CBI
THE VOICE OF BUSINESS

A healthy choice

Building a stronger NHS

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The PSSB campaigns for efficient public services that:

- Put the needs of the citizen first
- Provide quality and value for money
- Use the best providers from every sector
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- Contribute to economic growth

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Foreword

BY RICHARD LAMBERT | DIRECTOR-GENERAL | CBI

Like all supporters of the NHS business wants to see it improved and strengthened in its sixty-first year. As the population ages and scientific advance turns what were once killer diseases into long-term but manageable conditions, we need a health system that keeps pace.

Business helps pay for the NHS through corporate taxation. It relies on the NHS to get the job done. Without an effective health service Britain would be a poorer, less productive place. It is simply not in the interest of business to do anything other than strengthen the NHS.

Business also provides a growing range of services that are delivered through the NHS brand. Not just the family doctor service which since 1948 has been provided through a network of GPs acting as contractors to the NHS, but also through treatment centres and block-booked procedures and now through patient choice.

This report looks forward with a vision of a service which is local and delivers more choice and innovation.

A service that moves away from the thinking of 'the professionals know best' to one of 'the team is at your service' for all its customers.

A big shift towards patients making the key decisions about where to get their treatment and how to spend their budgets is key. More and more the role of the NHS will be to ensure they are making those choices on the basis of the best available information and are accessing the best available care. Patient choice and power will not replace evidence-based medicine but will couple it with consumer activism.

For choice to be effective we need a plurality of providers, but new providers will not enter the NHS unless effective market management is assured.

We need to grasp the opportunities that change makes available with both hands.

Richard Lambert

Introduction

At 60 years old, the National Health Service has reached a crucial point in its history. Championed as a British success story, and treating one million patients every 36 hours, the NHS has changed considerably since its launch in 1948 – an era when gene therapy, artificial hip joints and heart transplants were unheard of.

The challenge now is that far from slowing, the pace of change must accelerate if the NHS is to remain a viable and valued organisation and keep up with rising public expectations, advances in medical science, changes in life expectancy, and the many patients with long-term conditions.

The long-term viability of the NHS is of vital concern to the CBI because the economic prosperity of the country relies on a healthy workforce. The employees of UK businesses use the NHS and taxes from these same companies help fund it. Increasingly, businesses too are playing an important role in delivering the high-quality healthcare, support services and infrastructure the NHS needs. So it is wholly appropriate that the CBI, as the voice of business, sets out a vision for the future of publicly funded healthcare.

There has been significant change in the last decade: a flurry of policy initiatives and a large increase in NHS spending.

In England, secondary care has seen the introduction of foundation trusts and independent sector treatment centres; while new primary care trusts (PCTs) and strategic health authorities (SHAs) have been created to focus on service commissioning and governance of local healthcare economies. Practice-based commissioning, new IT systems and increased use of practice nurses have shaken up the local GP service, as has the new GP contract.

These have been important changes, to a greater or lesser extent all necessary to reform the NHS. But many of the planned reforms are still in transition and the government is still some way from reaping the benefits of its current reform agenda, and will only do so if it continues to respond creatively to the challenges inherent in transforming the architecture of the NHS. The 'personalised NHS' which the Prime Minister called for in January 2008 will only be realised if the underlying systems which keep the NHS operating are re-tuned.

That is why this CBI report focuses on three areas to accelerate reform and deliver an NHS fit for the 21st century. In particular, it sets out:

- How patient choices must be driven by advice, support and information
- A vision for commissioning in the NHS
- The foundations for effective health market management.

"To be true to its principles, the NHS must continue to change...so we will reject the views of those who say the NHS must put a moratorium on change and reject those who oppose further reform."[1]

GORDON BROWN, PRIME MINISTER

The aim must be to move towards a…"much more plural and diverse system wrapped around the individual needs of patients".[2]

DAVID NICHOLSON, NHS CHIEF EXECUTIVE

As of April 2008, patients needing elective procedures have been able to choose 'any willing provider' – from the public or independent sector – which matches the NHS tariff in elective care. That choice mechanism could be used to drive reform in the areas of care being considered by Lord Darzi's review of the NHS.

The CBI shares the vision for the NHS as a truly patient-led organisation, where the system serves the needs of the patient and not, as can sometimes seem the case, the other way round.

The government's reform agenda is designed to shift the balance of power to patients, allowing choice and competition to drive innovation and shape services, and focusing services around preventing illness and integrated care.

In this report we suggest that a system that is increasingly driven by patient choice and operates on the basis of 'any willing provider' will mean the role of commissioners begins to change radically. Instead of being an alternative to the market, they become strategic managers of the market.

We believe commissioning will be the driving force for progressive change. Commissioning is the means to secure best value and deliver the positive outcomes that meet the needs of patients.

It is a relatively new concept which will take time to be accepted and acted on. There are already many tools for commissioners, such as new standard contracts, guidelines and competencies – but they are not being used to their maximum potential.

Increasing patient access to independent providers and introducing managed competition will strengthen the NHS, by giving patients more choice, more innovation and better ways of getting the care they need more quickly.

The CBI believes the right tools exist with which to change and preserve the NHS ethos for the next 60 years, but as we outline, the challenge is not the principles of reform – but how they are implemented.

We believe change has to be managed, and that equity considerations have to be central in determining how a public health system is managed, if we are to meet the public policy challenge of how we can improve the quality and efficiency of our health services.

The report concludes by looking at how improving the conditions for competition and patient choice will enable commissioners to translate patient needs into services. It requires new ways of informing and empowering patients, and for healthcare providers to be able to compete in a well-managed market with a level playing field.

"Choice is fundamental to the delivery of a personalised NHS. People would like to have more control and be more involved in the decisions about their illness and treatment. More choice will also help drive up quality and standards across the NHS."[3]

BEN BRADSHAW, MINISTER FOR HEALTH SERVICES

CBI RECOMMENDATIONS

1 The Department of Health's national awareness campaign on patient choice should concentrate resources on making sure people can better determine where they should get treatment

2 The Department of Health should develop performance management competencies that focus on customer satisfaction for all providers

3 PCT commissioners and suppliers need to build on existing good practice to develop a shared understanding of how to contract for the delivery of complex outcomes. Both should also work together strategically to produce service plans that detail how the independent sector will be used to meet 18-week targets

4 PCTs should focus on and develop their roles as commissioners by market testing their provider arms

5 The Department of Health should ensure all PCTs have a strong leadership. This means increasing the status and careers of commissioners as key professionals. The Department of Health and SHAs should encourage PCTs to establish early and open engagement with suppliers – by holding 'vendor engagement days' – prior to all major commissioning exercises

6 The new principles and rules on competition must be rigorously enforced to ensure all commissioners comply

7 The Department of Health must define how help will be given to ensure poor providers improve

8 The Treasury should lead a government-wide review of competitive neutrality policy and practice in public services

9 The Department of Health should introduce an independent tariff-setting mechanism that balances quality and price pressures.

