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Comparative case studies of health reform in England

Report submitted to the Department of Health Policy Research Programme (PRP)

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Executive Summary

Aims and objectives

In 2005, the Department of Health set out a framework - called the Next Steps Reforms - comprising four reform streams - demand, supply, transactional and system management. These streams were argued to provide a coherent and mutually supporting set of reforms that together would lead to better care, better patient experiences, and better value for money.

This study examined the combined impact of these reforms to uncover the balance of levers and incentives within local health systems. The aims of the research were:

- To explore empirically how stakeholders regard the implementation of complex policy initiatives within a range of local health economies (contexts), including how these local implementations are intended to operate (process) and their observed effects (outcomes);
- To identify the extent to which policy initiatives were proving effective in addressing nationally specified outcomes in a range of service specialties with specific emphasis on understanding the interactions and dynamics *within* organizations as well as *between* them.

Methods and analysis

The methodological approach to the study recognised from the outset that the collective impact of the reforms would be influenced by a range of contextual factors and local contingencies. Consequently, the study employed a contextually-specific design ('realistic evaluation') to examine the complex interaction of the reform processes. This means that we aimed to discover the underlying 'programme theory' of the reforms. To enable this, the reforms were examined across three different tracer conditions/services (orthopaedics,

diabetes, and early intervention mental health) and across six local health economies (PCTs) in different contexts.

The research design consisted primarily of comparative case studies. Data was gathered using a mix of methods including: documentary analysis; two rounds of qualitative data collection resulting in over 200 face-to-face and telephone interviews with key informants; and quantitative data analysis examining comparative progress in each local health economy by tracer condition. In addition, the study undertook a non-systematic review of policy documentation and literature to examine the context for the reforms, and a series of 'high-level' interviews with key policy makers.

Results

Policy and Literature Review

Analysis of national policy documents found that the different reform levers contained in the Next Step Reforms were the result of an accretion of reform levers over time. While this resulted in 'programme theory' becoming clearer over time, with some later reforms attempting to rectify earlier problems, it was not fully clear how and why the reform elements should comprise a mutually reinforcing set of levers and incentives.

A review of the evaluation literature found that few studies had sought to examine the cumulative effects of reform levers. There was some support for the positive impact the reforms had had on waiting times and access to care, but it was also reported that the pressure for quick results had led to some reform initiatives being introduced without adequate understanding or preparation. Moreover, a common finding in the literature was how different reform levers created tensions - for example, in the commissioning of local versus national priorities; and of the power imbalance between commissioners and providers when making investment decisions.

High-level policy interviews

The high-level policy interviews clarified some of the components of 'programme theory', but some problems still remained. Moreover, it was clear from the interviews that the

framework appears to have been based primarily on addressing elective conditions (e.g. orthopaedics), with far less relevance for our other tracers (diabetes; early intervention mental health). There was some evidence of policy learning as some later policy levers were added or changed as problems emerged. For example, it became clear that 'payment by results' was more accurately viewed as 'payment by activity', and this led to discussions of 'best practice' and 'unbundled' tariffs, and to linking payment partly to quality, patient experience and patient satisfaction rather than simply to quantity. Policy makers were aware of some of these perverse incentives and unforeseen consequences, and attempted to pull the appropriate policy levers. Some later elements - such as World Class Commissioning - were necessary to restore system balance from earlier elements such as Foundation Trusts.

Impact on orthopaedic services

Urban sites were more successful in reaching their 18 week target than the rural sites, although the rural sites were initially further from the target, and 'closed the gap' to some degree over time. Within a context of rising activity, the main providers tended to lose some ground, although they still dominated activity in most sites. The activity levels of ISTCs varied significantly in our sites whilst the impact of choice and competition on patient flows appeared weak.

Most interviewees in this study were aware of the potential of choice and the threat of competition, even in largely monopolistic markets. For example, providers felt that they had to 'raise their game' in the face of potential choice on the part of consumers and competition from ISTCs. An awareness of programme theory was also more apparent amongst respondents in the orthopaedics tracer compared with diabetes and EIMH. There was some agreement that the reforms had been 'unbalanced' with providers dominating commissioners.

Impact on diabetes services

The research uncovered a general perception that change for the better had been achieved in diabetes care. The strongest forces of reform have been central regulation and guidance mixed with the nature of the payment and reward system - a combination that encouraged care management in general practice but also led to conflict in enabling vertical integration

between primary and secondary care. Some PCT commissioners sought to utilise best practice guidance and payment levers to enable change in primary care, but choice, competition and provider diversity were not reform levers that were actively encouraged. There was evidence to suggest that the reform architecture was never intended to be used in a collective fashion to improve diabetes care.

Impact on early intervention mental health services

The Next Step Reforms had limited impact on early intervention in psychosis (EIP). Service developments have been driven primarily by targets and best-practice guidance, and the pressure to adhere to them. This pressure has had both positive and negative consequences, but it seems unlikely that the 50 new EIP services nationally would have been established without top-down direction.

Choice and competition appear to have had little impact on EIP services. There was no direct financial reward for providers to attract patients since Payment by Results was yet to be implemented. Patient voice was perceived as being important in operational decision-making, but the extent to which the involvement of service users and carers at this level had led real changes in care provision was not clear. There was some evidence that commissioners played an active role in the development of EIP services in some sites. The future of EIP services remained uncertain, but there was consensus that the EIP approach provided a model for future services.

Conclusions

As expected, the reforms had more impact in some of our case studies than others. In particular, urban PCTs were more successful in hitting their 18 week targets than the rural PCTs, whilst there was also limited evidence to suggest that a history of partnership working led to pro-active strategies for the better management of people with diabetes.

Respondents were broadly clear across sites and tracers that transactional reforms and system management and regulation were stronger than demand and supply reforms. This appears to have had an influence on the observations that there had been increased activity and reduced waits across the sites and tracers examined, and some evidence of a greater

focus on innovation and a business culture. However, there has been little perceived progress towards redesigning care closer to home, enabling prevention, and promoting choice.

There were also some 'dogs that did not bark'. Few respondents mentioned outcomes such as health gain, reducing health inequalities and prevention. Similarly, few stressed mechanisms such as voice, workforce reform, and management information. Even fewer could clearly explain how the mechanisms of the Next Steps Reforms would lead to outcomes such as improving health and reducing health inequalities. This is hardly surprising as, despite the rhetorical importance of these objectives, they were not seen as being high priority, in the manner of 'P45' or 'must do' targets. Moreover, 'programme theory' gave few clues as to how they were to be achieved by the reform streams. For example, it was not clear how a reduction of health inequalities would be achieved by demand, supply or transactional reforms while for SMR reforms, health inequality targets tended to be long-term and lower priority to waiting list targets. Indeed, some saw the reforms as leading to negative outcomes such as the fragmentation of services.

Different local health economy contexts had a significant but varied impact on how the reform levers played out. It appears that the current set of reform levers are only likely to 'work' in areas that have real competition *and* informed choice: in other words, where the demand and supply side come together.

Overall, there was little evidence to suggest the conscious operationalisation of 'programme theory' in practice. The Next Steps Reforms do not appear to comprise a coherent and mutually supportive set of arrangements in general terms and they appear 'unbalanced in that the 'centre of gravity' favours suppliers over commissioners, although recent reform changes have sought to redress this imbalance. In short, is clear that the Next Steps Reforms, while having achieved much positive impact, has not delivered the full promise of mutually enhancing streams. Since the bulk of the data collection in this project, health care policy has changed with the 'Nicholson challenge' of efficiency savings and the White Paper of the Coalition Conservative/ Liberal Democrat government. This has resulted in some changes to programme theory. However, we draw on perspectives on programme theory and implementation to offer some lessons for policy makers:

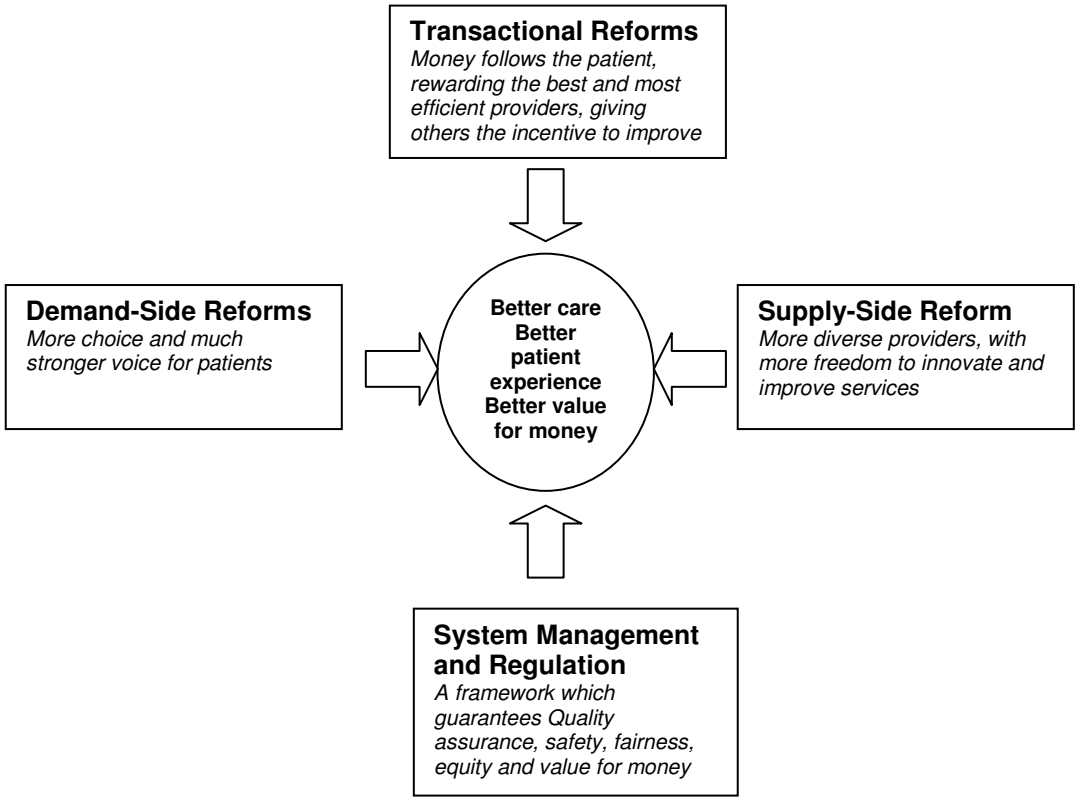
- **Programme theory is important;**
- **Context is important;**
- **Implementation is important;**
- **Do not assume that central programme theory is shared in vertical or horizontal terms;**
- **System alignment is important; and**
- **Policy Learning is important**

Chapter 1: Introduction

1.1 Presenting the 'Next Steps' policy agenda

The New Labour government's health policy agenda since 1997 has been very full. The 'Next Steps Reforms' (NSR) presented in 'Health Reform in England: Update and Next Steps' (DH, 2005a) outlined the programme health reform as four-interrelated work streams (see Figure 1). These four related streams of work provided 'a coherent and mutually supporting set of reforms, which together provide systems and incentives to drive improvements in health and health services' (DH 2005a: 9).

Fig.1.1 Framework for health reform in England



The benefits of health reform were 'realised through the interactions between all four elements'. Improvement to services was driven by 'a combined effect of more information on quality, patients exercising choice on the basis of such information and advice, and money following the patient' (DH 2005a: 9). For example, the combination of Payment by Results and better commissioning by practices and PCTs would make it easier to invest in local services. The introduction of a clear rules-based system would provide confidence for patients, and will encourage innovation, as providers understand the rewards and risks (DH 2005a: 9).

Annexe A (DH 2005a: 17) sets out the aims and policies in more detail (see Fig 1.2). It is stressed that these streams are both inter-related and also mutually reinforcing in nature. Moreover, reform is an evolving process rather than a single event. The 'Next Steps Reforms' were not designed as a blueprint for how services should be delivered; rather, they provided a means to improvement not an end in themselves.

Fig 1.2: Health reform in England: Framework

More choice and a much stronger voice for patients (demand-side reforms)	**More diverse providers, with more freedom to innovate and improve services** (supply-side reforms)	**Money following the patients, rewarding the best and most efficient providers, giving others the incentive to improve** (transaction reforms)	**System management, regulation and decision making to support safety and quality, fairness, equity and value for money** (system management reforms)
Aim: to create more knowledgeable, assertive and influential users of services	**Aim:** to create more flexible, responsive and innovative service providers	**Aim:** to ensure that the impact of patients' choice is understood, and that good provider response is rewarded	**Aim:** to ensure safety and to safeguard core standards in all services and to provide a transparent, rules-based framework for key management and decision-making functions in a more dynamic system
Policies: • patient choice • the commissioning framework including PBC • *Commissioning a Patient-led NHS* • information for patients • public and patient involvement	**Policies:** • NHS Foundation Trust status • a wider range of providers, including the independent (private and voluntary) sector • workforce reform	**Policies:** • PbR • management information	**Policies:** • definition of new performance management and regulatory functions • processes for ensuring quality, licensing providers and price setting, the competition policy and the performance and support regime • wider review of regulation

Source: Annexe A (DH 2005a)

1.2 Looking inside the 'black box': the challenge of evaluating complex policy interventions

The impact of Next steps reform seeks to embed the right balance of incentives, patient choice, plurality and transparency in the system (DH, 2005a: 7). The challenge this presents for evaluation is that given the NHS reform agenda has multiple aims and objectives at varying levels of detail (DH, 2006) it is clearly difficult to pin down 'policy success' (Powell, 2002). There may be some tensions or conflicts between the objectives, such as trade-offs between efficiency and equity, or equity and choice.

Most fundamentally, it is clear that 'success' is contextual (DH, 2006: 11) - just as health services are not 'one size fits all', neither is health reform. For reforms to achieve their objectives, the right balance of levers and incentives need to be found that can support the delivery of the highest quality of care, within budget, and in different contexts. Given this diversity, appropriate responses to certain services are likely to be different – for example, from 'patient-driven' (e.g. choice-led elective care), to 'commissioner-driven' and even 'nationally-driven'. As DH (2006d: 12-14) suggests:

> 'None of these approaches is completely self-contained. In reality there will be a blend of incentives in all service areas but usually one of these approaches is likely to be dominant…We start with a preference for patient-driven approaches because that is what will drive greater responsiveness of care, putting choice and control in the hands of patients and users'

Policy evaluation is problematic with multiple reforms, aims, mechanisms, and contexts. It is difficult to attribute change to any particular policy or incentive given the highly complex interactions between potential causal and confounding variables (cf Boyne et al 2003). Brereton and Vasoodaven (2010) note that while there is a abundance of research on individual policies, there are few studies that examine the cumulative effect of policies since 2002. Moreover, research on individual policies will relate to specific times and contexts. For example, studies conducted when PbR accounted for about 30% of hospital income may not apply when that figure is about 75%. In other words, much previous research has tended to be conducted in separate time-bound 'silos' rather than being 'joined up'. There is a need,

therefore, to look at how the whole system-wide reform processes interact in dynamic fashion in local health economies for certain service development (tracer) priorities.

Awareness of local and national contexts is essential in understanding the relative take-up of new initiatives and/or the responsiveness of local health economies to change (Smith and Goodwin, 2006). National evaluations of the relative achievements of different English primary care organisations in enabling service change, commonly found that the dynamic nature of local contexts meant that attributing change to any single reform mechanism or variable was not possible. This leads to a research design that recognises the importance of context (Pettigrew, 1992; Pawson and Tilley, 1997), and consists of comparative case studies using a mix of documentary, quantitative and qualitative data as a form of 'triangulation'.

1.3 Plan of investigation

The aim of this study is to examine the combined impact of recent health sector reforms in order to uncover the balance of levers and incentives within local health systems. Using contextual theory, the study will examine how the different 'Next Step' reforms interact as incentives both nationally, but specifically through an examination of three tracer conditions/services (orthopaedics, diabetes, and early intervention in psychosis) across six local health systems in different contexts (market diversity, degree of competition between providers, and level of integration with social care).

Aims:

- To explore empirically how complex policy initiatives are being operationalised (implemented) within a range of local health economies (contexts), including how these local implementations are intended to operate (process) and their observed effects (outcomes);
- To identify the extent to which policy initiatives were proving effective in addressing nationally specified outcomes in a range of service specialties with specific emphasis on understanding the interactions and dynamics *within* organizations as well as *between* them.

The analytical concept underpinning this study recognises that the impact of the reforms will be influenced by a range of contextual factors and local contingencies – that 'one size does

not fit all'. The proposed research, therefore, will employ a contextually-specific design, enabling the research to examine the complex interaction of reform processes in different locations.

1.4 Structure of report

The following chapter sets out the methods and design for the study. This sets out the overarching framework of realist evaluation, it sets out the case study criteria and characteristics, methods employed and the data analysis techniques utilised to understand the combined impact of reform.

Chapter three provides an overview of literature documenting the impact of health reform under the New Labour government. It analyses the impact of reform under the Next Steps themes before going on to present a policy review of the New Labour reform programme.

Chapter four presents the findings of 'elite' interviews with those involved in the formulation of the Next Steps reforms. It aims to map and illustrate the programme theory of reform underpinning policy development as well as present the reflections of those involved centrally and peripherally in the policy process.

Chapter five presents the findings of the impact of Next steps reforms in six health systems in England. The impact of reform is presented in relation to the 'Next Steps' diagram. This is followed by a discussion of how systems perceived the programme theory of reform as mutually supporting set of levers and incentives. The chapter documents the reflections of interviewees about the current and future prospects of reform.

Chapter six presents a summary of findings about the combined impact of health reform across three tracer conditions – orthopaedics, diabetes and early intervention mental health. As with chapter five, the chapter presents the findings for these tracer conditions under the reform streams as presented in the Next Steps Reform diagram. Within each, it presents a summary discussion of the influence of local contexts and mechanisms before a concluding assessment of the extent to which the 'Next Steps' reforms providing a mutually supporting set of levers and incentives.

Chapter seven brings together the main findings of the research to examine the collective impact of the NHS reforms as set out in the framework of programme theory. The synthesis reflects on how the reforms played out across the case study sites by exploring the links between context, mechanisms and outcomes, and sets these issues within a wider context of material on policy implementation.

Chapter eight concludes the study reflecting on findings and synthesis generated by the research. It begins by examining the health reforms of the current Conservative/ Liberal Democrat Coalition Government, and concludes by exploring what lessons from the Next Steps Reforms are relevant to the current reforms.

Chapter 2: Theory and Methods

2.1 Introduction

It was argued in Chapter 1 that a contextual approach was important to the examination of complex policy initiatives. This is because outcomes are dependent on a highly context-specific and complex range of inter-related factors. In particular, rigorous analysis of data related to the context in which an innovation took place helps facilitate the application of findings beyond study settings. The approach provides a credible alternative to 'traditional' evaluations that emphasize the primacy of experimental methods since these are often inappropriate in complex, community-based, situations (Green and Tones, 1999). This reflects a recent interest in 'realist' evaluation of health policy that is based on different 'schools' such as 'realistic evaluation (eg Smith and Goodwin, 2006; Greener and Mannion 2009; Coleman et al 2009) and 'theories of change' (eg Judge and Bauld 2001; Blamey and Mackenzie 2007).

The various realist approaches start from the viewpoint that whilst experimental logic can claim the program a 'success', we actually learn nothing about why it works. Such experimental logic draws our attention away from a more important task in gaining understanding of social programmes, namely, developing theoretical models of social interventions. In paying attention to know how and why a programme works, evaluators of programme theory concern themselves with questions about the internal structure of programs. They argue that social programmes are based upon explicit or implicit theories about how and why the programme will work. The task of evaluation is to surface those theories, identify the key assumptions and test their validity (eg Pawson and Tilley 1997).

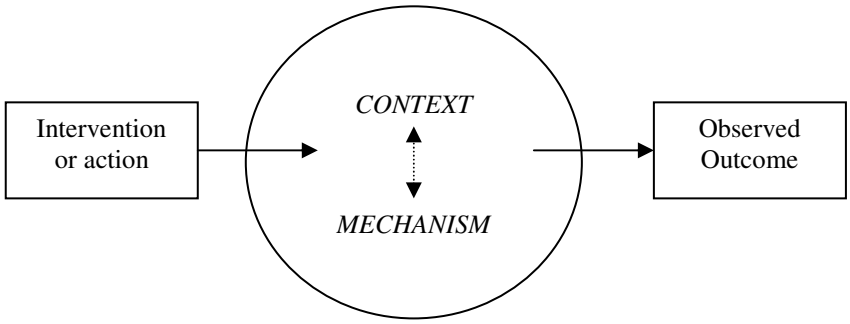
Within this research, *Realistic Evaluation* (Pawson and Tilley, 1997) was adopted as a conceptual framework that could be employed to enable such a 'contextual approach' through in-depth qualitative investigation in a purposefully selected set of case studies. It promotes a model of 'scientific realism' in which organisational outcomes are triggered by the interplay between mechanisms operating in a particular context. The model gives great importance to contextual factors in understanding causality, a conceptual approach which

Pawson and Tilley (1997) termed 'generative causation' (see Figure 2.1). More simply put, the theory can be summarized by the basic equation: Context + Mechanism = Outcome.

Pawson and Tilley (1997) set out some basic guidance about Programme Theory and CMO Configurations. Theories must be framed in terms of propositions about how mechanisms (M) are fired in contexts (C) to produce outcomes (O): what might work for whom in what circumstances (pp. 84-5). In other words, the relationship between causal mechanisms and their effects is contingent rather than fixed (p. 69). They present an example of 'realism in the car park' (pp. 78-82) with 8 mechanisms and 6 contexts. They stress that there is nothing about CCTV in car parks which intrinsically inhibits car crime. CCTV must work by instigating a chain of reasoning and reaction (p. 78). Put another way, we need a theory, which relates to human choices and capabilities, of why CCTV may be effective (pp. 82-3). They later argue that the policy maker's account has a rather specific significance as a source of testable theory, which takes the form of CMO configurations (201-2).

This study draws on realistic evaluation to examine whether the Next Steps reforms delivered the promised 'coherent and mutually supporting set of reforms'. We aim to identify the underlying 'programme theory' and context-mechanism-outcome (CMO) configurations of the Next Step Reforms.

Figure 2.1 The 'scientific realistic' model of generative causation



Source: adapted from Pawson and Tilley (1997).

The research study employed qualitative data analysis within the realistic evaluation framework with the main objective to systematically track the impact of health reform by examining the outcomes achieved and the mechanisms and contexts in which these outcomes were produced (Kazi 2003: 43). The research aimed to capture how people

understood, defined and perceived the combined and relative impact of the reform policies on behaviour, relationships, and social structures.

In other words, in teasing out the collective impact of the health sector reforms as set out in the Reform Diagram (Figure 1.1), the analytical approach enabled distinctions to be made between generic factors of causality (i.e. outcomes that can be linked to reform mechanisms) and those that are more context-specific (i.e. outcomes where local contexts and processes have led to alternative outcomes). Hence, the key conceptual task of the study design was to adopt an approach that could differentiate between these distinctions. A working definition of how this was undertaken by the researchers in the study is shown in Figure 2.2.

