RECENT DEVELOPMENTS IN THE NHS 1997-1999

Briefing Paper

A paper by IHSD, a Resource Centre for the Department for International Development

Introduction

Sir Alan Langlands, the Chief Executive of the NHS Executive, recently wrote, “The past 18 months has been an extraordinary period of policy development… The need now is to implement these policies and make them work. The task is made more challenging by high public expectations, advancing technology and the perennial pressures in the NHS to manage waiting lists, emergency pressures, budgets and service improvements. We are at a critical stage in developing the service for the future.”

This neatly encapsulates the present position of an NHS striving to meet day to day operational demands while implementing - yet another - massive programme of change. The NHS is a key component in the new Labour Government’s pursuit of “joined up” government at national and local levels, and of transforming public services. Modernising the NHS and raising its standards of service are seen as crucial to maintaining public confidence.

Many of the new approaches are now in place – Primary Care Groups, Health Improvement Programmes, statutory duties of partnership and quality, Health Action Zones, the first major NHS PFI deals, a 3-year Public Service Agreement between the Treasury and the Department of Health. But they are too new for any serious assessment of their likely impact. This briefing note is therefore more descriptive than evaluative.

Given the scale of change, it outlines major developments only. And it focuses on England, since constitutional devolution has heightened existing divergences between the NHS in England, Scotland, Wales and Northern Ireland. IHSD can provide details of individual developments, or of developments in other UK countries, on request.

Prime Documents and Principles

The government’s vision for the NHS, and the consequent programmes of action, are set out in a raft of policy documents: see list at end. The keystone document is” The *new NHS: Modern, Dependable*”, published in December 1997. It reaffirms the government’s commitment to long-standing features of the NHS: national, universal in being open to all, comprehensive in its range of services, based on need, largely funded out of taxes, largely free at the point of delivery.

In doing so, it specifically rejects the analysis that the NHS cannot accommodate growing pressures without “huge increases in taxation, a move to a charge-based service, or radical restrictions in patient care.” It argues that the “cost-effectiveness of the NHS helps to reduce the tax burden to well below the European Union average”, and that “rationing or a charge-based system would dissipate these advantages”.

There is an argument that this White Paper, like the previous government's "*A Service with Ambition*" (1996), fudges the funding and rationing debates. Some GPs in particular have expressed concern that it denies rationing is needed while devolving responsibility for precisely that from politicians to GPs. The level of baseline funding for the NHS is likely to remain a critical issue.

The government's solution lies in modernisation and a quantum improvement in performance. "*The new NHS"* White Paper is a hard-edged manifesto for standardised high performance with clear twin goals of **quality** and **efficiency**, reinforced by greater involvement of clinical **management**.

The Health Agenda

The government puts great emphasis on **health** not just **healthcare**, and on **equity** of both access and outcomes, themes pursued in more detail in the public health White Paper, "*Saving Lives: Our Healthier Nation*". This stresses the need for concerted action by government, local organisations and individuals, who bear a responsibility for their own health. Action on **smoking**, as the single biggest preventable cause of poor health, is covered in a separate White Paper, "*Smoking Kills*". A new post of **Minister for Public Health** operates across government.

Key Health Agenda Items

- targets for reduction in deaths by 2010 in 4 priority areas: **cancer, coronary heart disease and stroke, accidents and mental illness** (suicide and undetermined injury)
- a commitment to improve the health of the worst off and **narrow the health gap** (no targets specified)
- a new **Health Development Agency**
- measures to **reduce smoking in public places** but no outright ban
- specific **targets to reduce smoking in 3 priority groups**, children, deprived adults and pregnant women
- a Europe-wide **ban on tobacco advertising and sponsorship** by 2006

Joint Working

The Government recognises that "tackling poor health and health inequality needs the NHS and local government to take joint responsibility." They have introduced a battery of initiatives to support partnership working and the integration of services to respond to the needs of the individual user. More details can be found in the IHSD briefing note on **UK NHS/Local Government Joint Working.**

Key NHS/LA Joint Working Initiatives

- **a statutory duty of partnership,** (Health Act 1999)
  a)between NHS bodies
  b)between NHS bodies and local authorities
- **joint national priorities** guidance for health and social services.
- 3 yearly **"Health Improvement Programmes"** (HImPS) involving the NHS, LAs, and the community in local strategies to improve both health and healthcare services, and improved integration with social care, and including **Joint Investment Plans**
- new **operational flexibilities, like pooled budgets, lead commissioning** and **integrated provision**
- **joint inspection and monitoring** e.g. by NHS and Social Care Regional Offices
- **Health Action Zones** (HAZ) – trailblazing partnerships between the NHS, LAs, community groups, and the voluntary and business sectors to develop and implement a total health strategy for their area. 26 HAZs have so far been announced.