"Independent sector providers have…helped extend choice, add capacity and spur innovation. They have increasingly become a fixture of NHS provision, with three-quarters of a million NHS patient care episodes performed by the independent sector to date."[4]

PROFESSOR LORD DARZI, HEALTH MINISTER

1 Patient choices must be driven by advice, support and information

On 1 April 2008 the government extended the choice agenda to allow free choice of any provider to patients needing elective care. The CBI would also like to see patient choice expand to cover the choice of treatment and the pathway the patient takes through other parts of the system. Doing this would signal a real change in the way NHS services are commissioned and delivered.

But patients will only exercise the right to choose if there is a real choice to make, they are fully informed about the choices available to them and they understand why a particular course of action has been taken to ensure a range of services are on offer. Robust and reliable information is key and must enable people to compare and make informed decisions about where they choose to receive care. At the same time providers who adopt ways of gathering feedback and measuring patient satisfaction will ensure that changes they make will improve patients' experience.

Patient choice in the NHS will be successful if it becomes a tool to break down provider monopolies while challenging new providers to improve service. But this will require:

- Better informed patients
- Providers marketing their services and acting on patient feedback.

Better informed patients

Although data quality about the outcome of care is improving through the use of instruments of comparability like NHS Choices, more needs to be done. Data must be in the form of accessible and meaningful information: people want to know what other people are experiencing and ask for explanations. As the volume of information grows, so does the need for synthesis and interpretation by commissioners. The best providers will want to attract patients and share regular information with them about the performance of their service. But the information must be accessible, clear, reliable and comparable to allow patients to make informed choices.

Websites like NHS Choices and Dr Foster also allow the general public to compare not just clinical data but data about 'softer' elements of the NHS patient experience, such as the attitude of staff, cleanliness, attentiveness and quality of food. NHS Choices includes some comparative indicators such as MRSA rates, but information on the site is limited.

More accessible and meaningful data will allow patients to make informed choices, increasing their sense of ownership over their own care and helping them pick the most appropriate service to meet their particular needs.

Data on accident and emergency (A&E) visits for the third quarter of 2007/08 indicates that 78% of patients at major A&E departments were not admitted. Department of Health figures also show that in 2006/07 there were 3.7 million patient visits to walk-in centres and minor injury units which did not result in admission. Of those visits, 1.7 million did not result in treatment, yet still cost £58m.[5]

As the volume of this type of information increases, so will the need for interpretation. For instance, comparable infor-

"...the nature of NHS provision will and must change – to be based not just on what it can do for you but what, empowered with new advice, support and information, you can do for yourself and your family. Patients benefit from being treated as informed users and choice will help deliver this – so we will continue to make it more widely available.[6]

GORDON BROWN, PRIME MINISTER

mation on every hospital would allow consumer groups to create easy-to-read hospital guides. The ambition of shifting the direction of the NHS from a sickness service to a 'wellness' service will mean a greater role for many patients in understanding and managing their illnesses, and having the right incentives after treatment.

The Department of Health has recently announced a £1m campaign to improve awareness of patients' right to choose a provider. The CBI supports this initiative, but as with all public awareness campaigns, it will take some time before success can be evaluated.

RECOMMENDATION

The Department of Health's national awareness campaign on patient choice should concentrate resources on making sure patients receive accessible and comparable data and information so they are treated at the right point in the NHS, whether it is at A&E, a GP surgery, walk-in centre or high street pharmacy.

Providers marketing their services and acting on patient feedback

One way of getting accessible information to patients is via provider marketing. Under Patient Choice, the introduction of a marketing strategy not only allows providers to attract patients, it increases patient understanding of their options. It is too soon to evaluate how well providers will use their new freedoms, and target GPs and patients with information on their services, but the principle is sound and a crucial step towards the development of new types of partnership necessary for any 'wellness' culture.

All providers should seek to update their websites so they are easily accessible and usable by GPs and patients. The Department of Health has recently proposed a promotion code to advise on the best form of marketing, but we do not know how effective this will be. For instance, the effects of alternative provider branding on the core NHS brand are unknown. But there are many providers who co-brand sensitively when they offer NHS services – for example, Boots, Spire and Atos Origin – but this may not be the case for all alternative providers.

CASE STUDY

Information sharing improves patient satisfaction

Interhealth Canada's orthopaedic treatment centre in Runcorn has gained a 25% market share since 2006 for relevant procedures within the Cheshire Merseyside area in 2007. It is providing around 25% more procedures than the 'minimum take' in the contract, so it is successful in attracting patients. Interhealth believes referring GPs and therapists in triage services are the key influencers in helping patients choose where they go for surgery. That recommendation will, in large part, be based on the level of confidence that they have in surgeons and clinicians providing the service, and demonstrates that the patient choice agenda is often not solely dictated by the patient.

Interhealth has as a result held over 80 local clinical engagement and education events, where Interhealth's surgeons, nurses and therapists discuss a range of issues with referring clinicians. These include explaining the benefits of the one-stop shop approach to achieving a 7-10 week pathway, which only involves one pre-surgery visit for most patients, improvements in infection control (Interhealth has had zero C-Diff and MRSA rates to date), and sharing the latest evidence based practice in orthopaedics.

Interhealth then tracks PCT referrals by GP practice and by procedure, and combines this with qualitative feedback from referrers to identify areas where those referrers may benefit from further clinical engagement. A number of initially sceptical GPs have completely changed their attitudes, and that decision has been reinforced by positive feedback from patients (over 99% of patients would recommend the centre to a friend). Following feedback from referrers and PCTs, Interhealth Canada is now looking at further innovations, including satellite outpatient clinics.

This one example is evidence of the positive cycle of benefit to patient, provider and commissioner from good data gathering and analysis, because it provides so much more 'colour' than clinical statistics alone, and has at the heart some answers to the question 'what does this do for patients?' It also encourages commissioners to think they have real options.