Figure 2.2: context/mechanism/outcome configurations

Realist Evaluation Analytical Framework	**Working Definition**
Context **playing some causal role in affecting the impact of reforms**	Investigate the extent to which pre-existing structures 'enable' or 'disable' the intended mechanism of change (defined as new ideas/resources). In this sense 'context' is defined as the prior set of social rules, norms, values and interrelationships gathered which sets limits on the efficacy of program mechanisms. Context is not simply referring to the spatial or geographical factors but broader institutional factors. *What prevailing social conditions influencing the success and failure of social programs?*
Mechanism **How the reform levers have worked in practice, locally i.e. discussion of the processes involved**	Develop propositions about what it is within the program ('reform') which triggers a reaction from its subjects. Micro level analysis of how policy actually works in a weaving process which binds resources and reasoning together. A mechanism is an account of the make-up, behaviour and interrelationships of those processes which are responsible for the regularity. Here 'regularity' describes the behaviours under scrutiny before and after the intervention.
Outcome **Impact of reforms on service delivery, outcomes, or organisational**	The terms outcome and 'outcome pattern' will be used to describe the change in rates over time. Such outcomes constitute the explanatory goal of evaluation research. The potential for change in the programme mechanisms.

behaviour/strategy	It is not programs that 'work' but their ability to break into the existing chains of resources and reasoning which led to the 'problem'.

2.2 Study Design

A 'pure' realistic evaluation research design model would involve the observation of contextual factors *inductively* from the research process in 'real time' (i.e. not to set the variables *a priori*). However, we know from previous research that certain issues of context are important to achieving change - and so these might be predicted - whilst in-depth case study analysis that triangulates evidence from a range of sources enables studies to be undertaken retrospectively (Smith and Goodwin 2006).

In order to examine the impact of different contexts, the study utilised the PCT as its unit of analysis and selected three contextual variables. The main variable was:

- *provider market*: the extent to which the local health economy offered choice and the prospect of competitive behaviour between NHS providers - the selection was informed by data on the average number of hospitals accessible within 30 minutes at the level of Lower Super Output Areas (LSOAs) published by the Department for Transport (Department for Transport, 2007). A score for hospital accessibility at PCT-level was calculated as the mean value for all LSOAs within each post-2006 PCT boundary. Three case study PCTs were chosen with low accessibility scores (0.4, 0.6 and 0.8). Three case studies were chosen to represent high accessibility. The score for two were 1.7 and 2.1. The score for the third was not calculated as the data for this PCT were missing from the national dataset. However, we were confident that it could be classified as high accessibility on the basis of our knowledge of local NHS providers. In practice, this provider market criterion distinguished between PCTs which could be classified as 'urban' and 'rural'.

- *provider diversity:* whether the local health economy (LHE) has a diversity of providers (private and other independent as well as public). This is clearly multi-dimensional. This 'ideal type' diverse LHE would therefore have, in addition to (non FT) NHS providers, FTs, private hospitals, ISTCs and third sector providers. Conversely, the 'ideal type' non-diverse LHE would have only non FT NHS providers. Moreover, PCTs are not sealed systems in terms of patient flows, and it is possible for patients to use any 'diverse' provider in another PCT area. This means that

provider diversity was difficult to operationalise, and involved some trade-offs between the elements.

- *level of 'integration' with local government*: a history of good relationships and trust between local stakeholders - the selection w*as based on an assessment of three available* markers of integration: whether the PCT and local authority had coterminous boundaries; whether the PCT and local authority had pooled budgets of more than £1m using S31 flexibilities; and whether the PCT was an 'LTC demonstrator'. Sites were chosen to provide extremes between those where none of these elements were present (in two cases) to those where all three were present (in four cases).

These are clearly rather crude variables, and also miss other potentially important information such as financial balance and performance as judged by the Care Quality Commission. However, using these three criteria, eight possible types of case study site could be identified, labelled A to H in Figure 2.3. Six case studies were subsequently selected to ensure that a diversity of contexts was represented. We chose a case study from each of the categories A, B and C which together represent urban localities. Similarly, our choice of sites from categories E, F and G represent rural localities.

In each of the six case study sites the impact of the reforms was examined across three tracer conditions:

- *Orthopaedics:* to represent an elective service - the hypothesis being that positive outcomes would be more likely where choice and competition were present in the local context - in this case, four sites with ISTCs within or close to its boundary were purposefully selected to provide a contrast in contexts for this high-profile specialty-specific intervention.
- *Diabetes:* to represent a long-term condition - the hypothesis being that positive outcomes in integrating care would be more likely where a history of partnership working was present between primary and secondary care - in this case, variations in the Health Care Commission's diabetes ratings were also used to choose sites based on historical differences in their relative performance.

- *Early intervention mental health:* to represent a service requiring a complex response from health and social care providers - the hypothesis being that positive outcomes would be more likely where a history of partnership working was present between health and social care.

Figure 2.3: Possible PCT case study sites based on the interplay between three key contexts: provider competition, provider diversity and integration

	Provider competition	*Provider diversity*	*Integration*
Site A (n=9)	Yes	Yes	Yes
Site B (n=4)	Yes	Yes	No
Site C (n=47)	Yes	No	Yes
Site D (n=8)	Yes	No	No
Site E (n=47)	No	No	Yes
Site F (n=18)	No	No	No
Site G (n=12)	No	Yes	Yes
Site H (n=5)	No	Yes	No

Site A:
These sites were primarily located in inner-city/central urban locations where a high degree of provider competition, the presence of independent providers, and a history of partnership working

Site B:
These sites were primarily located in inner-city/central urban locations where a high degree of provider competition, the presence of independent providers, but with no history/strength of partnership working

Site C:
These sites were primarily located in suburban/urban locations where a high degree of provider competition but limited or no independent provider presence. History/strength of partnership working good.

Site D:
These sites were primarily located in suburban/urban locations where a high degree of provider competition but lack of independent provider presence. History/strength of partnership working poor.

Site E:
These sites were primarily located in more remote or rural locations with a lack of provider competition and a lack of independent provider presence. History/strength of partnership working good.

Site F:
These sites were primarily located in more remote or rural locations with a lack of provider competition. However, there was independent provider presence. History/strength of partnership working poor.

Site G:
These sites were primarily located in more remote or rural locations with a lack of provider competition. However, there was independent provider presence - notably in the PCT's market town. History/strength of partnership working good.

Site H:
These sites were primarily located in more remote or rural locations with a lack of provider competition but lack of independent provider presence. History/strength of partnership working poor.

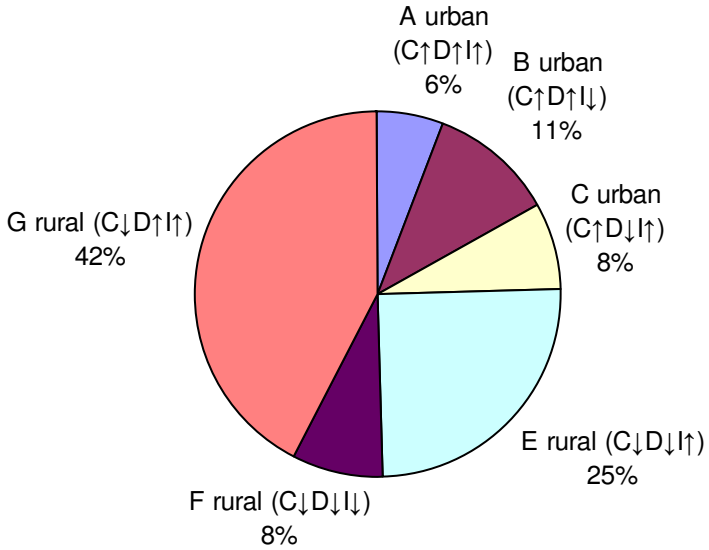
2.2.1 A profile of the six case study sites

The six sites selected for case study analysis were therefore representative of a diverse range of contexts. Whilst the nature of the realistic evaluation framework would not countenance placing any *predictive value* on these contextual differences (since local contexts are far more complex in nature) the ability to choose a wide range of contexts was important to the design of the study - increasing the ability to recognize generic causal factors in the impact of certain reform elements that were being felt across all or most local contexts and settings, compared to those which were more heavily contingent on whether a 'receptive' or 'non-receptive' context for change was present.

2.2.2 Case study characteristics

Two of the rural PCTs are much larger than the other case-study PCTs. The largest rural PCT (G) accounted for 42% of the total estimated population covered by the six case studies in 2008/9, compared to 25% for rural PCT (E) and 11% for the largest urban PCT (B) (Figure 2.4).

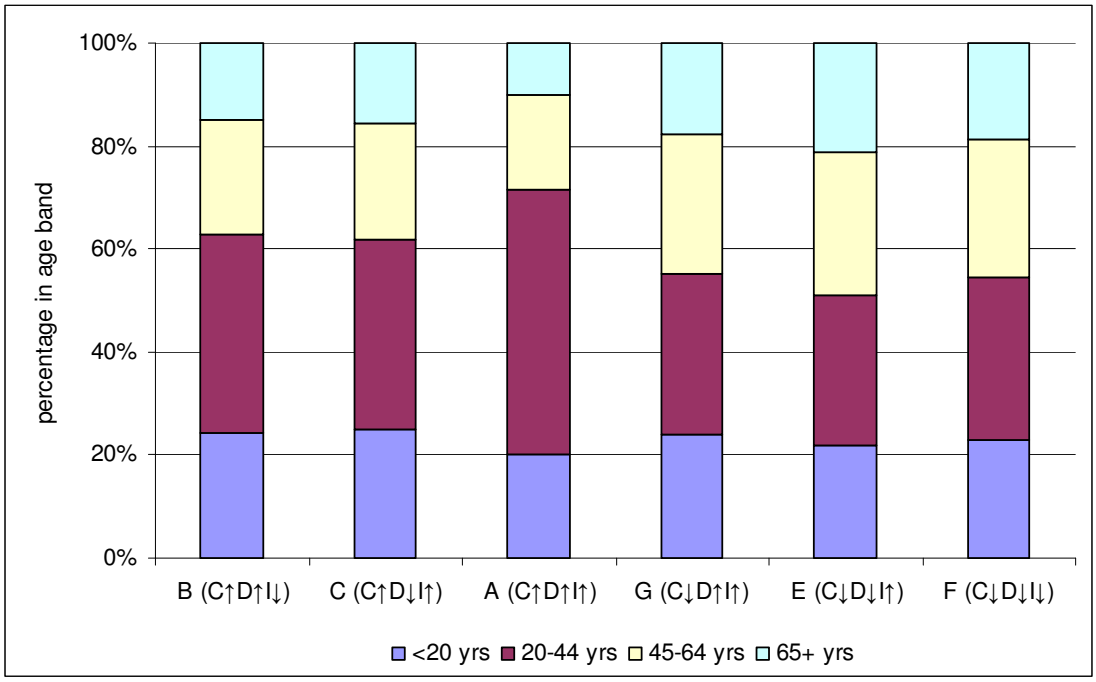
Figure 2.4: Proportion of the total case study estimated population by PCT



Source: Information Centre for health and social care (2009)

The urban PCT A has a younger resident population compared to the other case studies (figure 2.5). For example, in 2008/9, 10% were estimated to be aged 65 years and over, compared to 15% and 16% for the other urban PCTs and 18% to 21% for the rural case studies (figure 2.5).

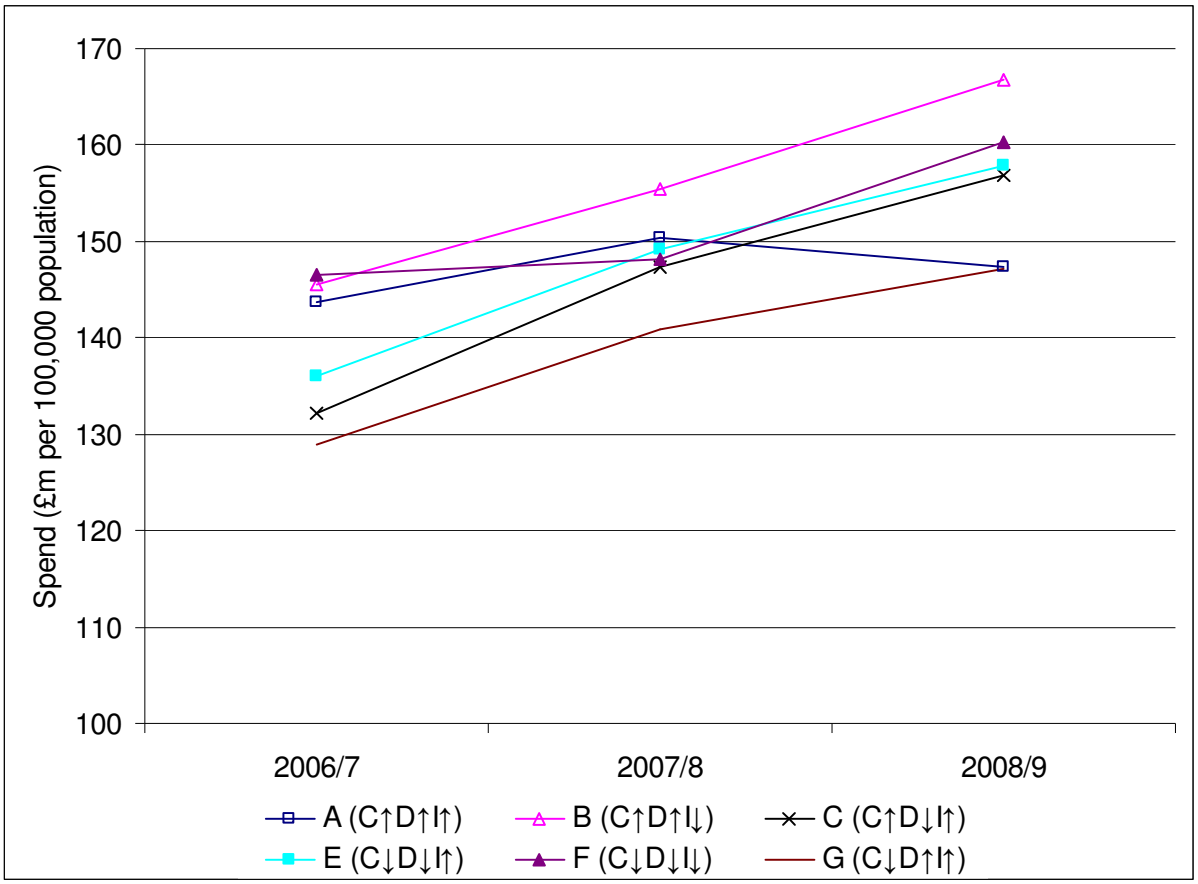
Figure 2.5: PCT-level population estimates by age bands in 2008/9



Source: Information Centre for health and social care (2009)

The total annual spend by the case study PCTs in the three years to 2008/9 is shown in Figure 2.6. The unified weighted population is shown here and it is the weighting used to calculate PCT allocations: the "PCT responsible population adjusted using the national capitation formula, for the age structure of the population, its additional need over and above that accounted for by age, and the unavoidable geographical variations in the cost of providing services" (Department of Health, 2010b).

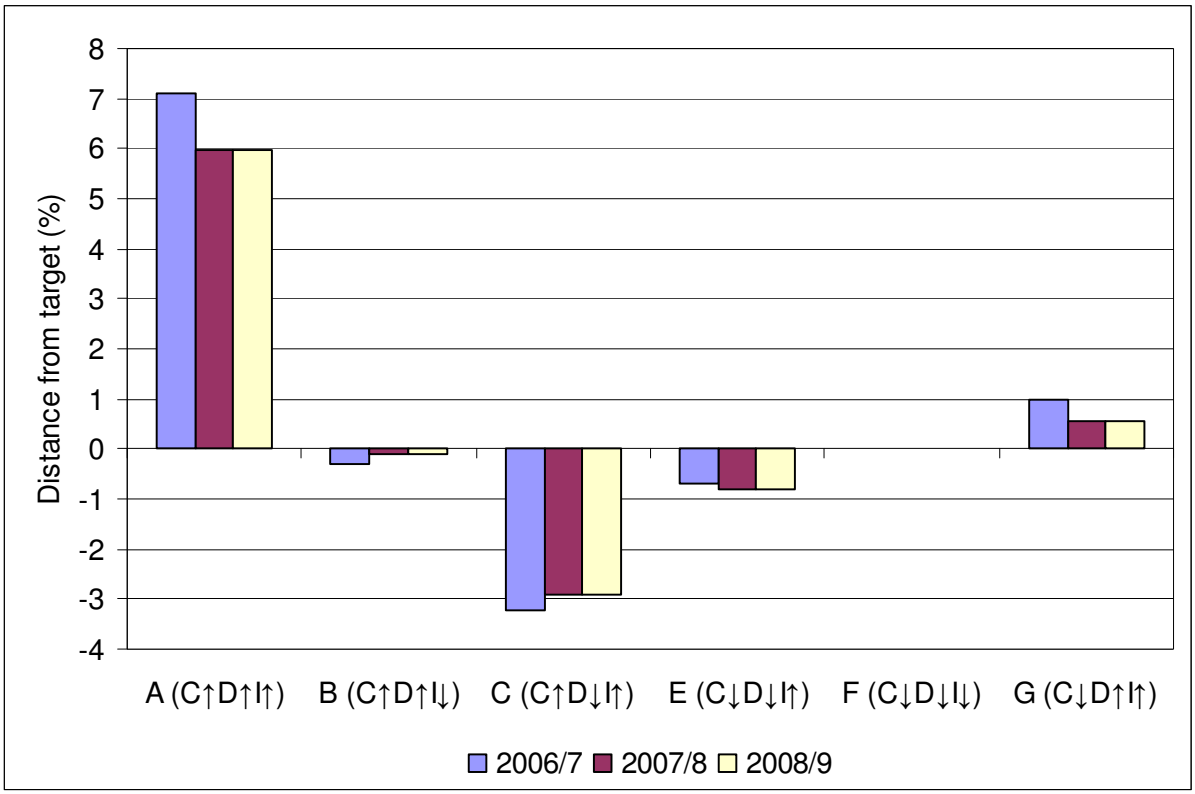
Figure 2.6: Total annual spend by the case study PCTs



Source: Department of Health (2010b)

Using this measure of total spend, the change on average across the six case study PCTs between 2006/7 and 2008/9 was an increase of 12.4%, ranging from 2.6% for case study A to 18.7% for case study C. This wide range of experience can be explained in terms of the PCTs' distance from their target allocations shown in Figure 2.7. The actual expenditure of four of the six case studies was within 1% of their target allocation in 2008/9 (with site F on target), whereas PCT A was 6.0% above target, and PCT C was 2.9% below target.

Figure 2.7: Difference between actual expenditure and target allocation for the case study PCTs in the three years to 2008/9



Source: Department of Health (2010b)

The Care Quality Commission (CQC) is the independent regulator of health and social care in England, and it superseded the Healthcare Commission in April 2009. The CQC publishes annual ratings for provider organisations. For PCTs there are two broad summary ratings for 'quality of services' and 'quality of financial management'. Each rating is classified into one of four options from 'excellent' to 'weak'.

Figure 2.8 summarises the quality of services rating for PCTs over the last three years. In 2008/9, 2% (3/152) of PCTs achieved an 'excellent' rating. Fifty-one percent (77/152) of PCTs achieved a 'good' rating, including case studies B, C, E, F and G. Case study A was one of the 45% (68/152) of PCTs rated as 'fair'. In 2007/8, case studies B and C were rated as 'good' for quality and other four achieved a 'fair' rating. In 2006/7, case study A received a 'good' rating for quality of services, compared to 'weak' for case study E and 'fair' for the other four.

The CQC ratings for quality of financial management are summarised in figure 2.9.

Figure 2.8: CQC ratings for quality of services for PCTs 2006/7 to 2008/9

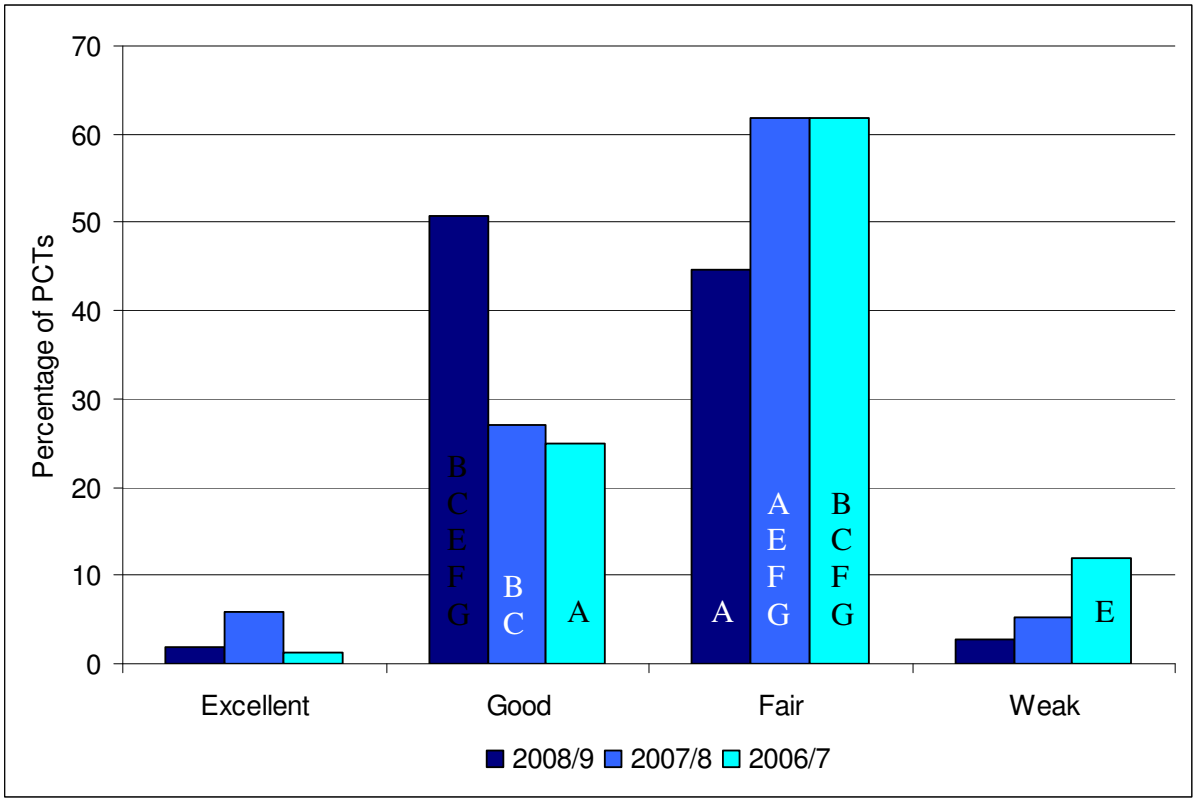
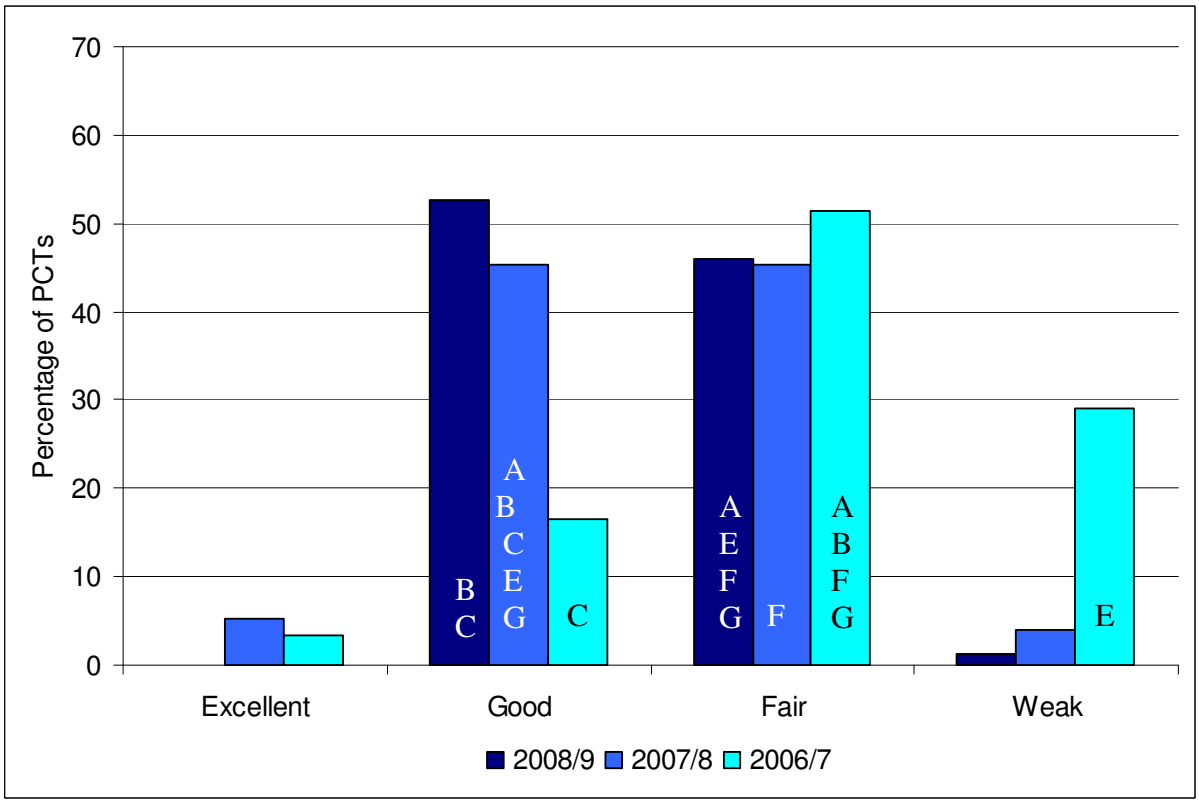


Figure 2.9: CQC ratings for quality of financial management for PCTs, 2006/7 to 2008/9



Site A

This site was located in a central urban location with a high degree of provider competition, the presence of independent providers, and a history of partnership working. Of all the sites identified, it was suggested that Site A was likely to have the most 'receptive' context for applying the various elements of the health care reforms across a range of service settings.