The Private Finance Initiative (PFI)

Since the current Labour government took power in May 1997, 18 major hospital construction projects have been approved, of which 4 have been publicly funded and 14 developed through the Private Finance Initiative (PFI) – now more of an institution than an initiative. The value of the NHS PFI schemes currently totals over £1 billion.

The government hails the PFI as a necessary and appropriate component of its major hospital building programme. The National Audit Office confirms the potential for better value for money. But the approach remains controversial. A key concern is the extent to which the long term PFI contracts for services, covering 20-30 years, will mortgage future revenue allocations, locking NHS purchasers into outmoded models of service delivery and depressing service innovation. There are other concerns about the PFI's preference for large (perhaps inappropriately large) structures, the difficulty of securing PFI deals for smaller mental health, community and primary care schemes, the bias to newbuild rather than renovation, and the challenging throughput assumptions underpinning some of the new hospitals' reductions in bed numbers.

Mental Health

Mental health services for working age adults are considered in a dedicated White Paper, "*Modernising Mental Health Services*".

Key Mental Health Policies

- too many failures from **care in the community**
- **a National Service Framework for Mental Health** (overdue from Spring 1999)
- **joint NHS/LA assessment of needs and present services**
- services to be **based in primary care**
- **involvement of patients, service users and carers**
- **secure hospital services** to be improved

Quality

The quality agenda is fundamental to restoring confidence in the new NHS, and merited a separate consultation document "*A First Class Service – Quality in the new NHS*" (1998). Unlike earlier quality drives, it takes the issue of clinical quality head on. Public concern in the wake of a number of high profile incidents, most notably the Bristol babies' case, is likely to secure professional support for the government's initiatives. Key objectives are to improve continuously the overall standard of clinical care and reduce unacceptable variations in clinical practice. There are three components to the strategy: setting clear standards, developing local systems for delivering them, and monitoring what has been achieved.

Key Quality Developments

- a **National Institute for Clinical Excellence,** (NICE) to provide clinical guidelines based on the relevant evidence, clinical audit methodologies, and information on good practice. The first list of treatments will include flu drugs, hip prostheses, hearing aids, wisdom teeth extraction, and asthma inhalers for children.
- new evidence-based **National Service Frameworks** for major care areas and disease groups. The first frameworks will address mental health, coronary heart disease and cancer.
- a new **NHS Charter** has been explored by Greg Dyke but the government has yet to announce its decisions.
- at local level, a new system of **clinical governance** in NHS Trusts and primary care, reinforced by a **statutory duty of quality** and a requirement for Board and annual reports.
- **Lifelong Learning** through locally managed **CPD** programmes. All NHS employees must agree development plans for the majority of health professional staff by April 2000.
- **strengthened professional self-regulation.**
- **NHS Beacon services** to demonstrate best practice.
- a new independent statutory body, the **Commission for Health Improvement** (CHI), to support and oversee the quality of clinical services at local level, disseminates good practice, and tackle shortcomings.
- a **National Performance Framework.**
- a **National Survey of NHS patients.**

IT and Information

The NHS' track record in information and IT has been pretty dismal. The government sees scope for major efficiency and quality gains from harnessing the information revolution, and its "*Information for Health: an information strategy for the modern NHS 1998-2005*" sets some challenging targets.

Key Information Strategy Aims

- to enable every local NHS body to invest in **electronic patient records** (EPR) to support their own organisational requirements, including exchanging information with others.
- the ultimate incorporation of this EPR into lifelong **electronic health records** for everyone in the country.
- round the clock **on-line access to patient records** and **information about best clinical practice** for all NHS clinicians.
- genuinely **seamless care for patients** through GPs, hospitals and community services sharing information.
- fast and convenient **public access to information and care** through on-line information services like **NHS Direct** and **telemedicine**.

Much of this remains aspirational, not least because a good deal of the NHS IM and T expertise has been engaged in tackling Year 2000 problems. More generally concerns have been expressed about costs, the

complexity and time needed for the procurement and installation of such major systems, and above all the challenge of persuading NHS staff, particularly clinicians, of the benefits of IT solutions. Immediately there are some specific goals, with all GPs and hospitals to be on the NHS net by 2002, on-line booking of appointments and quicker test results.

