



SMF HEALTH PROJECT: BACKGROUND PAPER 4

Providers of Healthcare

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Dr Niall Maclean, Lyndsay Mountford and Charitini Stavropoulou

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1 INTRODUCTION

This paper is the fourth of five papers which form the background to the ongoing work of the SMF Health Project. The papers have been prepared following an extensive literature review, as the basis for a research scoping exercise, which explores future policy challenges facing the NHS in England. Other papers consider the NHS in relation to high-level health systems issues (Background Paper 1), long-term financing pressures (Background Paper 2), the emerging role of commissioning (Background Paper 3), and issues and policies relating specifically to the role and expectations of patients (Background Paper 5). As they explore these topics in detail, these papers identify and propose possible research topics and questions for the next phase of the SMF Health Project.

This fourth paper looks in more detail at the provision of healthcare: the changing role and expectations of providers including the changing nature of healthcare, the role of new technologies and the challenges of coordinating care in an increasingly diverse and specialised provider environment. In the course of this discussion, the paper provides a critique of current policy initiatives which are shaping healthcare provision, and considers what questions might be appropriate for the SMF Health Project to consider further.

In the decade since 1997, and particularly in the years following the publication of *The NHS Plan* in 2000, there have been substantial changes to the way in which the NHS is run and organised. The NHS has undergone a period of significant reform that has introduced greater choice, new models of commissioning, a new organisational structure and substantial workforce change. These reforms have been coupled with substantial investment, at times via new and often controversial arrangements with the private sector.

The paper examines this reform under five broad headings: workforce reform, increased diversity of supply, reconfiguring hospital services, information technology systems and facilities management. The advance of medical technologies has an important bearing on the provision of healthcare, but this trend is covered in Background Paper 2.



2 WORKFORCE REFORM

THE NEED FOR WORKFORCE REFORM

The 1999 Health Select Committee report, *Future NHS Staffing Requirements*, concluded that the NHS was “in the midst of a staffing crisis.”¹ The report made a number of recommendations, including the development of a more integrated staff planning system and the creation of a single pay system for all NHS staff. The government broadly accepted these recommendations and undertook a review that resulted in the publication in 2000 of *A Health Service of all the Talents*. The report identified a need to improve the flexibility of the workforce and to increase staff numbers.² Thus, in July 2000, the government launched *The NHS Plan*, which set out a ten-year programme of reform with the aim of expanding capacity, improving access to care and increasing the responsiveness of the service.

A very significant increase in staff numbers was seen as a prerequisite for achieving these goals and in the early stages of workforce reform the government’s main focus was on increasing the size of the workforce and raising wages, rather than introducing reformed ways of working. Indeed, the Department of Health, in its evidence to the 2006 Health Select Committee’s inquiry into workforce planning admits that “the last five years has been 80% about growth and 20% about transformation and new ways of working.”³ Targets for the expansion of the NHS workforce were set out in *The NHS Plan*, and again two years later in *Delivering the NHS Plan*. In practice, the rise in the number of staff which was subsequently achieved actually exceeded most of the targets set out in *The NHS Plan*: between 1999 and 2005, the NHS workforce increased by 260,000, a growth of more than 24%.⁴

However, the Department of Health is now focusing on transformed working practices to ensure the most efficient use of resources. As Lord Warner has stated, greater workforce capacity “will need to come from

1 House of Commons Health Committee, *Future NHS Staffing Requirements: Third Report of Session 1998–1999* (London: HMSO, 1999).

2 Department of Health, *A Health Service of all the Talents: Developing the NHS Workforce* (London: HMSO, 2000), 5–6.

3 House of Commons Health Committee, *Workforce Planning: Fourth Report of Session 2006–07*, vol. 1 (London: HMSO, 2007), para 5.7.

4 Health Committee, *Workforce Planning*, 5.

more efficient ways of working and through even more productive use of the workforce",⁵ a comment echoed by Derek Wanless in his review of long-term resource allocation in the NHS, when he noted that NHS staff must "take on new and challenging roles."⁶

NEW CONTRACTS

Attempts to change working patterns, modernise pay and improve productivity in staff performance since 2000 have taken the form of new contracts and pay systems for nurses and other staff, all delivered under the heading "Agenda for Change." There have also been new contracts for NHS hospital consultants and for GPs. In the sections that follow, we will consider Agenda for Change, and the new contracts in greater detail.

AGENDA FOR CHANGE

At its inception in 1948, the NHS adopted the Whitley industrial relations system, which at the time was used in the civil service and local government. The system, based on work carried out by J. S. Whitley in 1916, provided a framework for pay, terms and conditions.⁷

The system was left essentially unaltered for more than 50 years. This was not, however, because of its lasting suitability: it had been strongly criticised for decades as being overly complex, centralised, inflexible and inequitable. By the mid-1990s there was a consensus amongst employers, trade unions, the Department of Health and professional organisations that the Whitley system was no longer suitable for the modern health service.

Meanwhile, reform within the NHS has changed the way services are provided, and a more flexible workforce, with less demarcation between and within primary, secondary and social care organisations, was seen as an important need.⁸

5 Lord Warner, Minister of State for NHS Delivery, "Breaking with tradition: The future role of doctors in UK healthcare" (speech to Joint Consultants Committee Conference, 5 October 2005).

6 Derek Wanless, *Securing our Future Health: Taking a Long-Term View* (London: HMSO, 2002).

7 Royal College of Nursing, "The history of Agenda for Change," Royal College of Nursing: www.rcn.org.uk/agendaforchange/overview/history.php.

8 NHS Employers, *From Pay Reform to System Improvement: Making the Most of Agenda for Change* (London: NHS Employers, 2006).

In 2004, therefore, the government introduced Agenda for Change (AfC), a programme designed to overcome perceived problems with the old system of pay and conditions. AfC has attempted to address these problems by paying staff for what they do rather than according to their grade and by linking the workforce development strategy to patient needs and organisational priorities.⁹ However, AfC was designed to be more than simply a new pay system. It was also created to support a shift in how the NHS delivers healthcare. While one of its aims, therefore, was to ensure fair pay for NHS staff and to set up a clearer system of career progression, it was also intended to improve productivity and service delivery. AfC therefore introduced not only simplified national pay “spines” covering different staff groups, but also a competency-based career framework known as the Knowledge and Skills Framework (KSF). Members of staff were to be paid on the basis of the jobs they did and the skills and knowledge they used, as opposed to their job title or grade.

The KSF also modernised the appraisal system and personal development plans of employees, and introduced a national job evaluation scheme. It was designed to allow staff to progress by taking on new responsibilities, and it was hoped this would allow jobs to be tailored around patient and staff needs (thereby improving productivity and job satisfaction). The new system also introduced standard arrangements for hours, annual leave, and overtime.

Productivity

A report by NHS employers highlights a number of NHS organisations that *have* improved their service quality and productivity by implementing AfC.¹⁰ One important example is Aintree University Hospital NHS Trust, which has modernised its cancer services to give patients greater support as they move from the ward back to the home. This has improved productivity by reducing the average length of hospital stay, and has also improved the patient experience.¹¹

The report argues that the KSF has also brought improvements. It claims that several NHS organisations have, as a result of implementing

9 Ibid.

10 Ibid.

11 Ibid.

the KSF, boosted their recruitment and retention rates, reduced their sickness rates and brought about better partnership working.

We might expect AfC to improve services still further by strengthening relationships between different NHS organisations. AfC is a partnership agreement requiring a high level of input from trade unions and professional bodies. According to the NHS employers' report, this has led to a maturing of the relationship between different organisations working in the system. The report highlights Burnley, Pendle and Rossendale PCT, which, since the introduction of AfC, has experienced fewer disciplinary cases, less use of formal modes of conflict resolution and improved recruitment and retention rates.

These claims are supported by a survey of health union members carried out by MORI, which found that the implementation process of AfC has helped to develop closer working ties between NHS professionals, organisations and unions. However, the MORI report also found that many respondents felt that the implementation of AfC has created a great deal of uncertainty and has contributed to the lowering of staff morale. Some also reported uncertainty regarding the potential of the KSF to work in practice.¹²

This disillusionment with AfC was also revealed in a more recent NHS survey carried out by the Healthcare Commission, which found that staff are starting to report negative views on the extent to which they feel their work is valued under AfC, and the fairness of promotion and career progression under its auspices.¹³ There also appear to be doubts about the effectiveness of AfC in improving quality of care and ensuring that patients are seen more quickly. A recent report by the King's Fund analysing the impact of AfC states that there are few signs to indicate that AfC has increased productivity or significantly improved practice.¹⁴

Why hasn't AfC improved productivity and service delivery? The initial timetable for the implementation of the agenda was ambitious,

12 Ipsos MORI, *Agenda For Change Research Study Conducted for the NHS Trade Unions* (London: Royal College of Nursing, 2006).

13 Healthcare Commission, *National Survey of NHS Staff* (London: Commission for Healthcare Audit and Inspection, 2007).

14 James Buchan and David Evans, *Realising the Benefits? Assessing the Implementation of Agenda for Change* (London: King's Fund, 2007).

and some feel it may have been rushed. This might have made it difficult for the new system to introduce real improvements in care.¹⁵ The hurried implementation has also meant that the KSF, an important instrument in improving productivity, is not being used properly by most trusts.¹⁶ This claim is supported by the results of a national survey showing that only 67% of staff have a full KSF job outline, and only 33% have a KSF personal development plan.¹⁷

The King's Fund has suggested that the lack of a systematic assessment of the progress made in reaping the benefits of AfC and KSF has also contributed to a loss of impetus in driving up productivity and service delivery. More information needs to be made available to allow for a systematic evaluation of the success or otherwise of AfC and KSF.¹⁸

PRIMARY CARE CONTRACTS

There have been a number of new contracts for primary care services in recent years. The most significant was the general medical services (GMS) contract (also referred to as the GP contract), which was drawn up in partnership between the NHS Confederation and the General Practitioners Committee of the BMA. GP practices have operated under the new contract since April 2004.

According to the Department of Health, the new GMS contract had three key aims: first, to ensure greater flexibility so that practices could better control their workload; second, to reward quality and outcomes; and, third, to invest in primary care services.¹⁹

15 Ibid.

16 House of Commons Health Committee, *Workforce Planning*.

17 A. O'Dowd, "Poor KSF progress puts careers at risk," *Nursing Times* 103, no. 8 (20 February 2007), 8–9.

18 Buchan and Evans, *Realising the Benefits?*

19 Department of Health, *Investing in General Practice: The New General Medical Services Contract* (London: HMSO, 2003).



Ensuring greater flexibility

The new contract allowed practices to control their workload by enabling them to choose the services they would provide. The GP workload was divided into three groups of tasks:

1. Essential tasks which all GPs undertake, such as treating those who are ill or believe themselves to be ill, treating those who are terminally ill and in-practice management of chronic diseases such as diabetes.
2. Services which most practices will provide, but which can be opted out of if the practice so chooses, such as antenatal and postnatal care.
3. Services which it is expected that most practices will not provide, but which can be opted into if the practice so chooses.

This freedom for practices to choose what activities they want to perform meant that, for the first time ever, GPs would not necessarily have round-the-clock responsibility for their patients, since practices could opt out of providing out-of-hours care.

