REFORM

Fewer hospitals, more competition

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March 2010

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Executive Summary

The NHS should not be immune from the drive to reduce public spending. The structural deficit in the public sector is due to sustained over-spending and the largest part of that spending was targeted on the NHS. The NHS accounted for 40 per cent of the increase in inputs across the whole public sector between 1997 and 2007.

The closure of hospital services, in most cases due to a redesign of service provision, will be one of the best ways for the NHS to reduce activities and control costs. It is consistent with the long term change in health needs. Since the conquest of infectious diseases sixty years ago, health services have defined their core business as short episodes of hospital-based treatment with the aim of reducing mortality from coronary heart disease and cancer. Now health services face the key challenge of improving quality of life for survivors with longer term conditions and reducing disability.

The NHS has been right to reduce hospital beds by over a third over the last twenty years, from 270,000 to 160,000. But these reductions have mainly been achieved in specialist care while the acute sector has only seen modest reductions since the early 1990s.

London, the North East and the North West have the highest density of hospital beds and should be expected to deliver the greatest closures of services. The North East has 4.13 beds for every 100,000 people compared to 2.54 beds in the South Central SHA. Similarly there is one acute trust site for every 73,000 people in the North East, compared to a ratio of one site for every 196,000 people in the South Central SHA.

The Department of Health asked Strategic Health Authorities to develop proposals to reconfigure services as part of the 2008 Darzi Review and, following the recession and the expectation of zero funding growth from 2011, called for updated plans by March 2010. The London Strategic Health Authority has published a plan to reduce bed numbers in the capital by a third, while other Strategic Health Authorities are currently developing plans to meet the spending squeeze.

The reconfiguration of services will be most effective if they are local initiatives carried out by locally accountable managers. But the current policy framework militates against this. While Primary Care Trusts are nominally in charge of individual reconfigurations, the Department of Health has sought to centralise decision-making over the last three years. As such, there is a risk that service redesigns become top-down exercises, which would not answer local needs and would lack local legitimacy.

A further constraint on the ability of Primary Care Trusts to effectively reconfigure services is the reluctance of Ministers and MPs to support local hospital reconfigurations. The Conservative Party is wrong to pledge a moratorium on service redesign should it win election. Such a moratorium will hold back the improvement in efficiency that the service needs.

The ability of competition to drive up health standards and productivity becomes especially important when service redesigns are being undertaken. Some take the opposite view, believing that greater competition will lead to greater capacity and so increasing cost. But this fails to consider the ability of competition to lead to productivity improvements. These can mean that the supply of health services can expand even when bed, ward and hospital numbers are falling.

In recent years NHS leaders have turned to integrated care as a model of health services that has the potential to deliver higher quality at reduced cost. However, without competition and reform on the front line, integrated care threatens to transfer bad working practices to another part of the system without reducing costs. Real innovation will come from reforming the front line, not simply driving change from the centre.

Key ways in which better standards and improved productivity could be driven in the health system include:

- Commission the service not the facility. Commissioning should not be used as a mechanism for protecting numbers of beds, wards and hospitals – commissioning should focus on health outcomes not inputs into the service.
- Commit to greater plurality in supply and reverse the "NHS preferred provider" policy. The ability of competition to drive better standards and productivity growth is crucial for ensuring that spending reductions do not lead to "salami slicing cuts" and a decline in quality.
- Commit to plurality of supply *within* existing settings – such as through approaches like service line management (where decision making and budgets are devolved to specific, clinically-led operational units).
- Ensure the rules for competition are clear, consistent and enforceable. This could involve asking the NHS Co-operation and Competition Panel to review existing provision (as well as changes to that provision).
- Incentivise service redesign through reform to make the NHS locally accountable and by clarifying the ability of Primary Care Trusts (PCTs) to retain some of the financial savings that they achieve from improvements in health outcomes and productivity.
- Incentivise service redesign through considering reforms such as giving patients a choice of PCT (to ensure that ongoing pressures for service redesign reflect the preferences and needs of consumers).

1
On the brink

Spending without reform

Over the past decade there has been unprecedented spending on the UK's public services. An equal drive to reform public services has, however, been lacking. Rather than supporting reform of services, spending increases have had the opposite effect. Public services have become less about maximising their positive impact on the community (their outcomes) and more about their inputs, such as the number of people employed. This is based on an incorrect view that the benefits of public services can be measured by the resources that they consume.

The squeeze

Given the poor state of the public finances, departments will face significant reductions in their budgets in the next Parliament.[1] Health reform must be at the heart of the debate on public spending. One in every six pounds the government spends goes on the health budget. Since 1997 spending on the NHS in England has tripled, from £35 billion in 1997-98 to £102 billion in 2009-10.[2]

Both the Government and the Opposition have pledged to protect the NHS budget. The IFS has calculated that ring-fencing the NHS budget would mean that other departments would have to face cuts of 8 per cent by 2017.[3] Ring-fencing the health budget would also isolate the service from incentives for reform.[4] Rather than changing how services are delivered to reduce spending, ring-fencing will maintain inefficiency and bring salami slicing and slash-and-burn spending cuts.

The health service on the brink

Governments can no longer use increases in budgets as an alternative to addressing structural failings in the NHS. 2010 will be the last year of significant growth in the health budget.[5] The Pre-Budget Report set out a real terms funding freeze for front line services – defined as 95 per cent of the NHS Budget – from 2011 onwards.[6] The remaining 5 per cent of services is set to see a cut. This freeze will come at a time when the health budget is facing pressure from an ageing population, the increasing costs of new drugs and new treatments, higher expectations of patients and annual increases in the wage bill. This means that, by 2017, the NHS could face a "funding gap" between £21 billion and £41 billion.[7]

Stuck on a cost escalator

The quality and quantity of care provided by the NHS has seen some improvement over the last decade. But these improvements have been less than could have been expected given the quantum of extra resources provided. As the 2002 Wanless review identified, getting more (in both volume and quality terms) for each health care pound is crucial.[8] By 2007, however, when Wanless updated his report, the NHS had failed to use the additional funding provided to produce the expected improvements in outputs and outcomes.[9] The report also highlighted how NHS inflation has absorbed much of the new investment in the past decade, with around £18.9 billion (43 per cent) of the £43.2 billion cash increase being absorbed in higher pay and prices.[10]

1 Institute for Fiscal Studies (2009), *Budget 2009: Tightening the Squeeze*.
2 House of Commons Health Select Committee (2010), *Public Expenditure on Health and Personal Social Service 2009.*
3 Institute for Fiscal Studies (2009), *How cold will it be? Prospects for NHS funding: 2011- 2017.*
4 Haldenby, A. et al (2009), *The front line*, *Reform*.
5 Primary Care Trust allocations will increase by 5.5 per cent for the next financial year with the departmental expenditure limit (DEL) for NHS England reaching £102.3 billion for the year 2010/11 (Department of Health (2009), *The operating framework for the NHS in England 2010/11*).
6 The 2009 PBR noted that NHS near-cash, front line spending – the 95 per cent of spending that supports patient care – will rise in line with inflation in 2011-12 and 2012-13 (HM Treasury (2009), *Pre-Budget Report 2009: Securing the recovery: growth and opportunity*).
7 Institute for Fiscal Studies (2009), *How cold will it be? Prospects for NHS funding: 2011- 2017.*
8 Wanless, D. (2002), *Securing Our Future Health, Taking a Long term View*, HM Treasury.
9 Wanless, D. (2002), *Securing Our Future Health, Taking a Long term View*, HM Treasury Wanless, D. et al (2007), *Our Future Health Secured? A Review of NHS Funding and Performance*, King's Fund.
10 Ibid.

Falling behind

The poor productivity performance of the public sector has been well documented. The Office for National Statistics' analysis of productivity has shown that public sector productivity declined on average by 0.3 per cent a year between 1997 and 2007. Private sector productivity, in contrast, rose by 2.3 per cent on average each year. These statistics hide the relative performance of spending in different areas – and in this respect health spending has performed particularly poorly. The NHS has lagged behind the rest of the public sector on delivering value for money.

Table 1: Private sector, public sector and NHS productivity
Source: Office for National Statistics (2009), *Total Public Service Output and Productivity;* Office for National Statistics (2009), Statistical Bulletin: *Productivity Q2 2009;* Office for National Statistics (2009), *Output per worker: whole economy: percentage change per annum, seasonally adjusted,* UK, Time Series Data.

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Average annual growth rate
Private sector	3.4	2.6	3.3	1.7	1.2	2.1	2.8	1.6	2.2	2.4	2.3
Public sector	0.2	-0.7	-0.9	0.4	-1.2	-1.4	-0.3	-0.6	0.6	0.6	-0.3
NHS	-1.0	-1.0	-2.1	-0.9	-3.4	-5.3	-5.5	-6.1	-5.4	-4.3	-0.4

Failing to learn

There are many examples of successful innovation and pioneering research within the NHS. But the service needs to get better at learning from these – addressing what the Cooksey review called the "translational gap."[11] The gains from greater innovation could be great, with some estimates being that £7 billion per year could be saved if all NHS organisations were performing as well as the top 25 per cent.[12] While there has been renewed interest in the role of the NHS Institute for Innovation and Improvement, real innovation will come from reforming the front line, not simply driving change from the centre.[13]

A problem of incentives

The design of the NHS encourages overcapacity. For example:

- Under the payment by results regime all hospitals receive a standard fee (tariff) for NHS work, such as delivering a baby. Through the tariff, NHS Trusts are incentivised to get patients through the door.
- Output based targets, such as for waiting times and patient guarantees, have further incentivised the expansion of hospital services. There are no incentives to decommission services.
- NHS services and spending continue to be directed through silos, which has allowed overcapacity to develop in some areas while allowing pressure to be built up in key junctions.

11 NHS Confederation (2009), *Making sense of the new innovation landscape*.
12 Featherstone, H. and N. Evans (2010), *Controlling public spending: The NHS in a period of tight funding*, Policy Exchange. Reducing clinical variations in working practices is seen by many to be key in increasing the productivity of the NHS. See for example, see Ham, C. "Health in a Cold Climate: Developing an intelligent response to the financial crisis the NHS", Nuffield Trust. For data on clinical variations, see for example, Smellie, W. et al (2002), "Is clinical practice variability the major reason for differences in pathology requesting patterns in general practice?", *Journal of Clinical Pathology*, Vol. 55, pp. 312-314 and Street, A. and M. Laudicella (2009), "Identifying inefficiency: Why do costs differ from one hospital to another?", University of York.
13 See for example, HM Government (2009), *Putting the frontline first: smarter government*, which outlined plans to encourage innovation through specific funds, awards, data sharing measures and a Innovators Council; see Ham, C. "Health in a Cold Climate: Developing an intelligent response to the financial crisis the NHS", Nuffield Trust, on the role of the NHS Institute for Innovation and Improvement in making savings in the future; see Haldenby, A. et al (2009), *The front line, Reform,* on how productivity and innovation in the public sector will only be achieved through changing conditions on the front line to introduce greater accountability and empowering local managers.

Silo spending

The lack of thought given to long term or strategic needs in workforce planning is an example of silo spending.