CASE STUDY

Information sharing enables choice

In 2007, Spire Leicester Hospital was one of the first sites to pioneer patient choice for NHS patients using the Choose and Book system, through its orthopaedic appointments. This enabled GPs throughout Leicestershire and Rutland to offer patients the opportunity to choose appointment times and book online.

GP practice staff were given guidance on booking online and a direct line was provided to the hospital's patient choice team. A GP engagement strategy to educate GPs and practice staff showed them how to process a booking through Choose and Book. Spire staff explained the specialties on offer and which of these had 'directly bookable' clinics, and each practice was then kept updated with new GP and patient services. The programme has since been extended to GPs seeking other services such as general surgery, urology, gynaecology, and ophthalmology.

Leicester will be one of the first hospitals to undertake an independent patient satisfaction study of its NHS patients using the same questionnaire used by the NHS. This will help patients make their choices using comparable data, and satisfaction levels will then be published on the NHS Choices website.

More broadly, the additional capacity offered by Spire Leicester Hospital has allowed patients waiting for surgery to be accommodated quickly. Working closely with Leicester PCT, the hospital has supported the local healthcare economy to deliver local waiting time standards and offer patients a choice of provider.

In the case of elective care providers, marketing is also about building the confidence of referring clinicians, such as GPs, and of practicing clinicians, such as surgeons. There is a need to think about how to build good local reputations, mainly through clinical engagement sessions, which is the approach taken by Interhealth Canada (see case study).

The multiplicity of patient needs

Marketing and patient information schemes are most effective when they are based on a thorough understanding of the patients they are trying to target. All providers will need insight into patient experience. This will allow them to shape services to their needs and preferences, using preferred access channels, promoted in ways that are unobtrusive but effective, and avoid problems associated with feedback fatigue.

Providers need to know several factors about those who use or are likely to use their service – including, for example, their expectations and how the service could be improved. Without this information, the structure of care pathways is always going to be determined by a number of assumptions, which are then often not tested. It is better to base new models of care delivery and service improvement on solid patient feedback.

Often it is addressing the small changes that improve a patient's experience, such as ensuring a friendly reception, providing updates on how long the waiting time is, or having better toys in the waiting room – these are frequently as important to patients as whether their NHS experience has made them feel better. The National Consumer Council (NCC) has found that getting the little things right sends a signal that this organisation respects and values the people who use it.[7]

The CBI's *Future Services Network* campaign, with the NCC and the Association of Chief Executives of Voluntary Organisations (ACEVO), sought to develop this understanding of how to apply consumer insight into the managed markets of public service delivery. *The Future Services consumer blueprint*[8] – developed through a national deliberative forum – asked members of the public to create a wishlist for how services could be more responsive and tailored to their needs. Their answers were services that should be open to criticism and change in response, there should be more information about the service they receive, and communication should be simple and obvious. These are things that all too often are difficult for a large organisation like the NHS to track over time, and more importantly, respond to appropriately.

The Future Services campaign also identified that customer engagement should be tailored and appropriate to the different NHS audiences. It is here, for example, that the third sector has much experience, because of the relationships it has with individuals using a care-based service over a long period of time. The important lesson from consumers was that engagement means nothing without producing tangible results. The evidence showed that consumers and patients recognise that with choice comes a degree of responsibility on them to use that appropriately: 57% of consumers consulted for Future Services agree that people should only access choice if they are prepared to take the time and effort to understand the options available to them.

It is good business in the broadest sense for any organisation to try and understand what its customers are thinking. Modern best practice from the commercial sector recognises that this can be done best by segmenting the market, as Boots does in detail in its stores (see case study).

RECOMMENDATION

To encourage providers to collect and act on information, NHS commissioners should incentivise providers by including performance measures that focus on customer experience and satisfaction, in any contract. When developing the NHS performance management system, the Department of Health should specify what happens when a provider fails to respond to patients.

CASE STUDY

The value of knowing your customer

Boots invests a great deal of time and energy in understanding its customer base. Primarily, it wants to know what type of person shops at Boots, what they buy, when and where they buy it, and why. The marketing team uses five stages to provide in-depth insights into customer needs and preferences:

Insights stage	Examples
Macro trends	Economic factors, footfall
Tracking	Campaign awareness, customer care, satisfaction levels, complaints/ compliments, competitor activity
Analysis	Marketing campaign effectiveness, direct mailings, coupons/vouchers, price and promotions, customer loyalty (via Advantage Card)
Research	Needs/preferences, shopping behaviour, product usage, concerns, habits, expectations, barriers. Research techniques include customer panels, focus groups and statistical analysis
Segmentation	A rich picture of customers is developed which forms basis for effective targeting and communication with relevant, motivating offer

Customer insights are used to build a deep picture, dividing the market into eight segments such as ‘young family’, ‘lunch convenience’, ‘cosmopolitan’ and ‘health concerned’. For each segment, shopping behaviours and attitudes are researched, so the role of Boots can play to help is targeted most effectively. For example, ‘health concerned’ users are over 55, are likely to be time rich and price aware, actively seek advice on health matters, value convenient store locations and pharmacist availability and like to use in-store health testing. For these customers, Boots can focus its marketing communication on the availability of private consultation rooms and training healthcare experts, in-store services on free testing on common health complaints and personal contact about the Boots Health Club.

2 A vision for commissioning in the NHS

The CBI shares the government's vision that a fair, personalised, effective, safe and locally accountable NHS must continue to be equally available to all, taking full account of personal circumstances and diversity.[9] NHS organisations are on a journey to meet this challenge.

We believe improving strategic commissioning by SHAs and PCTs is fundamental to meeting the needs of patients. But they cannot do it alone. Independent sector providers can work together with SHAs and PCTs, devising pragmatic solutions to the challenges that will inevitably arise during the process of transition to a new commissioning environment.

New ways of working will provide opportunities for commissioners to engage more effectively with the independent sector, but in response providers also have to be open to listening and learning from NHS organisations if the new relationship is to add real value to patients. What works in improving the direct commissioning of services will also be invaluable in encouraging commissioners and service providers to focus on outcomes and radically transform their perspective on how services are delivered.

This report therefore suggests:

- Commissioning must translate patient needs into new service designs
- The roles and responsibilities of commissioners must be better defined.

