



REVIEW OF DEVELOPMENTS IN THE UK NHS 2000-2003

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CONTENTS

OVERVIEW.....	4
1. CURRENT STRUCTURE AND KEY ISSUES IN THE NHS	9
1.1 Structure of the NHS.....	9
1.2 The Department of Health.....	9
1.3 Strategic health authorities.....	10
1.4 Primary care trusts.....	10
1.5 Care trusts.....	11
1.6 Childrens care trusts	12
1.7 NHS trusts.....	12
2. PRIMARY CARE TRUSTS – THE NEW ENHANCED ROLE.....	15
2.1 Primary care trusts.....	15
2.2 The development of PCTs	15
2.3 New GMS (general medical services) contract.....	16
2.4 Foundation trusts	17
3. NATIONAL SERVICE FRAMEWORKS: A CASE STUDY IN INTEGRATED CARE	18
3.1 National service frameworks (NSFs).....	18
3.2 A case study of Coronary Health Disease (CHD) National Service Framework in West Gloucestershire PCT (WGPCT)	18
3.3 Workforce development	19
3.4 WGPCT priorities for 2003 – 2006	20
4. ACCOUNTABILITY IN THE NHS AND THE CHANGING ROLE OF THE NON-EXECUTIVE AND COMMUNITY INVOLVEMENT	22
4.1 Accountability in the NHS.....	22
4.2 Role of boards.....	22
4.3 NHS boards	23
4.4 The future.....	24
5. PATIENT AND PUBLIC INVOLVEMENT IN HEALTH	25
5.1 Community health councils and patient and public involvement.....	25
5.2 Commission for Patient and Public Involvement in Health.....	25
5.3 Patient and Public Involvement Forums.....	25
5.4 Local network providers and independent complaints advocacy service....	26
5.5 Health scrutiny – overview and scrutiny committees	26
6. PLANNING AND PERFORMANCE MANAGEMENT IN THE NHS.....	27
6.1 NHS performance indicators	27
6.2 Star-rating system	27
6.3 Franchising	28
6.5 Local view of the performance framework	29
7. COMMISSION FOR HEALTH IMPROVEMENT ASSESSMENT PROCESS ...	31
7.1 The Commission for Health Improvement (CHI).....	31
7.2 Clinical governance.....	31
7.3 CHI clinical governance review	31
8. REVISED FINANCIAL FRAMEWORK FOR THE NHS AND REVIEW OF PROPOSED FURTHER DEVELOPMENTS	34
8.1 NHS financing and capital funding	34
8.2 Introducing payment by results	34
8.3 Context – why is a change in financial policy needed?.....	35
8.4 The components of the financial flows policy.....	36
8.5 Implementation of the financial flows policy.....	36

9. TACKLING HEALTH INEQUALITIES – BEYOND THE SECTOR WIDE	
APPROACH	39
9.1 Health inequalities.....	39
9.2 Policy	39
9.3 Common themes.....	39
9.4 Broader determinants of health.....	39
9.5 Initiatives to address inequalities in deprived areas.....	39
KEY DOCUMENTS	42
WEBSITES	42
Annex 1 - Glossary and short description of various NHS Institutions	45
Annex 2 – Foundation hospitals	47
Annex 3 – Performance targets	49
Annex 4 - Human resources	51

OVERVIEW

The agenda for the NHS during 2003 has been dominated by the implementation of further phases of the NHS Plan, the government's radical 10-year plan to modernise the NHS and social care system. The Plan sets out to create a prompt, convenient, high quality service, treating patients as partners.

An ambitious programme of change is underway to deliver the Plan. The most substantive initiatives during the government's first term were the introduction of Primary Care Trusts (PCTs), National Service Frameworks (NSFs), and the drive to tackle waiting lists. During this current term the most significant changes are the introduction of Patients Choice, Payment by Results, and Foundation Hospitals, which may fundamentally alter the NHS as we know it.

Patient choice

Patient choice is a key contributor to changes to create a patient-centred NHS, enabling patients to exercise choice over major decisions affecting their lives. The roll out of this initiative over the next three years was announced in February 2003.

Patient choice enables patients to choose where they are treated for planned surgery. At the GP surgery they are given information about alternative providers and the opportunity to switch to hospitals with shorter waits. They can compare different waiting times in different hospitals, including NHS hospitals locally or elsewhere, diagnostic and treatment centres, private hospitals or hospitals overseas. Two choice pilots were successfully undertaken during 2002, in heart surgery and cataract surgery. In one of the pilots, 67% of patients chose an alternative hospital after waiting more than 6 months for a procedure.

The extension of patient choice beyond elective care is currently under consideration, to eight services including children's health, emergency care, maternity, mental health and primary care. Issues also being examined are offering patients greater access to complementary medicine, the opportunity to retain the same doctor though their illness, and more time for patients to talk with health professionals. Roll out of this policy could galvanise changes to traditional ways of delivering services, as trusts strive to meet patients' wishes and so retain the work and the funding that goes with it.

Reforming NHS financial flows: introducing payment by results

The combination of patient choice with the payment by results system of funding may fundamentally alter the NHS. The new funding system, to be introduced on a phased basis to full implementation in 2005, means that hospitals will be paid a fixed fee for every operation, so that if they carry out fewer operations they get less money but fixed costs remain constant.

Closure of hospitals could result if patients choose to be treated in different hospitals, without reference to any PCT commissioning strategy or involvement, as there is no safety net to support hospitals losing work. The NHS Bank may be brought in to offer financial support to trusts facing the biggest financial losses (see annex 1).

Information

The choice initiative is underpinned by the provision of more and improved information to help patients make informed choices. Locally, PCTs now produce annual patient prospectuses, and nationally the Commission for Health Improvement (CHI) started to provide information about comparative NHS performance with effect from 2003.

NHS Direct

This nationwide, 24-hour, nurse-led health advice service is to be significantly expanded over the next three years to become a distinct national organisation, which will be established from April 2004. Its remit is to be extended to provide a single access point to NHS out of hours services; to handle all low priority '999' ambulance calls; to establish a new national NHS Direct digital TV service; and to offer the public a personal health organiser on NHS Direct online. Combined with changes to the GP contract there is potential for radical redesign of access to out of hours and emergency services.

Diagnostic and Treatment Centres

The development of more diverse provision and increased capacity has been a central part of the reform programme. Measures including the introduction of diagnostic and treatment centres (DTCs), the increase of GP specialists, and the use of international providers, contribute to the redesign of services with the patient as the focus.

DTCs provide low-risk, high volume elective surgery and diagnostic procedures, staffed by dedicated surgeons, nurses and support staff whose work is unaffected by seasonal and emergency demands of the NHS. This programme has modernised the way patients receive diagnostic and acute planned care: high quality and effective treatment in units protected from emergency pressures.

Sixteen DTCs run by the NHS were initially established, and 1 run by the independent sector. A further 31 NHS run centres are in development and earlier this year the independent sector was invited to bid for 5 year contracts to run 11 local schemes and 8 national chains.

To ensure the additional patients can be treated more rapidly, the DTCs will have to be staffed in a number of ways: using NHS staff alone; NHS staff with independent sector staff; NHS staff with overseas staff; and solely staffed by the independent sector.

There is concern that DTCs will unbalance the casemix of work in acute hospitals by taking responsibility for less complex surgery, leaving acute trusts with difficult procedures which are hard to resource and junior doctors with fewer cases for teaching. Also, the potential loss of staff from acute trusts to staff DTCs may destabilise local health systems.

GP specialists

There are now about 1250 GP specialists - GPs accredited by the PCT with a special interest in addition to their generalist role - taking referrals from their colleagues in specialties such as ophthalmology, orthopaedics, dermatology and ear, nose and throat (ENT). They help deliver services normally provided in hospital closer to the

patients home, but may also adversely affect the acute hospital case mix, teaching material, and staffing in a similar way to diagnostic and treatment centres (see above).

Foundation hospitals

The development of foundation hospitals, to begin in April 2004 (subject to legislation) is intended to set an example to the NHS. They were to have greater autonomy; to involve the local community in their governance; to have the power to pay staff at locally agreed rates; and the access to finance for capital investment, to sell land and borrow privately; all to facilitate innovation and present opportunity to provide services in very different ways.

These freedoms were causing concern as a two-tier system was anticipated, with NHS elite hospitals getting more resource at the expense of failing hospitals, thus widening inequalities.

However, following considerable objections, the proposals have been adjusted so that foundation hospitals cannot borrow on the capital market, they have to pay staff at agenda for change pay rates, and a regulator will oversee their business. All hospitals are expected to become foundation hospitals in due course so that the advantages are likely to be weakened.

Coupled with the complex governance arrangements of involving local communities there is a fear that the lesser freedoms would now be outweighed by the bureaucracy and chief executives would divert so much of their energy to public consultation they would not be free to exploit the opportunities left with foundation status (see Annex 2).

The NHS University

Modernisation of learning and development is part of the plan, to provide the NHS workforce with the tools to deliver the changes. Initiatives include the introduction of the NHS University (NHSU) and new standard setting and streamlined quality assurance systems across learning programmes for health professionals.

The NHSU is aiming to become the first fully recognised public sector corporate university in England, with its own degree-awarding powers, established to provide learning opportunities for staff at every level. It is intended to become a special health authority and a legal entity in its own right, with effect from 1 October 2003 (see annex 1). It is developing a portfolio of initial programmes, preparing for a system of e learning for the NHS workforce, and setting up arrangements for delivering and quality assuring NHSU courses.

Initially there were fears that the NHSU could duplicate existing university courses, but it is now clear that all degree-level courses for doctors, nurses and dentists will remain with the universities and will not be offered by the NHSU.

GP and consultant contracts

Both GP and consultant contracts have been the subject of negotiation during 2003 and include opportunities to enable changes in job design and work organisation which are crucial to enable services to be provided differently. The GP contract was finally accepted in June 2003 and will be fully implemented in all GMS (general medical services) practices from April 2004. Meantime personal medical services (PMS) practice numbers have increased, as GPs have wanted to move to a system where their terms and conditions were not subject to the new contract. About 30%

GPs are now in PMS practices. Amongst the reasons why GPs had been concerned about the new contract was that the formula used to calculate their remuneration was very complicated, and when applied, indicated that 70% would get less money than under the previous system. Their subsequent agreement followed changes to the original proposals.

One of the significant aspects of the new GP contract is that the contract is between the practice and the PCT rather than with each GP individually. This gives practices more freedom to decide how to design services. In addition, practices will be able to transfer some services, including out of hours services, to the PCT. Although this could present a challenge for PCTs to manage, it provides the opportunity to reshape out of hours care, making it easier to provide an integrated service using other parts of the NHS such as the ambulance service and walk in centres.

The consultants contract negotiations have been more difficult to conclude, but finally ¹heads of agreement were agreed in mid July 2003 with an aim to agree terms and conditions for the new contract in mid August for the BMA to ballot members in early September. Subject to approval, NHS trusts will have the option of either implementing the contract locally, or introducing new local incentive schemes. Consultants have been concerned that the proposals will increase managerial control and reduce their freedom, and there has been suggestion that some may opt out of the contract and set up "consultant chambers", becoming self-employed practitioners, charging the NHS for each service supplied.

The Commission for Healthcare and Audit, the foundation regulator

A new unified scrutiny system for the NHS and private sector is under development, to be based on new standards due in summer 2003. Subject to legislation, the Commission for Healthcare and Audit (CHAI) will be established in April 2004, taking on the functions of CHI and other bodies forming part of a new system of independent inspectorates and external standard setting.

There has been concern with regard to the inspection role of CHI, that the quality and seniority of inspectors is insufficient, and that use of the peer review process makes it too subjective. There is a wish for a more transparent system to be used with a recognised scoring system. These matters will be considered by CHAI as they establish their plans for managing their new responsibilities.

CHAI will provide the regulation of services, and there will be a foundation trust regulator, who will be business regulator of Foundation hospitals. He will determine the borrowing limits of foundation hospitals, publish annual reports on each trust, and ensure that they operate according to their licence. He is not accountable to the secretary of state for health but to parliament.

Two policy themes have emerged from this programme of change, which are not entirely compatible: the use of market incentives; and the decentralisation of power.