- Under the centrally planned approach, human resources are often planned on a silo basis without regard to team building, although it is impossible to make sensible decisions about medical manpower without regard to other team members and supporting staff that play vital roles in patient care (requiring a local approach).
- The NHS workforce is highly inflexible. Although some flexibility may be supported by the NHS staff passport, the NHS has focused on raising the headcount of nurses and doctors without investing in skills enabling staff to take on more complex and responsible tasks.[14]

Savings must be made in the front line

To "protect the front line" all political parties have committed to reducing backroom costs, such as the number of managers. Evidence presented to House of Commons Health Select Committee demonstrates, however, that the costs of management in the NHS are relatively small and account for a falling share of health spending.[15] In 1996-97 management costs made up 5.1 per cent of the NHS budget. By 2007-08 this had fallen to 3 per cent. It is not possible to commit to protect the front line as this is where most of the costs of services are and a better health system requires change in the front line.

Overinvesting in the wrong staff

The NHS has seen the biggest rise in staff numbers in the last decade of all public services, with headcount growing by nearly a third between 1999 and 2009. More than half of all health costs are now spent on staff, with labour costs in healthcare rising faster than those in the whole economy over the last decade, particularly since 2003.[16]

Table 2: NHS headcount, England
Source: The Information Centre for Health and Social Care (2009), *NHS Staff 1998 – 2008 Overview*.

	1998	2008	Growth, headcount	Growth, per cent
Doctors	91,837	133,662	41,825	46
Nurses	323,457	408,160	84,703	26
Scientific, therapeutic & technical staff	99,656	142,558	42,902	43
Ambulance staff	14,781	17,451	2,670	18
Clinical support	289,363	355,010	65,647	23
Infrastructure support	168,448	219,064	50,616	30
Other GP practice staff	82,081	92,436	10,355	13
Other	1,939	353	-1,586	-82
Total	**1,071,562**	**1,368,693**	**297,131**	**28**

14 Bosanquet, N. et al (2006), *Staffing and human resources in the NHS – facing up to the reform agenda*, *Reform*; House of Commons Health Select Committee (2007), *Workforce planning*; Imison, C. et al (2009), *NHS Workforce Planning: limitations and possibilities*, King's Fund.
15 House of Commons Health Select Committee (2010), *Public Expenditure on Health and Personal Social Services 2009*.
16 Office for National Statistics (2009), *Changing Costs of Public Services*, London. In 2007 labour costs represented 53.6 per cent of total costs, although for individual acute trusts, labour costs typically represent 70-75 per cent of total costs.

Pay rises have also driven up the NHS wage bill. The King's Fund has shown that growth in pay in the NHS outstripped pay in the whole economy by around 15 per cent between 2002 and 2007.[17] As *Reform* has previously documented, higher paid members of staff – i.e. registrars, consultants, GPs and managers – have done especially well from these pay rises.[18] The growth in the number of doctors has been almost twice that of the rise in lower paid employees, such as nurses and support staff.[19]

Overinvesting in the wrong buildings

The second biggest expense in the NHS is the cost of buildings, especially hospitals. Hospitals (the "medical infrastructure of the 19th century")[20] are, however, increasingly unable to meet the needs of a modern healthcare system. The key challenge of a modern healthcare system is to improve the quality of life for people with long term conditions, not the 20th century challenge of providing short episodes of hospital-based treatment to reduce mortality rates from major diseases.[21] At present more than 90 per cent of patient contacts with the NHS occur outside hospital, but 60 per cent of the NHS budget is spent in hospitals.[22] Despite this the focus continues to be on building new hospitals and expanding old ones.[23]

Table 3: Private Finance Initiative Liability for 1997 to 2017 by Strategic Health Authority
Source: House of Commons Health Select Committee (2010), *Expenditure on Health and Personal Social Services 2009*

Strategic Health Authority	PFI liability (millions)	PFI liability per 1,000 population
London	£3,113	£0.73
West Midlands	£2,116	£0.42
North East	£898	£0.35
North West	£1,919	£0.28
East of England	£1,333	£0.25
South Central	£911	£0.22
South West	£722	£0.18
East Midlands	£828	£0.16
Yorkshire & the Humber	£930	£0.13
South East Coast	£522	£0.10
England	£13,292	

17 Wanless, D. (2002), *Securing Our Future Health, Taking a Long term View*, HM Treasury; Wanless, D. et al (2007), *Our Future Health Secured? A Review of NHS Funding and Performance,* King's Fund.
18 Bassett, D. et al (2009), *Back to black*, *Reform*. The latest consultant contract has, for example, increased annual earnings by £17,500 to £119,400.
19 The Information Centre for Health and Social Care (2009), *NHS Staff 1998 – 2008 Overview*. The number of doctors rose by 46 per cent between 1998 and 2008, while the number of nurses grew by 26 per cent and support staff by 25 per cent.
20 Christie, S. (2010), "A crumbling model of healthcare", *Health Service Journal,* 14 January.
21 The Darzi Review also recognised the challenge of the "changing nature of disease" and called on the NHS to respond to the new demand of delivering personalised care to patients with long term conditions and the poor personal health, Department of Health (2008), *High Quality Care For All: NHS Next Stage Review Final Report*, pp. 27-8.
22 CBI (2010), *Best of health: Improving lives through smarter care*.
23 Data presented to the Health Select Committee in 2010 showed that public expenditure on capital spending (in nominal terms) increased from £1.5 billion a year in 1999-2000 to £5.8 billion in 2009-10. There has also been considerable capital expenditure funded by PFI. Reform has previously argued that PFI has played a significant part in getting more investment into infrastructure by providing support for public private partnerships. The role of banks in PFI brings an element of discipline and a greater appreciation of risk. Concerns have, however, been expressed over whether PFI has meant that government debts can be hidden off government accounts (Bosanquet, N. et al (2009), *Road to recovery*, *Reform*, p. 18).

Change on the front line – accountability for spending decisions

Models of service line management – which devolve decision making to specific, clinically-led operational units – have the potential to dramatically improve the productivity of health services. Decisions made by clinicians account for 80 per cent of hospital spending, but there is often little or no accountability for these spending decisions.[24] Consequently, doctors have no incentive or authority to find more cost-effective ways to deliver care.

In the UK, service line management has been developed by Monitor and McKinsey and introduced in over 35 NHS foundation trusts.[25] Treating teams of physicians as "business units", service line management allocates autonomy and accountability to the frontline. McKinsey has reported that service line management has led many hospitals to implement "activity-based" costing and more sophisticated information systems. For example:

- In County Durham and Darlington service line management encouraged the trust to introduce detailed unit level costings and revealed variations in service delivery.[26]
- Circle Healthcare has succeeded in delivering substantial productivity gains[27] through engaging individual clinicians and teams in delivery, taking ownership for targets and empowering them to make the necessary decisions and equipping them the tools and techniques to make the changes they wish to make.[28]

To achieve its full potential, however, service line management should be coupled with a shift away from the traditional centralised hospital unit. As Lord Darzi said, the NHS needs to be "localised where possible, centralised where necessary".[29] Undertaking service line management within the framework of centralised hospital trusts would provide devolved autonomy, but not encourage competition to create strong clinical leadership.

24 Bury, E. et al (2007), "How service-line management can improve hospital performance", *Health International*, Vol. 7, pp. 54-65.
25 Monitor (2009), *Service line management: an overview.*
26 Moyes, B. and G. Kane (2009), *Improving productivity and performance in the NHS – Service-line management: improving efficiency and quality*, Nuffield Trust.
27 Seddon, N. (2009), "Clinical leadership drives productivity in Nottingham", Circle Health, 22 October.
28 Bowcott, O. (2010), "First John Lewis style hospital is launched", *The Guardian*, 15 January. Also see Elins, J. and C. Ham (2009), "NHS Mutual: Engaging staff and aligning incentives to achieve higher levels of performance", Nuffield Trust.
29 NHS London (2007), *A Framework for Action.*

2
Health without hospitals

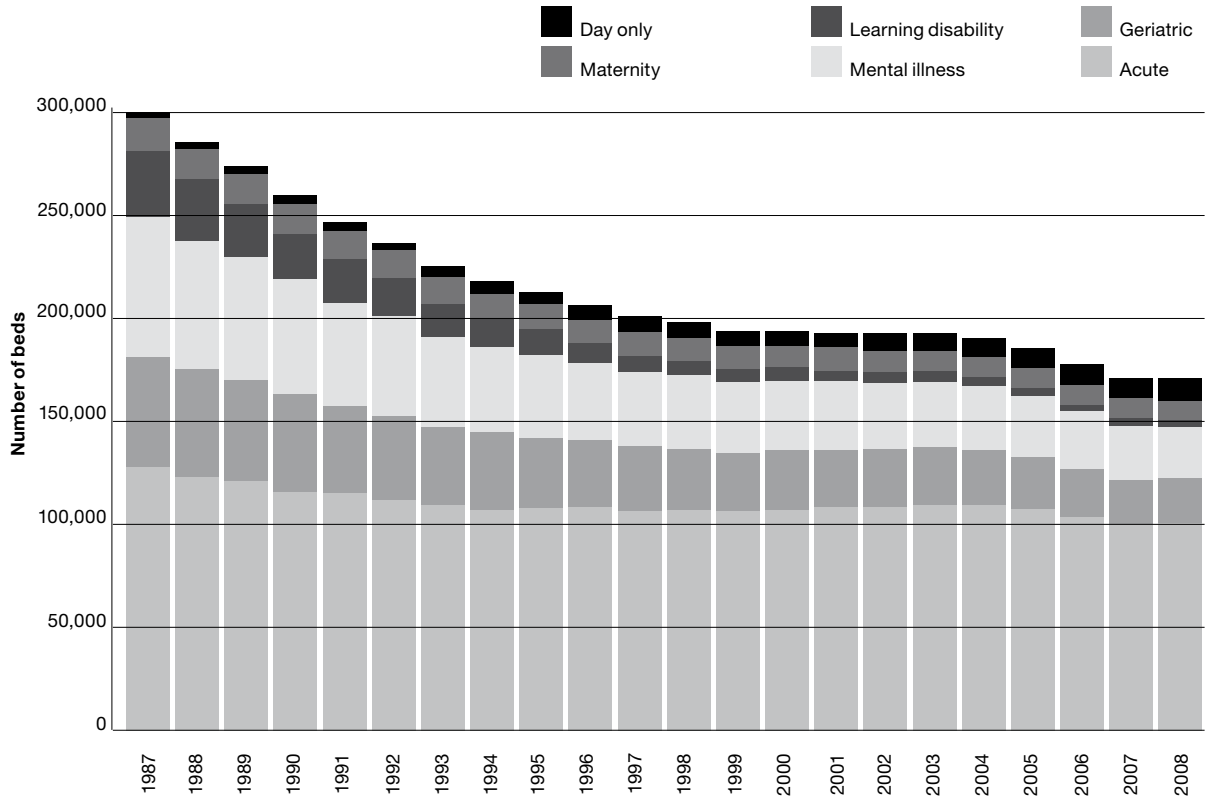
Redesigning services

Despite the hostility that the redesign of health services often provokes, there is a growing recognition that the era of declining budgets will mean that some services will not survive in their current form. Sophia Christie, Chief Executive of Birmingham East and North PCT, has argued: "it is possible to use the potential crisis of £20 billion savings to improve quality if we substitute 21st century technology for 19th century infrastructure."[30] Lord Carter, Chairman of the Co-operation and Competition Panel, has said that a "massive reconfiguration" of the NHS is necessary in the face of an imminent financial crisis.[31] Further, as Liam Byrne MP, Chief Secretary to the Treasury, recently noted: "Some hospitals will have to start doing more of their care in the community rather than in big expensive hospitals… A lot of hospitals are thinking of moving some of their business out into the community, because it is better care, more convenient, also cheaper."[32]

Health not beds

By international standards the UK has made good progress towards reducing the number of hospital beds.[33]

Figure 1: NHS beds, 1987-88 to 2008-09
Source: Department of Health, Average daily number of available beds, by sector, England, 1987-88 to 2008-09.