Commissioning must translate patient needs into new service designs

CBI members believe a strategic approach to commissioning requires NHS organisations to step back and take an overall view of their role in a locality. In the past commissioning in the NHS has been exclusively about an alternative to market and choice-driven resource allocation. Commissioners made the decisions about how many procedures to buy and who from – in most cases another part of the NHS.

As we move towards a system that is increasingly driven by patient choice and operates on the basis of 'any willing provider' the role of commissioners begins to change radically. Instead of being an alternative to the market they become strategic managers of the market – ensuring competition is effective through maintaining a sufficient number of suppliers, dealing with the inherent asymmetries of health information by acting to keep the consumers of health services informed and to ensure that potential providers are able to take advantage of innovations and opportunities as the science and the demographics change.

"...we will strengthen commissioning, give more responsibility to primary care professionals and open up primary care: with more providers, new primary care services, and more weekend and evening access."[10]

GORDON BROWN, PRIME MINISTER

In the future PCT or other central commissioners are less and less likely to be the direct purchasers of 'service' as that will be driven by choice. But they will not abandon that role completely as they will have to ensure, through a variety of market support mechanisms, that choice is real. It will require strategic planning and resource allocation, drawing on the expertise of local partners and cementing effective partnership working, collecting data on service costs, running a competitive procurement and monitoring and assessing performance. When performed well, it should allow a commissioner the oversight to check, gather feedback and improve on the quality of services provided to local people.

Since 1998, ministers have promoted the provision of NHS services by independent organisations. The CBI has consistently welcomed this and believes the independent sector does and will make an important contribution to improving patient care. But this involvement should be articulated as part of an over-arching vision for NHS reform.

At the moment, the independent sector appears to be simply parachuted in by the Department of Health to fill gaps in provision, or even used as a crude threat to boost the standards in poorly performing public sector providers. It is not being used by the NHS to its best advantage.

There are many potential benefits to having the independent sector working in collaboration with the NHS in sustainable and viable NHS markets, not least increasing the choices available to patients. As the NHS Chief Executive David Nicholson highlighted: *"Already the provision of NHS services by private-sector companies has had a galvanising effect…it has stimulated productivity, it has stimulated more responsive services for patients and we see it continuing to do so. It's inconceivable…that in ten years' time you won't have an NHS where a considerable proportion of its services are provided by the private sector."* [11]

All providers, from every sector, should be working towards the same objectives – to deliver the best care to patients in the long term. All commissioners should be open to using the best provider, from any sector, to ensure this objective is met. Allowing providers to compete on the value of patient care should be a long-term objective for the NHS.

The government's reform programme will be judged a success when patients can see through personal experience that the system is working in their interests.

In almost all cases, choice and competition through managed markets are the best means to build dynamic and responsive healthcare systems. What makes a market work smoothly and respond accordingly is choice. This not only empowers patients to take ownership of their wellbeing and to seek out the most appropriate care, but also has a functional purpose in terms of developing the market. Patient choice turns patient needs into market signals to which suppliers can respond – signals that are more accurate and easily interpreted than a departmental directive or target.

In a competitive market, engaged suppliers will offer the most patient responsive service. Patient choice is therefore not just about how the system will be run, but also about how it can develop in future.

This is the vision which the CBI sees as the logical endpoint of the current reform agenda: an NHS where patient choices shape the organisation. But it is a long way off because the choice model is in effect being grafted on to the existing system of levers and incentives which are not set up to deliver diverse patient outcomes.

For example, some patients want to be treated as quickly as possible but NHS trusts are generally a long way off from meeting their 18-week waiting time target. Only 22 out of 152 PCTs and 35 out of 170 trusts have already met the December 2008 target.[12]

"We will use all mechanisms available to us to improve our NHS – public, private and voluntary providers can all play their part and there will be no 'no-go areas' for reform as we seek to deliver the preventive and personal services which will renew and secure the health service for the future." [13]

GORDON BROWN, PRIME MINISTER

CASE STUDY

Commissioning a patient-centric care pathway for long-term condition managment

Somerset PCT has developed advanced commissioning arrangements. It has a countywide practice-based commissioning (PbC) group which developed six areas of action, including commissioning a patient centric care pathway for long-term condition management, to enhance existing primary and secondary services through the provision of specialist community services. The particular aim for Chronic Obstructive Pulmonary Disease (COPD) care was the introduction of community-based services, which were requested by patients.

The service specification was developed with the support of the local clinical advisory network whose members included the COPD GP lead and medical and nursing advice from respiratory specialists employed by the acute trusts, primary care and the community specialist service. In addition, the PCT commissioned a patient survey and a needs assessment both of which influenced the final specification. The resulting service specification was an in-depth and outcome-based document that formed the basis of the competitive tender.

The Somerset integrated COPD service will be run by the independent provider, Clinovia, in partnership with Avanaula Systems Ltd (a GP consortium). This unique relationship brings together local clinical leadership and extensive community care experience to ensure that the new service will significantly improve care for people with COPD.

The work to create an innovative care pathway for a fully integrated specialist community COPD service evolved as a result of listening to what patients wanted through a local patient forum called the 'Breath-ability Group'. The foundations of the service delivery model are underpinned by the vision from the group to provide local services as close to patients' homes as possible. As such, the service will be delivered by a mobile team across a variety of settings. This flexible multi-site location means services are taken to patients, self care is promoted, compliance optimised and the burden of disease minimised.

Local services consist of: specialist, oxygen and nebuliser assessments; access to specialist support seven days a week; pulmonary rehabilitation; 'drop in centres', case management; unscheduled response for acute exacerbation support; access to education and patient specific information.

Patients benefit by becoming the expert, having greater access, having an individualised self management plan, enjoying increased confidence, being able to self manage, experiencing an improved quality of life and undergoing fewer hospital visits.

At the same time, the independent sector is still only being used in a very narrow capacity to provide help in reducing waiting times in elective care. Such an approach reinforces a perception within the NHS of independent providers not being integral partners in improving patients' experiences.

There is potential for much greater use of the independent sector to meet targets, but it needs to be used strategically. The CBI would like to see PCTs develop viable plans about how they will use the independent sector to meet their 18-week targets.

Better for the patient would be for a commissioner to encourage collaboration between providers and clinicians, and promote the development of new capacity in the right places.