Primary care organisations (PCOs) such as PCTs were made responsible for ensuring that the new flexibility in provision did not result in a lack of availability of certain services. If a practice opted out of providing a service, its budget would be reduced accordingly, and the PCO would be able to use this money to secure alternative provision from other practices or primary care providers. As such, under the new contract it was up to PCOs to ensure that out-of-hours services were still available. It was envisaged that PCOs would be able to deliver out-of-hours care through providers such as NHS Direct, NHS walk-in centres, pharmacists, GPs, primary care nurses in A&E departments, and social work services.²⁰

20 Ibid.

The Department of Health predicted that different models of care would develop in different areas to meet the needs of local communities. It was argued that this new flexibility would actually *widen* the range of services available at GP surgeries, as more would choose to provide a range of different services to meet the needs of their local population and thereby get rewarded accordingly.

Rewarding quality and outcomes

A major objective of the GMS contract was to reward practices for delivering clinical and organisational quality. This was to be achieved by a new quality and outcomes framework (QOF), which incentivised the delivery of quality care. The QOF is an annual reward and incentive programme that awards surgeries achievement points for:

- managing a number of common chronic diseases – e.g., asthma and diabetes (clinical indicators);
- how well the practice is organised (organisational indicators);
- how patients view their experience at the surgery (patient experience);
- the extra services offered by the practice, such as contraceptive services and child health (additional services).

Surgeries receive points for meeting standards in each of these areas and thus gain financial rewards. The idea was that, for the first time, GPs would be rewarded for the quality of the services they provided, not just the number of patients they treated. The remainder of a practice's income would be made up largely from the "global sum", a figure paid to each practice based on the number of patients it treats (adjusted to take into account the age and sex of those patients).

Clinical indicators

In total, there are 76 clinical indicators for which GP practices can earn QOF points. The clinical indicators are organised by disease category and have been selected because the principle responsibility for the on-going management rests with the GP and Primary Health Care Team and there is good evidence that health benefits will be realised by improved primary care. The previous 10 disease areas: Coronary Heart Disease (CHD), Stroke, Cancer, Hypothyroidism, Mental Health,

Asthma, Chronic Obstructive Pulmonary Disease (COPD), Epilepsy have been increased to 19 and now include heart failure, palliative care, dementia, depression, chronic kidney disease, atrial fibrillation, obesity and learning disabilities. For the last two clinical areas in the list, points were achieved for establishing a register of patients and as yet not for providing a specific level of service provision as in other clinical domains²¹. The disease categories have been selected by the Department of Health to be included in the QOF for the following reasons:

- where the responsibility for ongoing management rests principally with the general practitioner and the primary care team;
- where there is good evidence of the health benefits likely to result from improved primary care – in particular if there is an accepted national clinical guideline;
- where the disease area is a priority in a number of the four nations.²²

The indicators for each disease category are divided into three groupings:

1. *Records* – GP practices receive points if they produce a register of patients for the different diseases. For example, if a practice creates a register of patients with coronary heart disease they earn six QOF points.²³
2. *Diagnosis and initial management* – QOF points can be earned for tasks such as referring newly diagnosed angina patients for exercise testing or specialist assessment (seven points), or for recording the smoking status of patients with hypertension (ten points).

21 Oldham NHS Trust, *Quality and Outcomes Framework End of Year Report 2006/07*: [http://www.oldham.nhs.uk/publica_/pctboard/September%202007/AI%2014%20-%20\(iii\)%20Quality%20Outcomes%20Framework%20End%20of%20Year%20Report.pdf](http://www.oldham.nhs.uk/publica_/pctboard/September%202007/AI%2014%20-%20(iii)%20Quality%20Outcomes%20Framework%20End%20of%20Year%20Report.pdf)

22 Department of Health, *Quality and Outcomes Framework: Guidance – Updated August 2004* (London: HMSO, 2004), 1: www.dh.gov.uk/en/Healthcare/Primarycare/Primarycarecontracting/QOF/DH_4125653.

23 The QOF points quoted here relate to the number of points available in August 2004.

3. *Ongoing management* – GP practices can earn points if, for example, mental health patients on lithium therapy have had their lithium levels checked within the previous six months (three points), or if patients aged 16 and over on drug treatment for epilepsy have been seizure free for the last 12 months (six points).²⁴

Organisational indicators

General practices can also earn QOF points depending on how their practice is organised and run. Organisational indicators are split into five domains:

1. *Records and information about patients* – this domain consists of 19 indicators for which GPs can earn points, including for example: if the entries in records are legible (one point); if the medicines that a patient is receiving are clearly listed in his or her record (one point); if the practice has up-to-date clinical summaries in at least 60% of patient records (25 points).
2. *Information for patients* – this domain consists of eight indicators, including: if the practice has a system to allow patients to contact the out-of-hours service by making no more than two telephone calls (0.5 points); if the practice supports smokers in stopping smoking by a strategy which includes providing literature and offering appropriate therapy (two points).
3. *Education and training* – this domain consists of nine indicators, including: if all practice-employed nurses have an annual appraisal (two points); if all new staff receive induction training (three points).
4. *Practice management* – this domain consists of ten indicators, including: if individual healthcare professionals have access to information on local procedures relating to child protection (one point); if person specifications and job descriptions are produced for all advertised vacancies (two points).

24 Department of Health, Quality and Outcomes Framework, 1.

5. *Medicines management* – this domain consists of ten indicators, including: if there is a system for checking the expiry dates of emergency drugs on at least an annual basis (two points); if the number of hours from requesting a prescription to availability for collection by the patient is 48 hours or less (excluding weekends and bank/local holidays) (six points).²⁵

Patient experience

The QOF framework provides incentives for practices to provide longer consultations and to carry out patient surveys:

1. *Length of Consultations* – if the length of routine booked appointments with the doctors in the practice is not less than 10 minutes (30 points).
2. *Patient Surveys* – practices can earn points if they have undertaken an approved patient survey each year. More points are awarded if the practice goes on to produce an action plan that amongst other things summarises the findings of the survey and sets priorities for the next two years (1–30 points).²⁶

Additional services

Finally, practices that provide additional services can earn extra QOF points. Such services include: cervical screening, additional child health surveillance, additional maternity services and additional contraceptive services. For example, a practice that has a system to ensure that inadequate/abnormal smear results are followed up gains three points, while a practice that offers child development checks at the intervals agreed in local or national guidelines, and follows up problems, will earn six points.

²⁵ Ibid.

²⁶ Ibid.

Investing in primary care services

The third aim of the new GMS contract was to provide record investment in primary care services. This was to be achieved through a three-year gross investment guarantee, which was designed to allocate resources on a more equitable basis by distributing funding based on the needs of each practice's patients. It also granted GPs freedom to work with other practice staff to design services to meet local patient needs. It was hoped that this would expand the roles of other primary care staff and promote new ways of working.

OUTCOMES OF THE NEW GP CONTRACT

Increase in GP pay

In its first year, the GMS contract led to an average increase in GP earnings of 22.8% (to an average annual salary of £100,170), according to revised figures published by the NHS Information Centre.²⁷ An earlier study by the same body revealed that under the new contract 30–50% of every GP's income was now made up of money earned from the QOF scheme.²⁸ Practices are able to earn up to 1,050 QOF points a year. In 2004–5, each point was worth £77.50, meaning a practice that met all the standards would have earned an extra £81,400. In 2004–5 practices earned on average 91% of the points available, giving an average gain in earnings of £74,000.²⁹

The BMA has argued that this increase in GP pay offers value for money. Hamish Meldrum, chairman of the BMA's General Practitioners Committee, argued that the pay increase was necessary to solve pre-existing recruitment problems caused by a fall in GP pay relative to comparable professions.³⁰ However, concern has been expressed about the greater proportion of practice income now going to earnings. Statistics from the NHS Information Centre show that in 2003–4, GPs took 40% of their gross earnings in profit once expenses were taken away, but this rose to 45% the following year under the new contract.³¹

27 NHS Information Centre News Release, "Revised income figures for family doctors under new GP contract," *NHS Information Centre*, 26 April 2007. www.ic.nhs.uk/webfiles/publications/press_releases/2007%20003%20Doctor%20pay%20update.pdf.

28 Ibid.

29 Zosia Kmietowicz, "New GP contract: modernisation or miscalculation?," *BMJ* 333 (2006), 1192.

30 BBC News, "Average GP pay rises to £106,000," 26 November 2006: <http://news.bbc.co.uk/1/hi/health/6157219.stm>.

31 "GP earnings and expenses enquiry 2004/5," NHS Information Centre: www.ic.nhs.uk/webfiles/publications/gpearnex0405/GPEarningsExpenses291106_PDF.pdf.

Such was the concern that Patricia Hewitt, then secretary of state for health, said that if the Department of Health had anticipated that GPs would take a higher share of income in profits, “we would have wanted to do something to try to ensure that the ratio of profits to the total income stayed the same and therefore more money was invested in even better services for patients.”³² This sentiment was supported by Barbara Hakin, chairwoman of the NHS employers’ negotiating team, who argued that GPs should be investing more of their profits in their practices.³³ Patient groups have also been critical of the increase in pay for GPs.³⁴

An investigation by the National Audit Office (NAO) published in early 2008 concluded that in the first three years the contract had cost nearly £1.8 billion more than the Department of Health had budgeted for. The report also indicated that the contract had not achieved the expected improvements in services. For example, the new contract has “not yet led to a measurable improvement in moving services into deprived or under-doctored areas”, and the total number of consultations carried out by each GP has decreased.³⁵

Access to primary care services

Provision of out-of-hours services

A particular issue has been the widespread concern over the lack of out-of-hours services provided by GP practices. Nine out of ten doctors have taken up the option to stop working out-of-hours. This has meant that PCTs have had to rely on private firms or groups of independent doctors and other health staff to provide cover, which some argue has affected quality.³⁶

A 2007 report criticised the new arrangements for out-of-hours care. The report, commissioned after the death of a woman who had been in contact with eight doctors from an out-of-hours service provider, states that the new system has led to confusion over what

32 BBC News, “GP pay ‘should have been capped’,” 19 January 2007: <http://news.bbc.co.uk/1/hi/health/6276793.stm>.

33 Ibid.

34 Ibid.

35 National Audit Office, *NHS Pay Modernisation: New contracts for general practice services in England*, (London: NAO, 2008) 9.

36 BBC News, “GP out-of-hours complaints soar,” 8 August 2007: <http://news.bbc.co.uk/1/hi/health/6935018.stm>.

level of care is expected outside normal practice hours. It calls for the Department of Health to address the perception that an out-of-hours service is merely a “holding bay” for patients until GPs resume work.³⁷

Ben Bradshaw MP, minister of state for health services, responded to the report, stating: “PCTs now have a legal responsibility to ensure they provide, or secure, provision of a high quality, sustainable service for their local population.” However, he did concede that some PCTs “would have welcomed clearer guidance on the type of service they should be delivering.” Bradshaw concluded by pointing out that the government had taken additional steps in response to the incident by issuing directions aimed at avoiding similar tragic incidents in the future.³⁸

Bradshaw was referring to *The Out of Hours Services Directions*, published in December 2006. These stated that every PCT must review, at the earliest opportunity and no later than 31 January 2007, the “terms of all primary medical services contracts it has entered into and which remain in force under which the contractor provides out of hours services.” The directions went on to state that PCTs should consider whether those arrangements were adequate to ensure that clinical notes of consultations are fully recorded and accessible.³⁹

Extending opening hours

Evidence also indicates that patients are keen for GP opening hours to be extended. Research by the Picker Institute found that 21% of patients were sometimes or often deterred from going to their GP because of inconvenient opening times, while 69% of patients wanted surgery opening times to be extended.⁴⁰

It is not just patients who are suffering from a lack of extended opening hours. A recent report by the CBI argued that restricted opening hours of GP surgeries result in employers losing up to £1

37 Rita Cusumano, “Out of hours service: Assurance following CAMIDOC serious untoward incident: Penny Campbell,” Enfield Primary Care Trust, www.enfieldpct.nhs.uk/foi/foi_docs/6227_revised_board%20report%20final.doc.