30 Christie, S. (2010), "A crumbling model of healthcare", *Health Service Journal,* 14 January.
31 *The Guardian* (2010), "Hospital closures inevitable over next five years", 14 January.
32 *The Times* (2010), "Hospitals to feel the axe as Treasury saves £11billion", 27 February.
33 OECD (2009), *Health at a glance: health indicators.*

The biggest reductions were made in the 1980s and early 1990s, and have tailed off in recent years. The greatest successes in moving healthcare away from hospital settings have been achieved in mental health and geriatric care, which have seen the number of beds fall by 50 per cent. Acute sector beds have remained static for most of the period, suggesting the NHS has had considerably less success in decommissioning hospital-based acute care.

Reform's review of occupancy rates reveals that the occupancy rates of maternity wards are relatively low.[34] Occupancy rates for maternity wards range from 26 per cent to 100 per cent, while the national average is 66 per cent. This contrasts with an average of 86 per cent for all ward types. 20 acute trusts run maternity wards with occupancy rates below 50 per cent, one trust with 112 maternity beds has just 45 per cent of them occupied on average.[35]

The highest rates of occupancy are for geriatric and acute plus geriatric care, with 92 and 87 per cent, respectively. These high rates of occupancy could reflect the blocking of beds by patients who could be treated in the community. Figures presented by McKinsey suggested that 40 per cent of patients were in beds unnecessarily, many of whom could be treated elsewhere.[36]

Overcapacity within Strategic Health Authorities

Farrington-Douglas and Brooks argued that while the problem of having too many hospitals applies generally across the UK, the SHAs with greatest overcapacity were London, the North East and the North West of England. Their findings are supported by recent data on overnight beds and trusts, which show that six SHAs have beds per head of population ratios higher than the national average of 3.18. These are the North East, the North West, London, the South West, Yorkshire and the Humber and the West Midlands.

Table 4: Bed Capacity by Strategic Health Authority
Source: Department of Health (2009), *Average daily number of available and occupied beds by sector, Strategic Health Authorities in England, 2008-09*; Care Quality Commission (2009), *Annual Health Check Data;* Department of Health (2006), *Strategic Health Authority Configurations*.

	Population (000s)	Total beds	General and acute beds	Total beds per 000 people	General and acute beds per 000 people
England	50,093	159,386	121,688	3.18	2.43
North East	2,545	10,516	7,730	4.13	3.04
North West	6,827	23,707	18,675	3.47	2.74
London	7,429	25,681	18,185	3.46	2.45
South West	5,038	16,760	13,527	3.33	2.68
Yorkshire and the Humber	5,039	16,526	13,140	3.28	2.61
West Midlands	5,334	17,129	13,204	3.21	2.48
East Midlands	4,280	12,210	8,828	2.85	2.06
East of England	5,491	15,533	11,803	2.83	2.15
South East Coast	4,188	11,362	8,827	2.71	2.11
South Central	3,922	9,963	7,769	2.54	1.98

34 Department of Health (2009), *Average daily number of available and occupied beds by sector.*
35 Maidstone and Tunbridge Wells NHS Trust's 75 maternity beds run at 52 per cent occupancy, and in 2008 maternity wards closed 97 times due to lack of staff. (*The Guardian* (2009), "NHS forced to turn away women in labour", 8 February).
36 *Health Service Journal* (2009), "McKinsey cost-saving proposals focus on waste in the acute sector", 3 September.

Overcapacity is further reflected in the concentration of acute care sites (hospitals). North West and London have the highest number of individual trusts, 29 and 31 respectively. The North West and London have 69 and 70 individual acute care sites, respectively. The North East, South West and North West have acute care sites per population well in excess of the national average. In addition, the distribution of Private Finance Initiative expenditure in the NHS suggests extra acute capacity has been built into London, the West Midlands, the North West and the North East.

Table 5: Acute Trust Sites by Strategic Health Authority
Source: Department of Health (2009), *Average daily number of available and occupied beds by sector, Strategic Health Authorities in England, 2008-09*; Care Quality Commission (2009), *Annual Health Check Data;* Department of Health (2006), *Strategic Health Authority Configurations*.

	Population (000s)	Acute trust sites	Population per acute trust site (000s)
England	50,093	436	115
North East	2,545	35	73
South West	5,038	56	90
North West	6,827	70	98
Yorkshire and the Humber	5,039	49	103
London	7,429	69	108
South East Coast	4,188	36	114
West Midlands	5,334	39	137
East of England	5,491	40	137
East Midlands	4,280	22	195
South Central	3,922	20	196

The overcapacity of acute care in London has been widely recognised, and the London SHA has proposed a significant reduction of the number of beds and general hospitals. In the North West, North East and West Midlands, acute facilities are concentrated in the major urban areas, particularly around Newcastle, Liverpool, Manchester and Birmingham. Service redesigns in these areas are likely to focus on providing specialised centres (hubs) and a supporting, stream-line network of general hospital facilities (spokes).

The long march to the community

Transferring care from hospitals to the community has been a key element of national policy for years.

- In 2006 the Department of Health White Paper, *Our health, our care, our say*, set out an agenda for reform that supported local innovation and the use of new providers to move services to the community. It called for a "radical and sustained shift in the way in which services are delivered" so that "more care [is] undertaken outside hospitals and in the home."[37]
- Lord Darzi's *Next Stage Review* of 2008 set out a vision to improve quality of care for all, creating a more responsive "locally-led, patient-centred, clinically driven" service.[38] It called for the further expansion of community services, moving caring closer to the home and the integration of primary and secondary care.
- This need for service redesign was reaffirmed in the Government's latest White Paper, *NHS 2010-2015: from good to great.* This paper spoke of "significant transformation in the way in which care is delivered", with the development of care in the community expected to bring annual savings of £2.7 billion.[39]

Current Strategic Health Authority Plans

The Department of Health asked SHAs to develop proposals to reconfigure services as part of the 2008 Darzi Review into NHS reform. But following the recession and with the expectation of zero funding growth after 2011 the Department of Health called on SHAs to deliver updated plans by March 2010.

With the exception of London, these plans are still to be published. However, the *Next Stage Review* of June 2008 set out a direction for the future reconfiguration of services. Following a consultation and research process, each SHA put forward a strategy for service redesign, to deliver quality, innovation and productivity in the regional health system.

Building on previous policies to transfer care from hospital to the community, these documents often called for integration of services, personal care plans for patients with long term care, redesigned patient pathways and the expanded use of ICT. These plans were laid out before the impact of the recession on future public spending became apparent, and consequently largely failed to accommodate the need to make urgent savings into these reforms.

37 Department of Health (2006), *Our Health, Our Care, Our Say,* pp.8-9; Also see p. 144: "Evidence shows that there are a number of benefits of community hospitals, one of which is that they provide better recuperative care than District General Hospitals (DGHs). 6 of the 11 leading causes of hospital bed use in the UK, eight are due to illnesses or conditions for which greater use of community facilities could lead to fewer patients needing to be in hospital or to be there for as long."
38 Department of Health (2008), *High Quality Care for All: NHS Next Stage Review Final Report.*
39 Department of Health (2009), *NHS 2010-2015: from great to good. preventative, people-centred, productive.*

Table 6: Selected features of Strategic Health Authority plans
Sources: see footnote[40]

SHA	Selected features of plans
East Midlands *Transforming services together*	Create a dedicated major trauma centre supported by centres based at other hospitals that will stabilise and care for less serious cases
	Heart attack victims taken by ambulance directly to the nearest hospital with a specialist centre that can offer Primary Percutaneous Coronary Intervention, rather than the closest hospital
	Specialist treatment for strokes at designated hospitals
	Investing £1.7 million to establish a specialist neonatal transport service to transfer newborn babies to the right level of neonatal unit in the region
	Creating an East Midlands-wide specialised mother and baby mental health service with a small number of "hubs" – specialised mother and baby in-patient units with ideally at least six beds – and "spokes" – specialised community mental health teams provided by each mental health trust
	PCTs called on to redesign services to improve the management of patient pathways between primary and secondary care
	Patients with long term conditions will be able to manage their care with support of NHS services outside the hospital, with particular focus on attempts to move care from the hospital to the home
East of England *Towards the best, together*	All 17 acute trusts will continue to have obstetric unit with a coordinated midwife-led unit
	All 17 acute trusts will continue to have an A&E department, while creating new specialist centres for primary angioplasty and major trauma
	Introduce universal 24/7 coverage of stroke thrombolysis
	Deliver more long term care close to the home, improve access to GP-led services, clinical information and diagnostics, develop better local support for post-operative recovery and ensure personal health plans for long term conditions
	Ensure that there is appropriate centralisation to improve clinical outcomes for patents who need rare or complex care, particularly specialised surgery
	Increase the emphasis on self care, pilot patient held budgets and ensure all relevant staff have received training on delivering a self care approach
	Split care from the acute sector through improved patient pathways
London *Delivering healthcare for London*	See below

40 NHS East Midlands (2008), *Transforming Services Together*; NHS East of England (2008), *Towards the best, together: A clinical vision for our NHS, now and for the next decade*; NHS Northeast (2008), *Our vision, our future*; NHS Northeast (2009), *Our strategic vision for transforming healthcare services within the north east of England*; NHS North West (2008), *Healthier Horizons for the North West;* NHS South Central (2008), *Towards a healthier future-A ten year vision for healthcare across NHS South Central;* NHS South West (2008), *NHS Next Stage Review: Our NHS, Our Future – Final Reports of Clinical Pathway Groups and System Wide Events;* NHS South West (2008), *The strategic framework for improving health in the South West 2008/09 to 2010/11*; NHS South East Coast (2008), *Healthier people, excellent care;* NHS South East Coast (2010), *Operating Framework 2010/11*; NHS West Midlands (2008), *West Midlands Acute Care Clinical Pathway Group Final Report*; NHS Yorkshire and the Humber (2008), *Healthy Ambitions*; NHS Yorkshire and Humber (2008), *Delivering Healthy Ambitions.*

Table 6: Selected features of Strategic Health Authority plans continued
Sources: see footnote[40]

