to a sufficient catchment area, relying as they did on a number of PCTs with small additional requirements, but potentially placing them at risk under the terms of patient choice.

In reality, there are relatively few places that can support a competitive marketplace, and while PCTs are free to commission this activity, most are reluctant to incur the difficulties and expense that the national procurement demonstrated.

Q15, The Change Foundation: To what extent has there been real competition in terms of price and quality?

A15, JAMIE BURN: There is no price competition in the NHS, because the tariff sets prices nationally. The white paper *Delivering the NHS Plan* announced the introduction of a policy allowing patients to choose the time and place of their elective appointment, and a system of payment by results (PbR) in which providers are paid on a cost per case basis for the services they perform according to a set central tariff⁵⁴. Money follows patient choice, effectively creating a form of a voucher system in which a GP referral for a service gives the patient a quasi-voucher that they can cash in with their chosen provider⁵⁵, who then receives payment in accordance with the tariff.

The hopes for quality competition were largely pinned to patients choosing services on the basis of quality, in the hope that this would create market pressures to improve. The problem is that information on quality is inadequate because it is aggregated at the level of hospitals, and detailed quality measures are still being determined. This means that patient choice has limited impact on quality competition, because the information to genuinely choose on this basis is not available. For example, there are problems with the comparability of data coding submitted by ISTCs and NHS providers.⁵⁶ A further complication with the way data is presented to patients is that some information is expressed as progress against targets for the baseline year, relaying how an organisation is cur-

49. Health Committee, 2006 *ibid*

50. Gavin, J. (2007). Bad Medicine. Have the independent sector treatment centres flopped? [Online] Private Public Finance. Available from <http://www.publicprivatefinance.com> [Accessed on 17 June 2007]

51. Bosanquet, N., de Zoete, H. and Haldenby, A. (2007) NHS reform: the empire strikes back. Reform January

52. Timmins, N. (2007) What's next for the NHS? BMJ 335 (7 July) 18-19.

53. House of Commons (2006) Independent Sector Treatment Centres: Messages from members of the NHS Alliance. [Online] House of Commons. Available from <http://www.publications.parliament.uk/pa/cm200506/cmselsct/cm> [Accessed on 14 May 2007]

54. NHS (2002) *Delivering the NHS Plan: Next steps on investment, next steps on reform* Norwich: The Stationary Office

55. Glennerster, H. (1997) *Paying for Welfare towards 2000*. 3rd Edition London: Prentice Hall.

56. Health Committee, 2006 *ibid*

able on the public register.⁶¹ Foundation Trusts are however, free to develop new services or to change the way services are provided.

There are now 109 FTs.⁶² The status has been an extremely successful incentive in improving and sustaining the level of financial governance in NHS Trusts and Monitor has announced that they have improved their performance for 3 years running.

Q17, The Change Foundation: To what extent is funding based on performance vs per capita? How is funding of either organisations or individuals tied to defined performance targets?

A17, JAMIE BURN: Funding at Trust level is not related to performance, except by increasing throughput. NHS providers are paid for their activity according to a tariff system, receiving an annually set payment per patient with a given referral. This is calculated annually as the average of a group of around fifty procedures (Health Resource Groups), using the previous year's data. It is therefore based on current practice, and does not subsidise the cost of innovative and possibly more expensive procedures that improve quality. This can lead to perverse incentives because if an innovation improves efficiency a Trust may actually be penalised for doing so since innovative practices may reduce activity. If this frees up capacity, income can be recovered, but the Trust will need to invest to utilise this capacity. This financial environment reinforces the tendency towards a lack of disengagement from outdated practices, and leads to the poor uptake of medical devices and diagnostics in particular, which are procured at Trust level and are subject to lower 'push' pressures from NICE.⁶³ Thus the tariff pays a set price per patient and the lack of sensitivity to costs incurred means that funding can actually fall as a result of improvements in performance. The introduction of CQUIN will be the first attempt to change this situation (see previous discussion on page 8-9).

The only funding that is linked to targets, as far as I am aware, is the funding allocations for PCTs. The weighted Capitation Formulae uses a distance from target measure to determine the share of additional resources to be made available to the PCT.⁶⁴ Targets are now being scaled back.⁶⁵ They were initially reduced in 2005 and no new targets were introduced by the Darzi review, because the new funding system under development aims to use effective commissioning to meet local priorities, using the outcomes information that is increasingly available as the basis for bonus payments. The waiting time targets set in 2000 expire this year, while cancer and cardiac targets will continue until 2010. Other targets, such as MRSA reduction, are ongoing.