The introduction of the choice initiative and foundation hospitals will inevitably lead to a market for planned secondary care. The choice initiative will lead to patients choosing their secondary care providers rather than the PCT commissioning planned care on their behalf. However, the need to commission other services, such as

¹ This document outlines how the negotiators agree to go forward with job planning, pay progression, appeals, evening / weekend work, recognition for evening & weekend work, putting the NHS patient first, etc. It includes the agreement to work in partnership to produce final documents on the new contract by 14 August.

emergency and chronic care, will remain with the PCT. These services are not provided in isolation but in partnership between primary and secondary care and across agencies. The development of a market for secondary care may make the integration of services across these boundaries more difficult.

1. CURRENT STRUCTURE AND KEY ISSUES IN THE NHS

1.1 Structure of the NHS

There have been major changes in the NHS structure in England in 2002/03. An outline of the new structure is detailed below and summarised in diagram 1.

1.2 The Department of Health

This Department's purpose is to support the government to improve the health and well being of the population.

The Department has undertaken a major change programme during 2003, designed to provide more effective leadership to the NHS and social care, and a better service to ministers and the public. The intention is to decentralise and streamline the top tiers of the Department of Health, and abolish the 4 English regional health and social care directorates. It will do less work directly, in performance management or in policy or standard setting; NHS and local authorities will take on greater responsibility, operating with less guidance and supervision; and other purpose designed bodies will take on key functions of inspection and standard setting. These changes took effect from 1 July 2003.

The Department now focuses on:

- setting overall direction and leading transformation of the NHS and social care
- setting national standards to enhance quality
- securing resources and making major investment decisions to ensure that the NHS and social care have the capacity to deliver
- working with key partners to ensure quality of services

The most senior official at the Department of Health is the Permanent Secretary (Sir Nigel Crisp), who is also the Chief Executive of the NHS.

The Department has a management board to manage the Department of Health's business and priorities, with the following membership:

- Permanent Secretary and Chief Executive, NHS
- Group Director, Delivery
- Group Director, Standards and Quality, and Chief Medical Officer
- Group Director, Strategy and Business Development
- Director of Finance and Investment
- Director of Communications
- Director of Policy
- Director of User Experience and Involvement

In support, the health and social care delivery board is responsible for overseeing and securing delivery across all national priorities, managing the relationship with strategic health authorities and the NHS and local government.

The Department is made up of three business groups:

- **health and social care delivery** bringing together performance management, the access programme, and key resource and capacity

functions of finance, physical capacity, workforce and information management and technology

- **health and social care standards and quality** overseeing quality and standards, the promotion of health, protection of the population, and patient safety
- **strategy and business development** covers communications, policy and strategy, and user involvement/experience, and corporate work such as private offices, human resources.

The NHS Modernisation Agency is to become a new next steps agency, responsible for building up local modernisation capacity in all parts of the NHS to enable delivery of national targets, including health systems development, primary care development, workforce development, leadership, IT development, and clinical practice development. It will also support challenged organisations, innovation and knowledge management and partnership development (see annex 1).

1.3 Strategic Health Authorities

In April 2002, 28 new health authorities (SHAs) were created. They are significantly different to the 95 health authorities they replace. Their main functions are:

- providing strategic leadership to ensure the maintenance of provision and the delivery of improvements in local health and health services by primary care trusts (PCTs) and NHS trusts, within the national framework of developing a patient-centred NHS and supported by effective controls and clinical governance systems;
- leading the development and empowerment of uniformly excellent frontline NHS organisations committed to innovation and improvement;
- considering the overall needs of the health economy across primary, community, secondary and tertiary care, and working with PCTs and NHS trusts to deliver a programme to meet these needs;
- managing the performance and accountability of local NHS trusts and PCT;
- leading on the creation and development of clinical and public health networks;
- creating capacity through the preparation and delivery of strategies for capital investment, information management and workforce development;
- ensuring effective networks and joint working exists between NHS organisations for the provision of health and social care;
- ensuring the development and training of an adequate workforce of competent clinical personnel.

1.4 Primary Care Trusts

There are 304 primary care trusts in England. From April 2002, PCTs have become the cornerstone of the local NHS and involve clinicians as well as local people. They have a tripartite structure led by a lay chair and board of non-executive directors. Local primary care clinicians, including nurses and other health professionals, form a professional executive committee (PEC) that is responsible for identifying health needs, driving change to service provision and ensuring clinical governance. A chief executive leads a senior team responsible for operational management of directly delivered services (such as health visiting and community hospitals) implementation of change and commissioning and monitoring of services provided by NHS trusts. PCTs do the majority of commissioning of healthcare and are expected to become responsible for the flow of 75% of NHS funding by 2004.

The aim of devolving power and responsibility to primary care trusts has been to create opportunities to engage local communities in the decisions that affect their local health services. PCTs are also expected to ensure that more power is devolved to frontline staff.

PCTs are responsible for improving health and securing the provision of services to meet the needs of their local community. Some of these services are delivered by the PCT themselves, particularly primary, community and intermediate care. They have been tasked to build new partnerships with a range of partners including local authorities, NHS trusts, strategic health authorities, other PCTs and local communities.

The functions of a PCT are:-

- to identify the health needs of the population
- to maintain an effective public health function
- to work to improve the health of the community
- to secure the provision of a full range of services
- to lead local planning
- to secure the provision of a full range of services
- to lead the integration of health and social care
- to deliver services within their remit

The role of the PCT will develop further as foundation trusts come on stream and as the patient choice and payment by results initiatives gather momentum. They will need to work with the trusts, particularly those with services likely to be above the national ²tariff, to determine how to manage the implications.

For some PCTs the choice of 5 providers for patients to choose from will be difficult. A key criterion is access for patients; however it is unsure how attractive all this will be to private providers. Their prices will be underwritten for a while but then they will need to standardise with NHS rates.

Patients will also need to be informed of their rights with these changes and this may be a role for NHS Direct (see p.6).

1.5 Care Trusts

Care trusts are new bodies that are formed through partnerships between NHS organisations and local authorities.

They are intended to provide seamless and co-ordinated services for patients whose needs over time may require hospital, intermediary and home care. The intention is that by creating this direct link between the NHS and local government, local authorities can play a direct role in improving the health of the local community. At the same time, the NHS can link its services more closely with the local authorities' range of support services.

Care trusts may be formed when either PCTs or NHS Trusts enter into partnership with local authorities. The local authority partners have non-executive representation on the board of the care trust.

² See finance section 8.

As NHS bodies, care trusts are accountable to strategic health authorities. The care trusts will also:

- be accountable to the local authority for those delegated functions of the authority that it undertakes on their behalf.
- receive NHS funding in the normal way depending on whether their role is that of a PCT or NHS trust. However they will also have the responsibility for managing funds from their local authority partners.

Many PCTs are using NHS flexibilities to create funding pools without adopting care trust status. This enables joint appointments. In at least one PCT the chief executive also holds the post of director of social services.

There are currently 7 care trusts in operation with another due to start in October 2003.

1.6 Childrens care trusts

Thirty five childrens' trust pathway pilot schemes (for three years) were announced in 2003, with start up funding, to develop integrated support for under 19s. They will provide a single point of access for children and families to all services, developing common approaches to assessment, improved information sharing between agencies, greater use of multidisciplinary teams, joint training, combined resources and pooled budgets.

1.7 NHS trusts

The first NHS trusts were established in 1991. They are directly responsible for providing services to patients. These may be acute services, ambulance services, mental health or other special services, eg for children.

NHS trusts were previously funded primarily through service level agreements (SLAs) with the former health authorities. From April 2003 these agreements are all with primary care trusts. Trusts are required to work with primary care trusts, strategic health authorities and other partners to meet the health care needs of communities.

New structures for patient and public involvement (see section 5) have been introduced which are designed to enable trusts to involve their community in decisions about the development of services (eg PALS, the Patient Advisory and Liaison Service – see annex 1).

Much of the agenda in the coming years will focus on the development of clinical networks to provide patient centred services across organisational boundaries where there is a need to develop seamless patient care. For example, networks between primary and secondary care or between secondary and tertiary care providers to ensure the provision of high quality, clinically effective services. These will be used increasingly to deliver and develop services across organisations and over the entire episode of care.

Cancer services typically benefit from the establishment of good clinical networks, as usually cancer patients need seamless, well-coordinated care from GP to the acute hospital then to the tertiary centre and back to hospital and community and palliative care. Organisational boundaries in such cases can prove to be a major hindrance and significantly reduce the effectiveness of care. An agreed network, which

anticipates the requirements of patients moving effortlessly between organisations, employing techniques such as care pathways and protocols can reduce the problems and make best use of finite resources

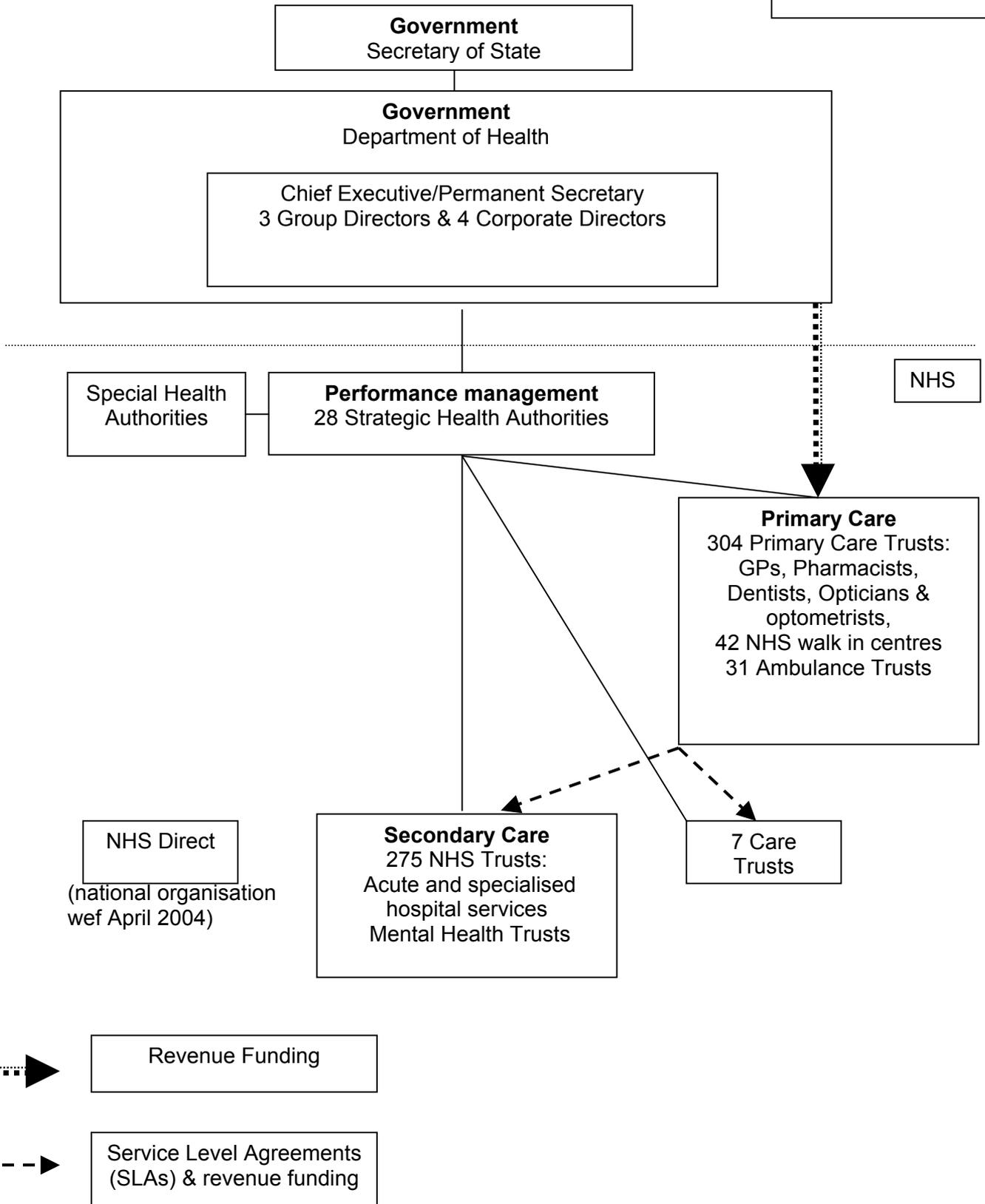
Care pathways determine locally agreed multidisciplinary practice, based on guidelines and evidence where available, for a specific patient/client group. It forms all or part of the clinical record, documents the care given and facilitates the evaluation of outcomes for continuous quality improvement.