SHA	Selected features of plans
North East *Our vision, our future*	The SHA has recognised its "extraordinarily high level of dependence on hospital-based care" and set out an intention to implement integrated patient pathways and greater centralisation of specialist care
	Earlier diagnostic interventions and personalised services through GP led clinics and walk in centres
	Integrated health and social care teams to ease the transfer of patients from hospitals to community settings
	Systematically review high admission rates and variations, with a view to rolling out positively evaluated community focused services such as urgent care teams and primary care centres
	Assessing future delivery models for major trauma
	Personalised services and a single underlying pathway for patients with long term conditions
	Pilot scheme in Darlington and County Durham to help with the closer alignment of services and with patients being directed to local services more effectively
	Plans drawn up to undertake an externally validated audit of acute stroke services
	New types of service ranging from primary care centres to nursing teams to support people wishing to die at home
North West *Healthier horizons for the North West*	Increase and improve alternatives to acute care to reduce hospital admissions
	Manage and commission trauma care on a regional network basis with specific work streams
	Specialisation and centralisation of maternity care through two major reconfigurations in Greater Manchester and East Lancashire
	Create a North West Quality Board and clinical leaders network to improve quality of service and innovation
	Move care to the community through personalised services and the integration of medical and social care
South Central *Towards a healthier future*	Integrated pathways for patients with long term conditions to support personalised care (a "one-stop-shop" approach to delivering care)
	Early intervention and a generic clinical pathway for mental health care developed and adapted to be used for all mental health service provision, care to be provided as far a possible in community and local settings
	Programmes such as personalised health care plans to reduce hospital admissions, which could help deliver £130 million in annual savings
	Another £18 million could be saved by ensuring greater consistency and reducing variation in referrals for surgery and emergency admissions
	Emergency and urgent care provided through a network of A&E departments, specialist emergency centres for stroke, heart attacks and trauma, urgent care centres, primary care centres, medical and surgical assessment units, GP Out-of-Hours services, minor injuries units and rapid assessment services for children and adults

Table 6: Selected features of Strategic Health Authority plans continued
Sources: see footnote[40]

SHA	Selected features of plans
South West *Better health for the South West*	Moving services, such as diagnostics, specialist out-patients and rehabilitation, closer to where people live and work
	Encouraging the integration of services traditionally divided between primary, community and social care so that a single facility may house health and social care teams, dentistry, dietetics, a chemist and a gymnasium
	Develop the optimal pathway and infrastructure for delivering care for patients with long term conditions
	Centralising services where best practice indicates this will deliver significant benefits in terms of clinical quality and safety or value for money
South East Coast *Healthier people excellent care*	By 2010 heart attack, stroke and major trauma patients will be taken to the most appropriate specialist units under an agreement with South East Coast Ambulance Service and local hospitals commissioned by PCTs
	Long term care plans, for a better approach to long term care and keeping patients out of hospital
	Specialisation and concentration of some services such as high-level trauma and cardiac catheterisation services in regional centres, centralising services where necessary and localising where possible
	Investing in community services to bring care closer to home
	Strategic intention to both improve the efficiency of specialist mental health services and to ensure that investment shifts from inpatient beds
West Midlands *Investing in health*	Emergency departments operating within networks which can deal with emergencies requiring specialist teams and which will deal with only a relatively small number of cases each year. This includes major trauma services such as neurosurgery, paediatric intensive care, burns services, primary coronary angioplasty, and hyper acute stroke services
	Reduce over reliance on hospitals through providing better information and clinical guidance for patients on alternatives to acute care
	Manage the process of reconfiguration and specialisation through local consultation and developing a vision of a health economy
Yorkshire and the Humber *Healthy Ambitions*	Ambulance bypass protocols developed for patients with stroke, acute MI, major trauma and paediatric emergencies
	Manage long term care through personal care plans, identifying people at risk, and ensuring each patient can access care and has an emergency point of contact
	Expand the use of telecare and information to enable self care and move more care nearer to the home
	Integration of services and redesign patient pathways to transfer care from the hospital to the community
	Self care increased through PCTs commissioning a wider range of services in pharmacies and primary care

London shows the way

London SHA has already floated its latest strategic plan to reconfigure services in light of future spending restraint. Major elements of this plan include:

- London is facing £5 billion in real term cuts by 2017, with hospitals required to deliver savings of £2.4 billion, the equivalent to a 3 to 4 per cent annual productivity gain.
- In 2010 the London SHA announced their intention to reduce the number of hospital beds by a third, cutting the number from 16,800 to 11,200 by 2017.
- The SHA plans that about 75 per cent of all visits to casualty and 50 per cent of all out-patient appointments, especially for long term conditions such as diabetes, will be dealt with by a network of 100 polyclinics.[41]

Reconfiguration in London is already happening in a number of locations, such as proposals to downsize Whittington Hospital in North London and transforming the King George Hospital in Ilford to a polyclinic.

Barriers to change

In spite of the examples above, a recent report by the Audit Commission reported that NHS trusts have made "little or no in-road" in shifting care from hospitals to the community or reducing demand.[42] Farrington-Douglas and Brooks also note how unpopular hospital closures can be, unless patients and staff are persuaded of the case for change and involved in the decision making process.[43] As recent examples, Ministers and MPs have often led efforts to block closures at their local hospitals:

- David Lammy, Minister of State for Higher Education, who led a march against closing the Whittington Hospital casualty department in north London.[44]
- Margaret Hodge, Minister of State for Culture, Media and Sport, and Mike Gapes, the Labour MP for Ilford South, who have campaigned against closing the Accident and Emergency unit at King George Hospital in Ilford.[45]
- Ivan Lewis, Minister of State for the Foreign and Commonwealth Office and former Parliamentary Under-Secretary of State for Health, who opposed plans to close a maternity ward at Fairfield Hosptial in Bury.[46]
- Hazel Blears, former Secretary of State and Labour Party Chair, who opposed proposals for the part closure of Hope Hospital in Salford.[47]
- David Cameron, the Leader of the Opposition, who challenged Lord Darzi's suggestion that "the days of the district general hospital are over" and claimed that the "district general hospital is an absolutely key part of the NHS", pledging a moratorium on all future hospital closures.[48]

41 NHS London (2010), *Delivering Healthcare for London: An Integrated Strategic Plan 2010-15.*
42 Audit Commission (2009), *More for less: Are productivity and efficiency improving in the NHS?*
43 Farrington-Douglas, J. and R. Brooks (2007), *The Future Hospital: The progressive case for change*, Institute for Public Policy Research.
44 *The Daily Telegraph* (2010), "Hundreds of NHS wards to be shut in secret plans", 5 March.
45 Ibid.
46 *The Daily Mail* (2006), "Farce as junior health minister joins protest against NHS closures", 29 December.
47 BBC Online (2006), "Minister defends hospital protest", 28 December.
48 *The Times* (2007), "Cameron promises 'bare knuckle fight' on NHS", 20 August.

Benefits of service redesign

Blind opposition to service redesign is wrong headed, as this means that the real benefits of change are foregone. The large literature on these benefits is summarised in an annex to this report. However, as Farrington-Douglas and Brooks note, they could include:

- Safety: more concentrated acute care can allow hospitals to recruit more experienced surgeons and ensure that they have enough staff to look after patients safely.
- Accessibility: more care could be provided in community hospitals, GP clinics or by ambulance staff at home.
- Efficiency: reconfiguration could reduce variations between hospitals in the length of time that people stay in hospital and ensure that more patients stay in hospital for shorter periods.
- Prevention: reconfiguration could reduce variations between SHAs in keeping people healthier outside hospital, make more resources available outside hospital and reduce the need for hospital care.
- Responsiveness: hospital systems (with their high fixed costs and specific assets (e.g., buildings)) tend to be less flexible than smaller and more flexible providers.
- Equity: a greater focus on prevention would also be reflected in improved equity, as there is a significant gap in life expectancy between the rich and poor.[49]

Integrated solutions?

In recent years NHS leaders have turned to integrated care as a new model of health service that has the potential to deliver higher quality at reduced cost. The Health Strategy Review undertaken by Adair Turner for the Prime Minister in 2001 examined the lessons the NHS might learn from integrated systems like Kaiser Permanente.[50]

However, experiences with integrated care in both the UK and the US have demonstrated that the successes of new models of health services are contingent on local factors, in particular a culture of responsibility, clinical leadership and a flexible workforce.[51]

Moreover, there is little evidence of vertical integration reducing costs. To make savings through the integration of care or redesigning services, working practices need to be fundamentally reformed. Without reform on the front line, integrated care threatens to transfer bad working practices to another part of the system without reducing costs.

Collaboration

Collaboration between NHS trusts and PCTs can provide many of the benefits that could be expected from the greater centralisation and integration of facilities. In London, Collaborative Commissioning and the London Procurement Programme have allowed the NHS to drive down procurement costs and commission specialist care.[52] In Birmingham, collaboration with other providers was central to the redesign of the services at the John Taylor Hospice.

49 Farrington-Douglas, J. and R. Brooks (2007), *The Future Hospital: The progressive case for change.* Institute for Public Policy Research.
50 Ham, C. (2007), "Clinically Integrated Systems: The next step in English health reform?", Nuffield Trust. See also Ham, C. et al (2008), "Altogether Now? Policy options for integrating care", University of Birmingham; Feachem, R., S. Neelam and K. White (2002), *Getting more for their dollar: a comparison of the NHS with California's Kaiser Permanente*; Shapiro, J. and S. Smith (2003), "Lessons for the NHS from Kaiser Permanente", *British Medical Journal*, 29 November. Ara Darzi's *Next Stage Review,* published in June 2008, affirmed the intention to give patients greater control over their care and personalise services. Personalised health budgets, integrated care organisation pilots, personal care plans and closer links between primary and secondary care aimed to achieve "more personal, responsive care and better health outcomes for a local population". Department of Health (2008), *Higher Quality Care For All: NHS Next Stage Review Final Report.*
51 Rosen, R. and C. Ham (2008), "Integrated Care: Lessons from Evidence and Experience", Nuffield Trust.
52 London Procurement Programme (2010), llp.nhs.uk; NHS London (2009), *World Class Commissioning: Governance criteria and evidence base.*

The empire strikes back

The current drive to integrated care and service redesign increasingly appears to focus on integrating organisations, as opposed to integrating services.[53] Andy Burnham, the Health Secretary, recently put forward the case for "radical redesign of services and patient pathways". Writing in the *Health Service Journal* he recognised that: "The last decade has essentially seen the expansion of the traditional hospital-based model of providing healthcare. Our collective challenge in the next decade is to re-engineer that traditional model."[54] Rather than using competition to drive innovation in the provision of care, the Health Secretary has called for service redesign through making the NHS the "preferred provider."[55] However, incumbency has almost never been synonymous with innovation.