Site B

This site was also located in an urban location with a high degree of provider competition and the presence of independent providers. However, no history/strength of partnership working was recorded. It was the hypothesis that Site B might be a 'receptive' context for improving orthopaedic services, but potentially less so for diabetes and early intervention mental health where integrated care between providers and professionals is more important.

Site C

This site was located in a mixed suburban/urban location where a high degree of provider competition existed but with a lack of independent provider presence. History/strength of partnership working was good.

Site E

This site was located in a rural location with a lack of provider competition and a little independent provider presence. History/strength of partnership working was good.

Site F

This site was also located in more remote location with limited independent provider presence but a lack of historical provider competition and where the history/strength of partnership working poor.

Site G

This site was primarily located in a semi-rural location with a lack of provider competition. However, there was independent provider presence in the PCT's market town and the history/strength of partnership working good.

2.3 Qualitative Data Analysis

A range of qualitative and quantitative data collection and analysis methods were used to enable a process of 'triangulation' to be performed that could enable the validity of results to be increased.

2.3.1 Content Analysis of Key Documents

Content analysis was undertaken on each case site of relevant documentary and web-based sources to help offer an informed account of the structure, activities, innovations and sometimes reported outcomes within each case site. The nature and depth of material of this documentation collection varied by site, but for example included documentary analysis of local delivery plans, board minutes, reports and strategy documents. We do not present text from the documents as this would compromise site anonymity. Rather, documents were used in a more confirmatory fashion to 'triangulate' the interview material.

Analysis was twofold. First, documents were used to inform a scoping exercise prior to fieldwork. Here, the research was able to obtain contextual material about the site, this included any contextual issues regarding system relationships, organisational history, financial health and any circumstances or particular events that potentially shaped the impact of reform. The results of this content analysis of written and web-based documentation contributed direct knowledge to the research questions posed in the study and were often essential in providing corroborating or explanatory information to be explored in subsequent fieldwork and/or to triangulate with data sources collected at interview. Second, analysis of site documents formed part of our contextual referencing and

verification of our emerging fieldwork findings. Freedom of information requests at all our sites allowed access to documents to confirm and reaffirm emerging findings about the combined impact of reform.

2.3.2 Interviews with high-level stakeholders

Interviews with policy makers were conducted to throw more light on the emerging programme theory from the policy documents (Chapter 3). Eight interviews were undertaken with people who were involved in policy making during the period from the 'NHS Plan' (DH, 2000) onwards. They held different positions and were in post for different periods of time. In order to preserve their anonymity, we give few details about them We explored how the individual reform streams evolved, and how they interacted. Due to the small number of interviews, manual analysis was carried out, but based on a similar frame to the electronic coding of the interviews in the case study sites.

2.3.3 Case Study Interviews

In all six case sites, two rounds of data collection were undertaken (figure 2.8). The first round of interviews was mainly face-to face at the interviewee's office. A semi-structured questionnaire (Appendix 1) was used to examine respondents' perceptions and experience of health reforms.

The second round of interviews was with a selection of interviewees from the first round; they were shorter, and mostly telephone-based, and were used to provide some limited dynamic element examining change over time to the analysis, and to test out key observations and findings from the first round.

The number of interviews for individual case study sites and for tracer conditions remains fairly high in comparison to other qualitative work, although 16 total interviews in site A is quite low, and perhaps less stress should be placed on those findings. In one sense, this gave us eighteen case studies. The number of interviewees varied between case study and tracer conditions, and was small in some cases (eg orthopaedics in site A).

Interviewees spanned the SHA, PCT, LA, relevant acute trusts and general practice. Interviewees were identified on the basis of their role and responsibilities and an assumption that this would require knowledge of reform implementation. Both senior managers and clinicians were included and the latter (and some former) were specifically selected for their responsibility for one of the tracer conditions. Delays in getting ethical approval and difficulties in getting positive responses for participation from those selected for interview restricted the number of interviews at some sites. In order to preserve anonymity but allow for quote attribution, participants are tagged under their main managerial or clinical role (i.e. a GP who serves as a PEC chair is referred to only as a GP) in subsequent chapters.

Figure 2.10: Number of interviewees at case study sites

	Round 1					Round 2	Round 1+2
Site	Non-Tracer	Ortho-paedics	Diabetes	Mental Health	Site Total	Site Total	Total
A	5	2	4	4	**15**	**1**	16
B	18	7	5	7	**37**	**10**	47
C	15	5	5	8	**33**	**10**	43
E	17	6	5	8	**36**	**10**	46
F	10	5	3	5	**23**	**7**	30
G	18	4	3	6	**31**	**2**	33
Total					175	40	215

2.4 Quantitative data analysis

The quantitative research was not intended to replicate the national studies of single streams of the reforms (see http://hrep.lshtm.ac.uk/), but rather to provide some helpful context for the wider qualitative study based on local stakeholders' perceptions of the reforms. It provides some insight into the similarities and differences between the six case-study PCTs. Although, the available data may be too limited for full or 'stand alone' quantitative analysis, they can nevertheless provide context for stakeholders' views, and adds value by allowing the reader some insight into the local circumstances, which are subject to considerable variation across the case-study sites.

Orthopaedics

Hospital Episode Statistics (HES) for the residents of the six case study PCTs were analysed using the post-2006 PCT configurations. Admission rates between 2002/3 and 2008/9 were assessed, defined as the number of discharges occurring within each financial year per 1,000 resident population, using estimates of resident population from National Statistics published by the Information Centre for Health and Social Care (2009). Changes in admission rates between 2002/3 and 2008/9 at PCT and main provider level were tested for statistical significance at the 5% level for day cases, inpatient admissions and all admissions.

Waiting times from the date of the decision to admit to the date of admission between 2002/3 and 2008/9 were assessed in terms of the biannual median and mean at PCT level and eight waiting time bands. Data for 130 discharges were excluded for having a negative waiting time, and 164 discharges were excluded for having a waiting time of more than three years. Data for PCT F in 2002/3 was excluded from the analysis as the majority of discharges at its main provider had both the decision to admit and admission recorded as the same date. These exclusions resulted in 301,386 discharges being included in the waiting time analysis. Differences in the proportion of patients waiting less than three months in the urban PCTs and rural PCTs were compared using the Chi squared test for association. DH monthly 'referral to treatment' returns for admitted care were used to calculate the proportion of orthopaedic admissions within the 18 week target during the three months to March 2009 for the case study PCTs and comparator PCTs (DH, 2009e). The comparator PCTs were those identified as comparators for PCT-level programme budget data.

Diabetes

The Quality and Outcomes Framework (QOF) as established by the Department of Health is the annual reward and incentive programme detailing GP practice achievement results. QOF was introduced as part of the new General Medical Services (GMS) contract on 1 April 2004. QOF scores for the five time periods spanning 2004/5-2008/9 have been collected by Quality Management and Analysis System (QMAS), a national IT system that supports general practice. QOF practice scores for the selected clinical indicators for diabetes of DM7 (HbA1c ≤ 10) and DM6/20 (HbA1c ≤ 7.5) and DM 12 (blood pressure <148/85) were downloaded

(http://www.gpcontract.co.uk/) into an Access database. DM6/20 and DM7 represent effective blood glucose management and DM12 effective blood pressure management for diabetic patients on the GP registers. Practices scores were aggregated for each PCT (ratio of the total achieved divided by the total points available) and for each year and the changes in the selected QOF scores over time for each case study site were compared. PCTs were reorganised in 2006 resulting in new PCT codes being assigned – the analyses took account of these changes. The QOF indicator DM6 was reassigned to DM20 in 2007.

The Department of Health's National Programme Budget Project (DH 2010b) has since 2002 provided annual data for PCT and SHA expenditure, including that on primary care services, to 23 programmes of care based on medical conditions which includes diabetes. These annual databases were used to select data for the six case site PCTs to reflect their spending for diabetes care per 100,000 people. Changes in PCT spending for the financial years 2004-2009 were then plotted graphically to allow comparison with one another and the national average.

Data from the Diabetes Community Health Profiles for each English PCT and the Diabetes Outcomes and Expenditure tool (DOVE; both hosted at http://www.yhpho.org.uk/) were also accessed for purposes of benchmarking case site PCTs.

Early Intervention Mental Health services

The mental health service provider for each Site was requested to supply anonymous data on the number of individuals enrolled in the EI service for the Site in each month since its instigation, and the target for enrolment. Any available data from local audits on the duration of untreated psychosis (DUP) for individuals enrolled in the EI service were also requested. In practice, data on the number of enrolled patients were only made available for three Sites, and DUP data were only available for one Site. Considerable uncertainty about the quality of DUP data was expressed by the local providers.

Feedback Event

A feedback event in November 2009 for policy, practitioner and academic audiences was held at the King's Fund, London. The aim of the event was to discuss and critically reflect on the emerging fieldwork findings. The dissemination exercise aimed to test and refine

empirical material. The outcomes of the event went on to inform the latter stages of data analysis by supporting and revising emerging themes.

2.5 Data Analysis

In line with realistic evaluation approach, the approach to analysis was partway between an a priori and inductive approach as a *retroduction* analysis. Codes were created based on an initial start list generated from research questions. These provided template ('bins') for data analysis that were then added to or amended according to what was emerging from the field (Miles and Huberman 1994: 58). Pattern coding was employed to analyse the combined impact of reforms as levers and incentives. Coding paid particular attention to interviewee reflections on the reforms in terms of how the reforms 'worked' along with the factors supporting and enabling the process.

The first stage of the analysis was an initial reading of the interviews. This phase was a process of descriptive coding used to group segments of data into a smaller number of sets and themes describing the impact of health reforms. Following a descriptive coding of interviewee accounts, the Pawson and Tilley CMO analytical framework was 'placed over' the selected quotes and passages of the text. This coding was inferential in responding to whether or not the text under analysis was categorised as 'Context', 'Mechanism' and 'Outcome' of the reforms (see Miles and Huberman 1994: 70-71). The computer package NVivo was used to assign and display coding schemes and assisted in the analysis of data generated by the in-depth interviews.

2.6 Methodological challenges

Ethics and Research Governance

The ethics and research governance approval process significantly held up the start of the fieldwork. Comparative case studies across 6 PCT sites required approval from 13 Research Governance bodies.

On reflection, it is estimated that the designated researcher had to spend 25 days on the initial ethics approval process and then spend at least a further 15 days dealing with the various research governance bodies. It is estimated that the process has taken 40 days of the researcher's time that roughly equates to 7% of the overall time spent on ethics approval process.

Access to sites

The research did have problems gaining access to case study site F. These problems were subsequently resolved but significantly delayed the fieldwork.

Chapter 3: Policy and Literature Review

3.1 Policy Review

This section traces the reform journey, highlighting the extent to which the themes of the Next Steps Reform and our tracer areas appear in system-wide reform documents. We indicate how the reform themes have varied over time, and discuss the fit with programme theory. We examine the main broad reform documents, which cover more than one reform stream, and do not cover documents that tend to focus on only one reform stream such as 'Building on the Best' (DH, 2003a) which relates mainly to choice (demand side reform). However, these documents do discuss our tracer areas, for supporting documents of the 'Building on the Best' task groups provide some discussion of the applicability of choice to mental health and long term conditions (DH, 2003b and c).

Similarly, 'Creating a Patient-Led NHS' (DH, 2005b) also provides more detail on LTC and MH; and links to other documents. It states that improving the management of long term conditions is one of the key priorities for 2008 and is set out in *Supporting People with Long Term Conditions* (DH, 2005c: 14). The programme for modernising mental health services was also intended to focus on giving people greater choice in their care and treatment, alongside improving access to effective treatment and care, reducing unfair variation, raising standards and providing prompt, convenient, high quality services (DH, 2005c:18). *Creating a Patient-Led NHS* (DH, 2005b) also states that new arrangements are needed to implement PbR for emergency and urgent care, long term conditions and mental health. More guidance was due to be published on these areas in autumn 2005, so that implementation could continue in 2006 (p. 33). The document also notes that while choice is the guiding principle, it is clear that the more specialised the service, the fewer the providers that can safely offer the service. However, while specialist services need a critical mass to perform, patients should still receive safe and effective treatment as close to home as possible (p. 18).

According to Simon Stevens (Stevens, 2004), one of the architects of reform, there are three broad strands of strategies to drive these reforms which provide a helpful underpinning of the reform journey. These are: support for providers to build capacity and capability; hierarchical challenge to drive quality; and localist challenge to provide local democratic accountability or external pressure from the market to increase responsiveness. In the first category were placed strategies for increasing the supply of healthcare professionals, improving the infrastructure i.e. PFI hospitals and national electronic health records and enhancing learning and training. In the second were strategies for introducing national standards and targets i.e. NSFs, NICE and health improvement targets and a more rigorous inspection and regulation regime including the introduction of star ratings. In Steven's third category come the creation of PCTs as active commissioners of services for their populations, patient choice of provider, the introduction of PbR and the creation of Foundation Trusts.

The main policy documents appear to set out two different narratives of the reform journey. The first starts with the Government's White Paper, the New NHS – published in 1997 (DH 1997)– and the subsequent Health Act of 1999. Considering the start of the journey retrospectively in the 'NHS Plan' (DH, 2000: 57), reform is seen as an incremental approach, as it was suggested the move from the internal market to the 'new' NHS had to be undertaken in stages to avoid wholesale disruption. The first stage therefore gave responsibility for shaping and commissioning care to local groups of doctors and nurses working together. At the same time NHS trusts were maintained but competition was replaced with co-operation. New systems were established to set and monitor national standards. By 2004, it was claimed that the new model NHS was ready to be taken a stage further, building on the previous seven year journey of major improvement (DH, 2004: 18).

The second reform journey narrative starts with the NHS Plan (DH, 2000). According to the DH (2002: 4), this journey represents nothing less than the replacement of an outdated system. So, the inference is that in just five years from 1997, this new architecture has radically changed the way the NHS operates. Having got the structures right, it is argued that stronger incentives need to be introduced to ensure the extra cash invested in the service produces improved performance (p. 4). There is therefore some discrepancy in when exactly

the reform journey began, with Blair claiming that reform started with the NHS Plan, but the Department also claiming improvements had been taking place since 1997.

3.2 Programme Theory

This section examines in detail how much of the four streams of the Next Steps Reform (NSR), discussion of tracer areas, and elements of programme theory can be found in earlier documents.

3.2.1 The New NHS (DH 1997)

It is claimed that this White paper marks a watershed for the NHS (p. 76), and according to the DH's own website, forms the basis '…for a ten year programme to renew and improve the NHS through evolutionary change rather than organisational upheaval.' but very little of the NSR streams can be found in this document, supporting the second version of the reform journey narrative as noted above.

'There will be no return to the old centralised command and control systems of the 1970s. But nor will there be a continuation of the divisive internal market of the 1990s. Instead there will be a 'third way' of running the NHS' (p. 10). This 'new model for a new century' involved replacing the internal market by a system called 'integrated care', based on partnership and driven by performance. 'Co-operation will replace competition' (p. 13). In a nod to the future and Darzi, it is claimed that, 'The new NHS will have quality at its heart' (p. 17).

In terms of tracer areas, the document references mental health services by suggesting that where health and social care boundaries are not fixed, and where joint work is particularly important, and an integrated range of services from community to hospital care is required, specialist mental health NHS Trusts are likely to be the best mechanism for coordinating service delivery (p. 36).

Outcomes

The Government pledges to cut waiting lists for hospital treatments and provide quicker access for specialist cancer services (p. 6). Local responsibility for improving overall health and reducing health inequalities will be at the heart of the new Health Authority (HA) role. (Following publication of the Green paper 'Our Healthier Nation', the Government notes that legislation will place a new statutory duty on HAs to improve the health of their population (p. 25))

Demand

On the demand side, the old Health Authorities and General Practitioner Fund Holders would be replaced by Primary Care Groups (which could subsequently develop into freestanding Primary Care Trusts). 'Primary Care Groups will be able to take devolved responsibility for a single unified budget covering most aspects of care so that they can get the best fit between resources and need.' (Section 3.9). A new NHS Charter is intended to set out the rights and responsibilities for patients. (Section 3.20)

Supply

NHS Trusts are expected to be involved in service planning and to enter into service agreements with Primary Care Groups. These agreements are expected to be arranged around care groups and linked to the new National Service Frameworks.

Transactional

The Government will establish a new statutory duty for NHS Trusts to work in partnership with other NHS organisations (p. 45). In the new NHS, the short-termism of the market will be replaced by a more stable framework based on longer-term relationships. These agreements will last for at least three years but could extend in some circumstances to five to 10 years (p. 71)

System Management Reform

There will be National Service Frameworks (NSFs), a National Institute for Clinical Excellence and clinical governance, backed by a new statutory duty for quality in NHS Trusts (p. 18). NSFs and NICE are intended to ensure greater consistency (p. 40), and to contribute to a

one-nation NHS (p. 55). A Commission for Health Improvement (CHI) will be introduced (p. 56). The Commission 'will be established to support and oversee the quality of clinical services at a local level, and to tackle shortcomings. It will be able to intervene where necessary.' (p. 48). A new national framework will focus on six areas to allow for a more rounded assessment of NHS performance. These areas are; health improvement, fair access, effective delivery of appropriate healthcare, efficiency, the patient/carer experience and health outcomes (pp. 64-5).

Summation

The New NHS is a classic early New Labour 'third way' document with cooperation as a major stated theme (Powell, 1999). However, there seem to be many 'statutory' obligations for a policy that claims not to be 'command and control'. In Le Grand's terms (2007), the document appears to be a mix of trust and targets. In line with the 1997 Election manifesto pledge card, reducing waiting lists is a major outcome measure, although improving health and reducing health inequalities also feature. There is relatively little on demand and supply themes while Transactional reforms stress 'relational' rather than 'spot' contracting.

3.2.2 NHS Plan (DH 2000)

The NHS Plan was presented as an 'ambitious and radical' ten year plan based on investment and reform, and as the most fundamental and far reaching reforms the NHS had seen since 1948. The Plan 'represents a fundamental package of reforms to address the systemic weaknesses inherent in the NHS since its creation in 1948' (p. 133).

Outcomes

It is stated that these major reforms will deliver real benefits for NHS patients: less waiting; faster, more convenient care; improvements in elderly care services and in the priority service areas of cancer, heart disease and mental health; visible improvements in the basics of hospital cleanliness and nutrition, together with a new focus on prevention and tackling health inequalities (p. 15). However, it is also acknowledged that the public's top concern is waiting for treatment (p. 101). The NHS Plan states that it will bring health improvements

across the board for patients but for the first time there is also a national inequalities target (p. 13).

The originality of the reform streams is highlighted by claims that the Plan deals with many issues 'for the first time'. It is claimed that modernising mental health services is one of the Government's core national priorities, with an emphasis on early intervention in psychosis, and an intention to establish 50 early intervention teams over the following three years (pp. 118-9).

Demand

The Plan was concerned with both choice and voice. Much of the choice discussion centred around the provision of greater information, but it was also claimed that by 2005 patients would have a choice of the date and time of their hospital treatment (p. 89). In terms of 'voice' patients were to benefit from an advocacy service in every hospital – the Patient Advocacy and Liaison Service (PALS) (p. 91).

Supply

For the first time, a concordat with private providers of healthcare was proposed to enable the NHS to use private hospital facilities (p. 12). The Plan also saw the expansion of the PFI role with a new hospital building programme and the encouragement of the NHS working in partnership with the private sector to deliver Diagnostic Treatment Centres (DCTs – later ISTCs) for routine electives and day surgery, to help drive waiting lists down and increase capacity (p. 100).

Transactional

The Plan claims that the NHS suffers from a lack of clear incentives, with the current system penalising success and rewarding failure so that perverse incentives have inhibited improvements (p. 28). It is stated that financial rewards for trusts will be linked to the results of the annual National Patients Survey (p. 94). This did not appear to happen in the short term, but the idea seems to have been later revisited with CQUIN (see below).

System Management Reform

The underlying principle for system management is one of national standards (NSFs and NICE p. 27) combined with a new system of independent inspection and accountability

(through the Commission for Health Improvement), combined with greater local autonomy and new money to reward good performance (p. 15). For the first time, organisations will be receive and annual public classification of 'green', 'yellow' or 'red' (p. 63).

Other streams

Although some elements of the NSR streams are present, the main stress appears to be on subsidiarity and a new system of earned autonomy with devolution of power to local health professionals and local communities. It is claimed that command-and-control does not work, and that the NHS cannot be run from Whitehall. A new model is therefore needed where intervention is in inverse proportion to success (p. 30)

Summation

The Plan outlines a new delivery system based around the NHS as a 'high trust' organisation. 'The NHS is an organisation glued together by a bond of trust between staff and patient or, what some have called, 'principled motivation'' (p. 57). New incentives are linked with earned autonomy and offer both financial recognition and non-financial reward to organisations and frontline staff.

It is clear that waiting times are still the main outcome measure, although improving health and reducing health inequalities (with health inequalities targets) still feature, along with a new focus on prevention. The Demand side reforms of 'voice' and 'choice' remain under-developed. The supply side sees a stronger relationship developing with the private sector. Although there is a diagnosis of weak incentives, transactional reforms remain under-developed with the idea of linking rewards to patient satisfaction as the main reform proposal.

There is little change on SMR. The main themes of Trust and Targets are still present, with the NHS still largely seen as a 'high trust' organisation staffed by 'knights' (Le Grand, 2007). Despite the stress on subsidiarity, 'earned autonomy' is a centralist term, with a central stick reserved for those who cannot be trusted.