Trust agendas will also be shaped by the patient choice initiative, where patients will be able to choose their hospital for planned care. This is likely to stimulate the market in secondary care, as trusts work to maintain and develop their share of the work.

Major NHS trusts will, in the future, be able to apply for foundation status (see annex 2). This will give them further levels of autonomy. The first wave of NHS foundation trusts is planned for April 2004, subject to legislation. They will be established as independent public benefit organisations, modelled on co-operative and mutual traditions. They will be accountable to a local body of elected governors with an absolute majority of representatives elected by local people as well as staff and PCT representatives.

Diagram 1
The NHS structure (from July 2003) (England only)

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2. PRIMARY CARE TRUSTS – THE NEW ENHANCED ROLE

2.1 Primary Care Trusts

The key responsibilities of primary care trusts are improving the health of the population, developing primary care and community health services, improving the quality of care and the integration of services, commissioning secondary care services from acute hospitals, and employing staff that provide community health services.

PCTs identify the health needs of the local population, and plan and commission services to meet those needs, working together with partners. Some acute services are on the cusp of viability and PCTs are considering how best to influence experienced NHS trusts to change, transfer or close services if necessary and provide the services in conjunction with other providers as clinical networks (see p.13).

With the huge pressure from the Department of Health on targets some PCTs have noticed a change in the way SHAs work, in that their role of involving and supporting has changed to a focus on performance targets. As a result there is a notable change in PCT relationships with SHAs.

2.2 The development of PCTs

The first primary care trusts were established on a voluntary basis in April 2000, evolving from primary care groups, which had developed from GP commissioning initiatives. They were a means to involve GPs, community nurses and others in the planning and provision of services.

Further responsibilities were put on PCTs from April 2002 when all primary care services were reorganised into PCTs. The majority of PCTs were new and although some experienced staff transferred from health authorities, many new staff lacked experience.

The role of PCTs was extended to embrace: commissioning all acute and specialised services for their populations; responsibility for securing the provision of personal medical and dental services; responsibility for securing all mental health services, walk-in centres, local NHS Direct services, emergency ambulance and patient transport services and the implementation of population screening programmes; and finally responsibility for all family health services (FHS).

As PCTs now hold trusts to account for the delivery of services that they have commissioned, they have effectively inherited the responsibility for waiting lists and other targets.

The introduction of the patient choice initiative will alter the role of the PCT yet again. With effect from summer 2004 all patients waiting for six months for any form of planned surgery will be able to choose at least one alternative hospital and normally four – public or private or diagnostic and treatment centre. From December 2005 choice will be extended to all patients, who will be offered choice at the point the GP refers them to hospital.

This effectively removes the commissioning role for planned care from PCTs and puts the patient in charge. At worst, hospitals could close if patients choose to go elsewhere in significant numbers. However, the PCT will still bear responsibility for commissioning chronic care and emergency services, which cut across primary and secondary care.

They will need to develop effective joint working with all concerned to enable clinical networks to thrive and pathways to be viable.

2.3 New GMS (general medical services) contract

The contractual terms between the NHS and GPs, defined in the ³red book, were put in place at the start of the NHS, and have governed the relationship between the two since.

The NHS (primary care) act 1997 allowed for the introduction of personal medical services (PMS) pilot schemes, giving GPs, nurses and community trusts flexibility and opportunity to innovate by offering different choices for addressing primary care needs. The NHS Plan encouraged development of the PMS scheme, and by April 2002 nearly 1/3 GPs were working to PMS contracts.

For the other GPs still on the GMS contract, the new GMS contract signals massive changes for primary care.

- allows the GP practices to determine what services they provide
- rewards quality for clinical and organisational targets
- facilitates improvement in practice infrastructure
- an income guarantee but income also linked to results?
- aims to help retention and recruitment
- out-of-hours services – responsibility of PCTs
- keeping PMS and GMS in-step
- PMS – list size 1500 contract between PCT and Practice
- practices to reduce services – responsibilities of PCTs

This new contract will mean changes to where patients are seen; who sees patients; out-of-hours arrangements; home visiting; registration and primary care trusts as providers. Most GPs believe in this contract as the emphasis is on quality and now they will not lose out financially either. The new contract recognises that there are other people with skills who can cover some of the out of hour work. It may not necessarily be a GP that the patient sees out-of-hours; it could be a paramedic or pharmacist.

The core services GPs are required to provide are nationally defined. Outside these core hours eg. at weekends, GPs can decide not to provide services. In a capacity strapped sector this will lead to the challenge for PCTs of providing out-of-hours services, a particular challenge for those PCTs covering areas that are geographically spread. PCTs will need to invest heavily to build capacity. Clustering access to paramedics, GPs, etc together will help. This will be driven by the PCT's PEC, the professional executive group of the PCT responsible for day to day management and for developing and initiating service policies, investment plans, priorities and projects for the PCT - the engine room of clinical service development.

³ The red book is the statement of fees and allowances payable to GPs (as independent contractors) updated annually after consultation with the independent review body on doctors' & dentists' remuneration. It sets out the fees reimbursed to general practitioners, including drugs and dressings, staff payments, and rents for premises. It also includes details of payments for certain services provided to encourage health promotion, including childhood immunisation schemes, cervical cytology programmes, and chronic disease management programmes.

2.4 Foundation trusts

Foundation trusts may bring additional financial flexibilities; accountable to the local community; and the ability to attract work on a wider basis. However PCTs are concerned about the impact foundation trusts will have on staffing as they will be able to offer their own terms and conditions to staff that may have a big impact on local system resources. The foundation status at present is just for NHS trusts although there may be plans to give foundation status to PCTs, which many would welcome (see annex 2).

Reflections

- Key challenges for PCTs can be summed up as supporting choice and flexibility; developing services and capacity; keeping primary care professionals on board; developing the GP specialist role where GPs take referrals from their colleagues; re-designing pathways (see p.14); working collaboratively with PCTs and acute services; demonstrating progress on national service framework targets (see p.20); rooting out poor performance; effective clinical governance; developing the workforce; making the NHS an attractive place to work; developing facilities and estates; the national ⁴IM and T development programme; implementing NICE guidance; integrating health and social Care; public Involvement; and, scrutiny.
- The PCT workload is huge and there are constrained management resources. There has been a great loss of capacity and corporate knowledge. Most PCTs are young, new and are finding difficulty in working out whose experience is good and who to listen to. PCTs believe this is the right way forward but are concerned with the speed of the implementation of the changes.
- There is a cap on HR targets and management cost limits which begs the question are some PCTs viable in terms of size, should some merge?
- Local delivery plans – 3 year plan but 1-year money. Not enough time to prepare plans. PCTs were created in April 2002 and told their plans were needed by Feb 2003.
- Partnership working is key for PCTs in this new structure. Their role is to manage the balance of different provisions and the tensions between secondary and tertiary provision. Getting some services decentralised difficult.
- Integrating health and social care is a challenge for PCTs as local government and health work so differently. Some former directors of social services have taken PCT chief executive jobs that have helped to ease working with local governments and bring PCTs into partnership in their areas. If these partnerships can work there are good opportunities in terms of care trusts and the flexibility to move money.
- PCTs in effect control waiting lists and will need to work with NHS trusts to balance these. There is a PCT incentive especially with patient choice.
- The implications of the new GMS contract will mean changes to the way primary care is delivered and brings new challenges for PCTs especially in out-of-hours service provision.
- The introduction of foundation trusts will impact on local system resources.
- The whole system is hugely ambitious and will need effective monitoring and data management. The IM and T issues nationally will need to be addressed quickly.

⁴ IM and T – information management and technology (or informatics as it is also known). The IM and T programme is the NHS strategy for information – to implement technology and systems to support and monitor staff in providing high quality patient care. The programme emphasises the need for collaborative working, provision of quality information and for governance over local care networks.

3. NATIONAL SERVICE FRAMEWORKS: A CASE STUDY IN INTEGRATED CARE

3.1 National service frameworks (NSFs)

National service frameworks (NSFs) set national standards and identify key interventions for a defined service or care group; put in place strategies to support implementation; establish ways to ensure progress within an agreed time-scale and form one of a range of measures to raise quality and decrease variations in service; introduced in *The new NHS* and *A first class service*. These are drivers for clinical modernisation within the new NHS.

NSFs are developed through consultation by an external reference group (ERG) comprised of health professionals, users, carers, managers, agencies and other interested parties. NSFs were launched in April 1998 and currently cover paediatric intensive care; coronary heart disease; cancer; older people; and, diabetes. NSFs are also being prepared for renal services; children's services; and, long term conditions. There will usually be only one new framework per year.

3.2 A case study of Coronary Health Disease (CHD) National Service Framework in West Gloucestershire PCT (WGPCT)

Heart disease is one of Britain's biggest killers with UK figures high in comparison with the rest of Europe. The CHD NSF was introduced to reduce mortality/morbidity from heart disease in UK. Set out within the plan are 12 national set standards across primary and secondary prevention and different disease areas as well a series of milestones and targets with implications for all primary care, secondary care, ambulance trust, local authorities etc.

Gloucestershire has taken a health community approach to CHD, with the 3 PCTs in the county, the Gloucestershire Hospitals NHS Trust and the Ambulance Trust working together to develop shared strategies and programmes. This reflects inter-connections across and between the different organisations, but also recognises there may be different methods of delivery to meet the requirements of local populations. A multi-disciplinary county-wide local implementation group was established whose role includes overseeing the implementation of national CHD policy across primary and secondary care; performance monitoring the implementation of the policy and progress towards achievement of targets; identifying shortfalls and actions to address; develop, agree and prioritise proposals for change and development; and share good practice. This local implementation group is chaired by WGPCT, which also provides management support to the work of the group and is the lead commissioner for CHD services on behalf of all of the PCTs in the county. (Other PCTs likewise provide a county lead for service development and commissioning for other disease groups).

In 2002/3 this group were successful in:

- achievement of smoking cessation targets within the general population.
- creation of fifth in-county consultant cardiology post.
- establishment of funding for a new heart failure service (*see below*) – exciting development in under-developed areas of service.
- establishment of new angioplasty service locally – previously provided out-of-county will provide easier access and increase level of provision for local residents.

-
- creation of new dietician post co-ordinating initiatives in support of the county-wide management of an obesity strategy; early work to develop a care pathway for people with morbid obesity.
 - establishment of “patient choice” initiative, providing choice of alternative provider if patients wait longer than six months for cardiac surgery.
 - innovative IT work to develop systems/data sets to improve CHD registers and associated patient care, and enable improved audit and monitoring of progress towards achievement of targets.
 - creation of some local CHD incentive scheme to enable GP practices improve their care registers, monitoring systems etc. for patients with CHD.
 - additional equipment for primary care, heart failure and rehabilitation.

Standard 11 of the CHD NSF states “doctors should arrange for people with suspected heart failure to be offered appropriate investigations (eg electrocardiography, echocardiography) that will confirm or refute the diagnosis. For those in whom heart failure is confirmed, its cause should be identified – treatments most likely to both relieve their symptoms and reduce their risk of death should be offered.” In Gloucestershire it was decided to establish a dedicated heart failure service to help deliver this standard. This is a nurse-led service based in primary care with strong links to secondary care. An integrated care pathway is being developed, care standards agreed, etc. To ensuring ownership at all levels and emphasising partnership working every group with an interest are involved in designing the care pathway from primary to hospital and home again. Re-defining care pathways is time consuming but necessary. With primary care included in this process this reflects the move towards primary care being the guardian of patients. The new service includes access to echocardiography within community settings provided by GPs (GPs with a special interest), network of heart failure nurses (nurses specialised in the management of heart failure to whom all patients with heart failure are referred by their GP for assessment and ongoing management of their heart failure). Following preparation over the summer the new service will commence in the autumn 2003.