The latest proposals to improve community care also suggest the NHS is looking to meet the challenge of redesign and integration within the service. The Department of Health has called on PCTs to submit plans by spring 2010 on how they will deliver community care.[56] Rather than tendering services from the market, in many cases NHS trusts are being tasked to deliver community services through approaches such as mergers to deliver integrated services.[57]

Managing patient pathways

Improving patient pathways to ease patients' journeys through the health system will put less pressure on key junctions, such as A&E or complicated surgery.[58] Improving pathways requires greater focus on ensuring treatment takes place in the right setting. A recent study revealed that, for example, 87 per cent of children and young attending accident and emergency could be better treated in primary and community care.[59]

Better management of patients with chronic or long term conditions will also deliver significant savings. Patients with long term conditions currently occupy 60 per cent of all hospital beds, 52 per cent of all GP consultations and 65 per cent of all out patient appointments.[60] Better management of these conditions will mean moving patients out of hospitals and treatment to the community and nearer the home.[61]

Managing medicines

Pharmaceuticals can play a key role in helping manage the financial pressures facing the NHS, for example allowing the delivery of more care outside of hospital settings. Spending on pharmaceuticals could help avoid paying for more expensive treatments down the road.[62] However, not all drug therapies are cost effective, and in an environment of heavily restricted public finances there is an even greater need to consider how to get more for less from this expenditure. Prescribing practices need to be improved to reduce wastage and take the needs of the patients, and their lifestyles, into account. Concerns expressed by the industry also include the time it takes to bring drugs to market (process of assessing value), the Pharmaceutical Pricing Regulation Scheme (PPRS) and the role and operation of NICE.[63]

53 A review of evidence by the Nuffield Trust supported clinical and service integration rather than organisation integration, with a focus on improving patient experience, clinical outcomes and value for money, while preserving choice as a key driver of integration, Rosen, R. and C. Ham (2008), "Integrated Care: Lessons from Evidence and Experience", Nuffield Trust.

54 Burnham, A. (2009), "Embrace the new era of service redesign to take the NHS from good to great", *Health Service Journal* , 29 October.

55 Ibid., "It is for this reason that we will need to find more engaging, less polarising ways of making change happen in the NHS than we have in the past. Clearer rules about managing change are needed so that everyone knows where they stand and what is expected of them. Why does this matter? Because failure to find a better approach to reform could mean change doesn't happen as quickly as it should, or that change is howled down by protest, and that would risk the NHS slipping back when it should be moving forward. This is the context for why I have chosen to be clear that there are times when the 'NHS is our preferred provider'. We need clear rules through which services can be challenged or changed in a range of scenarios. This is necessary as we expect primary care trusts to challenge poor performance more, not less, in the coming period. In essence, "preferred provider" status amounts to a chance to improve to the new quality standards that will be required."

56 Department of Health (2009), *The Operating Framework for the NHS in England 2010/11*.

57 *Health Service Journal* (2010), "Bucks PCT set for vertical integration", 22 February.

58 *Health Service Journal* (2009), "Variations shows NHS community services ripe for efficiencies", 13 August 2009.

59 NHS London (2010), *Delivering Healthcare for London: An Integrated Strategic Plan 2010-15*.

60 CBI (2010), *Best of Health: Improving lives through smarter care*.

61 Moving care to the community has the potential to reduce the emergency readmissions, support early discharge after hospital treatment and community based services have the potential to £1.2 billion nationally according to a study based on an analysis of the implementation of home based care in Birmingham North East (Dr Foster Intelligence (2010), *Healthcare at Home)*.

62 Crémieux, P., P. Ouellette, and P. Petit (2007), "Do Drugs Reduce Utilisation of Other Healthcare Resources?", *PharmacoEconomics*, Vol. 25 pp. 209-221.

63 There are concerns over the current remit of NICE (whether the assessment criteria should be broadened) and the engagement of members of the public and pharmaceutical companies in the NICE assessment process.

Managing IT

All political parties present a future vision of the NHS which is technology enabled and information driven. Recent centralised attempts to introduce the latest technology into the NHS, however, have been far from successful.[64] But some innovative NHS managers and clinicians have successfully used technology to transform services. E-health applications can also transform services.[65] These innovations have, however, been most successful when they have been introduced in conjunction with reform on the front line (such as in University Hospitals Birmingham NHS Foundation Trust).

Push the button

Table 7: Key policy and political events concerning closures of hospital services, 2006 – 2009

January 2006	Publication of White Paper *Our Health, Our Care, Our Say*.
April 2006	John Reid, then Home Secretary, opposes the closure of the A&E unit at Monklands Hospital in Lanarkshire.
October 2006	David Nicholson asks Sir Ian Carruthers "to review all existing proposals for major service and identify any schemes that may need further assessment and support."
December 2006	Hazel Blears, then the chairwoman of the Labour Party, opposes proposed changes to Hope Hospital in Salford. Roger Boyle, National Director of heart disease, calls for some centralisation of CHD services.
January 2007	Sir George Alberti, National Director for Emergency Access, calls for some centralisation of emergency healthcare services.
February 2007	David Nicholson's response to Sir Ian Carruthers demands greater involvement by SHAs and the Department in service redesign.
July 2007	Lord Darzi's review of the London NHS advocates 150 polyclinics.
August 2007	David Cameron promises the Government a "bare knuckle fight" over the future of the district general hospital.
May 2008	Department of Health publishes new guidance on service redesign, Changing for the Better.
December 2009	The NHS Operating Framework 2010-11 calls on PCTs "to commission transformed and integrated pathways to optimise health gains and reduce health inequalities". It states that the Department will review SHA's plans for redesign by the end of March 2010. David Cameron confirms that a Conservative Government would impose a moratorium on "closures of district general hospitals and their A&E and maternity units".

A review of the development of policy during this Parliament demonstrates that service redesign has been a national initiative rather than a local one. While the Department's publications suggest that redesign is a matter for PCTs, in practice it has pushed redesign through a series of publications and initiatives.

Politicians have felt the need to intervene in local services against the national push, even if it means opposing the policy of their own Government. The current Conservative policy to impose a moratorium on hospital closures is mistaken given the economic situation.[66]

64 Doctors for Reform (2009), *E-health or White Elephant? Doctors' Views on the National Programme for Information Technology.*

65 E-health applications can deliver more direct results in managing long term care. The use of telehealth monitors in managing care for patients with long term needs, such as chronic obstructive pulmonary disease (COPD) and congestive heart failure, can encourage patients to manage their own conditions and ease pressure on front line services. Other uses include text message reminders, which have led to a 30 to 50 per cent reduction in missed GP and hospital appointments, bringing savings of £240 million to £370 million a year (Liddell, A. et al (2008), *Technology in the NHS: transforming the patient's experience of care*, King's Fund).

66 Cameron, D. (2009), Speech, 2 November. "People say that because we will stop further re-organisations of the NHS and implement a moratorium on the closures of District General Hospitals and their A&E and maternity units we are committed to the status quo. It's true, with the Conservatives there will be no more of the tiresome, meddlesome, top-down re-structures that have dominated the last decade of the NHS… The disruption is terrible, the demoralisation worse – and the waste of money inexcusable. And yes – we will immediately stop the proposed closures of vital local services that are happening under this Government too."

During the last wave of reconfiguration, the focus of the Department was on the need to centralise some hospital services – in other words, to replace some hospital services by some other, more distant ones.[67] In fact the key task is to replace hospital services by new forms of service closer to home.

Improving the politics of change

The leadership of the NHS was scarred by the experience of the last wave of hospital reconfigurations at the beginning of this Parliament. In 2005 and early 2006 the Department of Health had strongly pushed the idea of reconfiguration. By mid 2006, however, the Department had lost confidence in the policy under the pressure of local opposition. In some cases Ministers had marched in support of local hospitals in contradiction to the Government's own policy.

The Department's response has been self-contradictory. On the one hand it has rightly stressed that it is the commissioners of care, Primary Care Trusts, who should be in the lead on redesign.[68] But on the other, the Department has given itself a role in all reconfigurations by providing funding for the quality control process.[69] It has given SHAs a strategic role in organising redesign. And it requires a level of consultation – with Practice Based Commissioners, local hospital trusts, primary care, third sector providers and social care partners, as well as "other stakeholder groups" – that is enough to delay any major change.[70] The Department also emphasised that the main reason for service redesign was to improve quality rather than to save money,[71] when in fact these two ideas go together.

In general the Department has seen the problem as one of process – poor planning, poor communication, and so on – rather than one of legitimacy. The reason for local opposition to change is that local people feel disenfranchised from the management of local health services. However, the solution is not endless consultation but is instead reform to make commissioners accountable to local people. There are three steps that could achieve this:

- First: allow choice of PCTs, turning PCTs into de facto social insurers. The Government has committed to giving people choice of GPs but that is not sufficient. Under this reform, PCTs would have a real incentive to achieve value since they would be able to offer better services to their populations.
- Second: bring together PCTs to give them stronger bargaining power over the acute trusts. The tug of war between commissioner and purchaser is still biased towards the latter.
- Third: allow PCTs to benefit from achieving savings. At present the savings achieved by efficient PCTs are taken by central government to be used elsewhere in the system, often to support the less efficient. Efficient PCTs should keep some of the savings that they achieve.

The great advantage of these recommendations is that they will transform the politics of service redesign. The design of services at the PCT level is nothing to do with the Chief Executive of the NHS, yet Richmond House has sought to involve itself even more closely in local decisions. Central involvement will inevitably create both the impression and the reality of top-down interference in local decisions. What is needed is reform to make the NHS locally accountable.

67 Department of Health (2007), *Emergency access – Clinical case for change: Report by Sir George Alberti, the National Director for Emergency Access*. "Every service cannot be offered by every A&E department – it never has been, and never can be – so it makes sense to create networks of care with regional specialist centres to give the best possible treatment to the sickest people."

68 Nicholson, D. (2007), *Service Improvement: Quality Assurance of Major Changes to Service Provision – Letter to Colleagues*.

69 Department of Health (2007), *Annex: Service Improvement: Quality Assurance of Major Changes to Service Provision*. This document noted that as "a minimum, all SHAs need to establish their own 'gateway' mechanisms to quality assure local proposals and make sure they are fit for purpose at the earliest possible stage. The Department of Health should hold the SHA to account for the effective introduction and maintenance of these systems. These processes should, where appropriate, use the Office of Government Commerce (OGC) Gateway system. OGC Gateway Reviews will be centrally funded by the Department of Health."

70 Ibid. "PCTs should take the overall lead on service design and change, but must work in partnership with Practice Based Commissioners, local hospital trusts, primary care, third sector providers and social care partners, as well as other stakeholder groups."

71 Ibid. "Reasons for change need to be clear and well articulated. The recent series of national Tsar reports make it clear that changes to services are first and foremost about saving lives, not money. It is the case, for example that 40-45 per cent of people attending A&E would be better off being treated elsewhere, because they have conditions that other units can deal with more effectively. This is not an isolated statistic. The Tsar reports are peppered with them. The NHS must make better use of this type of information to help make the case for change and explain to patients, the public and stakeholders the benefits that come with service improvement."

3
Healthy competition

Choice and competition

Since the NHS Plan was published in 2000 the government has implemented a set of NHS system reforms that have sought to modernise the health care system. The key principles underlying the reforms have been:

- Improved strategic purchasing (commissioning) of health services.
- Enhanced choice of provider for patients.
- Increased plurality of health care providers, including the development of not-for-profit foundation trusts and private providers.
- Better alignment of payment mechanisms with work undertaken (diagnosis-related group (DRG) financing or Payment by Results).
- Changes to employee contracts to raise quality and productivity.