3.2.3 Delivering the NHS Plan (DH 2002a)

'Delivering the NHS Plan' appears to move beyond a simple 'implementation' exercise, and suggests a rather different policy formulation to the 'NHS Plan'. The seeds of the Next Steps Reforms (DH 2005a) are clear: 'We believe it is time to move beyond the 1940s monolithic top down centralised NHS towards a devolved health service, offering wider choice and greater diversity bound together by common standards, tough inspection and NHS values.' (p. 3). This document set out a 'coherent framework' of the vision (p. 8).

Outcomes

Special effort is focused on reducing waiting times for treatment and increasing prevention initiatives. Action is stated as being focused on areas where it can have the most impact on improving health outcomes and tackling health inequalities. 'Our objective is to improve the nation's health and to improve the health of the poorest fastest.' (p. 13)

Demand

Choice is acknowledged as having a limited role to play in some services i.e. emergency care. For these services other mechanisms are to be developed to ensure local health services incorporate patient preferences as far as possible. It is therefore proposed that the star ratings performance system is in part linked to the feedback patients give in regular surveys of their views. There is a stated intention of shifting the balance of power towards patients.

Supply

Spare capacity in private hospitals to be used for NHS patients to help reduce waiting lists - it is estimated that up to 150,000 operations a year would be bought from the private sector for NHS patients. DTCs are also expected to increase the amount of activity which takes place in primary and community settings, and the document suggests that millions of outpatient appointments could take place in the community rather than in hospital (p. 16)

Foundation trusts will operate to NHS standards, be subject to NHS inspection and abide by NHS principles but will have greater independence and will enjoy the freedom and flexibility

within the new NHS pay systems to reward staff appropriately. It is stated that this '…will help promote diversity and encourage innovation' (p. 30). Chapter 9 of the document discusses workforce reform more generally and references the Agenda for Change programme but this appears rather disconnected from the wider NSR agenda.

Transactional

Payment by Results is introduced to replace block contracts and as an 'incentive for performance'. It is argued that 'Setting the price for units of activity (will) allow… the PCT to focus on volume, appropriateness and quality (pp. 20-1). It is anticipated that PbR will incentivise the expansion of elective surgery as waiting times fall.

System Management Reforms

Expansion of NSFs are anticipated (p. 14). Proposals are announced to establish an independent, single new Commission for Healthcare Audit and Inspection (CHAI) bringing together the work of the Audit Commission, the Commission for Health Improvement and the private healthcare role of the National Care Standards Commission. CHAI will be more independent and as well as an inspection role, will license private health care providers, conduct value for money audits, publish star ratings, and independently scrutinise patient complaints.

Other streams

The market's prominence re-emerges in this document with the introduction of transactional reforms and an expanded role for private and alternative providers. The document discusses the integration of health and social services into one care system (ch 8) and discusses successes in this field such as the establishment of an NSF for older people, investment in intermediate care, tackling delayed discharges, increasing the use of local pooling of health and social services budgets and establishing the first Care Trusts (p. 31).

Summation

All the building blocks for the Next Steps Review are in evidence at this early stage, so they cannot entirely be seen as a post-hoc rationalisation. Outcomes and System Management Reform are little changed in *Delivering the NHS Plan*. Voice still appears stronger than choice. The supply side agenda is strengthened with an expanded role for private hospitals, and DTCs and the establishment of FTs. PbR is the new element in transactional reform,

although its major purpose seems to be about increasing activity. There are clearly moves towards 'choice' and competition, although there may be some conflict between competition and cooperation (cf Le Grand 2007).

3.2.4 NHS Improvement Plan: Putting People at the Heart of Public Services (DH 2004)

This document is presented as moving '… to the next stage envisaged in The NHS Plan', with personalisation and patient-centredness as the driving forces. There is an acknowledgment that expectations and aspirations are changing as waiting lists have been shortened and waiting times lessened. (p3) Power is to be placed in the hands of patients and local communities with extended choice over how and where patients are treated and how priorities are determined. A greater emphasis is given to public health and preventative care.

In terms of specific tracer areas, the National Service Framework for Mental Health in Adults has been established and the Improvement Plan introduces the National Service Framework for Children, which is to include a new standard for child and adolescent mental health services, ensuring better availability of early intervention and prevention services (p. 40).

Outcomes

The focus here is on improving outcomes for people with Long Term Conditions, by improving care closer to home and introducing case management which it is to be hoped will reduce emergency admissions (p.10 and p38). There will also be a much stronger emphasis on prevention and reducing inequalities (p. 8).

Demand

The document states that, ''…from April 2005, any patient exercising choice will be paid for, by their host PCT, at the national tariff.' And that greater use of the independent sector for improving capacity and choice will be encouraged (p72). Empowering patients to be involved in more decisions about their treatment is discussed and direct payments in terms of social care services are highlighted as a means of empowering people to make choices about their care (p. 39).Empowering communities is also an important theme, with the balance of power subsequently expected to shift from the national to the local, with more stress on local priorities (p 74). A statutory duty on the NHS to involve and consult patients and the public

in service planning, service operation and the development of proposals for changes is also introduced, together with the establishment of local Overview and Scrutiny Committees.

Payment by results is seen as supporting the development of more effective commissioning by allowing PCTs to focus on the quality of care, rather than cost and volume. PCTs are encouraged to consider commissioning alternatives to hospital care, specifically care closer to home to improve the quality of care for people with long-term conditions (p70).

The introduction of PBC is announced with a launch date of April 2005. It is stressed as voluntary scheme, with the aims of stimulating primary care innovation to deliver better services for patients and improved clinical engagement.

Supply

The Improvement Plan states that, ''Developing a more diverse supply side with a greater plurality of providers will support patients to exercise real choice,' (p. 75). The Independent Sector Treatment Centre (ISTC) programme, which is expected to carry out 15% of procedures per annum for NHS patients by 2008, is expected to stimulate NHS providers to increase their responsiveness to patients (p. 52).

Workforce reform – 'more staff working differently' (Chapter 6) remains a little semi-detached from the mainstream.

Transactional

PbR is seen as supporting patient choice by enabling funds to follow the patient. It is expected that by 2008, the majority of hospital and community healthcare services will be paid for through the tariff. The system is designed to reward providers for activity and therefore should stimulate productivity. It should also stimulate greater efficiency as providers take action to bring their costs into line with the tariff and the example given is by reducing hospital lengths of stay (p. 70).

However, it is acknowledged that PbR will need regular review to manage any perverse incentives from emerging i.e. inappropriate levels of activity and/or actions which are not in

the patient's best interest such as premature discharge. The document also notes developing payment by results for care packages that reflect the patient journey and which overcome traditional institutional boundaries and developing 'unbundled tariffs' to suit local circumstances and to address the care needs of people with long-term conditions (p.72). The new contract for GPs to be introduced in April 2004 is referenced as rewarding family doctors who deliver higher standards of care to patients (p. 34).

System Management Reforms

Clinical governance, the existence of NSFs and NICE and the establishment of an independent Health Commission are all seen as the drivers for high quality care (p. 31). The Department of Health is to be held to account on national priorities through public service agreements with the Treasury (p76) while Strategic Health Authorities take the lead in performance-monitoring PCTs to ensure effective commissioning for their populations. Regulation and inspection of both commissioners and providers is to be devolved to a small number of key agencies. The independent Healthcare Commission will oversee commissioners and private providers with an Independent Regulator for NHS Foundation Trusts. It is noted that the DH will report on its recent review to ensure, '…that the regulatory burden on local NHS delivery organisations does not exceed that essential to promote quality and effective delivery of care.'

Summation

There is an optimistic shift in delivering outcomes focusing on prevention and a 'health service' rather than a 'sickness' service. The choice agenda seems strengthened by the earlier publication of 'Building on the Best' (DH 2003). Commissioning and PBC are discussed as demand reforms, although their focus on 'care closer to home' and prevention appear a little optimistic.

Perhaps the zenith of diverse supply is reached with the claim that ISTCs might treat 15% of NHS elective procedures. It is acknowledged that PbR will require regular review while SMR appears little changed though there is more discussion of interactions between the reforms, and seeing them as a system rather than discrete elements. For example, the introduction of greater choice for patients, the flow of funding through commissioners and the extension of

the range of providers is designed to support more responsive, innovative and efficient provision of service (p. 72).

3.2.5 Our Health, Our Care, Our Say (DH 2006a)

Introducing the White Paper, the Secretary of State, Patricia Hewitt, states that it builds upon the foundations laid in the last eight years, in particular the government's vision for public health as set out in *Our Healthier Nation* and *Choosing Health*. The White Paper, it is claimed will reform and improve community services in order to create a health and social care system that focuses on prevention and promoting health and well-being; that delivers care in more local settings; that tackles health inequalities and that delivers services that are flexible, integrated and responsive, particularly for people with longer –term care needs (p. 9).

Outcomes

Four goals are established; better preventative services with earlier intervention, more choice and a louder voice for service users, reducing inequalities and improving access to community services and more support for people with long-term needs. A slightly different list of goals are discussed further on in the document and these are; shifting resources into prevention; more care undertaken outside hospitals and in the home; better joining up of services at the local level; and the stimulation of innovation. This is understood to mean a shift in the centre of gravity for spending.

Demand

Choice and control over care remain important themes (p. 81). Strategies include a greater choice of GP practices, Direct Payments, Individual Budgets, and a stronger voice for service users. Individual Budgets are seen as a revolutionary way to provide care with a much stronger focus on personalised purchasing (p.81). It is anticipated that innovation will be encouraged by greater patient and user choice.

Commissioning strategies focus on 'care closer to home', including the shifting of care into community settings, the shift in health spending towards preventative, primary, community and social care services and a new generation of community hospitals providing a wider range of health and social care services (p. 128). Emphasis is given to delivering joined up services at the local level and joint commissioning between health and social care.

Six specialities are identified as 'test areas' for providing care closer to home with demonstration sites to be established. The specialities include trauma and orthopaedics and it's suggested that with suitable diagnostics, there is the potential to shift up to 40% of orthopaedics outpatient consultations to out of- hospital settings. (pp. 135).

PBC is seen as a driver for more responsive and innovative models of care within communities, delivering better health outcomes and emphasising prevention and well-being. It is anticipated that PBC will give primary health more freedom and a real incentive with more control over resources (p. 165)

Supply

Better use of health and social care 'third-sector' providers are seen as a way of improving quality, as it is suggested third-sector organisations have strengths and experience in delivering services to those not well served by traditional services. They are seen as having advantages over the public sector in terms of better relations with particular groups of service users i.e. mental health service users, expert knowledge in a specific area i.e. diabetes and expertise in specific types of care (p. 175).

Transactional

PCT commissioning, Choice, the use of tariff and PBC are all seen as important drivers in shifting resources from hospitals to community settings. A number of changes to the tariff system are proposed such as applying the tariff to activity in community settings, unbundling the tariff in specific areas, applying the tariff to take account of different case mix and applying the tariff on the basis of the most cost-effective way of delivering a service, as opposed to basing it on the average cost of providing a service (pp. 139 and 152).

In relation to tracer areas, the 'year of care approach' for people with diabetes is being considered with interest in terms of exploring whether refinements to the current tariff

could support co-operation between commissioners and providers in delivering integrated long-term conditions care.

The new primary medical services contracts and the development of QOF are seen as providing increasingly powerful incentives for practices to identify patients with long-term conditions or lifestyle risk factors and manage their care more effectively in line with the best evidence available. It is anticipated that by 2008/09 QOF will include new measures which provide a clear focus on the wider health and well-being outcomes (p. 48)

System Management Reform

Regulation is to become more streamlined with the merger of two regulators - the Commission for Social Care Inspection and the Healthcare Commission by 2008. Reform rules for 2007 and 2008 will set out how performance measures such as Public Service Agreements, developmental standards and Local Development Plan priorities can be integrated and streamlined and can reflect the new emphasis on prevention and well-being (p. 184).

The wider use of evidence-based practice, including the National Service Frameworks, and the use of the NHS and social care long-term conditions model are seen as having driven service improvements in these services which include diabetes (p. 109). It is noted that good progress has been made towards implementing recommendations from the Mental Health NSF with the establishment of multi-skilled community mental health teams and rapid access (p. 92).

It is anticipated that local consultations on the proposed reconfiguration of PCTs and SHA boundaries will lead to the development of greater co-terminosity between health and local government bodies (p41).

Combined levers

The seeds of discussion of combined levers and a system approach in the 'NHS Improvement Plan' (DH, 2004) bear more fruit in this document, with increased discussion of drivers and incentives e.g. the reform principles of patient choice, resources following the patient and greater autonomy for professionals are suggested as working together to create the further

improvements outlined in the document (p. 11). The combination of PBC and PbR is seen as encouraging commissioners to seek out providers who offer better quality care (pp. 120-1). Arrangements to improve quality are seen as a combination of better commissioning, national standards, the use of best practice, and a streamlined inspection regime (p. 184). Choice, the tariff system, PbC and PCT commissioning are all considered important drivers in the shift of resources from hospitals to care in community setting and preventative services (pp. 140-2).

Summation

This document is the first to appear after the Next Steps Reform framework (DH 2005a). It clearly draws on this framework, but focuses on primary and community rather than secondary care. The different context leads to different outcomes, although there is a continued stress on reducing inequalities and prevention. Voice and choice, including Individual Budgets and Direct Payments are also stressed while commissioning and PBC are linked with driving the development of prevention services and care closer to home. The supply side stresses an enhanced role for third sector organisations while transactional reforms see further developments in PbR and QOF. SMR sees the emergence of a more streamlined regulatory regime though remains little changed in essence. There is clearly a greater stress on combined levers.

3.2.6 High Quality Care for All (DH 2008)

The Darzi report's underpinning principle is that the NHS needs to move from focusing on increasing the quantity of care to focusing on improving the quality of care. The vision the report sets out is one of an NHS that gives patients and the public more information and choice, which works in partnership and has quality of care at its heart. (p. 8). In terms of tracer areas, the Darzi Working Groups included mental health and LTC (pp. 18-19)

Outcomes

The main outcomes are to create an NHS that places quality at its heart; helps people to stay healthy and prevent ill health; and provides convenient care closer to home. The report

notes that tackling variations in the quality of care that is provided will be the first priority (p. 8).

Demand

The document stresses the importance of empowering people in two main senses: more rights and control over the care provided and help to stay healthy**.** Choice is expected to become a defining feature of the service and the right to choice forms part of the NHS Constitution (p. 38). It is acknowledged that better information is vital for people to make informed choices (p. 39). Measures to improve the availability and content of information include the use of patients' own views on the success of their treatment and the quality of their experiences (PROMS) and the publication of 'Quality Accounts' by providers (p. 11). It is suggested that patients will have increased influence over NHS resources, as payments to providers will be conditional on the quality of care received as well as the volume. A range of quality measures will cover safety (including cleanliness and infection rates), clinical outcomes and patient experience (p. 41).

Everyone with a long-term condition is to receive a personalised care plan, and personal health budgets will be piloted. (p. 10).

PCTs are advised they will be held to account through the World Class Commissioning programme to increase clinical engagement, ''…to involve all clinician groups in strategic planning and service development to drive improvements in health outcomes,' (p53). Stronger support is to be given to PBC. One element of this is the invitation to clinicians to submit proposals to provide more integrated services for patients by piloting new integrated care organisations (ICOs), based on GP patient lists. These ICOs will bring together health and social care services and professionals to deliver a more personal and responsive service with better health outcomes for the local population.

Supply

Having been introduced in the plans for redesigning healthcare services in London and featuring in Darzi's interim report, Polyclinics receive no further mention here.

The report is sprinkled with references to innovation, which is discussed as being central to the NHS (the establishment of the Health Innovation Council). In the context of the report,

‘‘Service innovation means people at the frontline finding better ways of caring for patients – improving outcomes, experiences and safety’ (p55).

Transactional

The ‘Commissioning for Quality & Innovation’ (CQUIN) scheme is introduced as a means to drive quality. Described as a simple overlay to the Payment by Results system, payments to providers will reward outcomes under the scheme as part of commissioning contracts from no later than 2010 (pp. 41-42). It is noted that for the first time, patients’ own assessments of their treatment and quality of experience will have a direct impact on the way hospitals are funded (p. 12). There is also talk of ‘Never Events’ and the potential for withholding contract payments when they occur. PCTs are to choose priorities from a list of Never Events in the 2009/10 Operating Plan. QOF incentives for General Practice are to be changed to encourage clinicians to play a wider role in helping their patients stay healthy (p. 37).

System Management Reform

It is stressed that no new national targets are set in this report (p. 14), though the report points out that the introduction of standards through NSFs has led to major progress on tackling illnesses such as cancer and heart disease (p. 48).

Summation

The outcomes reflect that the move from ‘quantity’ to ‘quality’ as the driving principle of the NHS with the emphasis on wider issues such as prevention rather than waiting times. Choice and voice remain important. There are changes to both PbR (through CQUIN) and QOF. SMR stresses no new targets are to be introduced.

3.2.7 From Good to Great (DH 2009)

This document sets out a five year plan for the period 2010-2015 within the context of some £15-20 billion of efficiency savings in the three-year period from April 2011. While it was published after our fieldwork, it is reviewed here as it maps out future strategy in the NHS.

There is some mention of our tracers. In regard to LTC, OHOCOS set a clear direction of travel focusing on better prevention and earlier intervention; more choice and a louder voice for people; more on tackling health inequalities and improving access to community services; and more support for people with LTC. Various CCTH projects showed that it is possible to provide care in community settings that is more usually provided in hospital. There are around 2.4 million people in England with diabetes. There have already been major improvements in diabetes care, but more needs to be done (pp. 33-5)

Outcomes

The key outcomes are contained in the sub-title, and it is claimed that services are not as preventative, people-centred and productive as they could be (p. 9). Our commitment remains to implement the vision set out in HQCFA (p. 11). We need to build an NHS that starts with prevention. For too long, this has been an afterthought. We need a paradigm shift in health – away from 'diagnose and treat' towards 'predict and prevent'. Investing in prevention and early intervention are important because they will pay dividends over the medium and longer term (p.20). The NHS OF 2010/2011 will continue to emphasise the importance of delivering improvements to health and well-being (p. 23).

Demand

The NHS is entering a new era, building on the Darzi vision by putting more power in hands of patients (p. 7). By putting power in the hands of the people we have created a powerful engine for reform. Where once we had to rely on national targets to drive improvements, we can now drive change through the influence of patients (p. 12). We will give patients greater choice and control, and have already launched a pilot programme to explore the potential of personal health budgets to give patients more control (pp. 31-2)

We will create leaner, stronger commissioners (p. 51). We will require all commissioners to reach level 3 on the majority of WCC competencies by April 2011. We will offer freedoms and incentives to high-performing commissioners and will require poor performers to demonstrate clear and rapid improvements by including commissioners in the NHS Performance Assessment Framework from April 2010 (pp. 56-7).

Supply

There is little mention of the supply side.

Transactional

Payments to hospitals and rewards to GPs now more accurately reflect the work they deliver and have improved efficiency (p. 8). We will link a significant proportion of provider income to patient experience and satisfaction. This will give providers real incentives to understand and improve, and will ensure that commissioners have the power to act when patients have a poor experience. Over time, up to 10% of trusts' income could be dependent on patient experience and satisfaction. This represents a clear shift from a commoditised, production-line NHS to one that is people-centred (p. 31)

We will maximise efficiency by limiting or freezing tariff with maximum uplift of 0% for the next four years. The tariff payment system must incentivise the shift of care out of hospital settings if this is what patients want. This will mean limiting the payments providers receive when activity exceeds planned levels. For 2011/12 onwards, there needs to be significant reform to QOF to deliver improvements in quality and efficiency. (pp. 51-2).

System Management Reform

We will strengthen regulation and deal with failure (p. 51)

Summation

Outcomes stress the wider prevention and person-centred agendas. The demand side- increasing choice and control- is regarded as stronger than targets. Some may regard the achievement of leaner and stronger commissioners as problematic in the context of a goal of reducing costs by 30% over the next four years. Income will be linked to patient satisfaction.

Conclusion

Some themes wax and wane over time, with clear trends from the initial access targets towards wider issues such as health inequalities and prevention (see table 3.1). The importance of the demand side has increased over time, with a greater stress on patient choice. The supply side has also broadly increased over time with new elements such as ISTC, FT and the third sector, although there appears to be some retreat from the earlier view that private hospitals might carry out 15% of NHS treatments. SMR remains over time, although it is claimed that the importance of the 'targets' component has now reduced.

Some elements of programme theory are clear. For example, it is clear that PbR can increase activity. However, although there has been more stress on systems and levers and incentives over time, programme theory as a whole has not become significantly clearer. It is more difficult to see how PbR will achieve care closer to home. Indeed, it is recognised that perverse incentives may exist (DH, 2004), although discussion of 'best practice' and 'unbundled' tariffs may be promising (DH, 2005). Similarly, it is not fully clear how precisely commissioning will achieve a greater stress on prevention or inequalities.

Figure 3.1 Summary of Policy Review

	Demand	Supply	Transactional	System Management	Targets/ Outcomes	Other Streams; Interactions
New NHS	Primary Care Groups		Co-operation; long-term agreements	National Performance Framework; one-nation NHS; NSF; NICE;	Waiting Lists; Quality; Improving health; Reducing health inequalities	
NHS Plan	Limited choice; Voice	Concordat	National Patients Survey	NSF; NICE; CHI	Access targets	Earned Autonomy
Delivering the NHS Plan	Limited choice; voice	Private hospitals; DTC; FT	PbR	NSF	Waiting times; Improving health; Reducing health inequalities; Prevention	'coherent framework'; integration
NHS Improvement Plan	Choice; Voice	Private hospitals; ISTC			Prevention; health inequalities	Recognises interactions
Our Health, Our Care, Our say	Choice (IB, DP); voice; commissioning; PBC	Third sector providers	PbR: best practice and unbundling; QOF	NSF	Wider but prevention and inequalities common	Recognises interactions
HQCFA	Choice (PHB); voice; commissioning - CQUIN		CQUIN; QOF		Quality; prevention	
From Good to Great	Choice; Leaner stronger commissioners		Changes to PbR- linking income to satisfaction; QOF		Prevention; health and well- being	

3.3 Literature Review

This section reviews evaluations of the four reform streams of the Next Steps Reform (DH, 2005a): demand-side reforms, supply-side reforms, transactional reforms, and system management reforms. We do not aim to provide a comprehensive literature review as studies on the individual streams provide a full review (http://hrep.lshtm.ac.uk/) (see also eg Brereton and Vasoodaven, 2010; Thorlby and Maybin 2010), but rather to map studies onto reform streams with a particular focus on context, mechanism and outcomes, and to examine studies that examine the interaction between reform streams. Similarly, we do not discuss studies from the Conservative period of market reforms as the differences in context and mechanism make policy learning problematic. (but see Le Grand et al 1998; Mays et al 2000; cf Powell 2003) . For example, competition in markets with variable prices (eg Propper et al 2008) tends to suggest different conclusions to markets with fixed prices (see below). We examine the different streams broadly in terms of studies that broadly focus on the (unclear and overlapping) categories of context, mechanism and outcome

Demand Side Reform

3.3.1 Choice and Voice

Context

Since January 2006, all patients referred by their GP for elective surgery should have been offered a choice of four or more providers commissioned by their PCT. With the introduction of the NHS Constitution in 2009, patient choice of provider became a legal right (DH, 2009a).