3.3 Workforce development

Lack of human resources is recognised as a major hurdle to implementing the NSF. PCTs in Gloucestershire have worked closely with the University of Gloucestershire and other educational institutions to address some of these issues. Outcomes include:

- development of local CHD diploma course for primary care nurses in conjunction with University of Gloucestershire.
- discussions underway re: possible establishment of 18 month course for cardiology technicians in conjunction with University of Gloucestershire
- 18 month training programme being initiated to enable paramedics to support diagnosis and provide thrombolysis during ambulance journeys to hospital. (Target: deliver a ten percentage point increase per year in the proportion of people suffering from a heart attack who receive thrombolysis within 60 minutes of calling for professional help)

This recognises the different ways of working needed to push the NHS forward. Development of new courses for ongoing training and new training of staff. Boundaries between formal posts are moving with staff obtaining different skills mixes. This is shown in the increase in ‘new animals’ in the NHS such as nurse specialists referred to above (nurses with additional expertise developed by the PCT to improve patient care and increase local primary care capacity) and GP specialists (see p.6).

3.4 WGPCT priorities for 2003 – 2006

- The group have identified areas of work where further funding is needed in 2003-2006. These include additional revascularisation capacity in specialist centres and locally to meet waiting time targets; meeting thrombolysis call to needle targets; maintenance and further reductions in rates of smoking; and prescribing.
- They have also recognised local priorities and initiatives within PCTs to meet local needs – eg. prevention tailored to local groups, improving CHD registers and ensuring annual contacts, identifying people at high risk.
- There can be conflict between NSFs and local priorities. Also, PCTs are legally bound to implement certain categories of if NICE issue a guidance within a set time. As no earmarked funds are provided for the implementation of NICE guidance PCTs need to build into their budgets provision for anticipated guidance.. The workplan for the publication of guidance can be found on the NICE website and this enables estimates of the likely financial implications to be prepared.. The recent introduction of NICE guidance on ⁵statins for lowering cholesterol was a good example, with every PCT in the country substantially overspending their drugs budgets as a consequence.
- Encouraging cross-PCT working to implement NSFs with one PCT leading on a particular NSF eg. CHD.
- Robust information systems will be needed for auditing clinical based practice and there is a lot of work going into developing clinical systems for audit at present.
- Good commissioners are needed who work closely with clinicians and have the managerial expertise to say if services are affordable. There is an increasing need to explore opportunities for change and improvement within existing resources and through doing things differently. This includes the development of guidelines and pathways. Exploring different roles. Exploring secondary prevention in primary care. Effective prescribing which is not necessarily cheaper – at least in the short term (statins being a good example of ‘short term financial pain for long term health gain).

Reflections

- NSFs have been quite successful. There is strong national political commitment, which has led on to a clear policy framework, well supported incentives, strictures, research and development, additional resources.
- For PCTs to be successful in implementing NSFs needs strong leadership and clinical ownership. NSFs have been clinician led with national level leadership and good representation of GPs etc. There is strong ownership of standards amongst clinicians and they are recognised as evidence based standards.
- There is a risk of silo working if no connections are made between the work of the different NSFs. PCTs need to work across NSFs recognising multiple pathology – eg. with older people, diabetes etc,. There are also issues as you multiply the numbers of NSFs, with the effort going into each NSF a balance will be needed. Is there a need for an NSF for everything?
- The NHS is at the beginning of making effective connections between primary and secondary care; care pathways are critical to this but are time consuming to develop. Primary care are the guardians and in the future may have ownership

⁵ Statins inhibit an enzyme involved in cholesterol synthesis and reduce adverse coronary events and mortality in patients with CHD.

of the patient even when they admitted to hospital, so it is essential the primary care group are involved and monitor the agreed care pathway for the patient.

- There are now incentives coming in to keep and get people out of hospital so models of intermediate care need to be developed. There is a need for diversity for different dependency of patients – step down units; institutions and home; sheltered housing and nursing care; community homes. Increasingly we should keep people at home with appropriate support.
- Early NSFs were pilots with additional investment. New NSFs do not come with protected budgets - diabetes money has to be carved out of baseline budget unlike CHD money that was ring fenced.
- Once doctors move to evidence based prescribing it may actually cost more not less (see above).
- This is a huge cultural change for the NHS. There has to be a shift in provider attitude because the public are now educated users. In the past the NHS has been very bad at this and the way forward, how best to achieve this, is still uncertain. The patient centred approach advocates strongly the involvement of lay people and patients – patient forums, expert patients, etc. The NHS need to work hard at involving patients. If they are successful and get public ownership of health – it will begin to pay back in the next 20 years.
- Implications for practices - more services are provided locally with effective links with specialist nurses. Links are recognised with other disease groups/risk factors and there is effective communication across boundaries. The importance of registers and associated care/monitoring systems against boundaries, older people, effective systems, clinical governance and audit, demonstrating good practice and improvement. Finally keeping up to date and continuous professional development (CPD).
- HR issues – there is variability in management systems but there is still a robust, highly skilled committed workforce in NHS. The management skill and capacity is tremendous. With the increase in ‘new animals’ there is excitement but also concern about specialisation and lack of generic skills.
- Evaluation - the NHS in the past has not been good at evaluation. A major obstacle has been the lack of IM and T. Most indicators used at present for CHD NSF are process indicators. Investment in IT systems would allow better monitoring and evaluation of outcomes.
- Public perception - need to work with the press as they do influence the general public on the NHS.
- A lot of capital investment will be needed for the first few years although it may take 4/5 years to impact.

4. ACCOUNTABILITY IN THE NHS AND THE CHANGING ROLE OF THE NON-EXECUTIVE AND COMMUNITY INVOLVEMENT

4.1 Accountability in the NHS

In the new NHS structure the chairs of the strategic health authorities are accountable to the secretary of state for health. The chief executives of the strategic health authorities are accountable to the NHS chief executive, permanent secretary.

The chairs of primary care trusts and NHS trusts are accountable through the strategic health authority chairs to the secretary of state for health.

The chief executives of primary care trusts and NHS trusts are managed through their chair but are also accountable for the performance of their organisations to the NHS chief executive /permanent secretary.

The regional commissioners of the NHS appointments commission hold health authority chairs to account through annual appraisal. They will also work with health authority chairs to address performance issues of NHS trusts and PCT boards.

4.2 Role of boards

The role of boards within the NHS has increasingly changed with each NHS re-organisation with the initial role of boards and their members based on a standard commercial model.

UK commercial, public companies are governed by boards made up of executive and non-executive directors:

- the boards are unitary, in that all directors, non-executive and executive are collectively accountable, (this is not the case in American and German corporate governance models)
- the number of non-executive directors exceeds the number of executive
- the chairman is non-executive

The roles and responsibilities of boards have developed and been clarified over time. Historically, non-executive directors on boards were from the 'old boys' network, held many directorships and gave little time to them. However general disquiet about the lack of clarity about the role, responsibilities, and performance, of non-executive directors them, lead to the Cadbury Report Committee on the financial aspects of corporate governance 1992.

Cadbury said that the role of the non-executive director was to bring an 'independence of judgement' to matters of:

- strategy
- resources (including the appointment of executive directors)
- performance management
- governance

More recent events have lead to the issue being revisited. In the UK, the DTI set up the Higgs Review, the report of which was published in Jan '03. Higgs recommendations aim to 'promote the effectiveness and accountability of non-executive directors and increase rigour and transparency in the appointment process'. He sets out the non-

executive role as being 'the custodians of the governance process' with particular reference to:

- strategy
- performance
- risk
- people

The report stresses that the non-executive role is complex, demanding and requires skills, experience, integrity and particular behaviours and personal attributes.

4.3 NHS boards

The duty of an NHS board is to add value to the organisation, enabling it to deliver healthcare and health improvement within the law and without causing harm.

The board:

- is collectively responsible for promoting the success of the organisation by directing and supervising the organisation's affairs. Should provide active leadership of the organisation within a framework of prudent and effective controls which enable risk to be assessed and managed
- should set the organisation's strategic aims, ensure that the necessary financial and human resources are in place for the organisation to meet its objectives, and review management performance
- should set the organisation's values and standards and ensure that its obligations to patients the local community and the secretary of state are understood and met.

With the introduction of the internal market and the dismantling of the pre existing bureaucracy, came the need to establish new governance arrangements. The company board model was adopted. In addition to answering the governance need, it was felt that the board model would also bring with it a commercial mind set, and thereby assist in the organisational changes, which the government was seeking to achieve. The introduction of non-executive directors would also provide an opportunity for people from industry and commerce to contribute as non-executive directors, thereby introducing their commercial skills to the running of the NHS. The secretary of state for health appointed chairmen and non-executive directors. The expectations of NHS boards reflected those of boards in general.

The NHS adopted best practice as it developed, including the Cadbury recommendations, and the combined code on corporate governance.

In 1995, at the request of the Prime Minister, the Nolan Committee spent six months inquiring into standards in British public life. They concentrated on members of parliament, ministers and civil servants, executive quangos and NHS bodies.

Following the first Nolan report all non-executive positions in the NHS were subject to open competition, through public advert and interview. Appointment continued to be by the secretary of state of health.

Between their inception, and 1997, NHS boards reflected the changes that were taking place in commercial boards. Like them, they experienced the gradual increase in the role and requirements of the non-executive directors. NHS non-executives moved from a position of a maximum of 3 days per month input, (one board meeting per month and

two subcommittees), to one where at least 5 days were required to cover the increased responsibilities placed on them.

With the change of government in 1997 and the shift from competition to an emphasis on partnership, non-executive directors began to express some confusion about their role. In order to establish some clarity in the new environment, in February 2001, the NHS confederation undertook a review of the role of the non-executive director. The review described the role as being:

- steward
- guardian
- ambassador

In April 2001 the NHS Appointments Commission was established as a special health authority with responsibility for making all chairmen and non-executive appointments.

4.4 The future

The general view is that the government is seeking to achieve greater engagement of the public in general, and users and carers in particular. Commercial boards do accept that they have a responsibility to "ensure that shareholders, customers, employees and other stakeholder interests are given due consideration as well as ensuring that the company is run in a way that is not adverse to the wider community, recognising its social responsibility and any environmental impact" (response to the review of the role and effectiveness of non-executive directors consultation paper: legal and general). However such a commitment is complex enough for a company board, where the products and customers are clearly defined, it may not be achievable for trust boards, in an organisation as complex as the NHS. The mutual model is felt to be more appropriate.

A fundamental element in the proposal to establish NHS foundation trusts is the move to 'public interest companies' which will operate 'rather like a co-operative or mutual society with members drawn from the local community, effectively owners of the organisation'. Governance arrangements will be:

- **members**, who will be eligible to vote for their representatives on a
- **board of governors** who will elect the chair and non-executive directors of the
- **management board**

Reflections

- The establishment of the internal market was aided by the adoption of the commercial board model.
- The creation of trusts as statutory bodies was material in supporting the devolution of authority and responsibility.
- Insufficient attention was paid to full understanding across all aspects of the system. In particular health authorities were insufficiently engaged.
- There was no common understanding throughout the service, of the role and responsibility of the board. For example, some staff thought the board was responsible for the management rather than the governance of the service. This caused significant tensions.
- A model that had supported the market was perhaps less appropriate when competition was replaced with partnership working and a greater emphasis placed on citizen engagement.

5. PATIENT AND PUBLIC INVOLVEMENT IN HEALTH

5.1 Community health councils and patient and public involvement

The NHS Plan heralded the abolition of community health councils. For over 25 years they have played the role of health watchdog on behalf of users of health services. They breathe their last on 1st December 2003 to be replaced by a completely new system of patient and public involvement. The 2002 NHS reform and healthcare professions act put greater public involvement at the heart of the NHS modernisation agenda.

There is a new raft of organisations for us to get to grips with at national, regional and local levels of the NHS. These are in various stages of formation.

5.2 Commission for Patient and Public Involvement in Health

At the centre is the **Commission for Patient and Public Involvement in Health** (CPPIH) - a new independent non-departmental public body. It was set up in January 2003 by the Department of Health and reports to the secretary of state for health. The Commission is chaired by Sharon Grant and there are 10 other commissioners who monitor the Commission's performance. It is based in Birmingham and has nine regional centres.

The Commission's main role is to establish the new system of involvement for England that will give the public a voice in the decisions that affect their health and an influence in wider health issues. It aims to work closely with groups including those already involved in health care, government and non government organisations and the voluntary sector.

5.3 Patient and Public Involvement Forums

Patient and Public Involvement Forums (PPI forums) will be at the heart of the new approach. There will be one forum for each NHS trust and primary care trust in England, 571 in total. They will each comprise between 15-20 volunteer members, recruited locally, to reflect cultural, ethnic and social make up of their local communities and trained appropriately.

