

Is the treatment working?

Progress with the NHS system reform programme



Health

Summary

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Healthcare
Commission 

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Summary

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

their impact so far has been more limited than might have otherwise been the case.

- 3 The report is based on fieldwork that was undertaken between May and November 2007. This included: a literature review; national and local data analysis; national workshops in four local health economies; interviews with strategic health authorities (SHAs), primary care trusts (PCTs), FTs, acute trusts, health commentators, providers, regulators, commissioners, strategists and independent sector providers. It also draws on other work including major national studies undertaken by the Audit Commission and Healthcare Commission.
- 4 Individual elements of the reform programme have been implemented to different extents in the health economies we visited. This variation is also reflected in other national surveys and reports. While the new workforce contracts and to a certain degree PbR are almost universal across the NHS, patient choice is in reality not always offered; PBC has yet to be fully embedded; less than half of trusts have achieved FT status; and there are few ISTCs.
- 5 Given the controversy that has surrounded the reform programme, its ambition and the scale of the NHS, it is not surprising that more progress has not been made. In fact many health economies have only recently been provided with all the tools and levers for change.
- 6 Nevertheless, despite limited implementation, we found that the reform programme was having a positive effect on the NHS:
 - NHS patients are beginning to benefit from the existence of a diverse range of providers and there is anecdotal evidence that competition is improving services for patients in some areas.

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- The fear of the impact of patient choice, rather than actual choice, appears to be driving a positive change in attitude among providers. Some PCTs can also point successfully to improving services through tendering.
 - The focus that PbR and FT status have placed on improving existing financial management arrangements and encouraging a more business-like approach has provided all NHS providers with incentives to improve.
 - PbR has brought welcome clarity to NHS funding of hospital care for both commissioners and providers and has had some positive impact on trust efficiency and demand management by PCTs.

7 However, we also found that the reforms were not yet delivering the desired change:

- Despite the intention to move care out of hospitals and into a primary or community care setting, limited progress appears to have been made. Commissioning and contracting skills are not yet strong enough to drive this agenda, although some PCTs can point to successes. PbR also needs further refinement to facilitate care transfers more effectively.
- Choice is not offered universally and the infrastructure is still not fully in place to support patient choice that is based on the quality of care provided. The Department of Health (DH) is now improving the information available.
- On a national level, despite the improved quality of services, FT status does not yet seem to be empowering organisations to deliver innovative models of patient care.

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- The incentives and infrastructure to support PBC are not currently sufficient to engage most GPs in commissioning.
 - At the time of introduction, the new workforce contracts for hospital and community staff were a missed opportunity for change and have so far resulted in higher expenditure, without a proportionate increase in productivity. Nevertheless, the new contracts continue to offer opportunities for change and the full effects may only be seen in the longer term.
- 8** Progress on the implementation of the reform programme has been limited by several factors. These include two major structural reorganisations; under-developed commissioning capacity; and weaknesses in the infrastructure to support and monitor the reforms, particularly in regard to data collection. We also found that many of those who participated in our research did not fully understand the aims of the reform programme, how the individual elements contributed and how they could best be made to work.
- 9** Improving commissioning capacity and capability is critical to the success of the reform programme. Given the 2006 reorganisation, PCTs need time to progress this agenda. More work is needed to strengthen commissioning and without this, the reform programme will not provide the necessary balance of power between primary and secondary care. The DH are now placing an increasing emphasis on improving commissioning skills.
- 10** We have identified that service improvement in some areas has been substantially delivered without using the system reforms. Other policies pursued by the government such as waiting list targets, have had a much greater impact. Our fieldwork found that the health economies that had made greater progress in implementing the reforms were not performing at a significantly improved rate when

compared with those that had limited reform levers in place. There is some evidence, through the annual health check, that FTs are becoming even stronger organisations when compared with other acute trusts. But it is important to note that they were deliberately selected for foundation status on the strength of their service delivery track record, financial standing and financial management arrangements.

- 11** Many of the reforms have the potential to deliver significant service improvement but need time to bed in, as demonstrated by the implementation of PbR, which has now been largely mainstreamed by the NHS. There has so far been a stronger focus on the supply side (for example, the development of FTs) but greater development of the demand side using patients and commissioning to drive service improvement is now needed. For example, there is evidence that patients will choose alternatives if the choices are real and the relevant information is available. However, the barriers to progress that we have identified will need to be addressed and specific developments related to patient choice, PBC, the quality and convenience of care and efficiency also need to be considered.
- 12** Lord Darzi's review provides an opportunity to take stock of what the reforms have achieved so far and how they might need to develop to contribute to a renewed vision for the NHS. Many of the system reforms have also been developed on an elective, secondary care model, not on primary or community care or mental health models. They have also not focused on managing long term conditions nor specifically addressed health inequalities. His review will also need to address these key issues.

Recommendations

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

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

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- The DH should consider redesigning the GP choice incentive scheme and payment for future years to ensure that those who take up the incentive payments deliver choice to their patients accordingly. In addition, PCTs should manage this payment more robustly through data quality and spot checks. PCTs should also work with GP practices through workshops or sessions to effectively engage GPs in the policy, exploring how choice should be explained to patients.
 - Taxpayers and patients have a reasonable expectation that FTs will not retain large cash balances over prolonged periods. FTs in such a position must set out clearly how they intend to use these balances. Monitor should also consider whether the performance management and regulatory systems for FTs should ensure that where there is such a balance, it is used for the benefit of patients. In order to achieve this, PCTs need to clarify their commissioning intentions on a timely basis.
 - There should be a prolonged moratorium on any further national top-down reorganisation of NHS commissioners. This will enable the benefits of the choice and competition reforms of the NHS to be fully realised.
 - Lord Darzi's review presents an opportunity to clearly communicate and outline the NHS vision for the future. It should clearly demonstrate how the reforms work for patients and how they contribute to the overall vision he sets out.

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- When establishing the new Care Quality Commission, the DH needs to ensure that its terms of reference are wide enough to cover the complete risks and issues throughout the health service, including quality and value for money issues in primary care and community services. As more care is transferred into a primary setting this will be increasingly important.
 - The DH should assess the impact of the current reforms on an ongoing basis. It should also set clear measurable aims and objectives for all major new reform policies and plan a timetabled evaluation strategy in advance of implementation to review the relative success and achievements of these policies.

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