Somerset PCT is a leading example (see case study). For instance, there is too much focus on primary and secondary care in the treatment of chronic conditions, and less on the (otherwise crucial) bits in-between – community care, diagnostics, the role of minor injury units – which could play a crucial role in improving pain management and raising the quality of life for a patient. For example, introducing more competition to a community service such as physiotherapy could bring siginificant benefit to patients (see case study).

These markets should be seeing the biggest growth, given the enormous potential for innovative packages of care that allows people to stay in their homes, remain active, and less reliant on secondary care or the GP surgery. But that is not yet happening.

CASE STUDY

The expansion of post-op physiotherapy

Patient choice is currently limited to elective surgery, but there are other areas where choice could benefit patients, and questions should be asked why this is not the case if there is a clear need for innovative packages of care.

An example would be a community service such as physiotherapy. Alternative high-quality private sector alternatives do exist, but these are inaccessible for many NHS patients. Expanding choice could mean that patients with a referral for physiotherapy could go to any willing provider.

More open competition in physiotherapy would challenge PCT provider arms. Patients with joint replacements are dependent on community physiotherapists for post-discharge physiotherapy. PCTs could commission elective care providers for the whole pathway (from discharge through to complete remission) with the opportunity to deliver physiotherapy or subcontract with a choice of providers.

That is, the PCT could commission pathways and let the primary contractor manage the components of the pathway and the choice of interactions with the patient. This sort of flexible approach recognises that patients requiring physiotherapy are not a homogenous group and may require a whole range of different interventions and access points.

RECOMMENDATION

NHS commissioning systems should be responsive to meet patient needs. This allows more hospitals to specialise and PCTs to measure value better throughout a complete pathway, in order to commission better in the future.

PCT commissioners and suppliers need to build on existing good practice to develop a shared understanding of how to contract for the delivery of complex outcomes. Both should also work together strategically to produce service plans that detail how the independent sector will be used to meet 18-week targets.

The roles and responsibilities of commissioners must be better defined

For reform to endure, another blueprint for further organisational change from the centre should be avoided. Instead, Lord Darzi's review should be an opportunity to clarify current reforms, including the use of choice and competition, the role of regulation and performance management and how these elements work together in the interests of patients.

The review and the government's response to it, should clarify who makes decisions and at what level of commissioning, what is to be done locally, regionally and nationally, what is universal, what subject to local discretion, and what that all means for patients and communities. This requires more clarity on who holds the financial controls and the political levers. Democratic accountability demands politicians should have a role in overall healthcare policy, but they should concentrate on articulating the strategic direction and setting the parameters within which local decisions are made.

There should be clarity on local accountability, including how PCTs and GPs should work in partnership with other public service providers, employers, community organisations and individuals. These roles should be defined from the bottom up – from the point of view of the patient experience.

Some PCTs are leading the way. Examples are emerging of good practice based on mature and collaborative approaches to partnership and joint working. But for the majority, change has yet to happen.

Leadership is required to consider what is possible with the public sector budgets available and what is the best commissioning model needed to secure services to meet community priorities. Often, the outcomes will require joined-up service delivery. PCTs will therefore need a supply-side that understands the range of ways to deliver a service and can translate commissioning aims into practical services by coming up with an effective cost model.

In fact, strategic commissioning should be guided by seven clear principles:

- **Centred on patients:** putting local people and communities at the heart of the process, and ensuring they are engaged in the design and delivery of services so that results delivered are the ones that really matter
- **Smoother collaboration:** developing a three-way relationship between the commissioner, supplier and patients, based on trust, will create a shared sense of what people want to achieve and consensus on cause and effect – the things that will allow them to achieve it
- **Better evidence and deeper analysis:** a whole needs analysis of populations will better identify service priorities
- **Clearer outcomes:** clear signposting between outcomes, and identifying clear links with inputs and outputs, will show how they fit into the strategic policy
- **Better dialogue:** early dialogue within commissioning teams – for example, between technical staff (heads of procurement) and strategic staff (chief executives), and between commissioning teams and suppliers – will mean operational programmes are joined-up with strategic policy goals
- **Improved sustainability:** the sustainable management of services and assets demands a focus on quality and value for money – not lowest cost – so that more is achieved with less in an environmentally friendly way
- **Contractual challenge:** transparent information about the cost and performance of services will allow NHS organisations to make accurate assessments about whether existing services represent good value for money.

PCT commissioners must understand local communities and the other factors which affect health – such as housing, crime and education. But their core role should still be to buy healthcare services and encourage providers to come forward with new ideas that are more responsive and focused on preventing illness as well as treatment. Equally, working with local authorities on local strategic partnership boards and agreeing local area agreements is important but more resources should be dedicated to commissioning. This will have the additional benefit of increasing the status of the commissioning profession in relation to other NHS groups.

We believe commissioning targeted on patients needs offers significant opportunities and challenges for suppliers too. There will be a number of changes in the pattern of supply required by strategic commissioning. Suppliers will, either by themselves or with other suppliers, have to develop approaches in four main areas:

- **Outcome-based contracts:** success and payment will increasingly be determined by broad measures of wellbeing (economic, social and environmental) and will include a significant element of customer satisfaction
- **Co-operation** with other suppliers will be essential, since few suppliers by themselves are likely to be able to deliver all aspects of a commission in a form that meets local objectives
- **Flexibility** over time and between different groups or areas. Services will have to adapt rapidly to changing patient demand and to the needs of diverse groups within a locality. This will challenge the 'one size fits all', fixed output specification which is typical of much NHS contracting and the basis of most supplier business delivery models
- **Customer focus and engagement:** delivering 'choice and voice' to service users demands high levels of interaction with customers by providers. This needs to occur at all levels of an organisation and will challenge traditional 'command and control' organisational models across the NHS. In particular, commissioners and suppliers will both need to empower front line managers within clearly set limits to respond effectively to patient needs.

The initial responsibility to create the conditions in which a contestable, commissioning-based marketplace can develop, belongs to NHS organisations. But the independent sector has an integral part to play in the development of health service markets.

Commissioning is the catalyst that drives the reform programme forward, but PCTs are neither pure commissioning nor perfectly integrated organisations. The majority still deliver services as part of a provider arm. This limits their capacity to focus on what their communities need and how best to deliver this. Financially separating such provider arms would be an important step in helping to focus on commissioning.