The forums once established will:

- be the main vehicle for the public to influence strategic priorities and day-to-day management of health services in their local area;
- be an independent critical friend on wider health matters in their community such as environmental health;
- review services from the patient perspective and monitor responses from local health services to complaints from patients.

The PPI forums legal powers will include:

- the right to go where patients go, entering all buildings NHS patients go to
- the right to a response from the NHS to what they recommend
- the right to a PPI Forum member as a non-executive director of the trust
- the right to raise concerns with more senior NHS management or a national body.

It is anticipated that the majority of PPI forums will be in place by the end of 2003.

They will develop effective groups and ensure clear channels of communication in a local community. They will also very importantly help encourage maximum involvement in a wide variety of ways.

5.4 Local network providers and independent complaints advocacy service

Local network providers will support the PPI forums. They are not-for-profit organisations that have been contracted locally through a competitive tendering process. Each local network provider will use their knowledge, experience and existing contacts within the local community. The commission's nine regional centres will manage local network providers and offer additional support in areas such as training and regional communications.

An **independent complaints advocacy service** (ICAS) is also being established to support patients who have concerns about their care and treatment.

5.5 Health scrutiny – overview and scrutiny committees

The final piece of the jigsaw is the new system of health scrutiny that has been given to local authorities with social care responsibilities. **Overview and scrutiny committees** (OSCs) have been in existence since 1st January this year. For the first time, elected community representatives have the right to scrutinise how local health services are provided and developed for their constituents. OSCs have powers to consider local services by inviting senior staff to give evidence on how local health needs are being addressed.

They also have a major role to play in public consultation on major changes in services, being the only organisation with the power to refer a decision to the secretary of state for health.

By the end of 2003, all these new organisations will have taken the place of community health councils.

6. PLANNING AND PERFORMANCE MANAGEMENT IN THE NHS

6.1 NHS performance indicators

Performance targets were set out for the first time for a three year period in the priorities and planning framework for 2003 – 2006 “improvement, expansion and reform: the next 3 years” published in September 2002 (see Annex 3). This outlined the progress required towards realising the vision of the NHS Plan. Previously planning had been undertaken annually.

Primary care trusts take the lead in planning and are responsible for creating local delivery plans (LDPs) that describe NHS and joint NHS and social care priorities in their area. The targets in the priorities and planning framework and the objectives in the NHS Plan and national service frameworks, as well as the needs of the local community, guide the plans. The local development plan is a 3-year plan, which is agreed with the strategic health authority and has milestones at monthly, quarterly or annual intervals.

The arrangements for monitoring and performance management are that:

- each organisation has its own system.
- PCTs hold provider organisations to account for the delivery of services which they have commissioned
- strategic health authorities (SHAs) hold all NHS organisations to account for performance
- the Department of Health holds SHAs to account for the performance of the NHS within their area.

Monitoring and performance management focuses on targets for three years. There is routine monitoring of national standards and past targets where appropriate to ensure they continue to be met.

Thus the strategic health authority monitors the performance of the NHS trusts and PCTs against the progress outlined in the LDPs. They measure whether performance targets are being met and assist in addressing problems at an early stage.

Primary care trusts hold the trusts to account for the delivery of the services they have commissioned. As all targets are set by Department of Health it is important for PCTs to include local targets specific to their areas in local delivery plans. With all the pressure to meet NHS performance indicators, national targets, and CHI clinical governance areas there is a real possibility of local PCT priorities being squeezed out. Therefore it is the strategic health authority’s responsibility to monitor these for PCTs. In addition strategic health authorities need to ensure organisations are encouraged to work collectively not competitively for better service provision.

6.2 Star-rating system

All trusts are assessed on their performance each year against a limited number of key targets and a larger number and range of indicators. Key targets are the most significant factors in determining their overall performance ratings. Trusts with high performance ratings have to do well against a rounded set of indicators.

The indicators are spread across clinical, patient, and capacity and capability areas (see annex 3). Information from CHI's reviews is used to determine poorly performing (zero star) and high performing (three star) NHS organisations.

“Raising standards – improving performance in the NHS” has recently outlined measures to ensure that all hospitals achieve high levels of performance. Two and three star NHS trusts can access individual Modernisation Agency programmes to help remedy specific problem areas. The agency will target its support on zero and one star organisations.

Trusts know which indicators are used for the rating but not how they are marked, although targets are key to the rating. If a trust gains a 3* rating they will enjoy increasing freedom from the centre. This could include the ability to sign off capital expenditure and the connected ability to apply for foundation status, which will attract investment and patients and bring money under the new financial flows scheme.

However if the trust fails and gains a 1* or 0* rating then there is a sliding scale of consequences. Zero star trusts are allocated a client manager and £250k minimum of advice and support. If problems persist a franchise manager could be put in.

One star trusts will have an intense 9 month programme of work with the Modernisation Agency to improve performance, with 50% of the costs of the programme funded by the Agency.

CHI assumed responsibility for the performance ratings for the first time in 2003, and this responsibility will transfer to CHAI on its establishment. The NHS reform bill currently in process proposes that CHAI develops a new office for information on healthcare performance, which will be independent of the NHS and will publish an annual report to parliament (see annex 1).

The use of performance indicators to rate trusts is controversial for a number of reasons:

- it is possible to miss key targets but do well in other areas and still be awarded a low rating;
- the ratings are assessed comparatively – it is not a system using absolute measurement;
- public perception of the rating system is a problem;
- trusts may be seen as failing organisations when in fact their clinical governance is excellent;
- the system is retrospective and static, so trusts rapidly improving or deteriorating are very likely to be treated unfairly;
- the Audit Commission has recently criticised the system, having found several highly starred trusts had weak management and financial arrangements, and some zero starred trusts performed better than them.

6.3 Franchising

For failing trusts, franchising is a last resort. The franchise is for 3 years and is designed as a turnaround exercise. The strategic health authority will define what a hospital is to achieve and then advertise a specification for a management team. These teams can come from any 3* trusts, 8 identified private sector providers, or public sector management consultancies. The private sector providers listed are:

- BMI Healthcare Ltd
- BUPA Hospitals Ltd
- Capio Healthcare UK Ltd

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- Hospitalia activHealth gmbh
 - Interhealth Canada Ltd
 - Quo Health
 - Secta Group Ltd
 - Serco Health

However there is a fear from 3* trusts that if they take on this role and fail they will also lose their 3* rating. In addition with the advent of foundation hospitals there is little interest by 3* trusts in franchising at present.

The first NHS trust to be run by the private sector was announced in August 2003. Secta group has agreed a 3 year franchise agreement with the Department of Health for supplying the first franchise Chief Executive for the Good Hope Hospital Trust. The trust was given zero stars in the 2003 performance ratings.

6.4 Local view of the performance framework

Trusts can do well on targets but still have an unhealthy population. The emphasis on targets is difficult to get away from. SHAs should take a local view of the performance framework by also including the health of population, patient experience, clinical outcomes, staff experience and public perception to remind the board of the trusts that they should be concerned about these as well as targets.

Reflections

- SHAs are the local NHS headquarters and therefore must ensure that performance is managed.
- As SHAs have the responsibility for performance management they need techniques to drive authority. They have power of franchising but must also recognise that in order to motivate their PCTs they must include their local priorities too.
- With CHI taking on the responsibility for the star rating system, SHAs confirm the view of PCTs in their areas that CHI, previously seen as a developmental organisation, is increasingly feeling like an inspectorate, akin to OFSTED, the independent schools inspection service for the education service, but for the NHS. SHAs have responsibility to pick up on issues that CHI raises about the trusts' performance in their area and this pressure has led to the development of different styles of management between SHAs and PCTs.
- The obsession with targets is difficult – ultimately SHAs must assist their trusts to reach targets but must also balance public perception, patient experience and clinical governance. SHA's role can often lead them being pulled in either direction by the Department of Health and the trusts. They may find themselves arbitrator or negotiator one day and co-ordinator the next - developing clinical networks, getting organisations to work together.
- With the clear consequences of a 3* or 0* rating chasing the ratings is a balancing act for trusts. When trusts were told that they would be assessed for their accident and emergency ratings during one week in March all resources were thrown in for that week not reflecting the true picture. Targets are so political and the consequences so clear. The ability to reach targets is not a real view of quality in many organisations.
- Increased investment in information systems will be essential to successfully manage performance

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- SHAs have a PR role, to help public understanding of the star rating system. For public confidence to be maintained they need to understand that a 0* Trust is not a failing organisation. SHAs role must include liaison with the local media to explain performance management of trusts.
 - Ultimately SHA want to be a 5* health service not just a 3* health system.

7. THE COMMISSION FOR HEALTH IMPROVEMENT ASSESSMENT PROCESS

7.1 The Commission for Health Improvement (CHI)

The NHS Plan (2000) set out radical change for the NHS to be achieved over a number of years, including changed systems covering “core national standards and targets” and “independent inspection to assure quality”. This would enable local people to know how effective their local health services are and help identify all that is good about an organisation as well as highlighting problems that need to be addressed.

“A first class service – quality in the NHS” sets out a framework for setting, delivering and monitoring standards within the health service (June 1998). NICE (National Institute for Clinical Excellence) (see Annex 1) and the Department of Health are responsible for setting national standards including the national service frameworks that must be delivered locally. This local activity is assured through patient and public involvement, professional self-regulation, clinical governance, lifelong learning. Then the Commission for Health Improvement (CHI) is responsible for monitoring and reviewing how this is done through clinical governance reviews.

7.2 Clinical governance

Clinical governance is defined as “a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care can flourish”. The key components of clinical governance include:

- a comprehensive programme of quality improvement activity, such as clinical audit and evidence based practice;
- clear policies aimed at managing risk; and,
- clear lines of responsibility and accountability the overall quality of clinical care.

This framework gives organisations a clear view to see how they are doing things and how to continuously improve quality. Clear policies for accountability and clear lines of responsibility are essential. Trust boards in the past have always been accountable for finances now they are also accountable for clinical governance issues.

7.3 CHI clinical governance review

CHI started operating on 1 April 2000 with a remit to improve the quality of patient care in NHS across England and Wales; and to reduce unacceptable variations in care and ensure that every NHS patient receives a high level of care.

To achieve this CHI reviews every NHS organisation every 4 years (this include PCT trusts, acute trusts and mental health trusts); investigate matters referred by the secretary of state/first minister or matters chosen by CHI; and study the implications of national service frameworks.

CHI’s principles are to be patient-centred; independent and fair; developmental; evidence-based; open and accessible; and, same expectations apply to reviewers.

There are two parts to the clinical governance review – technical and organisational.

The technical components are:

- consultations and patient involvement
- clinical risk management
- clinical audit
- research and effectiveness
- use of information about patients' experience
- staffing and staff management
- education, training and continuing personal and professional development

These are aimed at looking at the culture of the organisation and what works well in their own particular circumstances. These are then scored.

The organisational components are:

- organisational and clinical leadership
- direction and planning
- performance review
- patient and public partnership

The findings in relation to both the technical and organisational components are fed back to the trust verbally and in a written report, which is a public document. The trust then has to agree an action plan with CHI to address any issues identified.

From July 2003, CHI has become responsible for assessing the 'star ratings' of trusts. They do so by reference to trusts' performance against a series of specific targets and by reference to their own report on the trust's clinical governance performance (see p.13).

“Effective clinical governance should therefore ensure:

- continuous improvement of patient services and care, a patient-centred approach that includes including patients courteously, involving them in decisions about their care and keeping them informed;
- a commitment to quality, which ensures that health professionals are up-to-date in their practices and properly supervised where necessary;
- a reduction of the risk from clinical errors and adverse events as well as a commitment to learn from mistakes and share that learning with others.”

The outcome of the review visit is a report, a series of scores and an action plan.

Reflections

- CHI aims to give a comprehensive, consistent and comparable review of NHS organisations and ensure a focus on clinical governance. CHI are not reviewing services but looking at processes. If the processes are working they could be spread across departments and vice versa.
- CHI assesses that the NHS, as a whole, is getting better. National standards are leading to better services, staff have higher skill levels and patients and users are more involved. However improvements are still patchy and inconsistent.
- CHI aims to assist organisations to know how well they are doing in terms of current benchmarks and how to improve. They are keen to be seen as developmental however trusts see their role as more of an inspectorate in

particular when CHI become responsible for setting the star ratings this will be more so.