The lowest choice of provider for elective care was demonstrated for patients living in the South East (excluding London), East Anglia, Cornwall and an area south of Bristol; requiring them to travel further to exercise meaningful choice of hospital (Damiani, Propper et al., 2005). The supply of acute beds in non-NHS facilities was also deemed to be too small to make an important contribution to patient choice (Damiani, Propper et al., 2005). Individuals living in more rural areas travel further for admissions whilst patients in highly deprived wards travel less far (Propper, Damiani et al., 2007).

Recent reports (DH, 2009b; Robertson and Dixon, 2009) indicate only half of patients recall being offered a choice of hospital for their first outpatient appointment; patients were most likely to have been offered a choice by their GP (60%), in a letter outlining the options (21%), or by a telephone-booking adviser (20%). Patients offered a choice were more likely to travel to a non-local hospital than those who were not offered a choice (29 versus 21%, respectively). Cleanliness, quality of care, and the standard of facilities were the three most important factors influencing patient choice of hospital (DH, 2009b; Robertson and Dixon, 2009; Burge, Devlin et al., 2006).

Definition and analysis of patient voice has been hampered by changing patient and public involvement (PPI) policies and broader regulatory frameworks. (Hughes, Mullen, et al., 2009). Voice reforms were perceived to be a significant shift of PPI policies towards a more exclusive focus on consumer choice and economic regulation, with collective voice and citizen participation at best playing a subordinate part (Vincent-Jones &Mullen, 2009).

Mechanism

There is enthusiasm for public involvement in planning primary health care. However, sustainable involvement in patient voice initiatives requires a commitment from leaders within statutory agencies, long-term support to build the confidence of local people, informal approaches that acknowledge local culture, and recognition of the concerns of both service users and providers (Anderson, Shepard et al., 2006).

Patients do want to be more involved in decisions about their own treatment, however, when ill they are increasingly likely to rely on a trusted health practitioner to choose their treatment (Fotaki, Roland et al., 2008). Choosing between hospitals or primary care providers is not a high priority for the public, except where local services are poor and where individual patients' circumstances do not limit their ability to travel. Patients do want choices about when they are treated but are reticent to take responsibility for choosing where they are treated or for choosing the treatment they will receive (Greener, 2007).

Waiting times above 10 weeks were found to negatively influence the likelihood of an individual choosing a hospital. Negative advice from a GP was given a higher weight than

positive advice in favour of a particular provider. A greater interest in choice among the elderly than was originally anticipated was also found, fuelled by perceived variability in hospital service provision (Weir, Kotecha et al., 2007). There was also a general preference for shorter travel times and lower travel costs regardless of eligibility for refunds and an inherent bias towards the local provider (Burge, Devlin et al. 2006; Greener & Mannion, 2009). Loyalty to the local hospital was related to respondent characteristics; with the possibility of a social gradient in the way that patients make choices (Burge, Devlin et al., 2006). Better educated populations make greater use of information and are more likely to exercise choice in health care (Fotaki, Roland et al., 2008). However, more recently, patient choice (along with provider competition and increased hospital capacity) was not found to harm equity in waiting times for elective care (Cooper, McGuire et al., 2009).

Most GPs made choices on the patient's behalf (with or without Choose and Book) unless the patient expressed a preference (Rosen, Florin et al., 2007). GPs only tried to override patient preferences to guide them towards what they perceive to be high quality providers or away from providers about whom they had concerns. Whilst most GPs distrusted official sources of information (e.g. waiting list data), there was no consensus on the type of information GPs wanted to support patient choice or about how it should be presented (Rosen, Florin et al., 2007). Existing referral patterns within the local area were strongly ingrained due to historical patterns and there was a prevalent view that GPs (not patients) were the real 'customers' of the hospital (Greener and Mannion, 2009).

Choose and Book was being utilised in less than half of referrals, of these, 66% reported not being given a choice of appointment date or time, 86% reported being given a choice of fewer than four hospitals in total, and 32% reported not being given any choice of hospital. Furthermore, Choose and Book did not change the experience of referral from that of conventionally referred patients; both groups were 'fairly satisfied' (Green, McDowall et al, 2008). For GPs, Choose and Book allowed for immediate appointment making, informed patients of approximate waiting times, improved attendance at outpatient appointments and enabled referral tracking, however, it also increased workload, created technical difficulties, and led to uneven distribution of hospital appointment placements. Very few GPs had used Choose and Book to actively engage patients in discussions about choice of provider (Rosen, Florin et al., 2007) and was in some instances, implemented as an add-on to other processes, such as a back-up information system, to ensure confidential data

transfer, or to provide a clear audit trail (Rashid, Abeysundra et al., 2007; BMA, 2009).

According to Dixon et al (2010), the vast majority of patients thought that having a choice of provider was important, particularly older patients and those from minority ethnic backgrounds. This contrasts with the prevailing view of health care professionals that patients did not want to be offered a choice of provider. Surveys suggest that about half of elective patients were being offered a choice of provider for their first outpatient appointment by the late 2000s (Dixon, et al, 2010), but that GPs were reluctant to offer choice routinely. Most of the patients offered a choice did choose their local provider (69%) but patients offered a choice were more likely to travel to a non-local hospital (29%) than those not (22%) (Dixon et al, 2010). Patients reporting a bad previous experience of a hospital were also more likely to go elsewhere following the offer of choice. Patients with higher levels of education were more likely to be aware that they were entitled to a choice and to go to a non-local hospital after having been offered a choice, suggesting a possible source of inequity generated by the choice policy, at least in its early stages until people became aware of the policy. On the other hand, there were no obvious signs of socioeconomic bias in the offer of choice. GPs and providers believed that choice was relevant only in urban centres, but patients living outside urban centres were more likely to be offered a choice and were more likely to choose to travel to a non-local provider. This is consistent with Gaynor et al's (2010) finding that the most marked increase in spatial competition associated with the reintroduction of the market occurred outside the conurbations.

Outcome

Voice reforms held some promise for increased responsiveness, but the overall effect was thought to be a weakening of the foundations of democratic decision making in the governance of healthcare compared with earlier patient an public involvement schemes (Vincent-Jones & Mullen, 2009). Both voice and patient and public involvement, have however taken hold to an extent, but whether this will result in greater equity and a real shift in power away from professionals to citizens and patients is another matter (Forster and Gabe, 2008).

Evidence on patient choice of provider within the English NHS is dominated by pilot studies that differed significantly from current choice policy. However, the evidence so far does

suggest that choice of provider should contribute to further reductions in waiting times and improved satisfaction with care quality (Jones and Mays, 2009). On the other hand, the scope of choices required by patients may be over-estimated by the national choice policy (Greener, 2008). Whilst the uptake of choice has improved since introduction, it is not yet widely realised and the degree of implementation varies geographically. Most patients do not experience choice in referral as the policy envisaged (Robertson and Dixon, 2009). The fear of the impact of patient choice, rather than actual choice, appears to be driving a change in attitude among some NHS providers (Audit Commission and Healthcare Commission, 2008). Patient choice policies had not resulted in an externally focused, pro-market approach and there was a shift to a more risk-averse culture focused on short-term gains (Greener and Mannion, 2009).

Choose and Book has not enabled choice as was expected to deliver nor functioning in the capacity it was intended to and is instead being used as an additional technological tool for administrative purposes (Rashid, Abeysundra et al., 2007; BMA 2009; Greener and Mannion; 2009). Choose and Book system has failed because the complex and far-reaching implications of the implementation were not appreciated (Ojiako, Maguire et al., 2010). As presently implemented, choose and book is more likely to be concerned with times rather than places for treatment. The absence of detailed comparative clinical information means patients make choices on the basis of other factors; as such it is doubtful whether it will lead to an improvement in patient care (Greener and Mannion, 2009).

3.3.2 Primary Care Trust (PCT) commissioning

Context

As PCTs have their populations fixed by catchment areas, and their income fixed by capitation funding formulae, they have weak incentives and inadequate management capacity to drive aggressive bargains with hospitals (Cookson, Dusheiko et al., 2010). The purchaser/provider split was intended to empower both types of organisation to operate autonomously and pursue self-interest; however, for PCTs, vertical autonomy is always conditional to the NHS retaining a centralised funding role (Exworthy and Frosini, 2008).

Mechanism

PCTs have struggled with an information deficit in carrying out population needs

assessments and often experience a lack of support from the DH (Lewis, Smith et al. 2009). Lack of ability or resources for commissioning has led many PCTs to ineffective purchasing, and sustained historical purchasing patterns with familiar providers which are often older organisations with more experience in contract negotiation (Lewis, Smith et al. 2009). PCTs have not yet taken full advantage of their potential power in the purchaser/provider relationship.

Distinct and polarised styles of management within PCTs are known to be a barrier to effective commissioning (Marshall, Mannion et al. 2003). However, poor management alone was unlikely to be the cause of subsequent PCT deficits as rural and more affluent areas were more prone to deficits; probably due to the challenges of providing for rural communities and increased demand for health services among more affluent populations (Badrinath, Currell et al., 2006).

Outcome

Overall, PCT commissioning had not brought about beneficial change as intended by the DH, particularly in the scale of services provided at home, seamless care between providers, and in meeting complex care needs by the right professionals. PCT commissioning decisions had so far penetrated only trust management; engagement of patients, public and frontline staff in local health commissioning strategies occurred only to a limited extent, and paid too little attention to many disease-specific issues (PatientView 2009; Picker Institute, 2009). Thus, whilst PCTs are being entrusted with developing care pathway models that aim to substantially reinvest in community-based care services in order to tackle long-term conditions, as commissioners they remain in a relatively weak position to achieve these goals (Goodwin, 2007).

World Class Commissioning (WCC)

WCC is the DH's relatively new framework for supporting and regulating PCT commissioning. It holds PCTs accountable for commissioning competencies, governance and certain outcomes, and rewards improvement. Three quarters of PCTs were using external support for commissioning, mostly outside of the DH's Framework for procuring External Support for Commissioning. The majority of PCTs held several contracts with external organisations and were largely positive about their experiences of using external support (Naylor and Goodwin, 2009). The impact of WCC, still a very young policy, on commissioning outcomes is

yet to be seen.

3.3.3 Practice-based commissioning

Context

Previous initiatives of PbC such as GP fundholding and total purchasing pilots suggested many potential benefits of PbC such as lower elective referral/admission rates, improved coordination of primary, intermediate and community services and less market concentration (Mannion, 2005; Dixon and Glennerster, 1995; Smith, Mays et al., 2004; Dusheiko, Goddard et al., 2008). Limitations which could also apply to PbC included reduced patient satisfaction; increased management and transaction costs and little impact on organising and delivering hospital care (Mannion, 2005; Dixon and Glennerster, 1995; Smith, Mays et al., 2004).

As half of GPs were not interested in taking on a commissioning budget, strong incentives were required for practice-based commissioners to innovate across the primary-secondary care interface (Smith, Mays et al., 2004, Smith, Dixon et al., 2005). Facilitators for effective PbC included stability in the commissioning organisation; sufficient time for clinical engagement; management and information support, and appropriate regulation as GPs could be both commissioners and providers (Smith, Mays et al., 2004).

Mechanism

The majority of general practices that had taken up PbC budgets were working together as localities or consortia for commissioning purposes with 92% of GP practices being part of a PbC group (Audit Commission, 2006; Parkinson, 2009). By late 2009, over 80% of PbC groups were receiving a budget from their PCT and had agreed a PbC commissioning plan with their PCT (Parkinson 2009). Most PbC groups had submitted at least some business cases or service redesign plans to their PCT of which the majority had been approved and two thirds at least partially implemented. A variety of management models were in place including seconded staff, directly employed staff and the employment of external consultants. None of these models were associated with better or worse outcomes (Coleman, Checkland et al., 2009).

The financial incentive to practices (75% of practices said they had been offered a

participation incentive scheme by their PCTs by 2009; Parkinson, 2009) and the requirement on PCTs to provide a supporting infrastructure were recognized as drivers for implementing PbC; however they were still not sufficient to engage most GPs in commissioning (Audit Commission and Healthcare Commission, 2008). Many practices viewed PbC as a means to fund an increase in their provision of new services than as a means to commission health care from others or manage financial risk (Audit Commission, 2006; Curry, Goodwin et al., 2008) because appropriate robust governance arrangements were not in place (Curry, Goodwin et al., 2008). A large number of new services had been set up in the name of PbC as it provided a handy medium for their ongoing development management, governance and financing (Coleman, Checkland et al., 2009).

The quality of the financial infrastructure underpinning PbC programmes was variable, with many practices unclear on how their budgets had been set or how financial risk was to be managed (Audit Commission, 2006). Indeed, budget setting was a source of contention between GP groups and PCTs (Coleman, Checkland et al., 2009; Audit Commission, 2006). Of the PCT leads, 62% had not been given their freed up resources to reinvest. Of those who had, the average amount made available by the PCT was 60% (Parkinson, 2010). Arrangements for sharing and using any savings, which were important incentives for many practices, were also still theoretical, unclear or criticised—particularly where savings would be taken by the PCT to fund any overall deficit. Lack of reliable up-to-date population and treatment information restricted both GPs' ability to set and manage virtual budgets and develop commissioning ideas and PCTs' willingness to approve these ideas (Audit Commission 2006; Curry, Goodwin et al., 2008). PbC groups were critical of the support given for data analysis, however GPs were also often unclear as to exactly what they wanted from their data analysts (Coleman, Checkland et al., 2009).

PbC had encouraged more collaborative working relationships between GPs and PCTs, and between GPs and hospital staff. However, in a few cases PbC had caused already poor relationships to deteriorate further (Curry, Goodwin et al., 2008). Whilst 82% of PBC leads stated that they had a good relationship with their PCT only 57% rated the quality of management support and 55% the PCT financial support as good. Even less ratings of good were found for quality of PCT feedback on business case decisions (29%) and the speed of PCT decision-making for business cases (25%) (Parkinson, 2009).

The lack of national guidance on the respective roles of GPs and PCTs offered flexibility within PbC but also led to disagreement over local agendas. GPs also had limited time to engage in commissioning and often lacked the requisite skills, at the same time the considerable support required from PCTs was limited by lack of resources and experience at PCT level as well (Checkland, Coleman et al., 2009).

Outcome

PbC implementation had progressed modestly; very few PbC-led initiatives had been established, and there was limited impact in terms of better services for patients or more efficient use of resources (Curry, Goodwin et al., 2008). PbC initiatives that were developed were small-scale, local pilots focusing on providing hospital services in community settings. However, general practices did now have a better understanding of the financial consequences of their decisions and engaged more in demand management (Audit Commission 2007; Curry, Goodwin et al., 2008).

Overall, PbC had not yet resulted in the service change envisaged by the Department of Health; PbC was being led by a few enthusiastic practices with supportive primary care trusts (Audit Commission 2007; Curry, Goodwin et al., 2008) working co-operatively with local providers (Coleman, Checkland et al., 2009).

Supply-Side Reform

3.4.1 Provider plurality

Context

The majority of studies focus on centrally negotiated contracts (such as ISTCs), and there is a lack of research on competition between providers for acute care contracts (Brereton and Vasoodaven, 2010). There is also limited evidence to support improved outcomes with increased provider competition, whilst promotion of hospital competition necessitates strong pro-competition strategies (Propper, Wilson et al., 2006). Senior management culture within English NHS acute hospital trusts has become 'rational' (goal-orientated, bonded by competition and an emphasis on winning) since 2007-2008, and this is consistent with a policy context in which provider competition is promoted (Mannion, Harrison et al., 2009).

Mechanism

Despite a shared framework of central government policy, PCT commissioners felt relationships between themselves and hospital service providers were biased towards providers, with hospitals not recognising PCT commissioning power in shaping hospital services. From the provider perspective, commissioning was seen as generally weak (Abbott, Procter et al., 2009). Contestability, or the threat of competition, may be driving up efficiency but perhaps at the expense of inter-professional and inter-organisational collaboration (Lewis and Dixon, 2005). The ISTC programme has been heavily criticised, e.g. for leaving public providers with the more difficult cases (Pollock and Godden, 2008).

Education and training of doctors was argued to be adversely affected by the presence of a treatment centre within their catchment area (BMA, 2005; Clamp, Baliu et al., 2008; Barsam, Heatley et al., 2008) and rather than providing extra capacity and staff, NHS beds in England have closed and many clinical staff transferred to the private sector since ISTCs were introduced (Pollock and Godden, 2008).

Outcome

The majority of NHS trust clinical directors who had a treatment centre in their trust catchment area agreed that the treatment centre had benefited patients in terms of improved access to care and shorter waiting times; at a cost to facilities/service provided by their trust. Respondents claimed ISTCs 'cherry-picked' patients, resulting in an imbalanced case-mix, loss of potential income for the NHS, and low NHS staff morale (BMA, 2005). However, the majority of experienced NHS consultants who visited ISTCs had positive impressions of facilities, procedures and quality of clinical practice (Healthcare Commission, 2007).

ISTCs rate better for patient experience and satisfaction (Browne, Jamieson et al., 2008; Healthcare Commission, 2007; Patiar, Lo et al., 2006) and treatment outcomes of patients are similar to NHS hospitals, if not better (Browne, Jamieson et al., 2008). Provider competition overall has resulted in improvements in clinical quality; mortality from acute myocardial infarction fell more quickly in patients living in more competitive markets (Cooper, Gibbons et al., 2009).

As Mays (2011) points out, the main difficulty comparing ISTC provision with NHS provision is how to ensure like for like comparisons when the case mix of patients treated in each sector differs. There are two studies of patient experience. First, the Healthcare Commission (2007), found that patients in ISTCs rated their care highly (97% rated their overall care as 'excellent' or 'good') and on a number of criteria more highly than NHS organisations. These included time of admission and no change to admission arrangements, involvement in decisions about their care, and the provision of information and explanations about their care. Second, a multi-variate analysis, Pérotin et al (2010) compared patient experience in terms of aspects of care such as cleanliness of facilities, food quality, explanations provided by medical staff, delays, privacy and dignity. After taking into account the characteristics of the patients, the patient selection process and individual hospital characteristics, there was no difference between ISTCs and NHS providers. The only comparative study of clinical quality, by Browne et al (2008), showed slightly better patient-reported outcomes in ISTCs versus NHS providers of elective surgery, though the differences were not statistically significant. Given the large difference in case mix between the two sectors and within groups of patients receiving the same operation (e.g. cataract surgery, hip replacement or hernia repair), all comparative findings must be treated with caution.

3.4.2 Foundation Trust (FT)

Context

The incentive for FT status for Trusts meeting certain financial management and clinical quality standards is earned autonomy, the ability to make independent governance and finance decisions. The evidence to date on FTs does not suggest that local democracy or improved service delivery can or has been achieved (Allen, 2006).

Mechanism

FT status associated incentives were not powerful enough to motivate providers to deliver better performance in order to apply for FT status. Some hospital managers reported that they already enjoyed a large degree of autonomy, regardless of their current performance ratings (Mannion, Goddard et al., 2005).

FT lay governors and directors perceived the new role of FT governor ambiguous and difficult to define, this impeded the development of a governance function. In practice, there was increased involvement of both governors and the public in the trust's activities (Lewis and Hinton, 2008). Other studies found better clarity for FT governance and showed it to be working with increased effect (Ipsos MORI, 2008). The statutory powers of governors have helped to ensure they are taken seriously but greater public membership was still required (Ham and Hunt, 2008) as it was still 'early days' for the role of a Foundation Trust Governor (Ipsos MORI, 2008).

Outcome

FTs have generally performed well financially and generated modest surpluses, and have been high performers in routine NHS process quality measures (House of Commons Health Committee, 2008). Other data suggest FT status itself to have had limited impact in indicating strong financial management (Marini, Miraldo et al., 2008). According to Monitor (2009) Key service performance issues for the 122 FTs authorised up to September 2009 were:

- Income and operating costs were on average 2% above planned levels for all FTs (attributed to increased referrals and A&E admissions).
- New thresholds for cancer targets were challenging and resulted in lowered governance risk ratings.
- The number of trusts with low and middle level ratings were rising.
- Good performance against the 18-week referral to treatment targets, but breaches against 4-hour A&E waiting time target.
- A handful of FTs were struggling to meet infection rate targets.

FTs are providing more care than other NHS trusts, and are providing it more efficiently. Although both FTs and non-FTs increased their overall activity levels between 2003/04 to 2006/07, the increase was greater in FTs by almost 3%; FTs continued to be lower cost providers and their relative cost position has been less subject to change than that of other trusts (Healthcare Commission and Audit Commission, 2008). However, it has been shown that FTs tended to outperform non-FTs, even before being granted FT freedoms (Marini, Miraldo et al., 2007; Healthcare Commission and Audit Commission, 2008). Likewise, the majority of FTs were scoring highly on quality of service before they obtained FT status and

there is no significant evidence to show further improvement as a result of their status (Healthcare Commission and Audit Commission, 2008)

The two major goals of FT policy of increased public involvement or innovation in service development are not being met (Monitor, 2009). The barriers to innovations by FTs were: timing (as FTs are still concentrating on achieving and maintaining financial stability); constraints by commissioners; introduction of Payment by Results and inadequate collaboration between PCTs and FTs to manage demand for acute care (House of Commons Health Committee, 2008).

In short, there is no evidence that NHS foundation trusts' superior performance versus other NHS trusts is attributable to their governance status and greater freedoms rather than their pre-foundation trust performance, except perhaps for their greater responsiveness to patients (Healthcare Commission, 2005; House of Commons Health Select Committee, 2008; Allen, et al, 2010a; Mays 2011).

A recent review (Allen et al 2010b) concluded that there is not a large amount of relevant comparative evidence to review. It is not possible to compare the performance of *all* of the different types of providers of care to the NHS directly with each other at the same time, as there have been no studies undertaking this task to date. The limited international evidence (which mainly comes from the USA and Canada) does not indicate that it is the governance structure and ownership of the organization which makes the most difference to performance. Mays (2011) concludes that the research on diverse providers suggests that the pace and extent of entry of new providers was modest, that the amount of head-to-head competition between NHS-owned, private and Third Sector providers was very limited, and thus the amount of evidence on the relative quality, outcomes and costs of the same services delivered by different providers remained small (Bartlett, et al, 2010; Brereton and Gubb, Allen and Jones, 2011). In short, there appears to be no solid evidence internationally or domestically favouring one sector over another in terms of innovation, quality and outcomes of care (Heins et al, 2010).

Transactional Reforms

3.5.1 Payment by Results

Context

The Payment by Results system introduced a national tariff for payment between purchasers and secondary care provider; paying providers by number of treatments provided. PbR was intended to provide strong incentives for providers to challenge historical patterns of service delivery and pursue cost-effective innovation. This requires a balance between exploiting financial incentives and destabilisation of local health economies so as not to adversely affect patients (Miraldo, Goddard et al., 2008). Both managers and clinicians lacked confidence in the stability of the tariff and said it affected motivation for long-term planning (Farrar, Sussex et al., 2007).

Mechanism

Minor efficiency improvements due to PbR have been noted in elective surgery such as an increased day cases and decreased length of stay in hospital (Farrar, Sussex et al., 2007). PCTs had also reduced the number of avoidable admissions to hospitals presumably to meet waiting time targets (Audit Commission, 2008). Capacity constraints, limitations in the infrastructure underpinning PbR (such as information systems), and significant changes in the tariff during the first two years of the transition period may all partly explain why PbR has not had more impact on activity and efficiency (Audit Commission, 2008). The Commission also found that most hospitals had improved their financial management and had a better understanding of how much it cost them to treat patients. Fear that care would suffer because hospitals would be tempted to cut costs at the expense of quality was found to be unwarranted.