Local accountability

Under the new market arrangements, PCTs will need to formally and systematically review whether local services are delivering high-quality efficient care, and whether they are tackling health inequalities. This applies both to directly provided and contracted services. Such an ongoing review will become a central part of each PCT's role as a commissioner, and give it and its staff real options when services are not delivering against clearly defined outcomes. Clearly, one important way forward is for the PCT to consider market testing the provision of key services.

To judge if a service is operating at or close to its optimum efficiency and effectiveness requires having something tangible to compare it with, and ask whether it could operate better. Any market testing exercise should involve not only a review of what third party providers can offer to the PCT in terms of provision, but it should also be used as a way to test, benchmark and evaluate the current provision of services by the PCT itself. In other words, PCTs could look at setting up competitive processes to test the value for money and quality of provision, and as part of that process, submit an in-house bid.

As PCTs review their roles and ability to provide services, it should be expected that they increasingly look to the market to benchmark their abilities and for others to provide appropriate care. If service provision is taken up by others, a PCT will need to think carefully about how it achieves successful transfer of relevant business to a new provider. It will need to think in detail about its own staff who are involved in providing services and consider how they fit into the process. It may well be that signing an agreement with a traditional provider will be the preferred way forward, involving a TUPE transfer of staff, but PCTs also need to be ready for in-house bids and current employees looking to set up their own business within a new corporate structure.

RECOMMENDATION

PCTs should focus on and develop their roles as commissioners by market testing their provider arms.

To support this, the new assurance system implemented under the World-Class Commissioning programme is a welcome step in the right direction. It sets out key competencies needed for the commissioning of health services and creates a performance management regime that allows managers to respond if these competencies are not achieved. This should help PCT staff be clearer about what they need and what is expected of them.

PCTs should also engage with suppliers early, for example, by holding 'vendor engagement days' to understand the opportunities that the market can present. Such vendor engagement opportunities help both commissioners and suppliers understand each other's needs and begin to develop relationships.

But if PCTs cannot meet these competencies themselves, they should outsource some commissioning functions to alternative providers under the framework for external support for commissioners (FESC).

The CBI supports the principle of the FESC. It enables PCTs to use private sector experience of commissioning to get the best value for patients from their local healthcare market, and should increase communication and understanding between the public and private sectors. But it is not being widely used by PCTs, which could be because effective commissioning is still not being seen as a key function to improving health services.

RECOMMENDATION

The Department of Health should ensure all PCTs have a strong leadership that focuses on commissionig and increasing the status of commissioning as a career, possibly through recognition and accreditation by a professional body. It also means articulating a clear vision of a PCT's role in the reform process and achieving staff support for this. The Department of Health and SHAs should encourage PCTs to establish early and open engagement with suppliers – for example, by holding 'vendor engagement days' – prior to all major commissioning exercises.

3 The foundations for effective health market management

If the government continues to develop a mixed economy in the delivery of health services, and as the public and independent sectors are brought into competition with one another, managing effective long-term markets will matter a great deal. The CBI believes competition must be used effectively and thought about strategically if we are to transform NHS services and make them more responsive to the needs of patients.

For the NHS to manage a fair and open market we believe:

- Competition policy should positively promote meaningful choice
- There should be effective recovery and failure mechanisms for poor providers
- The playing field for providers to compete must be more level.

Competition policy should positively promote meaningful choice

To encourage new providers from every sector, competition must be fair and be seen to be fair. The 2008/09 Operating Framework sets out for the first time a competition policy for the NHS. In many ways, this is a seismic shift in the way decision making in the NHS will work. It includes a document detailing the rules and principles of co-operation and competition aimed at ensuring PCTs support the development of open and fair market management. An independent competition panel to be established in autumn 2008 is intended to provide a route for providers to redress anti-competitive activities.

This is combined with measures to give patients the right to receive treatment from any willing provider who is accredited and offering NHS treatment at NHS tariff prices. From April 2008, patients have been offered a list of providers noted on their location and treatment quality. The Department is also spending £1m on increasing patient awareness of this right to choose.

The CBI supports the government's intentions to increase patient choice and these recent efforts to make competition for NHS services fair and effect are welcome. Competition is already driving the most adept providers to change their offering. For instance, Guy's and St Thomas' and UCLH Foundation Trusts in London are now increasingly specialist providers of secondary care. UCLH does not try to provide all services, rather it specialises in a number of areas – for example, cardiology, obstetrics, tropical diseases and neurology. But it is too early to determine whether these measures are enough to turn patients into informed health consumers and the NHS into a dynamic responsive market with many providers.

This health market strategy should ensure competition is now managed at the most appropriate level. The CBI therefore welcomes moves to devolve market management to SHAs and PCTs. But following this there must be vigilance about enforcing the competition rules. The Department of Health must be a central competition champion: where competition exists, support it; where it is lacking, promote it; where it is being blocked, challenge the barriers. Sustained positive market messages from the centre will send a strong signal about the benefits of compliance.

"The Department of Health must be a central competition champion: where competition exists, support it; where it is lacking, promote it; where it is being blocked, challenge the barriers."

The existing competition policy must not simply be enacted: it must be enforced, and behaviours which are against the spirit of the policy should be addressed by the Department of Health. CBI members have reported cases where PCTs have imposed limits on the number of patients they treat. Providers must have some way of seeking redress for these anti-competitive activities from the market managers. The market should operate in such a way that good PCTs will see the long-term benefits of active competition in that it provides them with many more tangible choices as commissioners to make real differences in service design.

RECOMMENDATION

The new principles and rules on competition must be rigorously enforced so all PCTs comply with them. The Department of Health should supplement these rules by undertaking public information campaigns so the public is made aware of the changes in the NHS and the benefits it will mean for them.

There should be effective recovery and failure mechanisms for poor providers

Patient choice should determine to a much greater extent than ever before in the NHS which healthcare providers stay and which have to restructure or even fail. At present, contracting to continue or stop the tenure of a provider is a bureaucratic decision rather than one of patient choice.

With much of the NHS, patients visit providers because there is (or is perceived to be) no alternative. Patients often feel the need to take what they are given: often this is very good, sometimes it is poor. This inertia in the system also prevents poor providers being driven from the market. But when underperforming providers are propped up, the NHS cannot improve.