38 Ben Bradshaw, “Response to the report of the panel overseeing the serious untoward incident investigation into the death of Penny Campbell,” Department of Health (2007): www.dh.gov.uk/en/Healthcare/Out-of-hours/index.htm.

39 Department of Health, *The Primary Medical Services (Out of Hours Services) Directions 2006* (London: HMSO, 2006).

40 Peter Cross, *GP Access: Are You Really Improving This?* (Oxford: Picker Institute Europe, 2006).

billion every year as a result of people taking 28 million hours off work to visit their GP. The CBI suggested that more competition between primary care providers should be introduced to encourage practices to extend opening hours in order to attract patients.⁴¹

This concern about access to GP services has been acknowledged by the government. In response to the CBI report, health secretary Alan Johnson stated that the days when GP surgeries were open “nine to five and closed at weekends and sometimes closed during the week ... has to change.”⁴² This sentiment was also emphasised in Lord Professor Ara Darzi’s interim review of the NHS, which announced that the government’s “guiding principle will be to ensure that any member of the public can access GP services at any time between 8am and 8pm, seven days a week.”⁴³ This would be achieved by introducing 150 GP-led health centres, as well as ensuring that “at least half of all GP practices will open each weekend or on one or more evenings each week.”⁴⁴ Like the CBI, Darzi believes that opening up the primary care provider market will help achieve this goal: “Where existing GPs do not start to offer these extended services, PCTs will be able to use the funding we make available for this to commission new services from other GPs, GP federations or other providers.”

Productivity

There is little evidence that the QOF scheme has succeeded in its twin aims of incentivising quality and improving productivity. The Health Committee Report on Workforce Planning states that the new GP contract may actually have *reduced* productivity.⁴⁵

CONSULTANT CONTRACTS

By the early 1990s, it was also becoming increasingly clear there was a need for better planning of consultants’ work and for a clearer definition of the role of the consultant within the NHS, particularly in relation to the split between their NHS work and private practice. In 1991, the Department of Health attempted to address these problems by requiring hospitals to use job plans to set out consultants’ working

41 CBI, *Just What the Patient Ordered: Better GP Services* (London: CBI, 2007).

42 Alan Johnson, cited in BBC News, “Call to reform ‘outdated’ GP care,” 17 September 2007: <http://news.bbc.co.uk/1/hi/health/6999264.stm>.

43 Ara Darzi, *Our NHS, Our Future: NHS Next Stage Review Interim Report* (London: HMSO, 2007), 25

44 *Ibid.*, 26

45 House of Commons Health Committee, *Workforce Planning*.

arrangements. These proved to be largely ineffective: in 1995 and again in 1996 the Audit Commission revealed concerns that many consultants lacked commitment to the NHS, and that most NHS trusts failed to plan the work of their consultants effectively.⁴⁶

In 1997 the BMA wrote to the government stressing the need for a new contract. The government agreed, and announced its aim to negotiate the first major revision of the consultant contract since the establishment of the NHS in 1948. The goal was to increase consultants' participation and productivity in the NHS.⁴⁷ This goal was reiterated in *The NHS Plan* of 2000.⁴⁸

The new contract was negotiated nationally between representatives of the UK health departments, the NHS Confederation, and the BMA. During negotiations, the government declared its aim of creating a "something for something deal, where consultants earn more, but only if they do more for NHS patients."⁴⁹ It was hoped that the contract would benefit all parties: consultants would get better pay and recognition for their NHS work, NHS employers would gain greater control and increased productivity and patients would be provided with a more flexible and responsive service.⁵⁰ The contract was designed to ensure that consultants came under greater NHS management control in return for a career structure and pay system that rewarded those who made a longterm commitment to the NHS and who improved service delivery.⁵¹

The new contract came into effect in April 2003. Under its auspices, a consultant's working week is organised into programmed activities (PAs). A full-time consultant is expected to work ten four-hour PAs

46 Audit Commission, *The Doctors' Tale: The Work of Hospital Doctors in England and Wales* (London: Audit Commission, 1995); Audit Commission, *The Doctors' Tale Continued: The Audits of Hospital Medical Staffing* (London: Audit Commission, 1996).

47 Department of Health, "Hospital consultants contract to be reformed as government sets out," Press release, 17 December 1998. "Pay Modernisation Agenda For NHS Staff" (Press release: 17 December 1998).

48 Department of Health, *The NHS Plan: A Plan For Investment, A Plan For Reform* (London: HMSO, 2000).

49 Alan Milburn MP (speech to the HR in NHS Conference, 2 July 2002): www.dh.gov.uk/en/News/Speeches/Speecheslist/DH_4000715.

50 National Audit Office, *Pay Modernisation: A New Contract for NHS Consultants in England* (London: HMSO, 2007).

51 Department of Health, *The NHS Plan: Proposal for a New Approach to the Consultant Contract* (London: HMSO, 2001).

per week. There are four types of PA: direct clinical care, supporting professional activities, additional NHS activities and external duties.⁵²

OUTCOMES OF THE NEW CONSULTANT CONTRACT

Increase in consultant pay

In the first three years of the new contract, consultants received an extra 27% in pay, increasing their average annual pay from £87,000 to £110,000 by 2005–6. Over the same period, the number of hours worked by full-time consultants for the NHS decreased by an average of 1.4 hours per week from 51.6 to 50.2 hours.

This rise in pay was greater than the Department of Health had anticipated: by the end of March 2006, it had spent £715 million on the new consultant contract – 27% more than the original estimate of £565 million. This additional cost is partly due to consultants' baseline workload being higher than anticipated – consultants have been performing more programmed activities than was predicted. A report by the King's Fund states that the funding formula used to determine the contract conditions was based on flawed financial and workload assumptions.⁵³ Not surprisingly, doctors' leaders have supported the growth in earnings.⁵⁴

Greater transparency

The contract has, however, provided greater clarity and transparency in the relationship between employers and consultants and has introduced some new managerial levers. It is now easier to ensure that consultants turn up for clinics, and the King's Fund report states that there is now a feeling that "consultants are more conscious that management could check that they are where they should be."⁵⁵ NHS trust managers can now see more clearly what roles consultants should be performing, while consultants themselves have a clearer idea about the contributions they should or should not be making at evenings and weekends. A report by the NAO lauds this gain in clarity, but goes

52 Sally Williams and James Buchan, *Assessing the New NHS Consultant Contract: A Something for Something Deal?* (London: King's Fund, 2006).

53 Ibid.

54 BMA, *Central Consultants and Specialists Committee Annual Report 2004* (London: BMA, 2004).

55 Williams and Buchan, *Assessing the New NHS Consultant Contract*.

on to argue that greater efforts must be made to ensure that job plans remain up to date and reflect the needs of the trust.

Private practice

Despite this, it appears that the new contract has made very little difference to consultants' commitment to their private practice. The NAO reveals that the amount of private practice work undertaken by consultants after the introduction of the new contract is almost identical to the amount undertaken previously.⁵⁶

Productivity and changes in working practice

Furthermore, notwithstanding the increase in wages for consultants, the contract has not resulted in greater productivity. In the first two years of the contract the number of consultants increased by 13%, but the amount of consultant-led activity increased by only 4%.⁵⁷ In addition, the aforementioned NAO report reveals that since the introduction of the new contract only 12% of consultants have increased the amount of time they spend on clinical care and that few trusts are using consultants' job plans as a lever for improving participation or productivity. The report found that, overall, few consultants or trusts believed that patient care had improved as a result of the new contract and that "the contract is not yet delivering the full value for money to the NHS and patients that was expected from it."⁵⁸ A King's Fund report has argued there is little evidence that the new contract has led to "any widespread changes in consultant working patterns or influence on patient care, as originally envisaged."⁵⁹

Why has the contract failed to improve productivity and change working patterns? The NAO report argues that one reason the contract failed to have a significant effect on the way in which consultants work was due to the short implementation timeframe given to trusts. Implementation difficulties are also highlighted in the King's Fund report, which reveals that the scale and complexity of the task was underestimated, leading to some trusts having to rush through implementation. The net result has been considerable variation both in the way trusts have approached the contract and in the outcomes

56 National Audit Office, *Pay Modernisation*.

57 Information Centre and Department of Health NHS activity data.

58 National Audit Office, *Pay Modernisation*.

59 Williams and Buchan, *Assessing the New NHS Consultant Contract*.

that have been achieved. Further negative consequences include the following: job-planning has often been process-driven rather than outcome-driven; many job plans have not truly reflected workloads; reviews of job plans have been variable; and, overall, objective-setting has been weak.⁶⁰

Another reason that the contract has not led to increased productivity is because of its time-based nature. The contract stipulates that a full-time consultant should work ten four-hour programmed activities a week. It has been argued that this focus on the clock has diverted the attention of management and consultants away from service needs.⁶¹ The King's Fund quotes a human resources director who reveals that, because the contract is hours-based, "the default is that we look at hours rather than the needs of the service." The contract has come to be regarded by some managers as "a box to be ticked – rather than a mechanism for change."⁶²

The NAO survey found that consultants' morale has been reduced in the process of implementing the contract. Specialist doctors have reported that they have lost autonomy under the deal, while the detailed job plans seem to have led to a culture of "clock-watching." Although consultants are now well remunerated and have greater clarity about their work, they also perceive a loss of autonomy and a diminution in their sense of vocation.⁶³

THE COST OF WORKFORCE REFORM

All the reforms to employment conditions discussed above have been hugely expensive. Agenda for Change, the GMS contract and the consultant contract have all led to substantial pay increases for staff. This has taken up a large chunk of the extra resources invested in the NHS since 2002. In 2005–6, 47% of this extra funding was spent on increases in pay.⁶⁴ The Department of Health now estimates that £2.2 billion will have been spent on implementing AfC by 2008–9,⁶⁵ and

60 Ibid.

61 National Audit Office, *Pay Modernisation*.

62 Ibid.

63 London medical director, cited in National Audit Office, *Pay Modernisation*.

64 House of Commons Health Committee, *Public Expenditure on Health and Personal Social Services 2006* (London: HSMO, 2005), Ev 10.

65 Ibid.

£444 million was spent on the new consultant contract by 2007–8.⁶⁶ The Department also estimates that spending on GP services rose by a third between 2003–4 and 2006–7.⁶⁷ The Health Select Committee report *Workforce Planning* reveals that in 2004–5 spending on AfC exceeded projections by as much as £220 million, on the consultant contract by £90 million and on the GP contract by £250 million.⁶⁸ What has this increase in funding bought?