Patient choice

The expansion of patient choice has been a major plank of health reform. There are several strands to the choice policy, but it is choice of location of service for elective care that has been central to reform. Since April 2008, Primary Care Trusts (PCTs) have been obliged to offer most patients a choice among providers – at hospital level, not that of individual clinician – at the time of first referral by a GP, including any NHS or independent providers in the country. Several initiatives have also been designed to help patients make effective choices.

- The "NHS Choices" website: to facilitate comparisons of hospitals by providing information such as waiting times, re-admission rates and comments and ratings from patients.
- The "Choose and Book" system: to allow people to book their first hospital appointment at their chosen hospital once they have a confirmed referral from their GP. By August 2008 over 80 per cent of GP practices were participating.

These policies were intended to give power to consumers and stimulate competition between suppliers. In turn it was believed that this would improve efficiency and diversity, quality and responsiveness and access. The intention was to make providers more responsive to patient preferences.

Information and choice

There are few indicators of clinical quality to inform patients' choices. Until recently the NHS had not been as good in collecting good data on quality beyond information about significant adverse events (re-admissions or death), which say little about the effectiveness of the majority of procedures – hence the saying "the operation was a great success, but the patient died."[72] As a move towards more general performance reporting, from April 2009 patient reported outcome measures (PROMS) have been collected for four hospital interventions: knee and hip replacement, varicose vein surgery, and hernia repair. The goal is for performance measures to emerge in addition to death rates for surgical interventions.

Choice in long term conditions

There are also plans to enhance treatment choice for those with long term conditions and mental health problems. The prospect of allocating personalised budgets to patients with some long term conditions, if implemented, would give patients even more direct control over healthcare purchasing decisions.

72 One of the first initiatives for collating and disseminating performance information for the public was the work of the private sector organisation Dr Foster Intelligence.

Plurality in provision

A common thread running through the system reforms is the diversification of the provider "market". The NHS Plan emphasised the potential for the private sector to play a bigger role in providing services and allow purchasers to secure gains in efficiency and enhance choice.

The increased range of providers has led to the creation of the "extended choice network", which allows GPs to offer choices to patients from approximately 149 approved independent providers, including independent sector treatment centres. Similarly, the use of the national tariff (Payment by Results) rewards those providers with increased business, meaning, in principle, improved incentives for increased quality and responsiveness. The public has been less ready to accept other consequences of choice, such as closure of under-utilised hospitals.

Why competition?

There is a large literature on the consequences of competition among suppliers in health systems.[73] This literature highlights that, if done in the right way, greater competition can lead to improvements in clinical quality (such as faster reductions in mortality from acute myocardial infarction (AMI)),[74] a more businesslike culture,[75] and higher levels of patient satisfaction.[76] However, the policy context for this competition is crucial. As Propper and Wilson have noted "the literature suggests that greater competition between hospitals can potentially improve outcomes, but the institutional design is critical. With respect to the current English arrangements, it is first clear that, to promote hospital competition, there will need to be stronger pro-competition strategies than operated during the internal market of the 1990s."[77]

Disruptive change

Christensen, Grossman and Hwang, of Harvard Business School and the Kennedy School of Government, highlight the importance of innovation for reducing cost and improving the quality and accessibility of health care.[78] They argue that as well as disruptive technologies (that can change the nature of care), lower-cost, higher-quality and more accessible health services require disruptive business model innovation. They argue that care increasingly needs to move away from working in "solution shops" (the traditional approaches of general hospitals and GPs' practices), towards "value added process businesses" (which carry out fairly standard procedures) and "facilitated networks" (incentivised to keep people out of expensive hospitals). Without business model innovation, many disruptive technologies are likely to simply be trapped in high-cost institutions.

The transformation of the care of coronary artery disease is an example of the process of innovation in healthcare. Angioplasty (a value added process business approach) has become a more affordable and convenient treatment than open heart bypass surgery (a solution shop approach), which in turn has been disrupted by "statins" which, when used as a preventative measure, reduced the need for angioplasty (a facilitated network approach).[79]

73 See for example, Brereton, L. and V. Vasoodaven (2010), *The impact of the NHS market: An overview of the literature*, Civitas; Naylor, C. and S. Gregory (2009), *Independent sector treatment centres*, King's Fund.
74 Cooper, Z., S. Gibbons, S. Jones and A. McGuire (2010), *A. Does hospital competition save lives? Evidence from the English NHS patient choice reforms*, LSE Working Paper No. 16/2010.
75 Mannion, R. et al (2009), "From cultural cohesion to rules and competition: the trajectory of senior management culture in English NHS hospitals, 2001-2008," *Journal Of The Royal Society Of Medicine*, Vol. 102, pp. 332-336.
76 Healthcare Commission (2007), *Independent Sector Treatment Centres: A review of the quality of care*.
77 Propper, C., D. Wilson and S. Burgess (2006), "Extending Choice in English Health Care: The Implications of the Economic Evidence", The Centre for Public and Market Organisation.
78 Christensen, C., J. Grossman and J. Hwang (2008), *The innovator's prescription: A disruptive solution for healthcare*, McGraw-Hill.
79 Ibid., pp. 39-40.

Enabling innovation

In discussions of the market evidence for the benefits of competition the roles of new entrants and failure regimes are often overlooked. An examination of the data on all UK manufacturing plants between 1980 and 1982 has shown that productivity increased as efficient new entrants joined the market and inefficient producers exited.[80] Lowering barriers to exit is as important as barriers to entry.

Indeed, as Christensen, Grossman and Hwang note:

> while the technological enablers almost always emerge from the laboratories of leading institutions in the industry, the business model innovations do not. Almost always these are forged by new entrants to the industry. Regulators must be aware, therefore, of attempts by the leading institutions to outlaw business model innovation. Regulation should facilitate it. What is in the interest of society most often does not coincide with the self-perceived interests of the leading institutions.[81]

Approaches that could enable greater business model innovation in the NHS could include:

- Central and local tendering – including to the private sector – requiring business model innovation as a criterion for assessment of tenders and consideration of introducing compulsory competitive tendering.[82]
- Introduction of physician group practices, with most consultants no longer employed by hospitals. These physician group practices could compete for patients. This would encourage greater competition and allow the creation of coherent solution shop practices (groups combining GPs, nurses, consultant specialists and a range of professionals to manage long-term, chronic diseases).

These approaches would allow business model innovation (the precise models of provision) to emerge from competition, rather than being planned from the centre.

The state of the independent sector

The independent sector should play a key role in a reconfigured health service.

Independent healthcare is worth around £27 billion in the UK market, including long term care for the elderly, physically disabled people and mental health conditions, as well as primary care and the acute hospital sector. The value of the UK private acute healthcare market, including independent hospitals and clinics, NHS private treatment and specialists' fees, was £6.6 billion in 2008/09.

In real terms, growth was 2.6 per cent in 2008, marginally higher than recorded in 2007 (up 1.7 per cent) and 2006 (up 1.8 per cent), but a sharp deceleration from 8.6 per cent in 2005. The last three years have seen the lowest period of growth on record, which reflects the economic slowdown which started in 2007 and accelerated in 2008. It may also reflect the mixed messages that the government has been communicating about the market in healthcare.

Sources of revenue

All the same, patient volumes under the extended choice network (ECN) have risen dramatically in 2009. According to latest figures, the monthly value of ECN activity purchased from independent hospitals hit a peak of over £20 million in June 2009 before falling the next month. Volumes recorded to date suggest that annual ECN activity was around 100,000 procedures and £200 million for 2009.

80 Haskell, J. (2000), *What raises productivity? The microeconomics of UK productivity growth,* Queen Mary, University of London.
81 Christensen, C., J. Grossman and J. Hwang (2008), *The innovator's prescription: A disruptive solution for healthcare*, McGraw-Hill, p. 38.
82 It is important to get the policy framework right when considering compulsory competitive tendering (CCT). There are some examples of local authorities that have successfully developed the concept of CCT. However, other evidence suggests that CCT, introduced throughout the 1980s in an attempt to bring greater efficiency to local government and health services, resulted in "resistance by local authorities and health trusts, an immature market and poorly-conducted procurements which focused on price at the expense of quality and employment conditions" (Serco (2010), *Compulsory Competitive Tendering (CCT)*, serco.co.uk).

Table 8: Expenditure by NHS bodies on healthcare from non-NHS bodies
Source: House of Commons Health Select Committee (2010), *Public Expenditure on Health and Personal Social Services 2009.*

Year	Total expenditure, £000s
1997-98	£1,108,182
1998-99	£1,230,425
1999-2000	£1,301,196
2000-01	£1,549,172
2001-02	£1,792,967
2002-03	£2,239,331
2003-04	£3,315,893
2004-05	£3,666,024
2005-06	£4,415,531
2006-07	£4,997,813
2007-08	£6,013,276
2008-09	£6,661,500

In 2007 the NHS overtook self-pay healthcare as the second largest funding source for independent acute medical/surgical hospitals behind PMI, generating £781 million or an estimated 23.1 per cent of the sector's £3.4 billion revenues in 2008 (total hospital sector amounted to £6.6 billion). The NHS's share has more than doubled in four years from just over 10 per cent in 2004, initially driven by a flurry of central procurement in 2005 as the Independent Sector Treatment Centre (ISTC) programme started, and also from supplementary short-term contracts known as G-supp. The development of ISTCs from 2006 to 2008 inclusive pushed up the NHS's share further, and in the last two years (2007 and 2008) a pick-up in local contracting, following the universal introduction of patient choice has provided further stimulus for higher NHS funding.

At critical mass?

To positively contribute to the service and improve performance there must be enough competition to drive innovation and productivity. In a 2005 memorandum, Ken Andersen, the then Commercial Director of the NHS, said that without significant further growth the ISTC market would collapse. "In order to create a pluralistic, highly innovative and competitive market across all levels of the value chain, the market needs to grow by at least 450,000 additional procedures per year," said Anderson.[83]

A strong increase in local NHS contracting in 2007 and 2008 has been reported by the major hospital groups. For example:

- The largest, General Healthcare Group (BMI Healthcare and Netcare UK), reported a 165 per cent rise in its NHS volumes in the 12 months to 30 September 2008 after winning a number of significant contracts.
- In its latest annual report Spire Healthcare estimated that 22 per cent of its patient admissions in 2008 were funded by the NHS, though in its previous year's report Spire predicted that the NHS would account for only around 10 per cent of its business going forward.
- Nuffield saw an increase of almost 60 per cent in its NHS patient volumes with 30 per cent of NHS volumes generated through patient choice.
- Of the top five groups, Ramsay Health Care has the largest share of its activity funded by the NHS, with the company's latest financials reporting that 44 per cent of its UK patient admissions were NHS funded in the 12 months ending 30 June 2009, growing by a quarter from a year earlier.[84]

83 Anderson, K. (2005), *ISTC Market Sustainability Analysis*.
84 Laing and Buisson (2009), *Laing's Healthcare Market Review 2009-10.*

These estimates for NHS spending on independent acute healthcare services fall well short of predicted activity proposed by the Labour government in 2004, prior to the central ISTC and diagnostic programmes getting underway. The then Secretary of State for Health, John Reid, stated that up to 15 per cent of NHS electives may be outsourced to the independent sector.