Failure in the NHS – clinical and financial – is not new. But until recently it has often been unspoken. Both types are becoming more evident with closer scrutiny from the Audit Commission, local government and in the NHS accounting system. And there has been a welcome change in culture, as many NHS providers are no longer willing to hide inadequacies. The Department of Health has acted to address this issue by introducing a new NHS performance management regime and a new merger and acquisition policy.[14] This is welcome but the CBI is concerned that policy on failure mechanisms will not go far enough to encourage a dynamic, patient-led healthcare market.

For instance, there is little experience of turning around failing PCTs because they are fairly new organisations. The majority of PCT funds are committed to contracts with external providers that often cannot easily be altered without changing the way in which treatment and care is delivered, and by influencing GP referral patterns. Experience of PCT turnaround therefore needs to be more widely shared.

Although most providers operating in a patient-led NHS system will probably succeed in attracting patients and improve, the first task of a failure regime is to spot problems early enough to avert more serious consequences later. Exit is the end of the process, beginning with a provider not being able to attract enough patients.

Alternative providers should, in addition, have more opportunity to help failing providers. Crucially, some NHS providers may need help from PCTs to change the focus of provision to more effectively meet changing patient demographic needs.

Any failure regime would need to take place in an independent and transparent regulatory framework which upholds public safety. The Healthcare Commission will be an important part of this, looking at outcomes which go beyond the individual patient and affect the wider NHS. Also important will be an independent adjudicator to determine failure due to patient choice because of the asymmetry of healthcare information. But central regulation must still coexist with patient choice.

A new failure regime needs to be well modelled and aware of future risks. Thorough scenario planning is required to identify risks and manage them. The commissioning framework therefore needs to get the balance right between creating and managing the market.

The issue of failing NHS trusts is politically sensitive, but without rational consideration of using restructuring and closure as a means of improving outcomes, the damage to the NHS is systemic, and not simply localised. Strategic considerations should not be deferred for the sake of avoiding negative coverage in the local media, for example.

The role of the reconfiguration panel may reconcile the logic of a system driven by competition but overseen by politicians.

RECOMMENDATION

A failure mechanism must be defined by the Department of Health which tackles the following areas:

- Patient safety
- Independent regulation
- Competitive neutrality – so the same system applies regardless of whether the failing organisation is from the public or independent sector
- Guidance on how failing organisations can be assisted.

The playing field for providers to compete must be more level

The CBI supports the concept of 'competitive neutrality'.[15] This involves a commitment to fair markets and maintains there should be a level playing field between public, private and voluntary providers of goods and services. It matters because where a public, private or voluntary sector provider competes with an unfair advantage, public spending will invariably be redirected to them but away from potentially more efficient providers.

If independent providers are not convinced of the fairness and sustainability of public service markets, then they will under-invest in those capabilities that will enable them to make a positive contribution to service improvement over the long-term. In particular, they will be averse to innovating with new technologies and new service models.

New providers wishing to develop innovative services to meet demand are often blocked from entering the market or are disadvantaged by not being able to operate on a level playing field. There are several elements that need to be addressed if providers from all sectors are to compete on fair terms, which are cultural, as well as market-related and related to the operation of the NHS tariff.

Cultural issues

Cultural acceptance of the independent sector could be encouraged by looking at how the sector is involved in health systems around the world, where its inclusion is evidently far less controversial.

For example, two thirds of hospitals in France and Germany are not publicly owned (Exhibit 1).[16] The state acts as the guarantor of services, not as the monopoly provider. Such evidence also implies that the cultural aversion in parts of the NHS to private sector provision is as much about learned behaviour as there is not strong evidence of a threat to NHS ideals.

Market issues

The CBI believes the following areas must be addressed to ensure viable, long-term markets are created across areas of care. The Independent Sector Treatment Centres (ISTC) programme aimed to do this. The CBI's assessment showed the NHS was 'getting there'. But the subsequent reduction in the capacity of the ISTC programme, and the mixed signals to the market about future contracting plans, has meant a viable market is now unlikely, cutting off that option to policymakers and the public, whose satisfaction ratings for ISTCs were higher than traditional NHS provision.[17]

The poor performance of the NHS as a client means many independent sector providers will be reluctant to invest in projects that are seen as short term.

If there were a long-term commitment to make sustained use of the independent sector – and this was communicated throughout the organisation and staff incentivised to develop it – new investment and innovation from private sector partners would become more widely available, provided a range of related issues is addressed:

The market forces factor (MFF) is the biggest short-term threat to an effective fair market under choice, and we believe the mechanism for paying MFF should be changed as soon as possible. MFF was introduced to allow for regional variations in cost while discouraging PCTs from commissioning on price. Unfortunately, this is not working. PCTs pay or receive balancing payments at the end of the year which reflect the actual MFFs spent against plan, and as such PCTs know that procuring from a provider with a low MFF will save them money.

Further, the exclusion of the independent sector from the centrally administered mechanism, obliging PCTs to pay upfront, provides a powerful disincentive for commissioners to use independent sector providers. At the moment, paying the MFF to independent providers upfront will at least damage cashflow, and can result in PCTs not being compensated for the MFF payments made (if work done exceeds plan). Independent providers with national footprints have concluded that the MFF system embeds a cost variation that is far too great. In their experience of working across many areas, costs do not vary as much as MFF suggests.

Practice-based commissioning and tariff unbundling
While both of these are good ideas, it seems in practice that the main thrust of activity on the ground is to use these mechanisms for commissioning below tariff, potentially undermining the principle of choice based on quality rather than price. In the sort of services already subject to tariff, a particular risk is that practice based commissioning (PbC) groups have little understanding of the amount of work that has been done to ensure independent providers under choice are properly accredited to work to NHS standards and tariff (as with the extended choice network). As a result there will be many examples of GPs commissioning themselves, other GPs or groups of consultants but these groups are not regulated, cannot offer choice through Choose & Book or report data to NHS standards.

The national programme for IT and other information management and technology costs (capital investment and ongoing costs). NHS providers receive grants which are not reflected in the tariff for meeting the costs of complying with the NHS National Programme for Information Technology requirements, whereas independent sector providers have to recover these costs from within the tariff prices. This distorts their relative capacity to deliver quality outcomes in a more efficient way.