Workforce flexibility

Achieving greater workforce flexibility was one of the driving ambitions of the reforms. A range of new clinical roles has been introduced and some efforts have been made to improve retention and increase productivity. However, according to the Health Select Committee, “the scale of progress on workforce reform pales in comparison with the scale of staffing growth and pay increases which took place over the same period.”⁶⁹

Productivity

Despite the huge investment of resources, an increase in productivity has also been difficult to achieve. As the Department of Health now acknowledges, a rapid growth of resources tends actually to diminish enthusiasm for increasing productivity.⁷⁰ This point is stressed by the Health Select Committee, which states that in the context of the expansion in staff numbers and pay levels, the drive to increase productivity has received relatively little attention.⁷¹ The committee states that workforce productivity is an essential goal that has been neglected by the workforce planning system. This sentiment is supported by Karen Bloor of the University of York, who argues that *before* increasing the size of a workforce it is essential to ensure that the existing workforce is functioning effectively.⁷²

CONCLUSIONS

66 Ibid.

67 Ibid.

68 House of Commons Health Committee, *Workforce Planning*.

69 Ibid.

70 Department of Health, *Explaining NHS Deficits: 2003/4–2005/6* (London: HMSO, 2007), 6.

71 House of Commons Health Committee, *Workforce Planning*.

72 K. Bloor and A. Maynard, *Planning Human Resources in Health Care, Towards an Economic Approach: An International Comparative Review* (Ottawa: Canadian Health Services Research Foundation, 2003).

It is clear that substantial workforce reform within the NHS was necessary, not simply because of low pay, but because existing modes of working were flawed in themselves, and because they were incapable of meeting the aims set out in *The NHS Plan*. A significant proportion of the extra funding that has been injected into the NHS in recent years has gone on funding new contractual arrangements for general practitioners, hospital consultants and other NHS staff. Currently, however, there is scant evidence to suggest that these expensive new arrangements are delivering value for money in the form of productivity gains. It is vital that the new working arrangements begin to do so within a short timeframe. When the anticipated NHS funding slowdown begins to bite, we can expect further scrutiny to be placed on working arrangements in the service, as politicians attempt to lever improvements in the standards of care patients receive without the injection of large sums of additional cash. This will ensure that the topic of workforce reform remains a live one for the foreseeable future.

The SMF Health Project will go on to consider the implications of the workforce reform package, both its success and failures to date, in the context of the wider delivery of reforms described elsewhere in these background papers.

3 INCREASED DIVERSITY OF SUPPLY

INTRODUCTION

The first stage of the government's reforms post-1997 was to set minimum standards across the health service to ensure improved access to key treatments and to renew the physical infrastructure through hospital building. Stage two of the reform was to widen diversity of supply to create new incentives for better local performance and more choice for patients.

The government has attempted to open up the supply side in healthcare in three ways: by expanding existing capacity and establishing new types of NHS provision, by reforming the funding of hospital treatment (see below) and by making greater use of the independent sector. These changes had the stated aims of extending patient choice and increasing capacity, encouraging innovation, and introducing new ways of working.⁷³

EXPANSION OF NHS CAPACITY

There has been significant investment in improving both the quantity and quality of NHS capital facilities. For example, the government is on track to deliver its 2001 commitment to complete more than 100 hospital schemes by 2010. A study by Carol Propper, cited by Professor Julian Le Grand, found that in 2002 (soon after the introduction of the current reforms) as many as 98% of the population lived within an hour's travel time of up to 100 available and unoccupied NHS beds, and 76% lived within an hour's travel of 500.⁷⁴

Around two-thirds of the new hospital schemes are being delivered through the Private Finance Initiative (PFI), originally introduced by the Conservative Government. Under a PFI scheme, a hospital is designed, built, financed and managed by a private-sector consortium, under a contract that typically lasts for 30 years.

73 Department of Health, *Technical Notes for Choice at Referral: Guidance Framework for 2006/7* (London: HMSO, 2006), 3.

74 Le Grand, "The Blair legacy? Choice and competition in public services." Public lecture, London School of Economics, 21 February 2006: www.lse.ac.uk/collections/LSEPublicLecturesAndEvents/pdf/20060221-LeGrand.pdf

Critics of PFI claim that, as with any form of hire purchase, buying a product over a long period of time is more expensive than paying “up front.” They point out that governments can borrow cash at a cheaper rate than the private sector, and public-sector accountants claim that hospitals and schools would be cheaper to build using traditional funding methods. There is also a question mark over how much risk is genuinely transferred to the private sector: it has been argued that the government must underwrite the risk to some degree, because it would be politically impossible to allow a hospital to go bankrupt. There is also concern that the long contracts will force the NHS to have a very inflexible building programme over the next decade. As PFI schemes have been the result of several major studies, including in work carried out by SMF, they are not discussed in detail in this paper.⁷⁵

INDEPENDENT-SECTOR INVOLVEMENT

After their election win in 1997, Labour’s first secretary of state for health, Frank Dobson, was opposed to the use of the private sector in the provision of healthcare. However, he was replaced in 1999 by Alan Milburn, one of the “architects of New Labour”,⁷⁶ and the subsequent *NHS Plan*, published in 2000, proposed a partnership between the independent (private and voluntary) sector and the NHS: the so-called concordat. The principal reason for this agreement was to increase capacity rapidly, in order to make rapid headway on waiting times.

At the end of 2002, the government decided to commission a number of independent sector treatment centres (ISTCs) to treat NHS patients requiring straightforward elective treatments and diagnostic procedures.⁷⁷ This first phase of the ISTC programme began in 2003, in selected areas of the country. In this phase, in order to ensure that they added to capacity rather than simply replaced existing NHS services (“additionality”), ISTCs were forbidden from hiring anyone who had worked for the NHS in the previous six months. A second, more widespread, phase of the programme was announced in March 2005, extending independent-sector provision into community diagnostic and treatment services. This involved covering additional medical

75 Ann Rossiter (ed.) *The Future of the Private Finance Initiative* (London: Social Market Foundation, 2004).

76 Patrick Wintour, “New Labour duo pitch for post-Blair agenda,” *Guardian*, 29 March 2006: www.guardian.co.uk/budget2006/story/0,,1741916,00.html.

77 Department of Health, *Delivering The NHS Plan* (London: HMSO, 2002), 6.

conditions, increasing the involvement of directly employed NHS staff in independent-sector clinics, and championing a policy of integration over the principle of additionality. As a consequence, all ISTCs are now obliged to offer training to NHS staff, if required locally.⁷⁸

ISTCs have received mixed reviews. The report of the House of Commons Health Committee found they had not made a substantial contribution to increasing NHS capacity. The report suggested that a number of ISTCs were operating significantly below capacity, which “casts doubt on the assertion that ISTCs were necessary to increase capacity.”⁷⁹ A similar picture was presented in the *Health Service Journal (HSJ)*, in October 2007. The *HSJ* declared that only 5 out of 22 ISTCs were performing at or above the contracted level, with “several operating at only around 50% of contracted value.”

As a result of the huge increase in capacity in the NHS that has occurred over the past seven years, it appears that a shift in emphasis away from the need to increase capacity further is now occurring. In *Our NHS, Our Future*, Ara Darzi states: “As we move from expanding capacity to focus on creating a more personalised service, so the focus of the independent sector should shift to helping services locally to respond quickly to patients’ needs.”⁸⁰ The second wave of ISTC contracts are therefore based on significantly different terms from those of the first wave, and on 25 July 2007, Alan Johnson told the Commons Health Select Committee that there would be no third wave of ISTC procurement undertaken centrally.⁸¹ Despite the Health Select Committee’s scepticism about the effect that ISTCs have had on capacity, it did find that patient choice had been increased, with more locations and earlier treatments on offer.⁸²

Several commentators have expressed concerns that ISTCs would “cream-skim” those operations that are most profitable.⁸³ The

78 House of Commons Health Committee, *Independent Sector Treatment Centres. Fourth Report of Session 2005–06*, vol. 1 (London: HMSO, 2006), 10.

79 *Ibid.*, 18.

80 Ara Darzi, *Our NHS, Our Future: NHS Next Stage Review Interim Report* (London: HMSO, 2007), 30.

81 Rebecca Smith, “Alan Johnson to limit private sector in NHS,” *Daily Telegraph*, 26 July 2007: www.telegraph.co.uk/news/main.jhtml?xml=/news/2007/07/26/nhosi226.xml.

82 House of Commons Health Committee, *Independent Sector Treatment Centres*, 10.

83 Unison, *In the Interests of Patients? The Impact of the Creation of a Commercial Market in the Provision of NHS Care* (London: Unison, 2007), 10.

government and other defenders of the scheme have recognised this as an important issue, but view the prevention of “cream-skimming” as a matter of good system design.⁸⁴ They describe, for example, the need to put in place funding regimes that reflect the higher costs of providing a service for certain groups. Regulatory and statutory guidance can also be used to prevent inappropriate selection.⁸⁵

It would seem slightly premature to describe this as any kind of break with the reforms set in motion during Tony Blair’s time in office, and, in any case, new contracts are still being signed with second-wave ISTC providers (e.g., a contract with Capio to provide 11,000 orthopaedic and general surgery procedures per year in Lancashire and Cumbria, signed on the same day Alan Johnson made his announcement regarding “no third wave”).⁸⁶

As such, issues surrounding ISTCs remain fruitful areas of further research for the SMF Health Project. Specific areas of investigation include:

- What problems are there with ISTCs, and how should these be overcome? In particular, does the provision of “guaranteed volumes of patients” reduce the likely value for money delivered by ISTCs?⁸⁷
- Does the NHS still require additional capacity? If not, do ISTCs still have value in introducing competition, choice and innovation?
- Are ISTCs meeting patient demand for a diverse range of services? What other choices might patients want to have on offer?

84 Pedro P. Barros, “Cream-skimming, incentives for efficiency and payment system,” *Journal of Health Economics* 22 (2003), 419–43.

85 The Prime Minister’s Strategy Unit, *The UK Government’s Approach to Public Service Reform: A Discussion Paper* (London: Cabinet Office, 2006), 10.

86 “Patients in Cumbria and Lancashire to benefit from extra healthcare provider,” Department of Health, 25 July 2007: www.gnn.gov.uk/environment/fullDetail.asp?ReleaseID=302613&NewsAreaID=2&NavigatedFromDepartment=False.

87 Nicholas Timmins, “Use of private health care in the NHS,” *BMJ* 331(2005), 1141–2.

FOUNDATION TRUSTS

Alongside ISTCs, one of the most controversial reforms of the NHS has been the creation of foundation trusts – self-governing acute hospitals with a large degree of independence from central control. Foundation trusts have played a key role in enabling market pressures to be introduced to the NHS: trusts have changed from operating as providers of “block”, fixed-cost services to health authorities, to providers of services commissioned by PCTs and, increasingly, through payment by results (PbR), providers of tariffed, single-unit treatment services, often in competition with independent-sector providers. It is government policy that all trusts should have foundation status by the end of the 2008, although it is not yet clear whether this goal will be achieved in time.

Foundation trusts were controversial at their inception, with certain MPs and trade unions objecting to the prospect of independently run hospitals, complaining that they undermined the collective ethos of the NHS.⁸⁸ However, the success of foundation trusts will be easier to judge when all hospitals are operating with the same advantages, possibly at the end of 2008. It is then that evidence will emerge that shows whether providers with the degree of autonomy afforded to foundation trusts are capable of creating the diverse market that is necessary for choice-based systems to operate effectively.

Nevertheless, it is currently possible to identify some strategic goals for foundation trusts that require further investigation. Monitor, the foundation trust regulator, cites “innovation” as one of the scheme’s key qualities.⁸⁹ However, the link between innovation in clinical care or hospital management and foundation trust status has not yet been properly explored.

A useful area for further research by the SMF Health Project would be the potential impact of the takeover of Good Hope hospital in Birmingham by the Heart of England Foundation Trust. This takeover, the first of its kind, took place early in 2007. It is the first time that one

88 Press release: “Public give foundation hospitals the thumbs down in latest NOP poll,” *Unison*, 18 November 2003: www.unison.org.uk/asppresspack/pressrelease.asp?pmo=11&py=2003.