- So where next for CHI? CHI is a relatively new organisation and is still developing processes. One of their main issues at present is credibility. The review process itself is time consuming and at present many of their reviewers are seen as too junior. This is compounded by the fact that many are seconded staff with restricted time availability. There is an urgent need for the involvement of more senior level, respected, dedicated staff in the review process.
- Although CHI is responsible for reviewing all NHS trusts they are not at present involved in reviewing the private sector. With the push to utilise private services to enable more patient choice in the future this may be a clinical governance area CHAI will have to focus on.
- CHI is a growing, evolving and changing organisation and will change again when the act goes through parliament to become the commission for healthcare audit and inspection (CHAI). Their role and remit expanding further in particular their ability to set the star ratings will have an impact on how they are viewed by the trusts.

8. REVISED FINANCIAL FRAMEWORK FOR THE NHS AND REVIEW OF PROPOSED FURTHER DEVELOPMENTS

8.1 NHS financing and capital funding

The main source of finance for the NHS is funds voted by parliament out of general taxation. These funds are allocated to the Department of Health to distribute and manage. The chief executive of the NHS, as the accounting officer, is accountable to parliament for the way in which the funds have been used.

Methods for distributing funds to the NHS are changing. The old system, where funds flowed through health authorities to primary care trusts and NHS trusts, has been replaced from April 2003. In the new system, funds are allocated directly to primary care trusts who have the responsibility for routing the money to NHS trusts.

Previously most revenue was allocated according to the national weighted capitation formula. This took into account population, age profile, health needs and the relative costs of products used in different parts of the country. This is being modified.

NHS trusts receive most of their funding from primary care trusts via service agreements. They also receive funding from central budgets, for example for research and development and education and training of medical and nursing staff.

Capital funding is spent on buildings and equipment. Again, the system changed in April 2003. Operational capital which is used to keep buildings and equipment up to standard was allocated directly from the department to NHS bodies on a formula basis; decision about distribution of strategic capital, which is used to achieve strategic changes such as a new hospital, is taken at strategic health authority level. Capital projects over an agreed size are required to be tested for potential private funding (through a PFI).

This new financial system, introducing payment by results, will aim to support the movement of patients between providers, enable choice, incentivise extra capacity and improve value for money.

8.2 Introducing payment by results

The Department of Health policy "*reforming NHS financial flows: introducing payment by results*" was published in October 2002 and heralds a radical modernisation of NHS finances.

A quotation from the DoH web site (see www.doh.gov.uk/nhsfinancialreforms for more information) is a useful introduction to the policy:

"The aim of the new financial system is to provide a transparent, rules-based system for paying trusts. It will reward efficiency, support patient choice and diversity and encourage activity for sustainable waiting time reductions. Payment will be linked to activity and adjusted for ⁶casemix. Importantly, this system will ensure a fair and consistent basis for hospital funding rather than being reliant principally on historic budgets and the negotiating skills of individual managers.

⁶ Casemix is the mix of different types of patients or the mix of treatments and care they receive

Under the reforms to NHS financial flows, instead of being commissioned through block agreements as previously, hospitals (and other providers) will be paid for the activity that they undertake; so:

Primary care trusts (PCTs) will commission:

the volume of activity required to deliver service priorities,⁷ adjusted for casemix (i.e. the mix of types of patients and/or treatment episodes)

from a plurality of providers

on the basis of a standard national price tariff, adjusted for regional variation in wages and other costs of service delivery.”

8.3 Context – why is a change in financial policy needed?

Rising public expectations and greater knowledge about options for health care are driving demand for better quality services, provided promptly and conveniently at the location of their choice.

The growth resources allocated to the NHS in national plans from 2003 to 2005 are at record levels and high growth is promised in the next plan from 2006 to 2008. The extra resources have many calls on them and challenging targets set for service improvements depend on the NHS achieving efficiency gains through service modernisation as well as investing growth money wisely.

The NHS reforms that require the adoption of the new financial flows policy are:

- patient choice – the policy to offer choice to patients will benefit from the introduction of national tariffs. Standard tariffs make choice less financially complex for PCTs to manage and reduce the potential disincentives of differential provider prices.
- waiting lists – the tariffs have been set at the full national average cost of treatment that will give most providers a financial incentive to offer more capacity.
- modernisation - prices based on full average cost rather than on the marginal cost of extra care give PCTs a financial incentive to redesign⁸ care pathways to improve access while avoiding some of the cost of extra capacity.
- structural changes including the devolution of resources to PCTs, the establishment of free standing foundation trusts, the increasing plurality of care provision as private, voluntary, the new diagnosis and treatment centres and international providers are commissioned to care for NHS patients.

The increasing complexity of modern medicine and the resultant sub specialisation and interdependencies between specialties require commissioning to become more sophisticated to meet patients' needs. An example is the need to commission along the

⁷ Casemix-adjusted payment means that providers are not just paid for the number of patients they treat in each specialty, but also for the complexity of the mix of patients treated. In future each HRG's average reference costs will be the basis for adjusting payment to trusts for the complexity of patients they treat.

⁸ Care pathways are the series of treatments/care a patient has with the health service for a given condition. These components make up a complete pathway and can include primary, secondary and palliative care and even social services. Streamlining patient care pathways and improving communication and coordination are key to improving the patient's outcome and experience.

whole care pathway in cancer networks that span primary, multiple secondary providers, tertiary providers and voluntary sector provision of home nursing support and hospices. Tariffs will enable the commissioning of more sophisticated patterns of care while avoiding some of the extra administrative costs which could arise from complex commissioning.

8.4 The components of the financial flows policy

Standard national tariffs

- these have been developed using the national⁹ healthcare resource group analysis of treatments and costs. HRGs have a number of shortcomings including that they mainly cover acute care at present but the scope is being widened to encompass the majority of care. HRGs have some advantages:
 - the data exists and has been produced annually for 6 years
 - the variation in costs and volumes between procedures and organisations has reduced substantially as the NHS became aware it may be used for tariffs
 - there was substantial clinical involvement in developing the HRG definitions so they reflect UK practice but it was done seven years ago and needs updating to reflect modern practice and the latest technologies
 - prices derived this way reconcile to the expenditure and resources actually available in the NHS
- the Department of Health is responsible for adjusting price tariffs for inflation and cost pressures, this avoids PCTs repeating that analytical work hundreds of times across the country each year. The DoH has adopted the role of price regulator in this reform; in other countries that role has been given to independent bodies.
- the tariffs are adjusted for market forces factors to reflect regional variations in costs, the adjustment mirrors that used in the resource allocation formula (weighted capitation) used for PCTs.

8.5 Implementation of the financial flows policy

The policy is being implemented gradually to give the NHS time to adapt working processes to take advantage of the opportunities. It is also being refined, for example, work to bring healthcare resource group definitions up to date and extend their scope beyond acute care.

The initial scope of financial flows from April 2003 includes commissioning all additional care for the top 15 waiting list HRG codes on a cost per case basis at national tariff prices. These include cataracts, hips, knees, arthroscopies, cardiac procedures and breast surgery. The tariff prices give providers a financial incentive to deliver extra volumes of care in these HRGs up to the levels agreed by PCTs. If a provider underperforms on the agreement then PCTs will have the resources back to buy elsewhere.

It also requires PCTs to commission the 6 main waiting list specialties (ophthalmology, cardiothoracic surgery, ENT, trauma and orthopaedics, general surgery, urology) using cost and volume agreements with national standard case mix weighting¹⁰. This replaces the block agreements used in many areas since the abolition of the internal market in

⁹ healthcare resource group – these are groupings of treatment episodes which are similar in resource use and in clinical response.

¹⁰ Cost and volume commissioning agreements state the volume, mix and price per case that the PCT pays for. Typically these agreements are based on forecasts and will be capped - they are not driven by demand.

1997. Block agreements operate on the basis of best endeavours with little or no penalty for underperformance whereas in cost and volume agreements there is a case mix weighted financial adjustment for under or over performance.

These implementation arrangements result in PCTs paying at national tariff prices for extra care in the 15 specific HRGs but at current locally negotiated prices for all other care. There are significant variations in relative costs between trusts with some as high as 20% above tariff and some 20% below so local purchasing power varies considerably according to which trusts a PCT commissions from. The published national reference cost index gives PCTs a clear view of the relative costs of all NHS providers and that information should be used as part of the commissioning process. The aim is for commissioners to encourage higher performance to meet local needs and to buy elsewhere if providers cannot deliver.

The second stage of implementation from April 2004 is expected to include more individual HRGs and commissioning all surgical specialties on a case mix weighted, cost and volume basis. It is of note that, although there are circa 600 HRG codes, the top 40 (by volume and by value) cover 70% of elective care.

The third stage from April 2005 will see all care commissioned on a case mix weighted, cost and volume basis at national tariff prices.

Local health communities are free to run ahead of these stages as some communities are better prepared in terms of information and current commissioning agreements than others.

When redesigning care pathways PCTs will need to make local arrangements to share the tariff price. An example would be if the PCT can improve quality and efficiency by providing post operative rehabilitation of patients after a hip replacement in a community or community hospital setting and reduce the acute care length of stay. Then because the HRG tariff price includes rehabilitation the acute trust and PCT would need to agree fair shares of that price according to which organisation carries out which element of the care.

There is a national debate about whether separate tariffs should be developed for acute care when it is delivered in a primary setting. One school of thought is that adhering to a single price regardless of setting will incentivise cost effective primary providers to offer more treatments. The contrary view is that some of the primary care (mainly premises) costs are already funded from a different budget and that the primary provider could be being paid twice for those costs. This issue will be part of this summer's national consultation on the next steps for the financial flows policy so PCTs will have an opportunity to influence the decision.

The Department of Health has ensured that the financial flows policy is congruent with PCT resource allocation policy. The same regional market forces factors have been used. It is likely, as tariffs attain comprehensive coverage in April 2005 that PCT allocations will be adjusted to reflect average national prices and that all care will be sold at those prices. This will mean PCTs pay the same price for treatments regardless of which provider is used and will make it easier to manage patient choice. It will leave all PCTs with the same purchasing power. Another major issue is how trusts will manage their expenditure to match the income they earn from national tariffs. The department anticipates managing this over a three-year transitional period from 2005 to 2008. The challenge for high cost trusts getting down to the average will be greatly eased by the growth resources and the need to expand NHS capacity which gives them the chance to

earn more resources and that the average will rise toward them. The issues are different for lower cost providers. It will not be as simple as 90th percentile trusts receiving a 10% bonus with no strings. They will need to find out why they are lower cost and do that in the context of care standards in the NHS Plan and national service frameworks and workforce development plans. A hospital may be lower cost because it is working in run down buildings or with old equipment or with insufficient doctors, nurses and other clinical staff to meet the rising quality standards of the new NHS.

Local health communities will need to consider national tariffs when developing business cases to expand services. Before the financial flows policy the key financial test was “can the health community afford the preferred option?”, now one has to ask whether the options are viable at national tariff prices for the extra care they will produce.

The tariffs bring a new dimension to costing local capacity plans and place more emphasis on exploring options for admission avoidance or redesigning care pathways because just buying more of the existing pattern of care will carry a substantial price tag. This needs to be built into PCTs’ financial strategies now rather than waiting until full implementation in 2005.

Tariffs move the emphasis of commissioning toward quality and the collaborative redesign of care pathways and away from cost because the price becomes a given.

Reflections

- There are a number of potential risks in the financial flows policy including that providers may select only the patients (for example people with no co-morbidities) who are easier to treat. There are some counters to that, firstly the clinical dialogue and collaboration between PCTs and providers, particularly as more clinical networks develop, will ensure the focus of institutions is on meeting real needs not gaming the system. A second counter is that there are plans to develop a fair price per day in addition to the treatment tariff for patients who have to stay longer in hospital for clinical reasons. The current refinement of HRGs being conducted for the department by the NHS information authority is informed by clinical reference panels and gives the opportunity to distinguish difficult cases from straightforward ones. Commissioners and strategic health authorities will need to keep a watchful eye for gaming and ensure the policy is kept up to date for those issues as it evolves.
- The incentive to add capacity may encourage thresholds for intervention to fall thus drawing in more patients. That could threaten waiting list reduction targets and financial stability. Clinical agreement about thresholds is a key aspect of the commissioning and planning dialogue between PCTs and trusts and is an essential part of care pathway redesign.
- The financial flows policy is a powerful tool for commissioners in an increasingly complex and dynamic care environment. It requires considerable thought and energy to be addressed to it during the lead in period to full implementation in April 2005. The implementation is on an exponential curve and it will be hard to catch up if the lead in period is not used to prepare for the later stage.