Other weaknesses of PbR were reported to be: strong incentive for increasing activity (particularly day surgery), such that activity is increased beyond affordable levels and possibly inducing demand inappropriately; destabilize expenditure control; divert resources away from primary care, distort needs-based funding; encourages providers to become 'average' (Street and Maynard, 2007); and promotes 'gaming' behaviours (Gray and Bailey, 2008). However, senior trust managers did not view PbR as having additional incentives to

increase quality or efficiency and did not plan to increase volume of activity in response to the introduction of PbR (Sussex and Farrar, 2009)

Outcome

The Audit Commission concluded that PbR had been fully embedded across the NHS (by 2008) but had not yet significantly increased NHS efficiency (Audit Commission, 2008) nor impacted on quality of care (Farrar, Sussex et al., 2007).

Evidence of an association between the introduction of PbR and growth in acute hospital activity (volume of patients treated) was also found. As cost reductions were attained through no change in quality of care, the change was attributed to PbR impacting on efficiency (Farrar, Sussex et al., 2007; Farrar, Yi et al., 2009). Introduction of PbR in England was likely to have increased administrative costs by a greater amount than that experienced by other countries with similar policies, because of the NHS's relatively low general management and administration costs, and less sophisticated clinical coding systems (Marini and Street, 2006). The replacement of block contracting with PbR had lowered negotiation costs, but these were outweighed by higher costs of volume control, data collection, contract monitoring and evaluation, and contract enforcement (Marini and Street, 2006).

The gap between high and low costs (reference costs above and below the national tariff) trusts had narrowed following the first year of PbR implementation, but substantial cost improvement and a large-scale transfer of resources was still required (Audit Commission, 2007). Between April 2003 and September 2004, mean episode costs for all foundation trusts were lower than those for non-foundation trusts, but possible upcoding (claim to perform more expensive or complex treatments than are actually provided) was identified among FTs when looking at short stay in-patients admitted through A&E (Rogers, Williams et al., 2005)

Overall it is argued that the strength of the incentives embodied in current PbR policies may have to be reduced to prevent poorer outcomes for higher severity patients (Propper, Wilson et al., 2006).

3.5.2 Quality and Outcomes Framework

Context

There is some confusion as to whether QOF which was introduced in 2004 is a system management or transactional reform. The 2005 Next Steps document does not mention QOF but lists the General Medical Services contractual arrangements which QOF is part of as a transactional reform, and new performance management and regulatory functions together with processes for ensuring quality, as a system management reform (DH, 2005a) The NHS Information Centre which manages the QOF database explicitly states '[QOF] is not about performance management but resourcing and then rewarding good practice'. Presumably some of the confusion arises from the older general practitioner contract being more about practice management (Checkland, 2004). However, even after several years of QOF implementation the nature of QOF as a vehicle to reward standard good practice, or a vehicle for changing practice is still being questioned (Roland, 2007).

Mechanism

QOF is a mechanism for an ongoing programme of quality improvement in new areas that is unique among national healthcare systems. High quality scores achieved from the first year onwards and this is suggested to be due to infrastructure for quality improvement already being in place, and GPs were able to respond rapidly to the new incentives (Roland, 2007).

For diabetes, multiple deprivation was significantly inversely related to QOF points achieved. Practices in villages and towns gained 2% more quality points than urban areas and hamlets; the pattern; across urban and rural areas was more complex (Wright, Martin et al., 2006). This negative impact of deprivation on QOF achievement for diabetes process measures was confirmed and more pronounced for smaller practices (Millett, Car et al., 2007) and less organized services (Gulliford, Ashworth et al., 2007).

Outcome

Care was already improving rapidly in the years leading up to the introduction of QOF. Quality of care did show further improvement with QOF, and in some disease areas such as diabetes, more rapidly than before the contract (Roland, 2007).Specifically, quality of care recording in diabetes services in Europe and North America showed the largest improvement within the British NHS, as a result of the QOF. Standards of many process

indicators and all major intermediate outcome measures improved significantly due to QOF financial incentives (Khunti, Gadsby et al., 2007). However, the translation of improved QOF measures into actual improved outcomes for people with diabetes is not clear (Khunti, Gadsby et al., 2007; Hughes, 2007).

System Management and Regulation

This broad category includes issues of performance management ('command and control'; 'targets and terror' and regulation.

Context

This aspect of the market-based reforms have been least evaluated with some literature not even addressing this reform stream (Brereton and Vasoodaven; 2010). National service frameworks (NSFs) and strategies set clear quality requirements for care and are based on the best available evidence of what treatments and services work most effectively for patients. There are NSF for diabetes and mental health.

FT experiences and plans demonstrate a very wide range of priorities and indicators being used nationally and across the range of trusts under the Darzi headings of safety, effectiveness and patient experience. Mental health trusts appear to have gone the furthest in developing ways to engage patients and carers in the development of standards and metrics (Foundation Trust Network, 2010).

As Dixon, Storey et al (2010) point out, the confusion about accountabilities were illustrated in part by the Maidstone and Tunbridge Wells case and the Mid-Staffordshire Foundation Trust case, which revealed the crosscutting accountabilities to the Secretary of State, the (then) Healthcare Commission, Monitor, and the Strategic Health Authority (SHA). They conclude that this 'maze of accountabilities' is likely to promote a ritualistic box-ticking approach to accountability, to induce caution and defensiveness while, at the same time, leaving gaps so that no one truly holds FTs to account.

Mechanism

The DH reports good progress in implementation of NSF for diabetes (DH, 2010) however, assessment by Diabetes UK a year earlier found much variation in progress across England,

which if allowed to continue, posed a risk of the NHS not achieving the NSF diabetes targets by 2013 (Diabetes UK, 2009).

Directors of foundation trusts perceive strong accountablility to their regulator, Monitor, particularly for financial performance, but there is some confusion about where accountability for quality of care rests. Accountability of FTs to the local population is weak (Dixon, Storey et al., 2010). There is also willingness by clinical directors to assume accountability for devolved profit centres in their service areas; non-clinical directors are supportive of this but cautious about releasing "too much" central control (Storey and Holti, 2009).

Outcome

It is known that whilst governance and incentive structures have important effects on outcomes in health the impact of a particular type of governance is not yet predictable (Davies, et al., 2005).

Introduction of NSF for clinical services such as coronary heart disease has impacted positively on mortality and thrombolysis (Graham, Timmis et al., 2005) the impact on diabetes and mental health outcomes are less clear.

The accountability of foundation trusts still needs to be simplified, clarified and strengthened to make them more accountable to the local population and its representatives (Dixon, Storey et al., 2010).

3.6.1 Targets

The introduction of targets in the NHS has generated much controversy and whilst ratings systems to benchmark trusts have improved performance at meeting targets there is evidence of data manipulation to achieve targets (Bevan & Hood, 2006) necessitating better audits and random checks (Bevan, 2009). Reported performance against targets show waiting times for treatment decreasing with very long waits (>12 months) eliminated between 2000 and 2005. Also, by 2005, more than 96% of Accident and Emergency patients were discharged, transferred or admitted to hospital within the target of four hours (Healthcare Commission, 2005). This was despite overall elective admissions to hospital

rising by 11% and emergency admissions increased by 35% over a similar time period. Others argue that after targets were introduced for inpatient and outpatient waiting times, median waits increased, waiting time was shifted to diagnostics (Gubb, 2008) and bed occupancy rose to levels associated with excessive risk of infection (Orendi, 2008).

3.7 Combined impact of policy reforms

The multiple aims and objectives of the NHS reform agenda at varying levels of detail and context (Department of Health 2005a) makes it difficult to pin down 'policy success' (Powell, 2002). The relative recentness of the reforms, their introduction at separate times, as well as frequent changes and additions (such as DH, 2008), means that the full impact of NHS reforms is still ambiguous (see eg Audit Commission and Healthcare Commission, 2008; Brereton and Gubb, 2010; Brereton and Vasoodaven, 2010; Mays 2011, Mays et al 2011; see also the website of the DH PRP Health Reforms Evaluation Programme http://hrep.lshtm.ac.uk/).

There has been a lack of literature addressing whether the cumulative effects of New Labour NHS market reforms have achieved their intended outcomes as most research has investigated individual policies (Brereton and Vasoodaven, 2010). When explored, the more comprehensive reviews found limited implementation but an overall positive effect of post-2002 market reforms on the NHS (Audit Commission and Healthcare Commission, 2008). However, whether this improvement was due to the unprecedented levels of financial investment in the NHS (spending on the NHS rose by nearly 50% equating to a total increase of £43.2 billion) and/or waiting time targets rather than reforms is unclear (Wanless, Appleby et al., 2007; Audit Commission and Healthcare Commission, 2008).

A recent review by Mays (2011) sums up that the overviews to date tend to conclude that the NHS market has not so far had a major impact, principally because it has not been systematically implemented in the face of numerous barriers to change and because other New Labour policies appear to have had more impact, particularly the increase in overall spending and the setting and enforcement of targets. However, by contrast, the most recent studies of specific aspects of the changes tend to demonstrate significant effects in the direction expected by the proponents of reform, but have not, so far, been fully taken into account in the syntheses. A number of recent studies have concluded that increasing inter-

hospital competition after 2003/04 was associated with an improvement in clinical outcomes (Gaynor, et al, 2010; Cooper et al 2010a,b; Bloom et al 2010). However, Brereton and Gubb (2010) used a different approach to conclude that the extent of competition was very limited. They reported that few services were reported to have been put out to tender in the period and that most providers retained monopoly power in their localities and were able to dictate to PCTs rather than having to compete for PCT business.

There are two main issues on evaluating the combined impact of policy reforms. First, there is the problem of separating out the different reform streams on individual outcomes. There is also limited research addressing the interplay of reforms to determine whether the different system reforms have been 'mutually supporting' as intended to deliver better patient experience, better care and better value for money (DH, 2005a). Supply side reform of FTs generating major innovations was impeded by transactional reform of PbR which gave trusts financial incentives to carry out as much as possible themselves resulting in opposition to demand side reforms too with inadequate collaboration between PCTs and FTs to manage demand for acute care (House of Commons Health Committee, 2008). The system reforms create tension in the power balance between demand and supply, between PCTs requirement to reconfigure the provision of services around the needs of their population and FTs being empowered to make their own investment decisions (Exworthy and Frosini, 2008). The intended consequence of rewarding the best provider with transactional reforms informing demand has not impacted as conceived, with increased demand not attributable specifically to PbR (Farrar, Sussex et al., 2007). Demand side reforms of commissioning for local healthcare priorities were in tension with system management reforms of nationally mandated service developments such as NICE-approved services (Wilson, Sussex et al., 2007). There are a number of 'post devolution' natural experiments which broadly report that performance in the English NHS was broadly superior to the other nations (eg Connolly et al 2010). Farrar et al (2009) use a difference-in-difference analysis to compare the impact of PbR over time between countries, and within England between different types of NHS hospital and different types of services. They found that between 2003/04-2005/06, there was a significant difference in the change in in-hospital mortality suggesting that quality of care had improved more quickly in England. Propper et al (2010) exploited a natural policy experiment between two countries of the UK (England and Scotland) to examine the effect of targets on waiting lists. They review a number of post-devolution studies that suggest that waiting times targets did reduce waiting times in England. Their empirical study similarly

concluded that targets met their goals of reducing waiting times without diverting activity from other less well monitored aspects of health care and without decreasing patient health on exit from hospital.

Second, there is the problem that a reform (or combined reforms) might improve one outcome at the expense of adverse effects on others. The main issue here is the concern with equity. In a study on hip replacements, Cookson and Laudicella (2010) showed that patients from the most deprived areas (the lowest 10%) stayed 6% longer than those from the least deprived (the top 10%) in 2001/02, falling to 2% by 2007/08. Cookson, et al (2010) found no obvious change in socio-economic equity of use from 2001/02 to 2008/09 for elective procedures and some signs that equity might have improved slightly since inpatient admission rates rose slightly faster in low income areas than elsewhere. According to Cooper, McGuire et al (2009) between 1997 and 2007 waiting times for patients having elective hip replacement, knee replacement, and cataract repair in England went down and the variation in waiting times for those procedures across socioeconomic groups was reduced. By 2007 the relation between deprivation and waiting time was less pronounced, and, in some cases, patients from the most deprived fifth were waiting less time than patients from the most advantaged fifth. However, in a wider sense, the Marmot Review (Marmot, 2010) concluded that successful strategies to overcome the inequalities requires effective local delivery systems, focused on health equity in all local policies, as national policies alone are not sufficient. The health of people in England has demonstrably improved over the past ten years; life expectancy has increased and infant mortality has fallen as has adult mortality from many diseases (Audit Commission, 2010). However, despite considerable funding allocation to tackle health inequalities there have been little improvements, and possibly worsening in some cases (Audit Commission, 2010).

Whilst patients had a poor understanding of new reforms and the majority of doctors were happy with their current position and career opportunities that the reforms brought, both were not in favour of the NHS internal market and competitive mechanisms (Wallace and Taylor-Gooby, 2008; Audit Commission and Healthcare Commission, 2008). It was also felt that the pressure for quick results had led to some reform initiatives being introduced without adequate understanding or preparation (Wanless, Appleby et al., 2007). The continuous change in policy agenda had created cynicism and 'game playing'; networks delivering care pathways felt especially threatened that their organisations could change

overnight (Greener, 2008). The instability in policy environment, together with refusal to create a 'real' market and weak incentives to engage and break historical patterns are proposed as the reasons the NHS reforms have failed to bring about all the benefits attributed to markets (Brereton and Vasoodaven 2010). They suggest that (contrary to some other studies) market-based reforms have altered the culture of the NHS; the balance of power has shifted from hospital specialists to primary care, and from providers to purchasers. Furthermore, the introduction of competition has brought about a system-wide awareness of costs, efficiency and accountability. However, current volatility on commitment to competition policy (such as NHS organisations should be considered preferred providers; Burnham 2009) suggests central obstacles to implementing market reforms will remain.

3.8 Conclusion

Many evaluations have examined recent and previous versions of these health reform processes, however assessment of the impact of new reforms, especially on different service areas is at an early stage. Much of the previous research has also been conducted on individual strands of the reforms; examination of the interactions of whole system-wide reform processes within local health economies is limited.

Mays (2011) concludes that by the time New Labour left office, the English NHS was still some distance away from functioning as a fully fledged market for publicly financed care, though there was evidence of increasing levels of inter-hospital competition on grounds of quality. Entry and growth of new providers was limited and had been relatively slow, and the hospital market remained fairly concentrated. This was reinforced by GPs' tendency to continue to choose on behalf of their patients, and to choose local providers that they knew. Implementation of the market-related changes varied by specialty and by area, with a strong focus on elective care. As Brereton and Gubb (2010, p xii) concluded: 'We found isolated examples of the NHS market delivering the benefits that were anticipated; however, the market, by and large, has failed thus far to deliver such benefits on any meaningful or systemic scale'. They argue that there had been too many barriers to the operation of a market for NHS services under New Labour, rather than a fatal flaw in the concept. The distortions they highlighted were power imbalances between PCT commissioners and providers, particularly ordinary NHS trusts, the lack of a level playing field between NHS and

non-NHS providers to the detriment of the latter and perverse incentives under PbR to admit patients who would be better off out of hospital. Moreover, the market reforms appear to be likely to work better when applied to elective services, for example, surgery and diagnostics, and in locations where there is much more potential or actual competition between providers.

According to Thorlby and Maybin (2010), there is no doubt that the NHS is closer to being a high-performing health system in 2010 than it was in 1997. However, as Mays (2011) points out, the specific impact of the market-related changes appears modest compared with the very significant improvements in the NHS attributable to additional resources and so called 'targets and terror' (Bevan and Hood, 2006). However, he concludes that the market reforms did seem to have made an independent contribution to improvement. Moreover, New Labour's market appeared to contain stronger incentives for quality and efficiency than its 1990s predecessor with no obvious detriment to equity of access, and these effects seemed to be gathering pace since the more recent studies tend to find more positive results.

Chapter 4: Insights into the reforms from the perspective of policymakers

Introduction

The perspectives of those involved in policymaking can illuminate the drivers that led to the introduction of the policies and the thinking that informed the design of the policy. It also enables us to understand from their perspective what the objectives were and anticipated impacts (both desired and potentially undesirable). In this study we are particularly interested in their views of the interaction of policy levers, and the way they operate in specific contexts (both geographical contexts and specific tracer conditions). In this chapter we focus on the 'programme theory' of policy constructed from interviews with people who were all involved in policy making in the period from the NHS Plan (DH, 2000) onwards. They held different positions and were in post for different periods of time. In order to preserve their anonymity, we give few details about them, referring to them simply as **(P1)** – **(P8)**. In this brief analysis we examine their views on the evolution and implementation of the reforms, issues around context, mechanisms and outcomes of the reforms. Necessarily these views and reflections on the reforms are with the benefit of hindsight and views are likely to have been coloured by subsequent events.

4.1 Evolution of system reform

The first term of the Labour government from 1997 (as outlined in Chapter 3) saw a commitment to abolish the internal market introduced by the Conservative government. 'The New NHS' (DH 1997) promoted a 'third way' of collaboration in contrast to the competition of the internal market and the 'command and control' of Old Labour. However, while some elements of the internal market such as GPFH were abolished, the NHS continued to be managed through a mix of mechanisms, variously described as hierarchy, market and network (Exworthy et al., 2000). The drivers for change were generally centrally driven.

It was during this period that a more radical approach began to emerge under the leadership of Alan Milburn, who became Secretary of State for Health (succeeding Frank Dobson) in 1999. The process of developing the NHS Plan was an inclusive process involving stakeholders in policy making. One policymaker described it as a *'big tent process with stakeholder buy in… a diagnosis that included things like the pathologies of the system as it then existed* **(P4)**. The Plan accompanied a significant commitment to increase funding for the NHS and identified some of the challenges the NHS faced but the prescription on the whole represented continuity with the past.

There was however frustration with the lack of improved performance by the NHS during Labour's first term in office. The system was '*essentially static*' **(P2)**. Indeed Le Grand (2007: 103) claims that efficiency fell following the partial roll-back of the internal market from 1997.

> The 2001 general election was seen as a '*watershed moment…. There were attempts to say it was continuity here but actually I don't think anybody actually bought that*' **(P5)**. The new policy was to '*do the internal market with knobs on* **(P3)**

Some of the ideas were developed in the run up to the 2001 election and were reflected in the Labour manifesto including giving control to PCTs, bringing in ISTCs, and allow successful hospitals to take over failing hospitals. Those involved were clear that the manifesto and the details subsequently contained in 'Delivering the NHS Plan' were central to the new reform agenda.

> *I should say in 2001 the NHS Plan was the second most important document but for me the manifesto was the most important document* **(P2)**

> *There were some inklings of the development of choice and competition and bigger use of the private sector, particularly in the NHS Plan but really the ideas only were worked up in detail after the 2001 election* **(P5)**

Delivering the NHS Plan (DH, 2002), despite its title suggesting it was simply an implementation document, was in fact seen as a much more radical document embodying

the market reforms. It was seen to be '*really very divergent from the NHS Plan*' (P3) and '*a key policy document as far as I'm concerned*' **(P5)**.

> *What it wasn't was actually a detailed implementation plan. It was actually 2002 'Delivering the NHS Plan' which was the most important, more so than the NHS Plan in some ways in policy terms. In political terms the NHS Plan was the most important but in policy terms it was 'Delivering the NHS Plan' two years later* **(P4)**

The later appearance of the Next Steps reforms published in 2005 was an attempt to make sense of the various elements of the reform agenda and how they fitted together, in part to satisfy a new Ministerial team.

> There '*wasn't a good understanding of how things were meant to fit together' and a 'need for clarity and coherence for the new Secretary of State* (Patricia Hewitt) **(P7)**

> *With the new Secretary of State, the Department was struggling to create a narrative to explain what the health reforms were set out to do* **(P8).**

> There was a '*new Secretary of State and Minister of State … asking how does all this work and why and nobody was really able to explain it'* **(P3)**

According to the Audit and Healthcare Commissions (2008), *Next Steps* was a 'post-hoc rationalisation'. While one informant (P5) agreed with this, others presented a more nuanced picture and were able to link the logic back to ideas within the NHS Plan.

> *No I wouldn't call it a post-hoc rationalisation. I think it was more of a proactive document than that, placing a more sophisticated architecture around existing reforms. Individual reforms were set up to do specific things, and needed to link these things together, work out where the holes were and what needed to be done next* **(P8)**

> *The 'NHS Plan' is a vision with loads of different levers, you start using them and then you end up with an overall analysis of levers, and then you can talk about the*

outcomes …let's pull the levers, let's now construct a theory of levers so it's not completely ad hoc because it starts with the NHS Plan. **(P2)**

Another informant felt that the framework could usefully have been produced earlier.

Not enough thinking had been done about how it all fits together and therefore the right sequencing, pace of development and implementation. So it did feel a bit like a rescue act. [But] I think post hoc rationalisation is probably a bit unfair because the diagram didn't come from nowhere… but it would have been better if that simple framework had just been set out more clearly earlier **(P7)**

4.2 The contribution of specific reform mechanisms

As well as discussing the overall reforms, we talked to informants about their views of specific elements and how they were working in practice.

4.2.1 Demand Side

Choice

There was recognition among those we spoke to that the choice policy had developed over time from a means to tackle waiting times to something that was more powerful as a driver for competition.

Initially choice was constructed '*in a very limited, specific way*' [the London Choice Pilots] and then rolled out **(P2)**

Choice of venue of treatment was really a beta release of the concept. The demand side reforms never went far enough **(P8)**

One informant felt that the model had not been clear while others that implementation had been weak.

I don't think we've ever really got a very clear model of choice **(P3)**

I think choice is an incredibly powerful and useful thing and it's probably slightly oversold, over talked about, not talked about in a sufficiently nuanced way, not implemented perfectly **(P3)**

While one informant felt that it did not matter whether it was the patient or GP making the choice, another was clear that patient choice was about empowering consumers more.

For some choice was clearly a means to an end rather than an end in itself. We need markets more than choice per se, with independent providers, some form of payment by results, money to follow the choice, and people to make choices, but it does not necessarily have to be patient choice, it could be GPs making the choice **(P1)**

However, '*there are some pretty sticky relationships between GPs and consultants…. So you've actually got to try and get some consumer ability … independent of the GP referral decision'* **(P4)**

Some informants stressed that not all consumers had to choose in order for the policy to work.

We never needed much by the way of patient choice to create these kind of incentive effects, we didn't need every patient going through some massive rational cost benefit analysis. We needed the threat of choice **(P1)**

It is important that marginal patient could in theory 'defect'…. you didn't need that many patients to actually switch as long as it was a credible enough threat that would produce some kind of behavioural effect on the part of the hospitals and surgeons **(P4)**

There is some disagreement about the extent to which choice can operate effectively in rural areas. Such concerns were dismissed by informants who felt that these should not stand in the way of the policy.

> *There are concerns about rural areas, but only about 10% of Britain is rural, so actually there was always this great danger of letting the rural tail wagging the urban dog* ***(P1)***

There is a view that we live on a small island with densely populated areas and therefore choice and competition could become a reality for 80% of the population. The fact that you couldn't make it work in Cumbria or rural East Anglia or Cornwall was not an argument for failing to apply those principles for the majority of the population **(P5)**.

There was little mention of voice, apart from the need to empower patients when choice may be lacking: voice is important to the extent that patient choice was never going to be an effective mechanism for driving quality in emergency services for instance **(P8)**.

Commissioning

It was broadly agreed that commissioning had developed more slowly and was weaker than the supply side. There were some concerns over the capacity of PCTs as commissioners, partly due to reasons of structure, personnel and potential destabilisation.