In this scenario, contracts from the NHS could potentially have accounted for over half of the independent sector's activity, compared with just under a quarter actually recorded in 2008. At its estimated peak in 2009, NHS spending is likely to account for no more than a quarter of independent acute sector revenues, and fund treatment for a high end estimate of 400,000 NHS patients.

A hesitating market

The first clear signal that the scale of NHS contracting would not fully materialise in the medium term was the cancellation of seven second wave ISTC schemes in April 2006. At the time, the government stated that it remained committed to spending the full second wave budget of £500 million per annum over five years but further second wave setbacks confirmed that the original budget would be significantly scaled down. Further signals of the scaling back continued in subsequent years, with a lack of impetus to renew expired Wave 1 contracts, and further projects were scraped. No ISTCs remain outstanding now.

An uneven playing field

The Office of Health Economics (OHE) identified the key non-discretionary cost differences between independent and NHS hospitals as being: labour costs, regulation and contracting arrangements, taxation, costs of capital and risk, costs of other inputs (e.g. bought-in goods and services), and teaching, training and research arrangements.[85]

An uneven playing field: pensions

A set of institutional arrangements that continues to impose a cost disadvantage on independent sector providers is the NHS Pension Scheme. A company that takes a going concern over from the NHS needs to set up an approved pension scheme to comply with regulations governing the transfer of undertakings. As this scheme would be outside the public sector it would have to be funded by separate assets and subject to transparent and prudent private sector regulations. Companies have been required to contribute roughly double what the public sector is charged to fund equivalent pension provision. Companies are also exposed to subsequent increases in contributions and an uncapped liability if, for example, investments do not perform well or life expectancy rates improve.

An uneven playing field: regulation and contracting arrangements

In relation to regulation and contracting arrangements, the OHE noted that "health care organisations, public, charitable and private, are subject to various obligations to report to regulators and other stakeholders on aspects of their performance, their finances and some dimensions of the quality of their services."[86] The OHE has noted that the magnitude and direction of any overall difference between organisation types in terms of costs of meeting regulatory and reporting requirements is unclear.

85 Sussex, J. (2009), *How fair? Competition between independent and NHS providers to supply non-emergency hospital care to NHS patients in England*, OHE Briefing, No. 50, p. 1.
86 Ibid., p. 19.

An uncertain investment environment

Rather than using competition to drive innovation in the provision of care, the Health Secretary has called for service redesign through making the NHS the "preferred provider."[87] The "preferred provider" statement represents a direct contradiction of previous guidance – leaving investors insecure about the framework for the healthcare market, in turn likely to lead to disinvestment, and encouraging all who resist change, such as those who oppose competition on ideological grounds.

Great Yarmouth and Waveney PCT invited any willing provider to tender to run its community services, under the existing NHS procurement rules designed to ensure best practice in procurement and deliver value to patient and taxpayer. But, following Mr Burnham's speech, it withdrew the invitation to the private and voluntary sectors, saying it was now "only able to accept bids from NHS organisations".

In December 2009, the NHS Partners Network, which represents private providers, and Acevo, which represents voluntary organisations, complained to the Cooperation and Competition Panel (CCP) that the move breached the NHS's existing procurement rules and almost certainly also breached European Union procurement law. As a result, the CCP initiated an inquiry to investigate the conduct of NHS Great Yarmouth and Waveney. The Department of Health has subsequently suspended all procurement in the East of England bringing an end to the CCP's inquiry.

"This outcome also leaves open the question of whether investors in UK healthcare can genuinely rely on a 'rules-based' system, consistent with wider procurement and competition law, or whether the rules may be easily overridden by changes of policy", said Mike Parish, chairman of the NHS Partners Network.

Marketisation

A large reconfiguration of health services has been taking place in France over the last several years. This reconfiguration has included closures of wards and hospitals. This process has been supported by the presence of a large independent healthcare sector and, at times, a pooling of services across the public and private sectors. The experience in France highlights the need for greater partnerships and joint working between the two sectors. Joint working requires a stable and predictable environment for investment (meaning changes in health supply are less subject to political whim).

Reducing excess capacity in the health service is not inconsistent with choice and competition. A view that choice and competition can only arise if the system contains overcapacity fails to consider scope for productivity improvements. Productivity improvements can mean that the supply of health services can expand even when bed, ward and hospital numbers are falling. Given this, the ability of competition to drive up health standards and productivity becomes especially important when service redesigns are being undertaken. Competition can help embed market disciplines in both the public and private providers (supporting a process of "marketisation").

87 Burnham, A. (2009), "Embrace the new era of service redesign to take the NHS from good to great", *Health Service Journal* , 29 October.

4
Delivering reform

Reviving competition in the NHS through reducing barriers to entry will allow innovative new providers to drive through service redesign. Creating real choice for patients will put them in control of their health and make healthcare providers more responsive to the needs of patients. Empowering local managers and creating the incentives to deliver services on a reduced budget will support redesign based on local initiative and local knowledge.

Flexibility

As the Office of Health Economics has noted it "is unclear to what extent NHS employers are yet using the flexibility available to them, but in principle they have it."[88] That the flexibility exists but is not being employed indicates that key barriers to greater flexibility in the terms and conditions of NHS staff are culture and a failure of financial incentives. Staff will need to be flexible about roles and responsibilities. For example, when there is a shortage of junior nurses on a ward, rather than hiring agency staff, more senior nurses could carry out lower grade work.

It has been argued that Agenda for Change provides a framework to deliver savings in the workforce. But, as the National Audit Office noted in January 2009, only half of trusts had used Agenda for Change to improve clinical pathways by creating new roles for staff .... Leveraging the flexibility that is already inherent in a system like this should be the first action trusts take to achieve savings."[89]

Cut, close or contract out

The NHS has overinvested in the wrong facilities. Further reductions in the numbers of beds, wards and hospitals are inevitable. A number of acute trusts are underperforming, while many hospitals could make savings through closing wards and cutting bed numbers. The example of Hinchingbrooke hospital suggests that in some cases closures could be avoided through contracting out entire facilities to new providers (see annex). In all cases, plans for service redesign must be driven by local initiative and local knowledge. Clinicians, NHS leaders and politicians also need to explain to the public that closing or redesigning facilities will not mean the decline of services. Instead this will mean different health services will be provided – which will be more cost effective and better deliver quality.

A competitive market

Having fewer hospitals does not necessarily mean less competition. A health system that delivers higher quality care outside the hospital has the potential to radically open up the market. Competition can also come from moving from a system of centralised hospitals to smaller clinical units and by lowering barriers for new entrants (including barriers to exit). Creating real choice for patients, supported with good quality information, will also promote competition. This competition is an important driver of better standards and productivity improvements, which can allow the supply (and benefits) of health services to expand even when bed, ward and hospital numbers are falling.

The start of an honest debate

The next decade will see the NHS face one of the greatest financial challenges in its history. Reforming the front line will be a vital first step, but delivering better quality healthcare over the long term will need more far reaching reform on NHS funding. The UK remains an unusual case among OECD nations in relying so heavily on funding from taxation. As *Reform* has argued previously increasing individual contributions to health care would provide a new source of sustainable funding for health care and provide a powerful tool for introducing market disciplines throughout the NHS (encouraging "marketisation").[90]

88 Sussex, J. (2009), *How fair? Competition between independent and NHS providers to supply non-emergency hospital care to NHS patients in England,* OHE Briefing, No. 50, p. 20.
89 NHS Employers (2009), *Leading the NHS workforce through to recovery,* Briefing 66, pp. 1, 11-12.
90 Bassett, D. et al (2009), *Back to black, Reform.*

Recommendations

Key ways in which better standards and improved productivity could be driven in the health system include:

- Commission the service not the facility. Commissioning should not be used as a mechanism for protecting numbers of beds, wards and hospitals – commissioning should focus on health outcomes not inputs into the service.
- Commit to greater plurality in supply and reverse the "NHS preferred provider" policy. The ability of competition to drive better standards and productivity growth is crucial for ensuring that spending reductions do not lead to "salami slicing cuts" and a decline in quality.
- Commit to plurality of supply within existing settings – such as through approaches like service line management (where decision making and budgets are devolved to specific, clinically-led operational units).
- Ensure the rules for competition are clear, consistent and enforceable. This could involve asking the NHS Co-operation and Competition Panel to review existing provision (as well as changes to that provision).[91]
- Incentivise service redesign through reform to make the NHS locally accountable and by clarifying the ability of Primary Care Trusts (PCTs) to retain some of the financial savings that they achieve from improvements in health outcomes and productivity.
- Incentivise service redesign through considering reforms such as giving patients a choice of PCT (to ensure that ongoing pressures for service redesign reflect the preferences and needs of consumers).

91 Eon (2004), *Assessing the Impact of Public Sector Procurement on Competition,* report prepared for the Office of Fair Trading.

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Annex 1: The case for service redesign

Redesigning services and decommissioning facilities has the potential to deliver significant savings in the NHS. Service redesign is also seen by NHS leaders as an important tool for improving the quality of care. The *Our Health, Our Care, Our Say* White Paper, the Darzi reforms, and *NHS 2010-2015* all see redesign of NHS services as part of delivering higher quality care to the patient.

Table 10: Evidence base for service redesign
Sources: See footnote[92]

Criteria	Feature
Safety	Service redesign can allow greater specialisation of care. Medical treatment has become more complex and health services will need to allow for specialisation to deliver quality care. There is considerable evidence from the US and UK to suggest a close correlation between hospital volume and health outcomes for complex procedures, such as cardiology, neurosurgery and major vascular surgery. Ensuring that clinicians can develop the skills in pioneering treatments cannot be achieved without the centralisation of clinical units.
Accessibility	Making treatment more accessible to more individuals, particularly in the community, was a major finding of both the consultation for *Our Health, Our Care, Our Say* and the clinical pathway groups during the *Next Stage Review.* There is considerable evidence to suggest the popularity of home care for the treatment of long term conditions and palliative care. Increasing the number of service locations through redesigning services to bring care into the community could allow early diagnostic intervention, access to prescriptions and greater clinical guidance. Walk in centres and GP-led clinics have been found to be successful alternatives to acute care and traditional primary care. Modern technology has also enabled care to be brought nearer to the home and redesigned around the needs of patients.
Efficiency	The current hospital-based system has resulted in an inefficient use of medical resources, which decreases the access and availability of essential care. Redesigning services into smaller clinical units could incentivise greater efficiency, particularly though greater capacity for clinical judgement, early intervention and quicker discharge. This efficiency of medical services could increase the volume of medical activity, accelerating competition and the improvement of medical outcomes.
Prevention	Redesigning services to bring care into the community would support infrastructure to support self care, preventative medicine and public health. While reconfigured services could encourage early diagnosis, earlier medical intervention and more innovative patient pathways.
Responsiveness	The disintegration of facilities and choice led integration of services will enable patients to access both primary and secondary care. Reconfiguring services away from centralised hospital-based organisations could create more innovative, more competitive and patient centred smaller medical units. Focused around the patients, services could become more responsive to individual needs and more adaptable to technological innovation.
Equity	The current distribution of health facilities and services has little relation to health needs and the much remarked "postcode lottery" reflects healthcare inequalities in access and quality of services. The reconfiguration of services and the move away from acute provision could both provide greater diversity and choice of health providers, ensuring more equitable distribution of scarce health resources. This is particularly significant for the most vulnerable and at risk patients.