9. TACKLING HEALTH INEQUALITIES – BEYOND THE SECTOR WIDE APPROACH

9.1 Health inequalities

Health inequalities continue to exist in Britain. 1999 / 2001 figures show that boys / girls in Manchester can expect to live 9½ / 7 fewer years than their contemporaries in North Dorset. The gap in mortality between professional and unskilled manual men has increased almost two and a half times since 1930/2.

9.2 Policy

In 1998 Sir Donald Acheson led an independent inquiry into Inequalities in health giving a firm foundation of evidence for health inequalities in UK. Then in 1999 saving lives: our healthier nation focused on tackling major killers – cancer, coronary heart disease and stroke, accidents and mental illness. In 2000 the government launched the NHS Plan with its 10-year programme of investment and reform. This was followed in 2002 with a cross-cutting spending review that combined the two national targets of infant mortality and life expectancy. A health inequalities unit has been established in the Department of Health. On 2 July 2003 health secretary John Reid published a 3 year action plan (health inequalities – a programme for action) to tackle health inequalities across England.

9.3 Common themes

These approaches are common to both health and broader regeneration / neighbourhood renewal strategies and programmes:

- outcome focused
- evidence based
- community involvement / development
- reducing inequalities
- broader determinants
- partnership working
- prevention

9.4 Broader determinants of health

These are the factors that influence health outcomes and include:

- housing
- environment
- education
- employment
- community safety

9.5 Initiatives to address inequalities in deprived areas

There are several examples of initiatives that are *additional* to mainstream programmes (which also aim to target inequalities):

Health-based (Department of Health)

Broader programmes (Office of the deputy prime minister/neighbourhood renewal unit or department for education and skills)

-
- Health Action Zones
 - Healthy Living Centres
 - involving patients and the public in health
 - New Deal for Communities (NDC)
 - neighbourhood management pathfinders
 - local strategic partnerships
 - Sure Start / Sure Start Plus / Connexions

Health action zones:

Schemes to provide a framework for the NHS and partners working together to reduce health inequality. They have 3 strategic aims:

- identifying and addressing the public health needs of the local area
- increasing the effectiveness, efficiency and responsiveness of services
- developing partnerships for improving health and services and adding value through creating synergy between the work of different agencies.

Healthy living centres:

A network of centres across the UK funded by £300 million from the new opportunities fund (national lottery) , set up in 1998.

New Deal for Communities:

Funding programme designed to kick-start regeneration in the poorest areas

Local strategic partnerships:

Partnerships established to strengthen links between health, education, employment and other causes of social exclusion

Sure Start:

A programme of support for young people in deprived areas. It aims to ensure that all children are ready to learn when they arrive at school. Funding is targeted at 0 – 3 year olds and was boosted in the NHS Plan.

New development: Department of Health. Tackling health inequalities: A programme for action. (July 2003).

This new strategic document sets out the government's plans to tackle health inequalities over the next three years. The overall national public service agreement (PSA) target is

By 2010 to reduce inequalities in health outcomes by 10 per cent as measured by infant mortality and life expectancy at birth.

The programme for action aims to address this through a range of interventions—both health and the broader determinants. The programme is organised around four themes:

- supporting families, mothers and children
- engaging communities and individuals
- preventing illness and providing effective treatment and care
- addressing underlying determinants of health

Reflections

- Targeting resources: The current Government is addressing inequalities by focusing resources on the 10% – 20% most deprived areas. It could be argued that this approach has already been taken with developing countries, in that Britain targets the most deprived for resources/development. Current area-based

targeting in England does not aim for total coverage but prioritises, for example, young people most at risk of teenage pregnancy, STIs, substance misuse (generally coinciding with crime/poor educational attainment).

- **Targets/Indicators:** Although the use of targets is currently under considerable debate, and there are many complex targets and indicators from all departments, this is the first time that inequality has been so specifically addressed with an aim to reducing the difference between most deprived and most advantaged. As such, it is a welcome development, although one which is evolving and needs refining.
- **Partnership:** Despite the complexity of cross sector (local authority (housing, social services, education etc)/ health/ police/ NGOs/ private sector /community etc) strategic planning and ongoing management mechanisms, the opportunity to develop and deliver efficient, integrated, 'joined up', strategically planned approaches and services has been broadly welcomed by all sectors. For example, there has been widespread take-up of local strategic partnerships, well beyond those required in the 88 Neighbourhood Renewal areas. Key issues include recognising and developing partnership working skills including communication, ensuring sufficient time for processes, having the right partners involved, dealing with historical mistrust and misunderstanding, celebrating and publicising success.

KEY DOCUMENTS

“The NHS Plan”, July 2000, Department of Health (DoH)

“HR in the NHS Plan: More staff working differently”, July 2002, DoH

“Raising Standards – Improving Performance in the NHS”, May 2003, DoH

“Reforming NHS Financial Flows : Introducing Payment by Results”, October 2002, DoH

“Payment by Results Consultation : Preparing for 2005”, August 2003, DoH

“Improvement, Expansion and Reform : The Next Three Years”, DoH

“Working Together – Learning Together : A Framework for Lifelong Learning for the NHS”, November 2001, DoH

“Delivering the NHS Plan – next steps on investment, next steps on reform”, 2002, DoH

“Governing the NHS : A guide for NHS Boards”

“Unfinished Business”

“Agenda for Change”

The Cadbury Report Committee on the Financial Aspects of Corporate Governance 1992

Summary of the Nolan Committee's First Report on Standards in Public Life (HMSO)

NHS Confederation Briefing Number 81 "The Higgs Report into the role of non-executive directors"

NHS Confederation Briefing Number 75 "NHS Foundation Trusts"

NHS Confederation Report on the role of the non-executive director in the NHS (Feb 2001)

Health and Neighbourhood Renewal: Guidance from the Department of Health and the Neighbourhood Renewal Unit (2002) (www.doh.gov.uk/healthinequalities): Useful tool for health and non-health practitioners for addressing health issues. Covers background information, targets, health impact assessments, health improvement programmes etc.

WEBSITES

<http://www.nhsconfed.org/England/>

NHS Confederation website

<http://www.doh.gov.uk/nhsfinancialreforms>

NHS Financial Reforms

<http://www.doh.gov.uk/nsf/>

National Service Frameworks

<http://www.chi.gov.uk/>

Commission for Health Improvement website

<http://www.doh.gov.uk/nhs.htm>

NHS General website

<http://www.doh.gov.uk/newnhs/consdoc/exe02.htm>

NHS Performance

<http://www.doh.gov.uk/newnhs/quality.htm>

NHS Quality

www.doh.gov.uk/healthinequalities

DH website setting out policy on health inequalities, includes targets, indicators, documents

www.doh.gov.uk/healthinequalities/programmeofaction

Tackling Health Inequalities: A programme for Action

www.doh.gov.uk/involvingpatients/

DH website on involving patients and the public in NHS services

www.healthaction.nhs.uk/

website on Health Action Zone activities and evidence base for work on health inequalities

www.hda-online.org.uk/

Health Development Agency. Covers a wide range of health issues

www.renewal.net

On-line guide of what works in neighbourhood renewal

www.neighbourhood.gov.uk

Neighbourhood Renewal Unit's website. Includes publications, guidance, glossary, news

www.connexions.gov.uk/: Department of Education and Skills' Connexions website for integrated services for young people

www.doh.gov.uk/ypdpilot information on Department of Health's holistic programme for addressing teenage pregnancy, substance misuse, low educational attainment etc in at-risk young people

www.bmj.com British Medical Journal online

www.hsj.co.uk Health Services Journal online

www.nhsuniversity.nhs.uk/learn NHS University

www.doh.gov.uk/gmscontract GP Contract

www.nhs.uk/thenhsexplained Basic information about the NHS

www.doh.gov.uk/consultantframework Consultant Contract

www.doh.gov.uk/pricare/gp-specialinterests GPs with special interests

www.nhsdirect.nhs.uk NHS Direct

www.doh.gov.uk/raisingstandardsnhs Raising standards in NHS

Annex 1 - Glossary and short description of various NHS Institutions

Commission for Health Improvement (CHI) / Commission for Healthcare Audit and Inspection (CHAI)

The Commission for Health Improvement (CHI) is responsible for monitoring and reviewing how the NHS delivers the national standards and national service frameworks set by NICE and the Department of Health through clinical governance reviews. They publicly identify where improvements are required, share good practice and help the NHS raise standards of patient care.

Legislation is currently passing through Parliament that will change CHI into the Commission for Healthcare Audit and Inspection (CHAI). CHAI will take on the functions of CHI, the national care standards commission (for voluntary and private health care), and the audit commission (in terms of national studies of efficiency, effectiveness and economy of healthcare). CHAI is also expected to take over the functions of the mental health act commission in future. In addition to these CHAI will also provide an independent assessment of complaints, assess current arrangements to promote public health and act as the leading inspectorate in relation to healthcare.

National Institute for Clinical Excellence (NICE)

The National Institute for Clinical Excellence (NICE) was established in 1999. As part of the NHS its role is to give guidance on "best practice" in England and Wales. This guidance covers health technologies including medicines, medical devices, diagnostic techniques and procedures) and clinical management of specific conditions. NICE guidance helps health professionals to provide more effective treatments. Before recommendations are finalised professional and patient groups likely to be affected by changes or new guidance are consulted before finalised. Topics for NICE are selected by the Department of Health and the Welsh Assembly Government although there is a website being piloted where public, health professionals, managers and other stakeholders can make suggestions. On average clinical guidelines take 2 years to develop and technology appraisals 12-14 months. Once NICE guidance is published they are expected to be implemented by health professionals. NHS organisations must budget to ensure that they have adequate resources and facilities to implement new NICE guidance that comes out. All guidance is published on NICE's website.

NHS Bank

In May 2002 health secretary, Alan Milburn, confirmed the government's commitment outlined in *Delivering the NHS Plan* to establishing an NHS Bank by announcing the initial allocation of £100million towards the project. The bank will initially be established in shadow form with a board of governors from the NHS. Once fully established the bank will provide risk reserves for primary care trusts and overdraft facilities for NHS trusts. The bank may also be more involved in financing NHS capital investment and ensuring that decisions about capital investment are taken nearer the NHS frontline in future than in Whitehall.

NHS Modernisation Agency

Created in April 2001 this agency works closely with strategic health authorities to modernise services and develop leadership across all sectors of the NHS – primary care trusts, acute trusts, ambulance and mental health trusts. So far the agency has made a difference to healthcare by ensuring faster access to GPs, supporting zero start trusts through a programme of action, ensuring all hospitals are now in one of 29 critical care networks, patients choice agenda is strengthened, increasing numbers of patients benefiting from collaboration action on cancer. Currently initiatives include working to

support the implementation of the new NHS pay system, the new consultant contract, retention and recruitment of staff and working time directive for doctors in training.

Responsibilities:

- expand its contribution to supporting implementation of policy in access, booking and choice across health systems including a new Hospital Improvement Partnership
- support a range of primary care development initiatives targeted at access; clinical practice; PCT development; service reconfiguration and enhance primary care and intermediate services
- expand its contribution to workforce development linking support for job and role redesign, pay modernisation, and the new incentives for GPs and consultants
- provide leadership development for individuals, teams and organisations and support for career development and succession planning through the leadership centre
- promote the service changes made possible through IT
- support evidence based clinical practice
- drive innovation and build effective partnerships to spread knowledge across the NHS
- develop strategic links with similar improvement and modernisation bodies in local government and social care
- provide customised support to the most challenged organisations in collaboration with strategic health authorities

NHS University (NHSU)

The NHS University is envisioned as a 'corporate university' working with NHS staff, patient carers and anyone involved in social care to develop skills and aptitudes to the tailored needs of individuals. It will be the largest university in the world for training and education. Using both electronic and distance learning techniques the university will be both a physical and virtual institution and will offer training and courses to every member of staff within the NHS both medical and non-medical. The university is to be launched in autumn 2004 as a special health authority. The aim is that by 2010 the NHSU will be one of the first chartered corporate universities. It will not compete with existing medical schools/universities that provide pre-registration training but does hope to offer post qualifying and professional development training. Non medical courses will also be offered which include basic literacy, numeracy, language skills, communication techniques, etc.