89 “NHS foundation trusts,” Monitor: Independent Regulator of NHS Foundation Trusts: www.monitor-nhsft.gov.uk/register_nhsft.php.

NHS trust has taken over the running of another, rather than merging to create a completely new body. Could this provide a partial solution to the challenges of managing the exit from the market of providers in the NHS?

Regulation could also become an issue, as more trusts gain foundation status. Currently, there is an uneasy division of labour between Monitor and the Healthcare Commission (the regulator of all other healthcare providers). The picture is further complicated by government plans to introduce a new “stronger health and social care regulator.”⁹⁰ A proper regulatory framework is key to enabling informed choice, as patients can be reassured about the providers by whom they choose to be treated. Further work is needed to identify how to regulate a more diverse provider market, and how existing agencies should develop to facilitate this process. This too could be a fruitful avenue for further research by the SMF Health Project.

The impact of foundation trusts on their local health economies is also yet to be fully understood. Critics have warned that foundation trusts will dominate their local area, making it difficult for PCTs to commission effectively. As PbR rolls out across the NHS and newly consolidated PCTs establish themselves, it will be necessary to re-examine the balance between commissioner and provider power in the acute sector.

In summary, then, possible areas of further research in this area for the SMF Health Project include:

- Are foundation trusts capable of ensuring the kind of diversity of provision that is required for choice mechanisms to be feasible and worthwhile?
- What lessons can be learned from the Good Hope takeover for the management of “failing” providers in the new “choice-driven” NHS?

90 The Prime Minister, “Legislative Programme Statement,” 10 Downing Street, 11 July 2007: www.pm.gov.uk/output/Page12422.asp.

- Does the current disengagement between foundation trusts and the public auger badly for the drive towards increased localism in the NHS as whole?
- Can the existing regulatory framework cope with the demands of an increasingly diverse set of NHS providers? In particular, how well do the different regulatory bodies currently communicate with one another, in order to facilitate the spread of best practice across the NHS?
- Have the fears that powerful foundation trusts will dominate local health economies (to the detriment of PCTs) proven well-founded?

ACCOMPANYING FINANCIAL REFORM

The reforms discussed above were introduced to increase diversity of supply, which it was hoped would enable patient choice and encourage innovation. To allow patient choice to operate, the provider reforms were accompanied by the introduction of a new funding mechanism: payment by results (PbR). Under the PbR scheme, hospitals and other service providers are paid a fixed price for each patient's completed stay in hospital or service received. The amount is based on the averaged cost of the procedure, based on costs of all providers in England, and then adjusted by a market forces factor (MFF) – a mechanism for taking into account local staff, building and land costs – to arrive at a trust-specific tariff. The original aim was for the completion of a comprehensive national tariff for services by 2008, with full implementation of the new financing arrangements completed in the same year. By the accounting year 2006/7, PbR tariffs applied to around two-thirds of hospital activity. (For more discussion of PbR, see Background Paper 3, Commissioning Healthcare.)

THE ROLE OF THE PRIVATE SECTOR

Institutionalised choice within the NHS is relatively recent, and many patients have chosen to be treated outside the health service. In all the discussions about the health system in the UK, it is often forgotten that while the NHS is clearly the single most important health provider, the private sector also plays a significant role. Private-sector capacity

used by the NHS is discussed elsewhere in this paper, while this section focuses on the often overlooked significance of private medical insurance and self-payment for medical care.

Many people pay for private healthcare, either through insurance or direct payments for medical treatment. According to market analysts Laing & Buisson, 12.2% of the population are covered by private medical insurance (PMI) plans.⁹¹ Although this overall figure has remained relatively static over the past ten years, the number of people with individual PMI policies has declined to 1.1 million in 2006 from a peak of 1.48 million in 1996.⁹² However, corporate insurance policies have increased in popularity, with more people now covered by a policy provided by their employer. Spending on medical insurance products was £3.65 billion in 2006.⁹³

Is demand for PMI simply a reflection of failure in the NHS? This view has been widely expressed, especially because of the long-term media focus on NHS waiting lists. Most PMI policies exclude primary care and chronic conditions, instead concentrating on acute elective hospital care, and this has led some commentators to argue that demand for these products will disappear as NHS waiting lists decline. In 2004, then BMA chairman James Johnson warned that the private-sector providers "stand to lose perhaps half of their corporate business as waiting lists fall, because employers will no longer feel the need to insure their employees in order to get them back to work quickly."⁹⁴ However, it is interesting to note that demand for private insurance has remained stable for several years despite the fall in waiting lists. This indicates that the insurance market is likely to maintain its role in the overall UK health system in the years to come.

So the empirical evidence suggests that PMI is not simply an overflow system for the NHS, but meets a separate demand for healthcare. This might be for a level of service that the NHS can never be reasonably expected to provide (such as immediate diagnostic

91 Laing and Buisson, *Health & Care Cover: UK Market Report 2007* (London: Laing and Buisson, 2007).

92 Ibid.

93 Ibid.

94 James Johnson, cited in BMA, "Speech from the chairman of the council," BMA: www.bma.org.uk/ap.nsf/Content/ARM04chCouncil.

tests) or because there is a core of people who do not wish to use the NHS whatever its level of service.

Private medical insurers assert that the independent sector treats nearly a million patients a year – procedures that would otherwise have to be carried out by the NHS.⁹⁵ Additionally, research from the CBI suggests that insurance plays an important part in getting people back to work promptly after they fall ill, possibly saving some 2.5 million working days that would otherwise have been lost.⁹⁶ Some have argued that the government should put in place incentives to encourage people to take out medical insurance – notably the Association of British Insurers.⁹⁷ However subsidies for private payments have proved politically unpopular, with the Conservatives moving away from their “Patient Passport” policy. It has been argued that it is unfair to subsidise those who can afford to be treated privately, and that government incentives would make little difference to demand for medical insurance.

The SMF Health Project could ask:

- Is there a political, economic or health case for providing incentives to purchase private medical insurance? In particular, is there anything to be learnt from the allowed roles and incentive structures of PMI in Australia, the Netherlands and Israel (as described in Background Paper 1 in more detail)?

CONCLUSIONS

Attempts to increase diversity of provision in the NHS have often taken the form of introducing new private providers. ISTCs are a notable example of this. While this has certainly improved diversity in a market sense – there are more providers competing for patients – there may be a tension between what policy-makers and patients understand to be a truly diverse range of providers. Patient expectations of health services are discussed in detail in Background Paper 5. However, in this discussion of reform to the health service provider market it should

95 “Your questions answered,” Making Britain Healthier: www.makingbritainhealthier.co.uk.

96 CBI, *Who Cares Wins: Annual Absence and Labour Turnover Survey* (London: CBI, 2005).

97 Cover Magazine, “ABI calls for tax breaks on group PMI policies,” *Incisive Media*: www.covermagazine.co.uk/public/showPage.html?page=153803.

be remembered that patients seem largely indifferent to whether their provider is publicly or privately owned so long as the treatment they receive is safe, effective and free at the point of delivery. As a Department of Health spokesman said in 2001: "Patients don't care who is providing the care as long as they are getting the treatment they need."⁹⁸ It is important to measure success in creating a diverse range of service against the priorities of patient choices rather than simply the different types of provider on offer.

The reforms described above are largely consistent with the conditions that must be met for choice systems to be effective. The government has tried to make choice for patients meaningful both through liberalising the supply market and changing financial flows in the NHS so that providers are given incentives to respond to patient choice. We would therefore expect that the system should be operating with some degree of success.

However, there are some areas that require care, and further thought. We need to ensure that competing incentives do not result in unintended consequences for the NHS, such as increased activity at the expense of levels of efficiency. What needs to be put in place to ensure that our choice system effectively manages demand? Moreover, while choice and competition might be effective tools to empower patients and to change the behaviour of providers, they are not universally welcomed. For example, the 2006 Inpatients Importance Study recommended the deletion of the question "Were you given a choice about what hospital you were admitted to?", on the ground that choice is not sufficiently important to patients.⁹⁹ The BMA has argued that private-sector provision should be limited to areas where the NHS identifies a need it cannot meet.¹⁰⁰ Are the benefits of choice and competition demonstrable beyond reasonable doubt? More importantly, and as we hope to have made clear in many of the avenues for further research set out above, are choice mechanisms cost-effective tools for improving the NHS?

98 "Milburn's overseas recruitment drive," BBC News, 7 November 2001: <http://news.bbc.co.uk/1/hi/health/1641483.stm>.

99 Jason Boyd, *The 2006 Inpatients Importance Study* (Oxford: Picker Institute Europe, 2007), 2.

100 BMA, *A Rational Way Forward for the NHS in England: A Discussion Paper Outlining an Alternative Approach to Health Reform* (London: BMA, 2007).

4 RECONFIGURING HOSPITAL SERVICES

INTRODUCTION

One of the more recent aspects of government reform of the NHS has been the drive to shift the focus of care from the hospital to the community. While attention in the early years of *The NHS Plan* was on reducing waiting times and improving hospital care, 2006 saw a change in emphasis with the publication of the White Paper, *Our Health, Our Care, Our Say*.¹⁰¹ This set out an ambitious aim for the NHS: to shift the focus of care away from the hospital and into the community.¹⁰²

This whole policy agenda should be seen in the context of the split between primary and secondary care enshrined at the establishment of the NHS in 1948. Although this model has functioned effectively for the best part of 60 years, it is clear that integrated care is not provided in the same way as it is, for example, under Kaiser Permanente in the USA. Additionally, there are fears that large secondary care providers can inadvertently increase the amount of expensive hospital care available on the NHS simply because “many services are provided in hospital merely due to tradition.”¹⁰³

While the general aim of moving care closer to home has been broadly welcomed,¹⁰⁴ some concerns have been raised that it could destabilise existing providers and undermine the NHS during a period of financial strain.¹⁰⁵ However, the government argues that delivering care closer to home has the potential to raise patient satisfaction, make efficiency savings, and improve clinical outcomes.¹⁰⁶

101 Department of Health, *Our Health, Our Care, Our Say: A New Direction for Community Services* (London: HMSO, 2006).

102 *Ibid.*, 17.

103 Debbie Singh, *Making the Shift: Key Success Factors. A Rapid Review of Best Practice in Shifting Hospital Care into the Community* (Birmingham: NHS Institute/HMSC, 2006), 1.

104 Richard Lewis, “A new direction for NHS community services,” *BMJ* 332 (2006), 315–16.

105 “GP: Providing healthcare closer to home,” BMA www.bma.org.uk/ap.nsf/Content/Providinghealthcarecloserhome#Summary.

106 Department of Health, *Our Health, Our Care, Our Say*.

MOVING HEALTHCARE OUT OF HOSPITAL

Recent government policy papers have envisaged a health system in which less complex procedures in certain specialties are provided in community facilities such as GP practices, newly established clinics or perhaps even in patients' homes. These would be backed up by regional centres that provide specialised care that cannot be delivered in a community setting.¹⁰⁷ A report into the future of health services in London argued for more centralisation of specialised services, with polyclinics supplying the vast majority of routine healthcare needs.¹⁰⁸

Our Health, Our Care, Our Say identified six medical specialties in which new clinical pathways could be defined to deliver more care outside hospitals: dermatology; ear, nose and throat medicine; general surgery; orthopaedics; urology; and gynaecology.¹⁰⁹ However, the evidence supporting this shift in service provision is not particularly strong. A major review into shifting care into the community warned that, while studies at home and abroad are analysing the *potential* benefits of transferring care into community settings, there is not yet a great deal of quality information available to policy-makers regarding *actual* benefits. Additionally, experience gained from international studies may not be translatable to the UK.¹¹⁰

In light of the above, the SMF Health Project might investigate the following questions:

- What is the evidence on the actual efficacy of shifting care into the community?
- Are the clinical specialities which have been identified genuinely suitable for a major shift in the location of care provision?