One concrete success is **NHS Direct**, a 24-hour nurse telephone helpline **(0845-4647),** offering health advice. It will cover the whole country during 2000 and go on-line in autumn 1999.

NHS Human Resources

The NHS today is a staff-intensive organisation. Success in realizing the government's vision for the NHS will depend heavily on sufficient numbers of well-motivated, appropriately trained staff. A new Human Resources strategy was launched in 1998: "*Working Together – Securing a quality workforce for the NHS".*

Key Features of the HR Strategy

- action on recruitment and retention for each local NHS employer to include an **annual workforce plan,** year on year **improvement in retention rates** for all staff, in **representation of the local community** and in **sickness absence rates**
- **training and development plans** for the majority of health professional staff
- policies and procedures to tackle **harassment** and promote **equal opportunities**
- **staff involvement** in planning and delivering healthcare
- an **annual staff attitude survey** to measure progress on improving the quality of working life for staff
- a new **NHS Social Partnership Forum** with representation from all the national NHS management, union and employer bodies

Other HR issues include:

pay, including a review of salary structures to explore the introduction of a common pay spine for all professional, managerial and other NHS staff

staff shortages in many professions, including doctors, nurses, pharmacists and physiotherapists. Nurse shortages have led some Trusts to seek to recruit overseas, leading to complaints e.g. from South Africa; the UK DOH is currently preparing guidance for Trusts on this issue. The government has promised up to 7000 extra doctors and at least 15,000 more nurses over 3 years, plus increases in medical and nurse training places. It has also announced a new, higher paid grade of nurse consultant. See *Making a Difference: strengthening the nursing, midwifery and health visiting contribution to health and healthcare* DoH.

NHS Finance

On coming into office, the government undertook a **comprehensive spending review** of all public sector expenditure. The results were announced in its White Paper "*Modern Public Services for Britain: investing*

in Reform". The 3 Year allocation to health and personal social services has been tied to specific aims, objectives and personal targets set out in a **Public Service Agreement** (PSA) between the Treasury and the Department of Health (see *Public Services for the Future: Modernization, Reform, Accountability. Public Service Agreements 1999-2002).*

Key Financial Features of the Health PSA 1999-2002

- a firm **3 year settlement** to allow proper advance planning
- **average annual increases of 4.7%** in real terms
- within that, a ring-fenced **NHS Modernization Fund** of £5bn over the 3 years, to cover waiting lists, modernizing hospitals and systems, CPD, mental health, primary care and health promotion,
- an **efficiency target** of 3% pa to yield £1bn pa
- **no new NHS patient charges** in the lifetime of this Parliament and free eye tests for pensioners from April 1999
- any increases in **public sector pay** to be paid for out of existing resources, not the additional investment.

A key issue will be whether this level of resource is sufficient to support the Government's ambitious plans, and whether the NHS will deliver the agreed performance targets by March 2002. Over the longer term, the NHS is facing financial pressures from a new generation of expensive but allegedly effective drug and genetic therapies.

One point of detail. "*The new NHS"* White Paper announced new **unified primary care group budgets**, bringing Hospital and Community Health Services, prescribing and GMS infrastructure budgets together "within a single cash-limited envelope". This will allow PCGs to deploy almost the total local health budget in the most cost-effective way (for example, by substituting drug treatments for hospital referrals) and, if desired, switch more resources from hospital to community and primary care. It also for the first time brings the majority of primary care expenditure, including GPs' prescribing costs, within the cash limits which have applied for many years to the NHS' hospital and community health services.

NHS Structure

Despite early reassurances to NHS staff about avoiding upheaval, the new NHS is in the throes of radical structural change. The fuse has been lit in primary care with the mandatory establishment in April 1999 of Primary Care Groups in place of GP fundholding, total purchasing, multifunds and locality commissioning. To reflect the different stages of development currently found in primary care, there is a spectrum of PCG models from simply advising their Health Authority to commissioning health services directly to becoming Primary Care Trusts accountable for commissioning care and providing community services. There will be major organisational implications for other NHS bodies, particularly Health Authorities and Community Trusts.