The Patient Advice and Liaison Service (PALS)

The Patient Advice and Liaison Service (PALS) is a new and confidential service that has been created to help patients, their families and carers, to find answers to questions or concerns regarding the care or treatment they receive from all NHS services. It is also aimed to be a powerful lever for change and improvement. The NHS Plan is committed to establishing PALS in every NHS trust.

Annex 2 – Foundation hospitals

What are they?

In 2002, health secretary, Alan Milburn, set out plans for a new initiative to release the best performing hospitals from Whitehall control. These “foundation hospitals” would be created as separate legal entities and be given greater autonomy. They would be non-profit public interest companies, limited by guarantee and independent of Whitehall.

Which hospitals can become foundation hospitals?

Any hospital achieving a 3 star rating would be eligible to apply for foundation status. There will no cap on numbers of foundation hospitals and the aim is to have all hospitals at foundation status within 4–5 years with the NHS improvement programme assisting every NHS hospital to achieve this. The government does not see this as a form of elitism but a way of ensuring equity.

How will they be made up?

Foundation hospitals will have “stakeholder councils” comprised of patients, NHS staff, representatives of PCTs, NHS purchasers, patients, locally elected residents. From this a management board will be appointed.

Accountability

Foundation hospitals would be accountable to PCTs and other commissioners through agreements and cash for performance contracts. However there is still confusion over this issue and concerns have been raised to ensure that foundation hospitals do not end up with more bureaucracy than before their changed status.

Inspection

Foundation hospitals, having reached a certain standard, will only need to be inspected and rated by CHAI every 4 years. There is anxiety that this is too long a period to allow possible failing standards to go without being checked.

Human Resources

One major area of contention is human resources. Capacity in the NHS is already stretched. There are initiatives underway to develop national pay flexibilities within the NHS however foundation hospitals will have the power to pay extra on top to attract the ‘best’ staff. Although Whitehall have stated this will be allowed as long as this “does not undermine the ability of other providers in the local health economy to meet their NHS obligations.” Concerns have been raised by the NHS and others to urge the government to monitor the impact of these reforms on staffing levels.

Finance

Foundation hospitals will have access to new initiatives to access finance for capital investment eg. go the money markets, private sector. They can sell land and use it to invest in new services.

Although they will be able to borrow privately the regulator will decide the limit of borrowing any hospital can take. In addition their assets will be “locked” and cannot be used as security if the hospital fails.

Foundation trusts will be able to borrow from the NHS Bank. There is an incentive to trusts to become specialised as the more they invest – the better the value. However developing centres of excellence such as these could lead to less patient choice.

Private v. NHS patients

It will state in the licences of foundation hospitals that their primary purpose is to treat NHS patients. Private patients will be allowed but any income from private work will be capped at the level it is at when the hospital becomes a foundation hospital. This could provide an incentive for hospitals in the running for foundation status to increase their private patient numbers during this period possibly to the detriment of NHS patients. After they have achieved foundation status any increase in private patient numbers would need to be cleared by the regulator.

Failure

If a foundation hospital fails the regulator can replace the board and chief executive or another foundation hospital can take it over. In this case the assets become property of secretary of state. The treasury would be responsible for repaying the debts. There are concerns that failing hospitals are actually the ones that need more flexibility and resources to improve when it will be foundation hospitals who have these.

Reflections

- Although it could be seen as a good opportunity to escape from Whitehall control sceptics worry that this could be privatisation of the NHS by the back door. However the government states this is not privatisation but a form of public ownership – giving the public more control over their health care with the aim of binding hospitals closer to the communities in which they work.
- Others worry it will end up a 2-tier NHS – foundation hospitals and the rest, where the rest will struggle to attract and keep staff, improve services and investment with only those patients living near, or pressing for referrals to, foundation hospitals getting a better class of service.
- This emphasis on particular institutions is also questioned – should the focus not be changing instead to networks eg. a foundation cancer network?
- If it all goes wrong it will not be easy to change the system back again. Caution is urged to push all NHS trusts to foundation status in the next few years. The policy should be tried and evaluated with a select few hospitals before being rolled out NHS wide.
- Many fear that foundation hospitals will just increase competition for staff and patients within the NHS, increase health inequalities and ultimately widen the gap between good and poor performing hospitals.

Annex 3 – Performance targets

Performance targets were set out for the first time for a three year period in the priorities and planning framework for 2003 – 2006 “improvement, expansion and reform: the next 3 years” published in September 2002. This outlined the progress required towards realising the vision of the NHS Plan. Previously planning had been undertaken annually.

The priorities for the 3-year period are based on the Department of Health’s public service agreement:

- **improve service standards**
 - reduce the maximum wait for an outpatient appointment to 3 months and the maximum wait for inpatient treatment to 6 months by the end of 2005, and achieve progressive further cuts with the aim of reducing the maximum inpatient and day case waiting time to 3 months by 2008
 - reduce to four hours the maximum wait in A and E from arrival to admission, transfer or discharge, by the end of 2004; and reduce the proportion waiting over one hour
 - guarantee access to a primary care professional within 24 hours and to a primary care doctor within 48 hours from 2004
 - ensure that by the end of 2005 every hospital appointment will be booked for the convenience of the patient, making it easier for patients and their GPs to choose the hospital and consultant that best meets their needs
 - enhance accountability to patients and the public and secure sustained national improvements in patient experience as measured by independently validated surveys

- **improve health and social care outcomes for everyone**
 - reduce substantially the mortality rates from the major killer diseases by 2010: from heart disease by at least 40 % in people under 75; from cancer by at least 20% in people under 75
 - improve life outcomes of adults and children with mental health problems through year on year improvements in access to crisis and CAMHS services, and reduce the mortality rate from suicide and undetermined injury by at least 20% by 2010
 - improve the quality of life and independence of older people so that they can live at home wherever possible, by increasing by March 2006 the number of those supported intensively to live at home to 30 % of the total being supported by social services at home or in residential care
 - improve life chances for children, including by:
 - improving the level of education, training and employment outcomes for care leavers aged 19, so that levels for this group are at least 75% of those achieved by all young people in the same area, and at least 15% of children in care attain five good GCSEs by 2004. (The government will review this target in the light of a Social Exclusion Unit study on improving the educational attainment of children in care.)
 - narrowing the gap between the proportions of children in care and their peers who are cautioned or convicted; and
 - reducing the under-18 conception rate by 50% by 2010
 - increase the participation of problem drug users in drug treatment programmes by 55% by 2004 and by 100% by 2008, and increase year on year the proportion of users successfully sustaining or completing treatment programmes

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- by 2010 reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth
 - **improve value for money**
 - value for money in the NHS and personal social services will improve by at least 2% per annum, with annual improvements of 1% in both cost efficiency and service effectiveness.

Annex 4 - Human resources

Achieving the programme of change underway following the NHS Plan is dependent on staff - nearly fifty commitments in the plan are workforce led. There are 2 key objectives:

- major expansion in staff numbers (more staff)
- a major redesign of jobs (working differently)

The programme of change to deliver more staff working differently is built on 4 pillars:

- making the NHS a model '3 star' employer
- ensuring the NHS provides a model career - the skills escalator
- improving staff morale
- building people management skills

More staff: a major expansion in staff numbers

Increased investment to fund additional NHS staff is underway, as well as a range of approaches to maximise recruitment and retention. Increases in numbers of staff in training have included the development of 4 new medical schools and 3 centres of medical education.

Recruitment and retention initiatives include a national recruitment campaign, an NHS careers advice service "NHS careers", Return to Practice courses, improvements to pay, international recruitment, and the establishment of NHS professionals (for recruiting temporary staff).

Working differently: a major redesign of jobs

Staff need to change the way they work, to be more flexible, to work around the needs of patients in the new patient centred services. In addition, the NHS has to reduce the average working hours of doctors in training to comply with the working time directive (WTD) from August 2004.

A "new ways of working" team is developing role and job redesign for NHS jobs. 18 pilot schemes on 50 sites are testing new ways of working, including working in surgery, non-medical roles in anaesthesia, neonatology, and CHD catheterisation laboratories.

To prepare for the working time directive 19 pilot projects are underway to test how trusts can redesign services and jobs to meet WTD requirements. By August 2004 all junior doctors must work no more than 58 hours per week, reducing to 48 hours per week by 2009. Currently, 32.1% England's junior doctors work more than 56 hours a week without sufficient rest: there is concern that hospitals will not be able to cope due to a shortage of doctors.

The 4 pillars of change:

Pillar 1: making the NHS a model employer

A range of initiatives are in progress to improve the NHS as employer: all NHS organisations are required to achieve the practice status of improving working Lives accreditation; to undertake the positively diverse programme to manage change relating to equalities and diversity in their workforce; and to implement the zero tolerance policy to stamp out violence against NHS staff.

Nationally, the NHS has introduced an NHS Childcare strategy, increased on-site nurseries is enabling all staff to have access to a childcare coordinator. It has established NHS Professionals to support temporary staffing as well as offering flexible working for staff; and will undertake a modernisation review of NHS Pensions.

Pillar 2: ensuring the NHS provides a model career - the skills escalator

Changing services will be redesigned around patients, which will require the workforce to grow and change. This is being facilitated by 4 areas of modernisation:

- pay and rewards
- learning and personal development
- regulation
- workforce planning

Pay and rewards: “agenda for change” - a new pay system – is in development. Twelve early implementer sites started in June 2003, the rest are scheduled to follow in October 2004.

The new contract for consultants will pay more to those who do most for the NHS, and the new GP contract will widen the range of services available at GP surgeries, reform the patient experience and reward GPs for the quality of service provided.

Learning and personal development: A lifelong learning strategy for all staff in the NHS was set out in “working together, learning together”. The programme of change is considerable, and includes:

- the development of Interprofessional education – 4 pilot schemes have been commissioned between university and workforce development confederation (see below) partnerships, investigating new ways of learning together to help staff understand each others roles and work better together
- funding for professional education being reorganised with a standard contract and pricing for all NHS funded learning and development
- modernising medical careers: “unfinished business” set out plans to reform the SHO (senior house officer) grade and has prompted discussion of more comprehensive work on medical training and career opportunities
- health and education strategic partnerships to be established locally

Further initiatives have included the development of cadet schemes to widen access to pre registration education; increased investment in continuous professional development and post registration training; quality assurance mechanisms for NHS funded health education being integrated and streamlined; appraisal developed for doctors and to roll out to all staff groups; and last but not least the NHS University is being established (see annex 1).

Modernising regulation is underway to ensure that poor performance by NHS professionals is handled quickly and fairly. New councils for nursing and midwifery and for allied health professionals were established in 2002, which establish new registration and fitness to practice procedures. Reform of the general medical council legislation has changed its make up and accountability, reformed its fitness to practice procedures and introduced revalidation for all doctors. The new council for the regulation of healthcare professions has been established to ensure greater consistency of standards and accountability for all healthcare professions.

The postgraduate medical education and training board replaces the joint committee for postgraduate training for GP and specialist training authority, providing an independent authority to supervise postgraduate medical education and training.

A modern workforce planning system is required to achieve the staffing targets in the Plan. New structures have been developed:

- national workforce development board – oversees workforce planning
- workforce development confederations (WDCs) – NHS and non NHS employers and those involved in education and training work together to plan and develop the healthcare workforce for the locality. They hold the total training budget for the locality, and are to be integrated with strategic health authorities in 2004.
- care group workforce teams – 7 teams work with local WDCs and frontline staff to workforce plan for services on a care group basis.

Pillar 3: improving staff morale

The changes underway are challenging for staff to deliver and improving and maintaining their morale is vital. The approach adopted has been to highlight the NHS, communicate well, and manage media relations.

A social partnership forum, with trade union, management, and Department of Health representation, has been established to focus on issues affecting staff morale. Similarly a doctors forum was established to focus on the issues for medical staff. Staff recognition and award schemes are encouraged and a staff opinion survey will be carried out by CHAI in Autumn 2003.

Pillar 4: building people management skills

Good people management skills are essential to achieve the programme of change. A strategic vision of NHS HR management has been developed and the following approach is in progress:

- leadership through effective HR management programme
- national HR induction programme
- national HR leadership capabilities framework
- research into Practice projects
- electronic staff record – replacing HR and payroll systems covering 1.2m NHS staff