107 *Ibid.*, ch.6.

108 Ara Darzi, *Healthcare for London: A Framework for Action* (London: NHS London, 2007), 90–1.

109 Department of Health, *Our Health, Our Care, Our Say*, 9.

110 Singh, *Shifting Care* (FULL DETAILS NEEDED), 5.

PATIENT DEMAND AND SATISFACTION

One of the major drivers for moving healthcare out of hospitals is patient demand: over 50% of people questioned say they support provision of more services closer to home even if this means that some large hospitals merge or close.¹¹¹ Patients also have positive perceptions about community services, believing that they will offer better customer service.¹¹²

However, when plans to downsize or close hospitals become real, the result has often been widespread local opposition. Therefore, although the government may wish to bring the NHS into line with other international health systems by increasing the proportion of care provided in community settings,¹¹³ we should remember that the public is often reluctant to accept the inevitable consequences of such a shift.¹¹⁴ The political problems of NHS reconfiguration are enormous. Local people are very attached to existing hospitals, and there have been protests across the country at plans to reconfigure services. It is easy for opponents of change to characterise reconfiguration as “cuts”, and even some government ministers have led protests in their constituencies. As well as all the arguments about the effectiveness of moving care out of hospitals, just as pertinent is the problem of communicating the need for change to the public.

Some commentators have seen this issue in the context of how the NHS sets priorities. Richard Lewis asks how far patient views should be taken into account relative to clinical and financial factors when designing services: “The proportion of NHS resources directed towards these innovations and their cost effectiveness should be carefully monitored.”¹¹⁵

111 Opinion Leader Research, *Your Health, Your Care, Your Say* (London: OLR, 2006), 118; Department of Health, *Our Health, Our Care, Our Say*, 148–9.

112 OLR, *Your Health, Your Care, Your Say*, 18.

113 Department of Health, *Our Health, Our Care, Our Say*, 140.

114 OLR, *Your Health, Your Care, Your Say*, 112.

115 Department of Health, *Our Health, Our Care, Our Say*.

Given the foregoing, potentially fruitful areas of further study by the SMF Health Project include:

- Is patient satisfaction likely to improve as a result of transferring care into a community setting, given local opposition to some of the inevitable consequences of this shift?
- How should we strike the balance between providing service reconfigurations that are popular with patients and ensuring the cost- and clinical-effectiveness of those interventions?
- How can service providers overcome local political opposition to moving healthcare out of hospitals?

SAVING MONEY THROUGH MOVING SERVICES

Another argument for moving healthcare out of hospitals and into the community is that it saves money. With spending increases for the NHS set to slow after 2008, the Department of Health argues that “the health service will need to focus even more strongly on delivering better care with better value for money. Finding new ways to provide services, in more local settings, will be one way to meet this challenge.”¹¹⁶ The Department argues that up to 50% of outpatient appointments in some specialties could eventually be provided in community settings.¹¹⁷

Unfortunately, there is a paucity of evidence to back up the claim that shifting the focus of care could save money. The Audit Commission report, *Quicker Treatment Closer to Home*, examined the success of PCTs in redesigning care pathways. Of the ten PCTs studied in detail, only two had detailed measurements about the cost-effectiveness of service redesign.¹¹⁸ A review of NHS experience of shifting care found that the evidence was not detailed enough to draw firm conclusions.¹¹⁹

Reasonable evidence does however exist for one policy partly aimed at reducing hospital outpatient appointments: the introduction

116 Ibid., 129.

117 Ibid., 135.

118 Audit Commission, *Quicker Treatment Closer to Home: Primary Care Trusts' Success in Redesigning Care Pathways* (London: Audit Commission, 2004).

119 Helen Parker, *Making the Shift: A Review of the NHS Experience* (Birmingham: NHS Institute/HMSC, 2006), 5.

of GPs with special interests (GPwSI). These are GPs with special training in a specific area who provide forms of care that would otherwise only be available in secondary settings.¹²⁰ A research summary published in the *British Medical Journal* found that GPwSIs do not reduce NHS costs. In dermatology (one of the specialties identified by the government as a candidate for reconfiguration), GPwSI consultations were 75% more expensive than those provided in specialist clinics. Several studies also associate GPwSIs with increased hospital referrals.¹²¹

For its part, the British Medical Association is sceptical about the potential for genuine and lasting cost savings from service reconfiguration, although it accepts there are cases where a shift in the location of care can be justified on clinical grounds.¹²²

In sum, there is limited evidence that shifting care into the community will result in cost savings for the NHS, and such evidence as does exist suggests that cost-savings might be difficult to achieve.

Therefore, the SMF Health Project might investigate:

- To what extent are NHS trusts measuring the cost-effectiveness of reconfiguration projects? How can they improve their evidence gathering?
- What can be learned from the evidence on GPwSIs? How can we ensure that further service reconfiguration actually produces cost savings?

IMPROVING STANDARDS OF CARE

Finding sound evidence on the potential for community-based services to provide high-quality care is crucial to the overall success of this policy. Services should not be moved out of hospitals unless it can be shown that equal or better outcomes can be achieved in a different setting.

120 "GP with a special interest," Royal College of General Practitioners: www.rcgp.org.uk/default.aspx?page=5221.

121 Martin Roland, "GPs with special interests – not a cheap option," *BMJ* 331 (2005), 1448–9.

122 "Hospital Reconfiguration: good practice guide," BMA, 4 May 2007: www.bma.org.uk/ap.nsf/Content/Hospitalreconfiguration040507.

However, the evidence on this issue is, so far, rather mixed. Following the publication of *Our Health, Our Care, Our Say*, the government set up the Care Closer to Home Programme to evaluate care pathways and models of care in the six specialities identified as having particular potential for reconfiguration. A report on this project was published in May 2007, concentrating on the challenges of clinical redesign.¹²³

The report analyses the results from various pilot programmes that were set up as a result of *Our Health, Our Care, Our Say*. Unfortunately, the report states that reliable data was hard to come by, largely because of the relatively small numbers of patients who participated in the pilots.¹²⁴ However, the report did put forward a framework for predicting the factors most likely to bring about improvements in standards of care. Amongst the most salient of these are goodwill towards the programme amongst frontline workers and stakeholders, clearly designed projects with measurable outcomes, good leadership (including clinical leadership) and project management, and proper training and support for staff.¹²⁵

There is some international evidence that clinical outcomes can be improved through better integration of services, including a greater proportion of care being delivered in a community setting. Although it is controversial, the example of the American HMO Kaiser Permanente has been influential in changing policy in the UK. Professor Chris Ham, then director of strategy at the Department of Health, said of Kaiser's success in minimising the use of acute hospital beds: "Compared with the NHS, more care is delivered in a community setting, and this includes the use of intermediate care, home care and self-care by patients."¹²⁶ However, some researchers highlight significant differences between Kaiser and the NHS, most notably the larger number of specialist clinicians in the American system.¹²⁷

123 Chris Ham et al., *Getting the Basics Right: Final Report on the Care Closer to Home: Making the Shift Programme* (Birmingham: NHS Institute/HMSc, 2007).

124 *Ibid.*, 5.

125 *Ibid.*, 6.

126 National Primary and Care Trust Development Programme, "Professional Executive Committee Paper 2: learning from Kaiser Permanente," NATPACT: www.natpact.nhs.uk/uploads/pecpapers2-kaiser.pdf.

127 King's Fund, "The reconfiguration of hospital services," King's Fund, November 2006: www.kingsfund.org.uk/publications/briefings/the_1.html.

In their review, the National Primary Care Research and Development Centre found that, while shifting care into the community can improve access to specialists, the quality of care may actually decline and also be more expensive to deliver.¹²⁸

Overall, then, the clinical case for a greater proportion of care being provided in the community is still largely to be made. With this in mind, the SMF Health Project might investigate:

- What evidence can be gleaned from the pilot projects as they develop as part of the Care Closer to Home project?
- To what extent are current attempts to shift the location of care aligned with the factors identified above as being likely to produce improved standards of care?

NHS ORGANISATIONAL CAPACITY

Even assuming an evidence base can be built up to support the assertion that service reconfiguration has the *potential* to produce certain kinds of positive outcomes, questions remain about the ability of the NHS to implement successfully the changes necessary to shift care into community settings.

The greatest responsibility for shifting the focus of NHS provision lies with commissioning organisations. PCTs and practice-based commissioners are charged with designing a range of services to meet the needs of local people, and part of this role now includes moving care out of hospitals and into community settings. There is also great pressure on the national tariff to prove flexible enough to recognise and accurately price the diverse range of community-based services envisaged in *Our Health, Our Care, Our Say*.

Because reform remains at a relatively early stage, there is limited evidence on whether NHS organisations are commissioning in such a way as to shift the focus of provision into community settings. PCTs are certainly *required* to have a clear strategy for developing primary and community care, “including ambitious goals for the shift of resources

128 B. Sibbald, R. McDonald and M. Roland, “Shifting care from hospitals to the community: a review of the evidence on quality and efficiency,” *Journal of Health Services Research & Policy*, April (2007).

rooted in the vision and agenda of [*Our Health, Our Care, Our Say*].¹²⁹ PCTs will also be assessed annually as to their performance in this area, but this scrutiny begins in 2008. As such, there is limited information available at this time.

Nevertheless, there are some warning signs that PCTs will struggle to fulfil the ambitious goals set for them by central government. The *Getting the Basics Right* report points out that change in health organisations is often incoherent and takes longer than expected.¹³⁰ The report also concludes that the introduction of PbC has created uncertainty about what services will be preferred.¹³¹ We might therefore expect a great deal of local variation in performance as well as unintended consequences of reform.

Reforms to the national tariff are intended to make it easier for commissioners to provide more services locally. The tariff will start by being applied to community-based alternatives to acute hospital treatment.¹³² However, implementation of the tariff has not been smooth, and some have argued that it is difficult to establish the true costs of community-based treatments.¹³³

Another issue is that of medical education: are doctors being trained to deliver the new types of care envisaged as part of this reform agenda? Some authors have raised this question,¹³⁴ and it would seem to warrant further investigation.

129 Department of Health, *Our Health, Our Care, Our Say*, 140–1.

130 Ham et al., *Getting the Basics Right*, 41.

131 *Ibid.*, 18.

132 Department of Health, *Our Health, Our Care, Our Say*, 152–3.

133 Roger Kneebone, "GPs, operations and the community," *BMJ* 334 (2007), 5–6.

134 Rodger Charlton, "A new direction for community-based health services," *Clinical Medicine*, July–August (2006).

Furthermore, it is possible that the legacy of PFI building projects will shape the future of the NHS – hospital buildings must be used so that they can be paid for.

In sum, there are clearly some question marks over the ability of the NHS to put government reforms into practice. The SMF Health Project could investigate the following questions:

- To what extent are significant regional differences in services likely to occur as a consequence of the process of reconfiguration?
- Will reforms to the national tariff adequately reflect a community care-based system?
- Will practice based commissioners engage with the reform programme sufficiently to make a real difference to the types of services they commission?
- Is medical education changing in response to the aim of shifting care into the community?