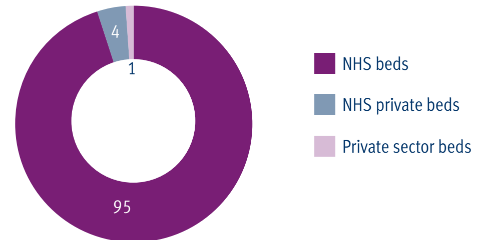
Transferred pensions: one of the biggest issues independent providers come up against as a barrier to reform. Independent sector providers have to account for the future retirement costs of their employees, while NHS providers only account for the costs of current retirees. The NHS does operate Admitted Body Status (ABS), which allows transferred staff to stay in the NHS pension scheme provisions. But this is only available to not-for-profit organisations and for-profit companies run by NHS clinicians. NHS employers contribute 14% of employees' salaries to their employee pension scheme. But this is significantly below the true economic cost of the scheme.

To deliver the same pensions benefits in an equivalent scheme a private provider would have to contribute 30-40% of an employee's salary to their pension fund. This has increased from 26-30% over the last 18 months. Even at this rate, the private contractor's liability is not capped, whereas that of an NHS trust is. The independent sector also has substantial administration fees in complying with

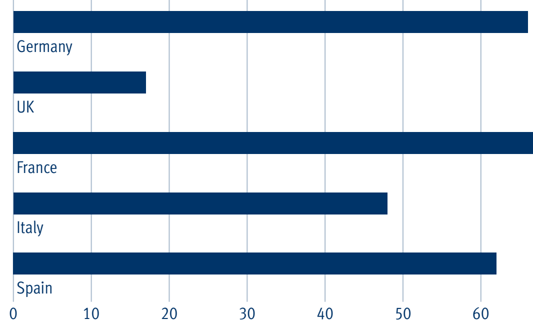
EXHIBIT 1 **UK level of private provision (%)**

Source: Espicom, Federal Statistical Office, Laing & Buisson

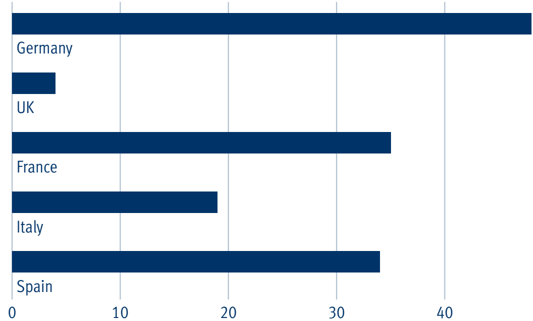
Distribution of beds – UK



Private provision – number of hospitals (%)



Private beds (%)



government and fund actuaries. Even for a small scheme this can come to approximately £30,000 for the first year and £10,000 ongoing.

The restrictions in the current ABS regime undermine the best value principles as contractors from the different sectors are unable to operate on a level playing field. To address such market issues in the short term, one solution could be to implement ABS provisions for all organisations contracting with the NHS regardless of who owns them.

Regulation: Independent sector organisations have to pay for the costs of regulation, which is not the case with NHS providers. In practice, NHS and independent providers of NHS services both treat a mix of NHS and private patients. The costs of regulation are not reflected in the tariff.

RECOMMENDATION

Working with the Department of Health, the Treasury should lead a government-wide review of competitive neutrality policy and practice in public services. This should take place as soon as possible.

NHS tariff

There are other additional market imperfections in the current strategy which any review of its implementation must take into account:

- There are procedures that can be carried out to a considerably higher quality using new techniques, but the accompanying costs are beyond the scope of an average-based tariff. This means the tariff has difficulty dealing with initially high investment costs, such as technological change. Revolutionary technology is often expensive at first, but as expertise develops, price falls. If the Department of Health does not account for initial high costs, it is unlikely that the technology would be bought at all. The impact for patients could mean some having to accept treatments that are more painful or require longer recovery periods
- Conversely, because tariffs are based on average service costs, they do not enable commissioners to take advantage of economies of scale, discounts for volume or efficiencies that providers can make
- There are also concerns that NHS tariffs do not reflect new capital costs. Payment by result tariffs are set to equal the national average of trusts' total costs, a proportion of which represents capital costs. But the proportion of capital costs varies across trusts because some operate old, fully depreciated assets while others operate new buildings. This means that basing tariffs on the average of total costs will overfund trusts with lower-than-average capital costs and underfund those with higher-than-average capital costs. Most new hospitals are PFI schemes, so it is likely that hospitals with large PFI schemes will be underfunded, and are therefore more likely to incur deficits. All parts of the NHS should, therefore, have a historic costs equalisation element.

Stubborn problems with price competition

The payment by results system is intended to rule out price competition and allow the Department of Health, rather than the market, to set tariffs. But CBI members have reported specific examples of prohibited price competition. Where this has been done explicitly and reported to the Department of Health, counter-measures have been taken to enforce the rules.

In extending PbR to a plurality of providers, the Department of Health has to recognise that differences will occur. Firstly, the tariff is based on the NHS case mix, so differential pricing may be needed to reflect this: the NHS and the independent sector have different cost models, industry and economic structures. Secondly, there are also central funding streams and accompanying responsibilities (such as education and training or research and development) which apply only to NHS providers. Appropriate solutions to these would allow PbR to self-correct for differences between providers without unduly distorting other market signals of value.

The CBI would therefore like to see potential solutions including:

- Applying a single tariff to the plurality of providers (if this is shown to be consistent with the operation of a fair market place)

- A formula for adjusting the tariff to support a level playing field
- Changing some of the elements that affect income and expenditure (such as pensions and central budgets) to level the playing field.

Payment by results currently relates to secondary care. In primary care too, PCTs should develop more powerful incentives for primary care providers (and GPs in particular) to engage in an expanded primary care market and to provide extended forms of care. The performance management system for GPs, the quality and outcomes framework (QOF), links GP performance to pay. QOF has improved the quality of diagnoses and some conditions and services covered by QOF are now being delivered more consistently. But it concentrates on what is easily measurable, rather than the more complex longer-term outcomes and academic studies have shown it increases activity and inequality.[18]

Given this, the Department of Health should look at unbundling the PbR tariff in order to give greater flexibility to PCT and GP commissioners when commissioning discrete parts of a pathway.[19]

RECOMMENDATION

An independent tariff-setting mechanism would balance quality and price pressures. It would preclude the tariff being set in the interests of NHS run institutions. Fixed tariffs have a limited lifespan, not least because they can have a negative effect on the rest of the market as things can sometimes be done cheaper than tariff: while the tariff remains, all providers must be obliged to adhere to it to avoid anti-competitive behaviour.

Footnotes

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