There were some concerns about the capacity of PCTs, and of 'World class commissioning', '*what on earth that means*' **(P2)** and the view that '*we're still some distance away from WCC*' **(P5).** The least developed component was around PCTs' commissioning and practice based commissioning '… world class commissioning came very late in the day in relation to what should have been happening much earlier on' **(P5)**.

There appeared to be some frustration from policymakers that PCTs despite having been given devolved budgets and responsibility for commissioning were not able to challenge providers and indeed in some cases were unwilling to do so.

> *I showed my cheque book to PCT Chairs and CEOs: 'you've got this and so you run the healthcare system'. They replied that 'no we are not allowed to do that'* **(P2)**

Tariff provides the competent commissioner with a toolkit they wouldn't otherwise have. And obviously the critical word there is competent…. You are giving more of the decision keys to the commissioners rather than to the acute trust **(P4)**

[In 2002 a person] said if you do what you're talking about, … then it'll destabilise the hospital … now here we are 2009, they said oh we can't do this, we can't touch the hospital **(P2)**

In general there was a sense of disappointment and by 2003 a realisation that changes were needed. 2005 saw the introduction of practice based commissioning. PBC was seen as a form of continuation of GP Fundholding and as a method of demand management.

… By 2003 there was more realisation than there had been that the weak link still in the reform programme was what PCTs and what became practice based commissioners were contributing to the reform programme **(P5)**

I found a weak spot in the setup was commissioning. I felt that… I think we'd hoped, I think the people that introduced them hoped that Primary Care Trusts were going to have the best of health authorities and the best of GP fundholding, you know, they were in a sense GP-led health authorities. Actually I think they had the worst of both. They weren't big enough to really deal properly with the big trusts, the big hospital trusts, and they weren't small enough to play the market in the way the GP fundholders had, and they didn't really mobilise the GPs again in the way the GP fundholders had, they became another bureaucracy and so on and so on. So I was very keen to try and reintroduce GP fundholding, and indeed did, sort of, with PBC **(P1)**

PBC was unsuccessful because it was portrayed as a threat to PCTs rather than an integral part of their role.

PBC has not developed into what I had hoped, like the TPP of the 1990s or GPFH Practice Based Commissioning … I would still like to see it much more energised and powerful **(P1)**

4.2.2 Supply Side

The need for greater plurality of providers was seen an important component of the reforms. One reason was to increase capacity to reduce public and private waiting lists (P4) but also through foundation trusts to give successful NHS providers greater autonomy. Their birth followed from the need to provide an incentive for those with highest star ratings in 2001, with more stars bringing more freedom.

> *The freeing up of FT from the dead hand of the state was a perfectly rational thing to do. The supply side reforms needed more diversity within the NHS* **(P8)**

FTs were not supported by all at the centre and were very divisive politically. To make the model more politically acceptable a cooperative form of local ownership was developed.

> *I got very hooked on constructing an organisational form for public services which could not be bought by the private sector and which would not distribute shareholder profit* **(P2)**

Not everyone saw the model positively, with one informant concerned that it would lead to capture by local interests and prohibit change.

> *We needed autonomous public providers, but the worry I had about FT is that they would be accountable in too many different directions. … I was a bit dubious about some aspects of foundation trusts, and still am, the worry was in some senses that by giving them this semi-democratic legitimacy, that's kind of boards and so on, you might make it much more difficult to transform or close them down or whatever, that you'll fossilise them in some senses* **(P1)**

The introduction of independent sector treatment centres (ISTCs) through a first wave of centrally commissioned contracts was seen as a means of increasing capacity and challenging the NHS. However, the initial policy ambitions were scaled back before the policy had got off the ground.

There was a concern that in too many parts of the country local DGHs were if not monopolies certainly oligopolies and so two ways of trying to tackle that problem which didn't exist in the early 1990s when some of the similar mechanisms were used, the first of which was giving patients the ability to go elsewhere directly rather than relying on GP referral decisions and secondly bringing in new surgical capacity to sit alongside established **(P4)**

I would like to have seen more using the independent sector [Problems over the ISTC programme] You start off with saying we'll have 500,000 electives provided by the independent sector a year, then I go to the next meeting and suddenly it was 400,000, then it was 300,000. I remember at one point it got down to 70,000, and for no very obvious reasons (**P1)**

4.2.3 Transactional

PbR replaced block contracts with payment for activity. It was seen as a key driver of competition for creating incentives to reduce waiting lists.

Money following the patient as the vehicle for driving competition **(P3)**

Creating '*incentives to reduce hospital waiting lists.*' **(P5)**

Supporting '*the movement of patients between hospitals*.' **(P8)**

Putting '*a measure of competitive pressure on the Trusts … PbR for electives seems to be fine. I mean, I think it has rolled out pretty well*' **(P1)**

The decision to have fixed prices was in part recognition of weak commissioners and was expected to drive technical efficiency within the acute sector.

PbR involved '*moving away from global facility budgets which is de facto what we'd got in the form of block contracts to a tariff based system with strong volume*

incentives. There was also a recognition of the fact that if you didn't do that then you were reliant on the power of your local purchasers to extract good deals from hospitals and I think a number of us were quite sceptical about the likelihood that that would happen. So the purpose of the tariff system was to shift where the unit pricing power sat from hospitals to commissioners, so that the commissioners in theory only would now have to concern themselves with allocative efficiency not technical efficiency **(P4)**

From early on it was clear that tariff needed to be developed further beyond electives and to be refined so that the incentives were not only for more activity but also to ensure best practice care and care outside hospital.

I think it's absolutely clear that mixed tariff and non-tariff systems struggle because of cross subsidy. If you have part of your hospital output operating in a price fixed system and part in a price negotiated system then hospitals are very adept at just moving their fixed costs around and allocating costs in to the part of the system that is the price negotiating part of the system **(P4)**

However the original tariff was a beta release 0.1. Patricia Hewitt in a speech to the NHS Confederation in about June 2005 said that the tariff needed to be reformed. She talked about creating a tariff based on best practice and a tariff that incentivised care outside of hospitals and so even at that point we were clear the tariff was not fit for the long term purpose. (**P8**)

4.2.4 System Management & Regulation

Among those we spoke to there was little recognition that the system of targets and performance management continued to co-exist alongside the market reforms (though the experience of local health economies suggests this was the case) nor about the role of SHAs in wider system management. The main focus was on the creation of independent regulators to assure patients of quality and safety and to have greater transparency about the quality of care.

Patients should not be choosing between good and bad services, but should be safe and appropriate …. In the same ways that when you buy house you should be able to take it as a given that it is not going to fall on you **(P8)**

There was no regulator in healthcare- no HMI as in education- 'we need a regulator' … I said [to Sir Ian Kennedy] that I want scandals. I want you to find the bad stuff that is going on. People thought I was joking. It was like I was talking a foreign language. With the closed culture of NHS, it is important to bring in outside people…. **(P2)**

4.3 Outcomes of system reforms

Objectives

The objectives of the system reforms were not fully articulated until the *Next Steps* (DH, 2005a) and there was a sense that the means had sometimes been elevated above the ends **(P3)**. While ends were drawn from what would have been the department's key outcomes from time immemorial (**P7**), it was generally considered that the main target was the 18 week wait.

reducing waiting times was THE focus, that was the overriding policy objective **(P5)**

One informant was able to articulate the link between the specific reform mechanisms and the outcomes though this was seen to be problematic:

choice was the primary driver for a better patient experience, regulation as a primary driver for better quality; tariff as a primary driver for better value for money. So they operated an interlinked set but some of them were more important in certain aspects **(P8)**

Implementation

Among informants there was a view that the process of implementation had been slower than hoped for / anticipated. A number of reasons were identified including changes in personnel at the Department of Health (including among Ministers and key advisers), lack of commitment (locally and among civil servants), the complexity of the reforms and inaction.

> *Implementation has been a messier, slower process that it ought to have been* **(P4)**

> Implementation was originally anticipated '*up to a point'.; yes- pretty much as imagined. But the challenge is getting buy-in on the ground'*. **(P5)**

> *There was an implementation failure throughout the system. I think that great chunks of the DoH has never bought into the reforms and therefore never used them as levers to deliver stuff. As soon as you wanted something else to happen, you created a new set of targets and a new set of instructions. You didn't say, 'how do I use the reform levers in order to deliver the thing that I want'*. **(P8)**

> *I still think that the system architecture is correct. I just think that we're using Windows 3 when everybody else has moved onto Vista. The DoH never concentrated on making the reforms fit for the purpose they wanted. They were just something that were left behind because Ministers asked for them. The trick is making it more sophisticated and to simplify it at the same time. You don't want too many levers. It needs to be understandable and I think on the whole that the Department takes view that if only they had a bigger spreadsheet and a sharper pencil they could solve something* **(P8)**

> *There has been a tendency for some in the department to view the NHS as just one very large hospital* **(P4)**

> *Most of the problems with the reform architecture were entirely predictable and could have been resolved at the time. I failed to spot that we were not resolving them because we sat in meetings and everybody agreed that they needed to be done and then no-one did it*. **(P8)**

There was some confusion over whether recent announcements signalled a pulling back from the reforms and a feeling that this was likely to further slow down implementation.

> *There are mixed messages about Brown's view on the role of markets in public service reform, reducing ISTC but extending competition choice to primary care, so 'riding two horses at the same time'. Burnham's views on preferred providers represents a general drift towards being more lukewarm in the use of market based mechanisms*. **(P5)**

> *I am slightly saddened by an apparent pulling back a bit on the preferred provider, but encouraged by Conservatives proposals to give GP fundholding another go or to strengthen PBC and make it real* **(P1)**

> *I think that the current reform trajectory is stalled. But I do not see another game in town. I think a return to the NHS as an institution planned from Whitehall is bonkers* **(P7)**

4.3.1 Impact

The impact of the reforms was generally regarded as positive in that most indicators were going in the right and predicted directions, although it was acknowledged that attribution problems exist.

> *there are a number of output indicators that are going in precisely the direction that we wanted, productivity is up … equity is up … waiting times have fallen dramatically … our patient satisfaction is as high as it has ever been, never been higher … adverse incidents have fallen sharply. All of these things are what we would have predicted would result from introducing these kind of reforms. Now of course there's an attribution problem … However, we have not seen these similar changes in Wales and Scotland, who have had more resources per head than we have, so it can't be just resources. Targets and performance management obviously terribly important, particularly in the early years in bringing down waiting times and so on. On the other hand, I can't think of any reason why targets performance management would lead to increases in productivity, in fact I think if anything the reverse given how*

inefficient many of the strategies to deal with the targets were. And also the timing of many of these improvements, many of the improvements really began to kick in as the choice in competition agenda was rolled out … it does seem to me as though… if people want to deny the role of choice in competition, then they've got to provide evidence, the ball's in their court in some senses **(P1)**

Some informants recognised the difficulties of teasing out the impact of these reforms from other changes including increased investment and tighter performance management against targets.

My overall judgement is that the market based reforms have made some contribution but quite a limited contribution to the clear improvements in performance there have been in the last decade. The biggest contribution I would say, based on my reading of the evidence would be through the extra spending, through targets, through performance management, because they were put in place earlier and they continue to have a big impact. Because of the time delay in getting the market based reforms in place, you wouldn't expect them to have had the same degree of impact, nor have they done so in my view. So I think they made some contribution around improving access, reducing waiting times, the planned care objectives as they were designed to address. I think they've made life more difficult in delivering some of the other priorities, whether it's around prevention **(P5)**

Some predictable but unwanted outcomes were also identified, including the expenditure growth associated with the strength of providers and the incentives from PbR.

It is important to rebalance the commissioning side- powerful providers who were getting their income from fee for service and so had a very strong incentive to try and hoover up as much activity as possible. Unless you had a strong instrument for managing demand you got a classic recipe for, in a few years time, massive cost inflation. **(P1)**

Proper checks and balances were not as strong as they need to be. For example, PbR gives incentives on providers to get more activity through. **(P7)**

It was also recognised that PBR acted as a barrier to moving care outside the hospital

> *We recognised that the tariff was a blockage to moving money outside of hospital* **(P8)**

Clearly differences in quality persist despite the introduction of regulation and national standards and targets.

> *However, there are still variations in quality: most people assume that actually there is very little difference that exists in quality of care or resource use across the NHS. Most people who study it believe the opposite*. **(P4)**

4.4 Tracer conditions

Although there were limited direct references to our tracer conditions of orthopaedics, diabetes and early intervention mental health, some views were expressed about the validity of policies beyond elective conditions.

A number of informants stressed the importance of context, recognising that one size does not fit all and that a different set of mechanism may be required for different conditions.

> *But I think it was about seeing an interconnection and it was designed really around elective surgery I think; designed really for the hospital services surgery. … I don't think that we have fully completed the jigsaw of what the right blend of policy mechanism has been for different pathways. We have done quite well in three or four other services and pathways but that's still quite a 2D picture. … and need to think about how you get the right mix of mechanisms for different pathways in different places.***(P3)**

Orthopaedics was clearly a central focus of the reforms given that it was in this area that the issue of waiting lists was such a problem.

I remember loads of people said, oh you're never going to get these waiting times, it's just impossible and orthopaedics was always the example they gave, it's absolutely impossible to do this quicker and so there is something about orthopaedics which mean it was really important to achieve. So cracking that is important…. In a sense orthopaedics becomes symbolic **(P2)**

In general however, the view was that most areas could be opened up to choice and competition.

Competition makes more sense to people in the electives than it does for emergency admissions, although as about 97% of A&E admissions are walk in, people do make choices ***(P1)***

We always had a reservation about cancer. I was always deeply suspicious of the cancer networks, but there are a cartel basically dividing up the work, absolutely negating competition and I'm sure it's not a coincidence that cancer is one of the areas in which we have had most difficulty. It has been said that cancer networks are just 'jobs for the boys'. I think we would have done better, a least worst system, if we had a more competitive role in cancer. **(P1)**

One informant felt there were limits to the applicability of the reforms and that in some areas different incentives were needed.

in mental health and community services …. We should never get there [PbR] because it would be wrong to apply those kinds of incentives to all aspects of healthcare. **(P5)**

Another felt strongly that there was no evidence that the NHS pre-reform was any better at delivering good outcomes.

For all those who argue it's the tariff that's standing in the way of properly integrated diabetic care… presumably therefore you're telling me that you had a fully integrated primary and secondary diabetic care system in existence prior to the

arrival of these new incentives…. Mental health was not 'contaminated' with any of this stuff and yet have we seen fantastic longitudinal, inter-sectoral and primary/secondary care integration existing in mental health services? **(P4)**

In the context of chronic illness (and diabetes) the reforms to the GP contract were highlighted as an attempt to reform the incentives for better outcomes.

I think several things have happened on that front but I don't think that the impact has been nearly as substantial in that domain as it has been in elective care. One of the things that happened obviously has been the new incentive structures around chronic disease in general practice – QOF. I think with hindsight it's stating the obvious to say that the changes that were being incentivised through QOF were low balled so that the hurdles should have been set higher. Once it became clear that it wasn't set high enough it should have been ratcheted up faster than it was **(P4)**

4.5 Balance

This section examines the informants' views of the interaction between the levers. They recognised that there were tensions and that some areas of reform had been stronger and been given greater attention.

There are some risk of disincentives because of tensions and lack of balance. … Policies are at different stages. The diagram showed that they could not exist in isolation. … There is a real risk in uneven or very differently paced developments. My perception was that supply side reforms had been more advanced and were picked up more quickly that the demand side, which would have been reversed in an ideal world **(P7)**

The system was originally unbalanced when it was designed but it did not matter as the first generation of reforms were created in the context of long waiting lists. As it became successful it made itself out of date. [To use the interviewer's weights example] the ballast was right but as you were unloading the cargo you needed to change the ballast. **(P8)**

We have to ask whether it is the package of reforms that are fit for purpose rather than individual items. For example, Bill Moyes has spoken many times that the failures of FT may be the failures of commissioning rather than the failures of FT per se **(P5)**

'*Delivering the NHS Plan' – a fantastic document'*- (DH, 2002) *has a lot of the levers but has not got them in an organised way*. **(P2)**

On balance looking across the reforms the informants we spoke to felt that the supply side reforms had been pursued at the expense of the demand side reforms and that in terms of order, more attention should have been paid to commissioning in the early phases of reform.

Supply side reforms had been more advanced and were picked up more quickly than the demand side, which would have been reversed in an ideal world. **(P7)**

If I was doing these reforms, if I knew where they were going to end up I wouldn't have started by doing FT. So quite a lot of phase 2 reforms were designed to catch up on the commissioning side **(P8)**

One of the well rehearsed criticisms is that one should have sorted out commissioning before doing any of the supply side stuff. In the abstract one can see the attractions of that argument. In practice there are a series of political problematics… and the first was around waiting times **(P4)**

4.5.1 Next Steps to Next Stage

Our informants had little official engagement with the Darzi reforms, and stressed that their views were therefore as policy 'outsiders'. The Darzi reforms were broadly welcomed, with some being very positive. The key themes identified were quality, transparency and clinical engagement. It was broadly agreed that Darzi represents some degree of continuity.

Continuity, I think Darzi sets it out well as three stages **(P7)**

More broadly, there is some continuity between the phases. The strategy and philosophy of public sector reform under Gordon Brown has been much more in tune with what Ara Darzi was saying in the health reform debate than what Tony Blair was saying before about the use of markets. There is some continuity but also subtle shifts **(P5)**

I think Darzi added a piece that was missing from the reforms. It was a rational direction, and created more clarity about the role of systems and incentives and planning. But I think that the idea of phases is a post-hoc justification **(P8)**

The focus on clinical leadership was seen as addressing one of the problems of earlier reforms - lack of implementation.

I think Darzi was saying the key thing is how do you engage clinicians is partly the implementation challenge we have been describing…. He was a bit lighter on the market mechanism and clearer about personalisation as a broader theme which encompasses choice… Although it may have an important contributory role, the invisible hand is not by itself going to sort out pathway redesign, long term conditions management, hospital reconfiguration, leadership and so on. I think Darzi was a nice corrective to choice alone. **(P3)**

And the focus on quality and transparency was helpful in challenging some of the practices within the NHS.

I think transparency is a new means. I don't know if it is means or an end, His very tight linking of value for money and quality I think has been one of his lasting legacies. I think that the NHS was designed to create poor quality care in the sense that the degree of secrecy in which things take place are designed not to be a deliberate way. **(P8)**

The Next Stage Review was seen as helpful in reemphasising the objectives which the NHS should be meeting rather than on the how, which was the general emphasis of the system reforms.

> *Probably 'clearer ends'. We focus people on what really matters, which is the experience of care and clinical quality. Darzi is a great move because it raises people's eyes again. From time to time the service can become a bit narrow and think 'Oh, 10 targets I've got to meet'. Darzi was important both practically and symbolically in re-stating, 'Well, don't forget what this is all about'. Not sure I have spotted anything hugely new in terms of means*. **(P7)**

However, one informant heeded the warning that new policies might detract from implementation of existing ones.

> *The danger is that what often happens in the NHS is that you merrily skip on from one big idea to the next bigger idea without going through the intervening stage of making anything change* **(P4)**

4.6 Conclusion

The interviews with key national informants underline the reality that the system reforms evolved and were developed over a period of time in response to a number of different drivers. In particular they were precipitated by a frustration that despite increased investment (with the NHS Plan) there was little evidence of impact particularly on the most public aspect of performance in the early period of reforms - waiting times. The Next Steps document provided the opportunity to articulate more clearly how the various system reform levers, set out previously, fitted together, particularly as the original architects of the reforms moved on.

This has a number of consequences. Firstly, the layering of policies means that the reforms were additive, combined with pre-existing policies of targets and performance management, and later supplemented with the ideas from the Next Stage Review. Secondly, it is not clear how strong the dose of reform was that the NHS received, given the staged approach to

design and implementation. Thirdly, because the reforms were designed to address problems in elective surgery they were not sufficiently adapted as the system priorities changed or they were rolled out to other areas. Finally, the lack of understanding within the Department of Health and locally of the policies and what they were trying to achieve, meant that they were not adapted or used as the architects of reform intended. The emphasis in this period was on means not ends. There was a feeling that Darzi had rectified this and had more clearly articulated for the NHS the objectives of the reforms. While regulation had led to greater transparency about quality, Darzi had taken this issue further.

Overall, informants felt there was an imbalance between supply and demand. Commissioning has been the weaker driver in the system compared to the power of providers, strengthened by the creation of foundation trusts. Views on choice were more divided with a sense from some that it could have been more powerful, while for others the threat of exit was sufficient. PbR was seen to be a powerful lever which had driven up activity and technical efficiency but the lack of counter balance on demand from PCTs and practice based commissioning meant that it had also led to expenditure growth and inhibited the move to shift care out of hospital.

Chapter five: system perspectives on the impact of 'Next Steps Reforms'

Introduction

The following chapter presents a summary of findings about the combined impact of health reform across six health care systems in England. Based on the results of comparative case studies, the chapter presents the findings under the reform streams as presented in the Next Steps Reform diagram. It discusses how systems perceived the programme theory of reform as mutually supporting set of levers and incentives, before outlining the reflections of interviewees about the combined impact of reform, its impact and future prospects.

5.1 Demand Side

5.1.1 Choice

In broad terms, our system perspective respondents believed choice had a limited impact. Many respondents, particularly clinicians, considered that patients tended to trust professional views, and doubted that they wished to be active choosers.

> *I think choice is something that is probably more in the minds of Ministers and politicians than it is in the minds of patients … As a GP the vast majority of my patients actually don't give two hoots about choice in terms of where they want to be treated. They want my assurance frankly that where they are going to be treated is safe and is going to give them a quality service and if I tell them it is then they are not prepared to question my judgement* **(Site E GP 1)**

Some pointed out that 'choice' was limited largely to choice of location and time rather than more far-reaching dimensions. In order to create choice, commissioners and GPs were

implementing redesign programmes and services based more on 'personalisation', self management and co-production.

> *one of the things that didn't help I think was that choice started with choice of acute hospital and choice in elective care. To me that's not real choice, it's a bit of a transactional choice and I have a much broader understanding and I think it's about shared decision making and people having the opportunity to actually make decisions about their own care* **(Site B PCT Commissioner 2)**

> *we've got some work to do with our population in terms of promoting choice. And I think that's really good when you're looking at Secondary Care and, you know, if you need your hip done, you should know there's a choice and you should make that choice. But in terms of actually making people, like, you know, look after themselves, I mean, the bigger challenge for me is about self management, self care … so there is something about people feeling confident to manage themselves and their family's health and taking responsibility for their health.* (**Site B PCT Commissioner 3)**

Others saw concerns such as the practical problems of 'Choose and Book', ineffective IT systems, a lack of necessary information to affect choice, and the possibility of increasing inequality, favouring those more articulate than others.

> *I still don't think choice has had a major impact upon the NHS to date. I think its impact has been more illusionary than real in that choice actually only provides more choice to the middle classes because it's only the people who understand what's happening who actually make use of the choice.* **(Site B FT Director 2)**

> *the IT, in the sense it is not user friendly, it is hugely - if you have an IT system that's bureaucratic we have got it - so it is very clunky. I think it assumes - it doesn't give people choice about whether they want help, whether they want to access it in that way or not. So it is not very patient friendly in that sense and I think it constrains some of the personalised approach that you could have in place previously.* **(Site E FT Director 1)**

you're going to have some people that are more articulate than others. That are more able to use the system as we want them to some extent, but that gives an inequality to those people in the deprived areas. **(Site C Local Authority 1)**

There were concerns that 'choice' was limited in the rural areas. Even in the urban areas that (in theory) offered choice, the consensus view was that patients were not exercising 'choice' and were staying local. Lack of surplus capacity and embedded referral patterns to the main FT providers with good reputations meant that patients rarely wanted to go elsewhere.