CONCLUSIONS

The government has set out ambitious goals for the health service, which, if successful, will mean a fundamental shift in patterns of healthcare provision. The government argues that reforming healthcare to bring it closer to home will benefit patients who generally prefer local services. While there is certainly evidence to suggest that patients do prefer care delivered in convenient locations, further work is needed on the necessary trade-offs between patient priorities, best clinical practice, efficiency and the status of local acute general hospitals whose days might be numbered.

Regional variations in care will also be a challenge. Darzi's review of London health services proposed radical new models of service delivery, but it remains to be seen what the picture will be for the rest of the country.¹³⁵ This question is particularly important

135 Darzi, *A Framework for Action*.



given legitimate doubts about the capability of commissioning organisations to effect the changes set out in *Our Health, Our Care, Our Say*.

The evidence that care can be moved safely and cost-effectively into the community is thin. The NHS is working hard on pilot programmes that it hopes will demonstrate how patients can benefit from service redesign. However, the clock is ticking – PCTs will be assessed from 2008 on their plans for shifting care. Much more work is needed to show how innovation from within the NHS or without (e.g. Kaiser Permanente, European-style polyclinics, etc.) can be spread throughout the UK's healthcare system. This is a considerable challenge.

5 INFORMATION TECHNOLOGY SYSTEMS

INTRODUCTION

Information technology is a key factor in delivering improvements in healthcare, but according to a 2003 chief executive's report to the NHS, "there is a huge amount more to do."¹³⁶ Similarly, Derek Wanless in his report emphasised the particularly poor investment record that the UK health service has in information and communication technology, and highlighted the need for more investment in this area.¹³⁷ In response, NHS Connecting for Health came into operation on 1 April 2005, as an agency of the Department of Health. Its avowed aim is to "support the NHS to deliver better, safer care to patients, by bringing in new computer systems and services."¹³⁸

NHS CONNECTING FOR HEALTH

Under the NHS Connecting for Health banner, a number of schemes are being put in place to improve the running of the NHS. One such initiative that aims to revolutionise the patient experience is Choose and Book, a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic. Patients can choose their hospital or clinic and then book their appointment at a time convenient to them.

A number of other IT initiatives have been introduced in an attempt to improve patients' experience of the NHS and drive up efficiency and quality of care. These include:

- an electronic prescription service, which should allow prescribers, such as GPs and practice nurses, to send prescriptions electronically to a dispenser, such as a pharmacy, of a patient's choice;

136 Nigel Crisp, *Chief Executive's Report to the NHS* (London: Department of Health, 2003).

137 Wanless, *Securing our Future Health*.

138 "Connecting for health: A guide to the National Programme for Information Technology," NHS (2005): www.connectingforhealth.nhs.uk/resources/brochures/npfit_brochure_apr_05_final.pdf.

- GP2GP, which aims to enable patients' electronic health records to be transferred directly and securely between GP practices; if successful this will mean that GPs will have medical records available to them for a new patient's first consultation;
- NHS Care Records Service, which should give healthcare staff faster, easier access to information about patients;
- and the NHS number, a unique identifier that makes it possible to share patient information across the whole of the NHS, it is hoped in a safe, efficient and accurate way.

However, successful implementation of the programme presents significant challenges for the Department of Health, NHS Connecting for Health and the NHS generally, especially in three key areas:

- ensuring that the IT suppliers deliver systems that meet the needs of the NHS, and to agreed timescales, without further slippage;
- ensuring that NHS organisations can, and do, fully play their part in implementing the programme's systems;
- winning the support of NHS staff and the public in making the best use of the systems to improve services.

To these we might add the additional challenge of winning the public debate regarding the cost of the IT programme. A recent study by the London School of Economics and Oxford University reveals that the initial costs were originally set at £6 billion, but by April 2007 the House of Commons Committee of Public Accounts was recording planned national expenditure as £4.1 billion and related local expenditure as £8.3 billion. The authors of the LSE/Oxford report predict the final total figure will be in excess of £18 billion.¹³⁹

139 Chris Sauer and Leslie Willcocks, "Unreasonable expectations: NHS IT, Greek choruses and the games institutions play around mega-programmes," *Journal of Information Technology* 22 (2007), 195–201.

CONCLUSION

There can be no doubt that IT can have significant benefits for the NHS, including more flexible services (e.g., online booking appointments), fewer medical errors and significant cost savings. However, it seems that until fairly recently the NHS had not managed to take full advantage of these benefits. While NHS Connecting for Health was set up to improve the NHS IT programme, and while there may be some evidence to suggest it is making progress in this regard, it is clear that the challenges set out above are very demanding in nature.

In light of the above, it might be potentially fruitful for the SMF Health Project to devote aspects of its proposed empirical work stream to investigating the following questions:

- How well prepared are the major IT suppliers to ensure that the remainder of the NHS IT programme is delivered efficiently? What problems do these suppliers foresee? How might these problems be overcome?
- Are there any significant mismatches between the aims and objectives of the programme and the hopes and desires of frontline NHS staff? How well do frontline NHS staff understand the aims and goals of the programme? Are staff sufficiently prepared to use the new IT systems to maximal benefit when these become operational?



6 FACILITIES MANAGEMENT IN THE NHS

INTRODUCTION

The NHS has accumulated an enormous wealth of resources in the form of buildings and medical equipment. Communities in every area of the country have benefited from new facilities as part of a £10.6 billion investment since 1997 into NHS building schemes.¹⁴⁰ In conjunction with Strategic Health Authorities (SHAs), 160 new MRI scanners were allocated between 2000 and 2006 – a 150% increase since 1997.¹⁴¹

However, the anticipated NHS funding slowdown means there is a need to ensure that current facilities are used as efficiently as possible.¹⁴² Vital to this is good management of facilities.¹⁴³ In addition, the increasingly recognised importance of the healthcare environment to the quality of patient care has led to the emergence of “facilities management” as an important discipline within the NHS. The Department of Health defines facilities management as “the strategic development of the delivery of improved health outcomes through innovative, flexible and responsive estates and facilities solutions.”¹⁴⁴ Of course, it should be remembered that the effective use of NHS facilities is an issue closely connected to the productivity of the workforce (examined elsewhere in this paper).

Yet concerns remain that some NHS buildings and facilities remain significantly underused, with variations in efficiency both between and within individual NHS trusts. This chapter will review the evidence that underpins these claims, identifies possible causes of the inefficiencies and evaluates recent proposals to resolve them. Potential areas of further exploration over the course of the SMF Health Project will also be identified.

140 “Mapping the success of NHS Building Schemes,” Department of Health, www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Healthreform/DH_072391.

141 Parliamentary Debates, “Magnetic resonance imaging scanners,” *Commons Publication and Records*, vol. 420, col. 555W, 21 April 2004; www.publications.parliament.uk/pa/cm200304/cmhansrd/vo040421/text/40421w19.htm.

142 Chris Giles and Nicholas Timmins, “Brown cuts budget for English hospitals,” *Financial Times*, 29 June 2007.

143 John Locke, “Wasting your assets: How to make better use of the NHS estate,” *Health Service Management* 90, no. 5 (1994), 10–13.

144 Estates and Facilities Management,” Department of Health: www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Estatesandfacilitiesmanagement/index.htm.

INEFFICIENCIES IN NHS FACILITIES MANAGEMENT: THE EVIDENCE

Most of the available evidence on the efficiency of NHS facilities management concerns the use of day-surgery units and magnetic resonance image (MRI) scanners. Day surgery (when a patient is admitted to hospital, receives a surgical intervention and is discharged on the same day) is often viewed as having considerable advantages for the patient, the NHS and the taxpayer. There is no need for an overnight bed or overnight staffing of the unit. The procedures carried out tend to be more standardised and predictable, allowing for more efficient use of surgery hours and concomitantly shorter waiting times.¹⁴⁵ In 2000, *The NHS Plan* set a target of 75% of elective admissions for surgery to be undertaken as day cases.¹⁴⁶ Since then, there has been considerable support and commitment from the Department of Health and from the NHS Modernisation Agency, which promoted the substitution of day surgery for inpatient stays as one of its Ten High Impact Changes.¹⁴⁷ Crucially however, although the physical capacity of day-surgery units in terms of numbers of staffed beds, trolleys or reclining chairs has increased since 2001, this expansion does *not* seem to have been matched by proportionate increases in the numbers of patients treated.¹⁴⁸

MRI scanning is used to diagnose conditions such as cancer, multiple sclerosis, epilepsy, strokes and orthopaedic problems. From 1999 to 2004, approximately £38.5 million was spent on the provision of 57 MRI scanners via the New Opportunities Fund, in addition to approximately £33.5 million from Department of Health cancer funds.¹⁴⁹ However, despite the funding initiatives, MRI provision was identified by the 2002 Audit Commission report as lacking in many areas. There was unequal access and waiting times varied greatly between NHS

145 Healthcare Commission, *Acute Hospital Portfolio Review: Day Surgery* (London: Commission for Healthcare Audit and Inspection, 2005).

146 Department of Health, *The NHS Plan*.

147 "10 high impact changes for service improvement and delivery: A guide for NHS leaders," NHS Modernisation Agency: www.ogc.gov.uk/documents/Health_High_Impact_Changes.pdf.

148 Healthcare Commission, *Acute Hospital Portfolio Review*.

149 Parliamentary Debates, "Magnetic resonance imaging scanners."

Trusts.¹⁵⁰ The Commission found that although the median wait for an MRI scan was 20 weeks, at one in four departments it was more than 34 weeks.¹⁵¹

Given the foregoing, possible areas of further research for the SMF Health Project include:

- What are the reasons for the continued inefficiencies in day surgery and in MRI scanning despite the considerable investment in relevant facilities?
- How can efficiency levels be improved in these areas of service provision?
- Is there any evidence to suggest that the increased investment has actually played a causal role in driving the inefficiencies, echoing the point made above that efficiency levels ought to be improved prior to making major new investments?¹⁵²

CAUSES OF INEFFICIENT FACILITIES MANAGEMENT

A report published by the Healthcare Commission in 2005, which assessed working practices in 313 NHS day-surgery units, identified organisational failings as a key driver of inefficient facility usage. Almost half of day-surgery patients were not assessed for suitability before they arrived for their operation, and there was a lack of clear leadership in many units (with nearly 40% of units having no single consultant in charge). These organisational failings led to cancelled operations, short-running operating lists, gaps between patients that accounted for up to 45% of planned operating hours, and an overall average level of usage of 16 hours a week, at a time when NHS trusts were striving for average usage of 29.8 hours.¹⁵³

150 Healthcare Commission, *Acute Hospital Portfolio Review*.

151 "Review of Radiology Services: 2002," Audit Commission: www.auditcommission.gov.uk/reports/NATIONALREPORT.asp?CategoryID=&ProdID=AB95E11A-A6C1-4335-9482-9618441DB347.