Q18, The Change Foundation: What is the extent of EMR/EHR adoption? How much data and reporting are available in real time?

A18, JAMIE BURN: The National Programme for IT (NPfIT) was established in late 2002

61. <http://www.monitor-nhsft.gov.uk/register.php>

62. http://www.monitor-nhsft.gov.uk/register_nhsft.php

63. All Change Please, 2008, *ibid*

64. Finance Directorate (2005) Resource Allocation: Weighted capitation formulae fifth edition, Department of Health

65. National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06-2007/08

following several Department of Health reports on strategies for the NHS.⁶⁶ The ambition was to create a single electronic care record for patients and to connect 30,000 General Practices to 300 hospitals by providing secure access to patient records by authorised professionals. Connecting for Health (CfH) was created in 2005 to deliver the ambitious programme, which it calls “the world’s biggest civil information technology programme”.⁶⁷

Roll-out is underway of the NHS Care Records Service, which aims to create an electronic record for more than 50 million patients in England. Full patient records will be created for every patient and held at their local GP or hospital, while summary records will be held on ‘the Spine’, a national, central database, enabling immediate data availability. When fully implemented, local records will automatically upload important information to the summary patient record on the Spine, including demographic information and summarised clinical information. NpfiT also procured computer systems for roll-out throughout the NHS, unlocking the economy of scale and ensuring these computer systems would be fully compatible with the NHS spine.

Current projects include:

- Personal Demographics Service—enabling accurate patient identification
- Personal Spine Information Service—The availability of up-to-date information is intended to eliminate the source of numerous errors and make service delivery more efficient, by removing the data collection requirement at point of contact
- Transaction Messaging Service—manages electronic information requests
- Secondary Uses Service—protects patient confidentiality and enables secondary usage of anonymised data to analyse health trends, outcomes and NHS capacity. This is intended to support the future system of Payment by Results, where payment will be linked to outcomes.
- Clinical Spine Application—enables clinical access to spine systems.
- Spine Directory Service—a search engine for spine information
- Access Control Framework—registers and authenticates users
- Choose and Book—the spine is also intended to support Choose and Book, the new electronic booking service that enables primary care staff to make appointments for secondary care.
- Electronic Transmission of Prescriptions (ETP)—allows prescriptions to be transferred electronically to pharmacies, which will log the information on the patient records when the prescription is dispensed.⁶⁸

The Spine, delivered by BT, is largely in place, after significant delays and great expense. The costs of the National procurement were originally expected to be £2.3 billion over three years, but are now expected to approach £20 billion over a decade.⁶⁹ This is not entirely born by the Government, because IT contractors had to prove their systems worked before they were paid. Two of the four original contractors have now withdrawn due to serious financial

66. See NHS Connecting for Health —History of our organisation.

67. See NHS Connecting for Health —Service implementation

68. <http://www.connectingforhealth.nhs.uk/resources/sytserv/spine-factsheet>

69. Bill for high-tech NHS soars to £20 billion, The Daily Telegraph (10/12/2004)

difficulties. Richard Grainger, the highest paid Civil servant in Britain when appointed, has since fallen on his sword earlier this year.

The problem has been in the rollout of individual computer systems, which were designed according to a single set of specifications, to be applied in every setting. GP practice systems are now up and running in a handful of PCTs (see Early Adopter programme) but most hospitals are still awaiting their systems, and those that have implemented them report significant problems.⁷⁰ (There is a case study on Newcastle Foundation Trust, which has become the first Trust to procure its own system to its own specification, at far greater expense. They are consulting the University of Pittsburgh Medical Centre, who were an early successful IT adopter in the USA.)

Companion Pieces

To provide further insights and prompt additional reflection on the lessons from NHS England's health reforms, The Change Foundation offers the following companion pieces and supportive charts to accompany our case study:

- Health System Reforms in NHS England: Context, Culture, Power, a Q&A with Jamie Burn;
- A Commentary by Tony Woolgar on *Integrated Health Systems in England: Lessons for Ontario* (The Change Foundation, May 2009) and a feature video podcast interview with him and The Change Foundation;
- A summary of key components/characteristics of NHS England;
- Integrated health systems—England case study: Comparative analysis with Ontario.

All companion pieces can be found at www.changefoundation.com

70. Jamie Doward (08/10/2008) Chaos as £13 billion pound computer system falters, The Guardian