Key Changes in NHS Structure

- abolition of **GP fund-holding scheme** from 1.4.99
- universal establishment of **Primary Care Groups** (PCGs) from 1.4.99, to improve health and address health inequalities, develop primary care and community health services and eventually to commission hospital services for average populations of about 100,000 people
- the development of PCGs to freestanding **Primary Care Trusts** (PCTs), which will blur the purchaser/provider split and provide community and primary health care, while commissioning hospital care. First PCTs to be established in April 2000
- the consequence is likely to be the amalgamation or absorption of **NHS Community Trusts**
- fewer, leaner **Health Authorities** covering larger areas, to assess health needs and lead the development of Health Improvement Programmes, but over time to relinquish direct commissioning to PCGs/PCTs
- restructured **NHS Executive Regional Offices** from 1.4.99, with a new London Regional Office to liaise with the imminent Greater London Authority
- a sizeable number of **NHS Trust mergers** and acute service reconfigurations. In England as distinct from Scotland, Wales and Northern Ireland, these tend to be locally driven, rather than centrally planned.

Performance and Services

In designing its new start, the government says that it has consciously retained what has worked and discarded what has failed. There is a strong emphasis on central targets and rigorous performance management.

Key Performance and Service Issues

- **purchaser/provider split retained** for hospital care
- **abolition of the internal market, GP fund-holding** and **extra-contractual referrals**
- **strategic co-ordination** through HImPs to replace fragmentation
- an increasingly important role for **primary care**
- **less bureaucracy, more openness**
- **better and broader performance measures** to replace the Efficiency Index
- a pledge to **reduce waiting lists by 100,000** over 5 years (baseline 1.14 million)
- faster, more responsive services like new **NHS walk-in centres** and **NHS Direct**

Conclusion

This briefing note illustrates the massive programme of change currently underway in the NHS in England. It is selective rather than comprehensive, focusing attention on major new policies and processes. Meanwhile the NHS wrestles with familiar operational challenges of ever-rising demand,

constant innovation, resource constraints, media attention and stressed staff (as evidenced by a major research publication).

Overall, reactions to the government's proposals have been characterised by support for its basic aims and principles. Few dissent from the vision of a high quality, modern NHS, working in partnership to achieve marked improvements in health as well as healthcare.

But two key questions arise about implementation. The new NHS programme in its totality is complex and wide-ranging. There are issues now about whether the NHS has the capacity and capability to deliver so much, so quickly without undermining the government's own aim of delivering to high standards and reducing levels of stress.

Beyond this immediate concern about how the changes are to be achieved lurks a larger, harder issue about where the dynamics will lead. When the 1991 NHS reforms were framed, there was no thought of "a primary care-led NHS" but the dynamics of the purchaser/provider split and the introduction of GP fundholding led to that vision in a remarkably short time.

It is hard to assess now the likely outcome of the new NHS, with its much more tightly managed systems, its clear intent to monitor and manage clinical quality, its central directives and bodies like the National Institute for Clinical Effectiveness and the Commission for Health Improvement. How far will lean, strategically focused Health Authorities working in partnership secure real improvements in health and equity? What will be the impact of powerful Primary Care Groups/Trusts and unified budgets on service delivery, on primary and community services and on the role and distribution of hospitals? Will the NHS establish itself as an attractive employer? Can rationing be avoided by improvements in productivity and cost effectiveness? The answers will become clear within the 10-year time frame the government has set for its modernisation of the NHS.

List of Key Documents

The new NHS: Modern, Dependable, Cm 3807 London 1997

Our Healthier Nation: Saving Lives CM 4386 London 1999

Independent Inquiry into Inequalities in Health Report (chaired by Sir Donald Acheson) Stationery Office 1998

Smoking Kills CM 4177 London 1998

Partnership in Action (new opportunities for joint working between Health and Social Services)
A discussion document, Department of Health London 1999

Health Act 1999

Modernising Health and Social Services National Priorities Guidance 1999/00 - 2001/02
Health Services Circular (98) 159, LAC 1998/22

Health Improvement Programmes- Supporting Guidance
Health Service Circular (98) 167 October 1998

Modernising Social Services, Promoting Independence, improving protection, raising standards CM 4169 London 1998

Modernising Mental Health Services Department of Health 1998

Managing Dangerous People with Severe Personality Disorder: proposals for policy development, Department of Health 1999

A First Class Service – Quality in the NHS, Department of Health 1998

The New NHS Charter, Department of Health 1998

Working Together – Securing a quality workforce for the NHS Department of Health 1998

Making a Difference: strengthening the nursing, midwifery and health visiting contribution to health and healthcare, Department of Health 1999

Information for Health: and information strategy for the modern NHS 1998-2005
Department of Health 1998

Modern Public Services for Britain: Investing in Reform Cm 4011 London 1998

Public Services for the Future: Modernisation, Reform, Accountability.
Comprehensive Spending Review: Public Service Agreements 1999-2002 Cm 4181 London 1998

The Department of Health website - www.doh.gov.uk – has most major DoH documents.

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