92 Farrington-Douglas, J. and R. Brooks (2007), *The Future Hospital: The progressive case for change,* Institute for Public Policy Research; Department of Health (2004), *The Configuring Hospitals Evidence File;* Department of Health (2006), *Our Health, Our Care, Our Say;* Department of Health (2007), *Keeping it Personal: Clinical case for change: Report by David Colin-Thomé, National Director for Primary Care;* Department of Health (2008), *Higher Quality Care For All: NHS Next Stage Review Final Report;* Department of Health (2008), *Changing for the better: guidance when undertaking major changes to NHS services;* Department of Health (2009), *NHS 2010-2015: from good to great. preventative, people-centred and productive.*

Annex 2: Case studies

University Hospitals Birmingham NHS Foundation Trust

University Hospitals Birmingham NHS Foundation Trust (UHBFT) is an example where reform on the frontline has been combined with information technology systems to monitor and manage the quality of care provided to patients.[93] The key features are:

- The prescribing information and communication system (PICS).
- Clinical quality dashboard.
- Quality and outcomes research unit.

The Prescribing Information and Communication System (PICS)

The Trust has developed an electronic, rules-based clinical information, drug prescribing and administration system. This system supports clinical decision-making and allows the Trust to monitor and feedback to clinical teams on a weekly basis.[94] The system can report on the number of drugs prescribed to patients but not administered (omitted)[95] and monitor and update patients' length of stay based on historical data and refined using clinicians' estimates. This not only helps in efficient discharge planning but contributes to the future modelling of patient movement.[96]

Clinical Quality Dashboard

The ward level digital Clinical Quality Dashboard gives staff real-time information on a variety of clinical quality indicators for their ward area and for the Trust overall, including falls, infection control, length of stay, patient experience feedback, complaints, staff sickness levels, and pressure ulcer data. The findings from the dashboard are informing a 'Back to the Floor' initiative, which involves senior nursing staff visiting clinical areas weekly.[97] An automatic escalation system is being developed which sends notifications from the dashboard to alert different levels of management staff.

Quality and outcomes research unit

The Outcomes Research Unit focuses on linking datasets from multiple information systems to monitor quality care delivery and care outcomes for patients. This enables the Trust to closely monitor the outcomes of patients and assess clinical care delivery and the patient's experience.[98]

93 University Hospitals Birmingham NHS Foundation Trust (2009), *Annual Report 2008-09*.
94 Ibid.
95 This data includes both drug doses internationally omitted (the vast majority being by nursing staff making appropriate clinical decisions) and unintentionally omitted due to a variety of administrative reasons. The Trust also monitors the number of times that serious alerts raised by the clinical decision support system lead to a proposed action being aborted, as well as "hard stops", where an action is prevented due to the embedded rules in the system (e.g., serious drug overdose or drug interaction).
96 University Hospitals Birmingham NHS Foundation Trust (2009), *Annual Report 2008-09*.
97 Ibid.
98 Ibid.

NHS Birmingham East and North

NHS Birmingham East and North was the first PCT to construct a detailed set of health profiles (or typologies) of the local population. Their Programme for Relationships, Intelligence, Metrics, and Equalities (PRIME) had three key objectives:

- To gain a rich picture of the Trust's communities, neighbourhoods and healthcare settings.
- To pinpoint the greatest health needs of those communities that have not benefitted from general improvements in life expectancy and overall health.
- To bring considerable, measurable, lasting improvements in life expectancy and overall health.[99]

They typologies were used to show the extent to which certain populations were carrying higher burdens of ill health. The typologies revealed pockets of ill health in areas that were previously seen as healthy. The typologies also gave a finer understanding of how different people of different ages from different communities behave during their daily lives and how these attitudes and behaviour can impact on their health.[100]

This information put the Trust into a much better position to identify people who were not fully engaged with services and to ensure that these services were responsive and effective.[101] This allowed the Trust to tailor-make health services for and target messages at smaller groups ("find the missing patients"), as opposed to providing a "one size fits all" approach. This approach can be seen in services such as the Partners in Health Centre, Ann Marie Howes Centre and the John Taylor Hospice.

London SHA

London has an unsustainably high number of hospitals per head of population.[102] Ara Darzi's review of healthcare services in London, *A Framework for Action,* documented that London had on average one of the smallest catchment areas per hospital in the country. As Lord Darzi recognised, "the hospital is not always the answer", while "the days of the district general hospital seeking to provide all services to a high enough standard are over."[103]

As the 2010-2015 strategic review suggests, London is facing £5 billion in real term cuts by 2017, with hospitals facing the challenge of delivering a saving of £2.4 billion, the equivalent to a 3 to 4 per cent productivity gain each year.[104] Many of London's PCTs are already facing a difficult financial period, with at least 18 projecting overspends on services totalling over £170 million.[105]

In 2010 the London SHA announced their intention to reduce the number of hospital beds by a third, cutting the number from 16,800 to 11,200 by 2017. The SHA plans that about 75 per cent of all visits to casualty and 50 per cent of all out-patient appointments, especially for long term conditions such as diabetes, will be dealt with by a network of 100 polyclinics.[106] One in three A&E facilities could be closed as part of the rationalisation of services.[107] The SHA has not announced how many of London's 50 hospitals would need to be reconfigured.[108]

London SHA has received widespread criticism and opposition to plans. Pressure groups such as the British Medical Association (BMA) and Health Emergency (HE) have voiced their concern about potential closures and also claimed that the SHA have failed to be honest about their plans.[109] The recent wave of opposition to the proposed "closure" of Whittington Hospital in North London reveals how it important to communicate that reconfiguration of facilities will improve health services.

99 NHS Birmingham East and North (2010), *Your PRIME Toolkit: A resource for all PRIME material*.
100 Ibid.
101 Ibid.
102 NHS London (2010) *Delivering Healthcare for London: An Integrated Strategic Plan 2010-15*, the number of hospital beds per 1,000 population in London is 3.7 compared to the national average of 2.8.
103 *The Guardian* (2007), "Labour's NHS plan: the end of the local general hospital", 11 July.
104 NHS London (2010) *Delivering Healthcare for London: An Integrated Strategic Plan 2010-15*.
105 Ibid.
106 *The Guardian* (2010), "NHS to close hospitals across London to cope with spending squeeze", 19 January.
107 BBC Online (2010), "One third of A&E units in London 'could close'", 10 February.
108 Ibid. Also see, BMA (2010), *London's NHS: On the Brink*.
109 *The Guardian* (2010), "NHS secrecy in cutting services is an affront to the public", 3 March.

North Lincolnshire

In 2008 NHS North Lincolnshire and North East Lincolnshire Care Trust commissioned a "proof of concept" trial to assess the potential benefits of improved mobile working facilities for clinical staff, with the objective of providing access to clinical records at the point of care.[110] The approach taken was to give clinicians access to core systems through staff laptops with unlimited mobile access and the benefits for patient care, productivity, and staff wellbeing were assessed.[111] The results were:

- 88 per cent of participants identified having more time for work.
- 53 per cent identified that it had a positive impact on patient care.
- 80 per cent said better access to information in the field enabled more informed clinical decision-making and improved patient safety.

A key factor in the success of this trial was the ability to update clinical records in real time at the point of care. This reduced travelling time, aided diagnosis and helped to avoid unnecessary referrals and admissions.[112]

Somerset Primary Care Trust

Somerset PCT has introduced a service for reducing avoidable emergency admissions (a Referral Management Centre (RMC)). All GP referrals "for all specialities and all destinations" pass through the RMC. The RMC works with patients and GPs to ensure the most appropriate pathway for the patient.[113]

The Somerset Local Medical Committee (LMC) noted that the increasing demand for outpatient appointments, the cost of secondary care referral and the demand for lower waiting times have challenged the traditional model of referral (where GPs to refer individual patients to specific named consultants at a nearby hospital).[114]

The LMC noted that a referral management centre approach allows:

- Better tracking and monitoring of referrals.
- Clinical assessment of referrals, so that the most appropriate person sees the patient and at lowest reasonable cost.
- Better understanding of the range of referral options available to patients.
- Better identification of specialist services for GPs and identification of gaps in these services.

Southend University Hospital Foundation Trust

Southend University Hospital Foundation Trust decided to reject the National Health Services' pay agreement Agenda for Change and did so without legal repercussions. In 2006 the Trust balloted its members on a new locally administered contract to improve the competitiveness of the Trust in the regional labour marker with 95 per cent of staff voting in favour. The contract implemented had some important differences from the national agreement with more performance related incentives alongside better basic pay, management were also given full control over any future changes.[115]

The move was met by opposition from national trades unions who feared the impact such local disparities in contracts would have on national pay bargaining and union strength. However, Southend successfully implemented the changes and is one of the best performing trusts in the country, receiving a double excellent standard in its annual health check last year.[116]

110 BT (2009), 'Case Study: Northern Lincolnshire Local Health Community – Improving Patient Service at the Point of Delivery'.
111 Ibid.
112 Ibid.
113 Somerset PCT (2007), "Results of the Inter Provider Transfer Pilot: July 2007 – September 2007."
114 Somerset Local Medical Committee (2004), "LMC Position Paper on Referral Management Centres."
115 *Health Services Journal* (2009), "How long can Southend Hospital remain off the NHS Agenda for Change", 21 May.
116 *Personnel Today* (2006), "Southend hospital trust staff vote to ditch Agenda for Change", 4 July.

Hinchingbrooke Hospital

In February 2007, Cambridgeshire Primary Care Trust (now known as NHS Cambridgeshire) launched a public consultation to look at how hospital services might be delivered in Huntingtonshire. The public consultation focused on the Hinchingbroke hospital which was opened in 1983 and currently provides 369 beds and health services to 161,000 people. [117]

The hospital has encountered significant financial difficulties, accumulating a £40 million deficit on £81 million turnover, while the Care Quality Commission rated the hospital "weak" for financial management between 2005 and 2008. As David Worskett of the NHS Partners Network suggested "Hinchingbrooke shows us that there are hospitals using conventional NHS approaches and, with all the will in the world, have not been able to make it work".[118] In spite of all this, there was significant popular opposition to closing the hospital.

Rather than closure, East of England SHA put the hospitals services up for tender. Currently there are five private health companies competing for the seven-nine year contract to run the hospital from 2011. Cambridge University Hospitals Foundation Trust withdrew from the bidding process, citing the "considerable investment of both time and money" involved in the bidding process.[119]

117 Hinchingbroke Health Care NHS Trust (2010), hinchingbroke.nhs.uk.
118 *The Times* (2010), "Debt-ridden Hinchingbroke Hospital to run by a private company", 18 February.
119 Ibid.

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