152 Bloor and Maynard, *Planning Human Resources in Health Care*.

153 Healthcare Commission, *Acute Hospital Portfolio Review*.

A different set of reasons for the inefficient usage of MRI scanners has been put forward. Ian Leslie, a former president of the Royal College of Radiologists, highlighted the fact that many radiology reports are being sent abroad for interpretation, to countries such as Holland.¹⁵⁴ According to Janet Husband, also a former president of the Royal College of Radiologists, these foreign interpretations are much more likely to “hedge bets” and recommend further investigations, thus potentially increasing the inefficient use of NHS resources.¹⁵⁵

In addition, there are arguments that the causes of inefficient facility management are to be located in more systemic factors. Caroline Ward, a consultant radiologist at Kingston Hospital Trust, identified funding as the key issue.¹⁵⁶ She identified constantly rising demand for MRI scans in a fiscal context, where the trust is only paid to carry out 3,000 scans per year – regardless of how many are actually performed. This means that the MRI scanner has been left unused when “the current year’s budget has been fully spent.”¹⁵⁷ A different funding-based argument has been put forward by Richard Evans, chief executive of the Society and College of Radiographers. He has argued that the huge investment in NHS capital provision has not been matched by a proportionate increase in funding for the support infrastructure needed to run services efficiently.¹⁵⁸

The consequences of poor facilities management can be severe. The Healthcare Commission pointed to the ineffective use of facilities (such as the failure to establish an isolation ward in time) as one of the reasons behind for the fatal outbreak of *Clostridium difficile* (*C. difficile*) at Maidstone and Tunbridge Wells NHS Trust.¹⁵⁹

154 Ian Leslie, “Health Committee minutes of evidence,” *Publications and Records*, 9 March 2006: www.publications.parliament.uk/pa/cm200506/cmselect/cmhealth/934/93412.htm.

155 Janet Husband, “Health Committee minutes of evidence,” *Publications and Records*, 9 March 2006: www.publications.parliament.uk/pa/cm200506/cmselect/cmhealth/934/93412.htm.

156 Caroline Ward, cited in Jo Revill, “Private scan deal brings NHS chaos,” *Observer*, 24 April 2005.

157 *Ibid.*

158 Richard Evans, cited in: “Scanners stay switched off,” *Times Online*, 5 October 2004: www.timesonline.co.uk/tol/life_and_style/career_and_jobs/public_sector/article490658.ece.

159 Healthcare Commission, *Investigation into the Outbreak of Clostridium difficile at Maidstone and Tunbridge Wells NHS Trust* (London, Commission for Healthcare Audit and Inspection, 2007).

For such reasons, facilities management should not be separated from the management of the NHS in its widest sense. Failure to keep facilities clean and safe is an issue of much greater importance to patients than effective use of theatre time.

In light of the foregoing, there are several possible avenues of further investigation for the SMF Health Project:

- How serious are the organisational problems identified above? And what might be the interrelationship between these supposed problems: for example, does the lack of clinical leadership in day-surgery units contribute to the lack of adequate pre-operative assessment of patients? What might be done to tackle these organisational problems?
- How serious are the systemic causes set out above? Can we expect greater sensitivity in the way that MRI scans are funded as the national tariff evolves? How might we improve the support infrastructure surrounding capital investments, particularly when the anticipated funding slowdown begins to bite? Is this an area where we might have to lever productivity gains from what we have already, by, for example, encouraging staff to work in innovative ways?

PROPOSED SOLUTIONS FOR INEFFICIENT FACILITIES MANAGEMENT

In light of the political debate and the growing evidence base from independent studies, politicians, policy-makers and academics have proposed a variety of solutions to the problems of inefficient NHS facilities management.

Increased flexibility in working hours

Some researchers working in the field of facilities management have called for greater overall flexibility in working patterns and changes in “opening hours” in the healthcare estate.¹⁶⁰ Furthermore, in the context of new targets to cut NHS waiting times to a maximum of 18 weeks by the end of 2008, the government has proposed the introduction of round-the-clock surgery,¹⁶¹ whereby operating theatres are to open for longer in order to make more efficient use of facilities. A number of pilot schemes have been introduced. For example, in Yeovil District Hospital in Somerset, the staff work longer hours for four days a week in return for “time off in lieu” (TOIL). This hospital also uses “one-stop clinics” for cancer and orthopaedics, where patients see a consultant, undergo tests and get results all on the same day, instead of having several separate appointments.¹⁶² At the East Kent District Hospitals Trust, additional theatre sessions have been introduced during the day, in the evening and at weekends.¹⁶³ It is hoped that these initiatives will increase the number of operations performed, cutting down waiting lists and making better use of existing buildings and equipment.

However, the extension of operating theatre hours has sparked considerable debate. First, there are a number of arguments on grounds of clinical safety. The National Confidential Enquiry into Perioperative Deaths (NCEPOD) showed that elective procedures performed out of normal theatre hours are associated with higher rates of death and complications.¹⁶⁴ Furthermore, operating theatres require deep cleaning on a regular basis, especially if MRSA is not to become even more prevalent than at present.¹⁶⁵ Finally, some clinicians argue that operations already take place at night – namely, in emergency cases. Were operating hours to be extended in order to undertake more elective work, these procedures would simply have to be cancelled when emergency cases arrived.¹⁶⁶

160 Trevor Payne and David Rees, “NHS facilities management: a prescription for change,” *Facilities* 17, no. 7/8 (1999), 217–21.

161 “24-hour surgery could help cut waiting times,” *The Times*, 19 February 2007.

162 Isabel Oakeshott, “Night surgery plan to cut waiting lists,” *The Times*, 20 February 2007.

163 *Ibid.*

164 “Who operates when?,” National Confidential Enquiry into Patient Outcome and Death: www.ncepod.org.uk/2003.htm.

165 Rebecca Coombes, “Round-the-clock surgery will not save the NHS,” *Daily Telegraph*, 20 February 2007.

166 Colin Clements, cited in: “Surgical Chaos,” *The Times*, 25 February 2007.

There are also a number of organisational and financial arguments against increasing flexibility in working hours. If staff work longer hours in return for time off in lieu, then productivity may increase without cost for a limited time. However, once the staff “call in” their TOIL, there is likely to be a concomitant reduction in the number of daytime staff.¹⁶⁷ Furthermore, operating theatres require support services such as nurses, pathology laboratories, porters and cleaners. Additional staffing and other necessary resources for post-operative care will add considerably to running costs. Indeed, given the speculation over existing restrictions on the number of operations performed per annum as PCTs try to balance their books, it is unlikely that they will be able to afford the sudden drain on their budgets if the number of operations suddenly increases.¹⁶⁸

While it is perhaps unavoidable that costs will increase if the kinds of flexibility in working hours suggested above are encouraged, a more interesting set of questions surround the issue of whether such a move would be cost-effective: would the benefits of more efficient facilities usage outweigh the likely costs? This might be a fertile area of further research by the SMF Health Project. In considering this question it will be important to construe costs broadly, to include both financial costs and clinical costs (e.g. an increased risk of certain kinds of medical risks or complications).

“Multiskilling”

Within the facilities management literature there has been an increasing focus on the idea that “multiskilling” (training workers to perform two or more traditionally separate roles) allows for more efficient use of existing resource capacity.¹⁶⁹ When she was Secretary of State for Health, Patricia Hewitt argued that the Agenda for Change programme (discussed at length above in chapter 2) could allow for the development of multiskilling; she cited the example of Huntingdon Healthcare Trust, where radiographers have been trained to take on some of the roles of radiologists. This leaves radiologists free to focus on what they really need to do, and allows them to make more efficient use of equipment.

167 Daniel Moore, “Night surgery plan to cut waiting lists,” *Sunday Times*, 18 February 2007: www.timesonline.co.uk/tol/news/uk/article1400778.ece.

168 Coombes, “Round-the-clock surgery will not save the NHS.”

169 Fari Aklaghi and Liz Malony. “Service integration and multiskilling in facilities management within the UK National Health Service,” *Facilities* 15, no. 3 (1997), 66–71.

Radiology reporting times were reduced significantly as a result.¹⁷⁰ However, the broader applicability of workforce multiskilling depends on whether the potential costs (e.g. of staff retraining) are outweighed by the potential benefits (e.g., the presence of multiskilled employees allowing for more efficient use of facilities).¹⁷¹

Innovative practice and lessons from abroad

The literature also contains several examples of genuinely innovative practice in the use of NHS facilities. For example, John Petri, consultant orthopaedic surgeon at James Paget Healthcare Trust, uses a technique that he calls “dual surgery.”¹⁷² While he is operating on one patient, anaesthetists prepare the next, ensuring that no time is wasted before the patient arrives in theatre.¹⁷³ Mr Petri has tripled the number of operations he performs and has reduced his own waiting lists from over a year to virtually nil. He also persuaded his trust’s chief executive to agree to a pilot study that measures “surgeon utilisation” rather than “theatre utilisation.”¹⁷⁴ This sits well with recent attempts to improve the productivity of individual surgeons through the implementation of a system of performance indicators, introduced after claims that patients had not benefited from the recent salary increase for consultants (discussed more fully in chapter 2 above).¹⁷⁵ However, concerns have been raised about the clinical desirability of increasing “surgeon utilisation,” and questions remain regarding its applicability outside defined specialities like orthopaedics.¹⁷⁶

There is some interesting evidence from abroad that might be worth investigating further: Canada ranks below the OECD median for MRI scanners per million of population,¹⁷⁷ and yet manages to use its scanners more intensively than either the UK or the US (the only other

170 Patricia Hewitt, “Select Committee on Health: minutes of evidence,” 26 April 2006.

171 Aklaghi and Malony, “Service integration and multiskilling.”

172 “Case studies: innovation in services,” Medical Futures: www.medicalfutures.co.uk/pdfs/case_studies.pdf.

173 Isabel Oakeshott, “Rankings to identify slow surgeons,” *Sunday Times*, 2 July 2006: www.timesonline.co.uk/tol/news/uk/article681960.ece.

174 Medical Futures, “Case studies: innovation in services.”

175 Oakeshott, “Rankings to identify slow surgeons.”

176 *Ibid.*

177 “MRI units per million population,” OECD Health Data: www.oecd.org/dataoecd/7/44/35530027.xls.

countries collecting comparable data).¹⁷⁸ In 2004–5, the number of MRI exams per scanner was almost 40% higher in Canada than in the US or the UK.¹⁷⁹

The organisational structures that allow Canadian healthcare providers to produce this level of efficiency, and the potential to translate these into the NHS, might be interesting areas of further research for the SMF Health Project.

CONCLUSIONS

The anticipated funding slowdown is likely to result in the focus of future NHS reform being on improving the efficient usage of existing resources. Upping the quality of NHS facilities management will be crucial in this regard. In this chapter, we hope to have identified a range of possible causes of current inefficiencies in NHS facilities management, and we have suggested a number of possible solutions. Although we have sought to use the best available empirical evidence, it is plain there is a paucity of good-quality data on these issues. Whichever areas of further research are pursued by the SMF Health Project, it is likely that a considerable amount of primary research will have to be undertaken. It might, for example, be interesting to use aspects of our proposed qualitative interviewing to work out with professionals on the front line what the causes are for existing inefficiencies, and to garner their views on what kinds of solutions are most likely to be successful.

178 "MRI scanners in Canada used more intensively than those in the United States and England," Canadian Institute for Health Information: http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=media_08feb2006_e.

179 "Nursing News," *Nursing Leadership* 19, no. 1 (2006), 8–16.

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The SMF Health Project is a major two year study looking at the future of the health system in England. The past few years have seen unprecedented investment in healthcare that has brought the UK into line with the rest of Europe. While waiting times have come down, over the same period health costs have risen and public health has not significantly improved. With an ageing population, expensive new medical treatments, ever more demanding patients and an end to large funding increases for the NHS, the time is now right to look ahead at the health system of the future.

These background papers provide an extensive review of the literature on different aspects of health policy – from the implications of ageing to the reformed provider market in the NHS. Intended as an introduction for the general reader these papers also identify the key challenges facing the health system and suggest areas for further research. The SMF Health Project will be building on these background papers and publishing a series of reports on key aspects of health policy before a final publication in 2009.

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