[in rural areas] you've got one choice and you know, ninety nine times out of a hundred, patients will choose that. I think that's [choice] something that has not probably worked quite as the government expected to work, and it doesn't drive patient, patients don't really take it on board I don't think to the extent the government thought they might. **(Site E GP 2)**

If you know the options to choose then you can make a sensible choice and if you don't, you can't… There isn't a choice within the area. But that's because it's a city and it's compact. **(Site B FT Director 2)**

The whole element of choice is based on a capacity which we don't necessarily have **(Site A PCT 2)**

However, providers were aware of the potential threat of switching, and this encouraged them to make changes such as moving care into community clinics.

I think choice is a driver for an individual Trust in the sense that we've got to lever up standards if patients are going to want to choose us and GPs are going to want to choose us. **(Site B FT Director 3)**

5.1.2 Voice

System perspectives were unanimous in supporting the idea of patient voice. PCTs were actively pursuing a number of public engagement strategies around stated local priorities,

arrangements for GP extended hours service, developing Diabetes services. Providers felt that PPI forums and Governor Membership for Foundation Trusts were in progress.

> *I think one of the areas that we've moved into more recently is looking at how we do use our membership and our governors far more to get more local input into what we're doing … we're beginning to see the real potential behind our membership. So that's been a big change…. our membership … makes us one of the biggest players in the local democracy actually. But we're not actually being allowed to respond to what our members want. Either cut us free or don't, but tell us which one you're going to do* **(Site B FT Director 2)**

Concerns were raised that members of the public faced public conclusion overload. They were at risk of getting very confused about engagement and involvement activities when faced with multiple membership initiatives and activities. Moreover, some regarded current feedback surveys referred to as 'a waste of time' in that they failed to ask the right questions. Like 'choice', 'voice'

> *…Tended to be 'the white middle class, not necessarily the voices the NHS needed to hear'* **(Site B GP 1)**

> *The patient surveys frankly are a waste of time. I think they are normally badly constructed and they deliver an answer which isn't the right answer… I've not come across a model where it works very well to be honest. We've tried it in lots of areas, you know having people sitting on committees, on commissioning committees, on consortium meetings but … and the people who tend to turn up have their own bees in their bonnet … I sometimes think that patient involvement is just trying to tick a box really* **(Site E GP 1)**

While some regarded the PPI Forums as positive, others saw problems.

> *I think... the organised voice element, PPI forums not worked really in all honesty… I mean that's not really up and going yet. Membership I think is useful for Foundation Trusts but I'm not sure we've made a huge amount of progress in that direction* **(Site B FT Director 2)**

They did away with all the local PPI's… where you had a lot of local engagement. Now they created a patch wide PPI which is obviously centred as everything else is down in... And so it doesn't feel that we've got the level of engagement that we would have, we used to have **(Site E Trust Director 2)**

5.1.3 Commissioning

PCTs were developing a number of demand side interventions that were creating primary care alternatives to hospital provision. These included strategies for GP referral management and pathway redesign for long term conditions. In site B pathway redesign the PCT was actively working on 22 pathway redesign programmes driven by care closer to home agenda around prevention and partnership working. However, it was generally felt that commissioning struggled to make an impact. There were legitimacy problems in that the public tended to regard large, visible acute providers as the local leaders of the NHS rather than PCTs.

PCTs are being seen as the local leaders of the health community … We're a very visible organisation, both locally and regionally… we are a Foundation Trust with a membership and we want to be visible to that membership. It's not to say we think we should be the local leaders but I think it's hard for PCTs to focus peoples' minds on what they do as opposed to what hospitals do **(Site B FT Director 2)**

that's sometimes where the tension comes in, because although in world class commissioning PCTs are supposed to be the local leaders of the NHS, probably in reality, most of the public would view the huge monolithic structure at [FT] as the local leader of the NHS **(Site B PCT Commissioner 4)**

There was a feeling that commissioning was a late developer, relatively weak, and unable to shift the balance of power from the acute sector. In site C, despite achieving an excellent outcome with 'green' on all the three rated areas of WCC strategy, finance and board performance, the impact of commissioning was limited due to the immaturity of the organisation, turnover of staff and an over reliance on tendering with its expensive overheads. Commissioners struggled as FT provider did not accept the PCT's right to

commission and redesign services. Redesign was problematic with 'big beast' FTs sitting in the middle of localities.

> *Very often commissioning has been the afterthought, commissioning has been the cart following the horse really. So now commissioners are playing catch up and you have got very well established Foundation Trusts. We have got a very well established Foundation Trust on our doorstep which has got a very large surplus, facing a PCT which has got financial problems - who is going to win that one?* **(Site E GP 2)**

Some providers had concerns about PCT capacity.

> *I think tendering is potentially a powerful tool but you need quite a lot of expertise on the part of the commissioner in order to be able to do that effectively and I think so for we haven't been – that aspect of commissioning or that sense of, you know, defining what we want and how we're going to deliver it and compare that with what's being delivered has been fairly weak* **(Site B FT Director 3)**

> *I think there is a lot of work to be done around pathways of care that will change demand side management - or how the demand side works, but we have not yet got there … commissioning is… in its infancy and for many hasn't moved much beyond contracting … because they actually aren't stepping back and saying 'as a commissioner this is what we want to commission* **(Site E FT Director 1)**

Indeed, one PCT considered that the FT did not accept their 'right to commission'.

> *I don't think that, it's not a strong enough tool yet to allow the commissioner to get a grip on it all, to be honest. I mean, I don't think [the FT] really still, really accept that we have a right to commission them. You know, they don't accept that we have a right to decide what services we'd like to review and redesign, they don't accept that. … I think we're still seen as, you know, just a load of Primary Care people who don't really know what they're on about* **(Site B PCT Commissioner 3)**

Commissioner perspectives were unanimous in the view that moving care closer to home and working with primary care pathways were particularly important. However, others questioned the evidence base for such changes.

> *I still don't believe that the evidence is there to support the policy around shifting from secondary to primary and nobody has ever shown me the evidence in this country of where it is proved more effective, where it's proved cheaper, where it's increased patient satisfaction. I do think that that policy is lacking any credible foundation to it* **(Site B FT Director 3)**

> *the reform of care closer to home was never really made explicit, was it, but it seems to be the theme that's driving a lot of changes and, sort of, especially when you're living in a city as compact as this, when you're moving a service out of a hospital to move it a mile and a half down the road, is it really nearer your home. So that's been a strange one, but the amount of money that's been expended on moving things closer to home has been absolutely frightening really and you do wonder what their, sort of, evidential basis for doing it is* **(Site B Local Government 2)**

Some sites struggled with 'distractions' such as PCT organisational change, which stalled system reform. The knock on effect of organisational merger created problems with inherited financial deficit, dismantling local relationships and strained relationships with the SHA.

> *Merging the x PCTs in E was a disaster, frankly. I think we have spent 2 years going backwards and since then we have just stood still or even going backwards even further* **(Site E GP 2)**

There were hopes that the further development of WCC and stronger commissioning tools would level the playing field.

> *I think world class commissioning is something that I think is really good… I think it gives us a lot of the tools and the information to really sharpen up our commissioning act, so I think that's, so long as we can capitalise on it and carry on working through the score card and working up through the competencies then I think that was a really positive driver to change* **(Site B PCT commissioner 4)**

I think most Trusts would regard the key targets within World Class Commissioning of significantly tightening up the service specifications and focusing on improved outcomes as absolutely laudable - I think Trusts have said for some considerable time that the quality of commissioning in the NHS needs to improve. I think we also have to recognise that when it does, that presents a threat to Trusts **(Site C Trust Provider 1)**

at the moment, you know, a lot of Acute Trusts are a much bigger and stronger partner than the PCT and they're able to get their own way and I would like some firmer tools around the contract, which means that we can make them do some of the things … And quality, you know, the CQUIN thing, that needs to be much stronger… for the GPs, about 40% of their income comes from QOF you know, from quality, so the same should be true of Foundation Trusts, I think **(Site B PCT Commissioner 3)**

5.1.4 Practice Based Commissioning

Most respondents saw PBC as having a great potential impact, in terms of clinical involvement and rebalancing power.

PBC for me as a provider is fantastic. Because it allows me to have a group of GPs who form one group working together who you can work with to drive change. … , it's the thing that is leading us into integrated care, because it's given us natural groupings of GPs to come together with to improve their delivery of care **(Site G Community provider)**

we try and see them as co-commissioners, so what we'd want to develop is a culture where, which we are doing, where you know the ideas are being generated from the practise based commissioners **(Site B PCT Commissioner 4)**

PBC, all of that seems to me designed explicitly to shift the balance of power if you like and I can see why conceptually the Government may feel it needs to rebalance that equation **(Site E FT Director 1)**

The impact of PBC varied to some extent across sites. Sites with a history of clinical relationships, active PCT clinical engagement strategies and previously strong GPFH arrangements had greater PBC activity. In these areas, PBC had developed some new approaches to improving care quality. For example, in one site, PBC provided a lever to develop services and increase funding for developing musculoskeletal services and diabetes services. In other sites, the policy of PBC was welcomed as a response to the inherent imbalance introduced by PbR where 'PCTs were being bankrupted by these more entrepreneurial hospitals'. PBC was also seen as a potentially positive means to ensure service design is clinically-led and bridging the divide between primary and secondary care.

Despite this, there was a feeling PBC had not produced a 'huge sea change' on GP activity with limited impact on patients and services. The core reason for this was that PBC lacked strong financial incentive for GPs to take part.

> *There's no clear incentives for support for the amount of work they need to do, you know, they would need to carry out. It's like fund holding they were clear incentives there for GPs if they made savings so over here they're not incentives* (**Site E GP 1)**

> *It will eventually be absorbed in to PCTs budget and then PCTs will do it's own commissioning. And this is where the GP say well at the end of the day no matter what I do, the PCT is going to take control of it and manipulate the system so that they actually keep control of the money* **(Site B GP 3)**

It was also felt that PCT reorganisation had stalled PBC, with the former system of smaller PCTs being more conducive.

> *For me, the trouble is everything was so badly distorted by 'Commissioning a patient led NHS' and the formation of X PCT. I have no doubt that we would have been a lot further down the road of actually developing practice based commissioning, real practice based commissioning and bringing the service out of Secondary Care and into the community, if the existing PCTs had still be in existence*
> *… I think the current PCT has sort of lost clinical engagement. … Previously there was a loss of good work done between the old PCTs and general practice, you felt almost part of their PCT* **(Site E GP 1)**

GPs believed their role as commissioner was ill thought out, an ambiguity of relationships that led them to express disappointment with progress. For example, in site A PBC was still considered to be very immature, producing only modest achievements. It was suggested that two years' worth of momentum with PBC were lost because of the PCT's financial situation. A level of frustration was also expressed that PBC development money kept being siphoned off to take into account increased activity in the acute sector. The problem was that drivers were in the direction in the acute sector rather than PCT commissioner or GPs. There was limited attention given to PBC. For example in B, GPs complained that PBC locality managers were distracted by day to day PCT activity.

> *In theory it's a good idea, in practice PCTs had so many other requirements. So there are other agendas which keep on arriving which have to be done by somebody and they are often the locality directors have to pick them up. So the locality director might be officially for Practice Based Commissioning but she will also be asked to be a lead on anticoagulation, redesign or on mental health or alcohol or you know diabetes for example, or whatever. They have many other hats as well. So, which illustrates the obvious point which is there is not a clear divide between practice based commissioning and PCT commissioning, it's not possible to separate them* **(Site B GP 1)**

On the other hand, commissioners felt that PBC consortium had not taken ownership of the commissioning agenda but had 'cherry-picked' areas to work on. PBC groups were reluctant in taking full ownership of the commissioning agenda. In this site, There was a strong PBC consortium, but it was felt that PBC groups wanted the money but shirked the responsibilities and accountabilities associated with commissioning.

> *Sometimes the Practice Based Commissioning clusters say, 'well, we're not involved enough, but, well, we're not sure what terms we want to be involved on' and I think people haven't quite got to the point where they realise if they have more money and more resource then that becomes more corporate responsibility… if you want all this resource, then you're responsible for how are you going to deliver that responsibility* **(Site B Director of Provider Services)**

In relation to other policies, PBC was in tension with PbR as one depended on getting people into hospital whilst the other depended on keeping people out of hospital providing alternative treatment areas. Without the financial incentive, it did little in the sense of transferring care out of hospitals into the community or 'commissioning' services *per se.*

> *PbR relies on the tariff, Practice based Commissioning will only save money if practices are enabled to commission services perhaps in different settings that cost less than services in hospitals* **(Site C GP 1)**

> *I would argue that you would have to tie in the activity at the Acute Trust level with the activity at the General Practice level and if you haven't got the financial incentives right at General Practice, to stop the referrals going in, but you have got the incentive to get the referrals in at the Acute end, well what do you expect is going to happen? …. All the drivers are in one direction* **(Site E GP 1).**

> *what appealed to the doctors about fundholding is there was absolute clarity about the flows of the funding. … you referred one patient you paid for one patient. … You didn't refer one patient you could keep the money. … PBC I'm not sure has won their hearts and minds and I'm really still not quite sure what's in it for them to really throw their hearts and souls into getting PBC right, because it all seems to me quite remote. … They've had two years of practice based commissioning so far and I don't think it's made a huge amount of difference* **(Site G Trust Director 1)**

Tensions with WCC were also expressed.

> *I still don't understand how practise based commissioning and world class commissioning gel together. They seem to be to going in two completely separate directions… Is it the practise based commissioners have the power, or is it the world class commissioner with the PCT? I'm not sure and that makes it very difficult for us* **(Site B FT Director)**

The impression was of a policy treading water. There was a need for the centre to decide what was going to happen. PBC needed to be strengthened, replaced or reinvigorated.

I know people feel like practice based commissioning hasn't really delivered. Maybe that's because people weren't clear at the start what it needed to deliver **(Site B PCT Locality Manager)**

5.2 Supply Side

5.2.1 Diverse providers

Diverse providers from outside the NHS did not have a significant impact. At one extreme, there was limited private capacity.

To be honest the involvement of the independent sector, it's a little bit of grit around the edges … as a proportion of activity it's just not there … it is significant but its small fry it's not going to change the face of the NHS acute unit. It's not actually been threatened in terms of viability £x million on private providers is spread across x private providers, not one of them could ever actually threaten any of the acute units, it's just not there **(Site E PCT Commissioner 1)**

When we talk to independent sector providers in terms of what's going on, their dialogue - there are a number that protect us - one is our population base is slightly too small for them to really get a good foothold … The second thing is the reputation is strong and therefore it makes market entry more difficult and so I think in that sense we are in a fairly benign market environment compared to others **(Site E FT Director 1)**

Conversely, a PCT did not wish to destabilise the local health economy and did not want to put services out to tender. It stressed the need to preserve a viable local hospital in order to ensure a local A&E as other emergency services were too far away.

We've not really utilised the private sector as much as other economies and I guess partly that's because we are where we are and actually we're very well provided for in terms of acute care

…It goes back to the debate about the policy. There is a conflicting – there is a balance to be achieved between supporting competition and choice and actually managing your local health economy… it is our job as system managers to manage all of that. So I don't think we've used the independent sector very much
… I mean our approach in this PCT I think is very much, you know collaboration across pathways and I think that is more challenging with the independent sector. I mean that's not to say that I don't think we should do it but I think it is difficult **(Site B PCT Commissioner 2)**

What we did have was a situation where we had long, long waits for MRI and so we brought in an additional provider because we had these long waits for MRI. And suddenly our providers were able to do it… it is an incredibly difficult one … because we have a real tension as commissioners, which is, you know, I am reliant on my main provider for a significant number of services. I have to be very cognisant that I do not undermine their ability to deliver the high end services by taking away some of the kind of lower end services. And so there's a real market management skill that we require in PCTs to enable us to do that. So I think that, that's one that we've still, we're still really working hard to deliver. I would say it's the one that if you look at all the world class commissioning assurance processes, it's the one that the vast majority of PCTs would self access themselves down on **(Site B PCT Commissioner 1)**

5.2.2 ISTCs

Despite limited diversity, providers believed that it was the threat of bringing in additional providers that forced providers to up their game. There was a belief among commissioners and providers that sites with ISTCs had been catalysts contributing to making the acute trusts more efficient. Although the ISTC did not significantly change referral patterns as patients still liked their local hospital. Sites E and G were positive about the ISTC.

Personally I think the patients that I've had that have gone through it have been treated really well. They have been able to give us much better clinical outcome measures and measures of MRSA and all the infection control stuff to a much better level than the Acute Trusts have… the data that we're getting from this unit is

actually much better than the quality date that we're getting from your Acute Trust that you've been using, so we know that they're safe units, so I don't have any question over the safety of the patients that go through the ISTC **(Site E GP 2)**

It has been a very positive experience down here and it really has … on the whole, because we've had such good outcomes, because the quality is high, because the patients have been happy, I believe the GP's in the areas are happy with the service **(Site E ISTC provider 1)**

There were claims from both sides that competition was not on a level playing field. NHS providers pointed to 'cherry picking', reduced standards to save money, private providers did not have to provide initial and basic training, and system damage to integration, There were criticisms of the initial contracts that did not align workload with finance. In other words, there was no payment by results/activity for ISTC.

I understand why the Department of Health wanted to set them up in the first place as a lever for change to shake the system up, I think what has happened though is that the initial waves that were set up have not worked in terms of the capacity that they have put in to the system, so we've got over capacity because they were over specified in the first instance. Because as the Acute Trusts have got more efficient, and I accept that's in response to the competition that's gone out from there, our patients like going to the local hospital because they feel safe with that, it's a familiar setting they know its been there for donkeys years, so when the new kid on the block arrives, they've got to do something really special to move a very conservative population to use the service. And when they've given us too much capacity that's been commissioned in the first place, we have a problem filling that capacity but we also have to pay for it at a hundred percent so even if we use fifty percent of it, we've still got a hundred percent of the cost … it's got another year or so to run and if we're given any choice we won't be commissioning nearly as much activity from it as we had to in the first place **(Site E GP 2)**

The ISTC has continuously failed to hit our minimum take. Nationally negotiated contract -which we have to pay for irrespective of whether we have the activity **(Site C PCT Commissioner 1)**

I think it's fair to say this PCT's lost a lot of money that it could have pumped in to care. That, because we haven't been able to reach our minimum take, despite all our efforts. Basically patients don't want to travel up to x **(Site C GP 2)**

I think the contracts as they were set up didn't really lever out sufficient improvements in productivity to give the NHS exceptionally good value for money. And I think as and when these contracts come up for renewal, then that's certainly what I think our commissioners should be looking for **(Site G Trust Director 2)**

On the other hand, ISTCs felt they had to jump through more hoops than NHS organisations in terms of monitoring and performance management. For the ISTC, the additionality clause also meant that they could not recruit NHS staff if they have been employed by the NHS within the last six months.

5.2.3 FT Status

Systems were divided as to the impact of FT status. For some, there was uncertainty as to what the main benefits FT status had achieved other than kudos. For C, FT status had not made much difference in terms of supply side reform.

I think the FT I'm not sure what the major benefits been. We are a FT; we were one of the first waves I think if my memory serves me correctly. I'm not sure that it's brought a great difference it's there for kudos really; it feels quite nice to work for a foundation trust **(Site C FT Nurse Director)**

In contrast other sites believed it had brought significant changes to the landscape. FT status had led to a greater sense of being in control of its own destiny and has increased staff pride. It also increased financial autonomy, and good governance.

What FT's and organisations have to understand is for the first time ever you are working in a much more autonomous fashion, you are accountable to your membership through your governors, you are regulated by Monitor and you are accountable to Parliament directly in that sense. But for the first time in my NHS

career my Board is accountable. Its role isn't to deliver what somebody else has told them to deliver, they are actually accountable for everything that we do **(Site E FT Director 1)**

I think Foundation Trusts have improved governance in the health service in those organisations and I think that's spreading and I think what I sense is that the latest performance framework document tries to do is to say well let's take some of the lessons from Foundation Trusts and spread them more widely and get people to behave in a more similar fashion **(Site B FT Director 2)**

I do think the foundation trust has been a very strong driver towards a more corporate view **(Site A Commissioner 1)**

Internally, FT status has encouraged better management process, however, some felt frustrated in that the freedoms had not come through that they were expecting.

You can argue it's changed nothing or changed everything, given that the freedoms haven't come through that we were expecting, however we're just beginning to mature in the way that we are using the freedoms we've got **(Site B FT Director 3)**

The balance between autonomy and accountability also created problems between boardroom and membership demand on the one hand and national regulator 'must dos' on the other.

The financial planning over longer horizons and the ability to retain surpluses I think is helpful, although of course Monitor, the calculation of risk ratings is very much focused on short term performance so there is a counter-balance to that argument. I think a sense in which so long as you do your job and things go OK and you are demonstrating to Monitor the board is on top of understanding the risks the organisation faces and dealing with performance issues, you will be left alone, there is a greater sense of that than I think if you were not a Foundation Trust **(Site B FT Director 2)**

Externally, FT status had led to difficult relations, particularly with PCTs, which felt that FT autonomy was associated with the lack of reporting mechanisms.

> *I think we've probably seen more perverse incentives with it than not, because of the reporting mechanisms that the FT are able to do. They don't have to feed us some very basic performance information that we are desperate to get… they don't need to report all their financial information to us whereas ordinary Acute Trusts do, so, I think, we missed a bit of a trick in setting them up in a way that they were allowed to be that one step removed from the local health economy. So that's not been good news for us* **(Site E GP 2)**

FT status was not coherent in the context of the NHS reforms overall, with FT in tension with demand side reform as it gave more power to the acute sector. PCT deficit was seen as being associated with FT surplus.

> *I think the balance is in favour of the FT* ***(Site E GP 2)***

> *I think one of the real barriers is the foundation trust* **(Site B Local Government 1)**

> *I think the FT movement… has perhaps had an impact on what previously you know you used to sort of think of it as like the NHS family* **(Site B PCT Director 4)**

> *The Acute Trusts are actually posting significant profits I think to the tune of £20 million and the PCT is £20 million in the red. And you don't have to be a rocket scientist to work out why that's happened* **(Site E GP 1)**

> *it's also ossifying the provider market, it's creating potential monopolies … you would have to think about whether foundation, not so much foundation trust status, but the pressure towards having lots of FTs doesn't help that* **(Site A PCT 1)**

5.2.4 Workforce

Workforce reform did not feature as having an impact on the local system. The few mentions of workforce included that European Working Time Directive and the new consultant contract.

> *I mean a big, big driver for change at the moment as well is the European Working Time Directive. We just can't rely on junior doctors in the way we have in the past.* **(Site E FT Director 2)**

> *again, we've been caught out… we needed more of everything, more of the juniors need to be supernumerary, so you've lost the whole input without enough consultant to middle grade… And what we're finding now is it's just not enough… they've got so many gaps in their junior roster* **(Site F FT Director 1)**

There was universal recognition that the DH had massively underestimated the costs of Agenda for Change (AfC) and new consultant and GP contracts and that NHS growth money has largely gone on salary increases. Though AfC was intended to standardise and simplify salary rates which interviewees recognised as positive in terms of efficiency and fairness, it was not being consistently applied across organisations. The FT noted that while AfC had modernisation potential, the opportunity had not been grabbed at the time, though the FT was now subsequently looking to develop new roles.

> *HR reforms, Agenda for Change, etc., we manage to cut ourselves off from a whole talent pool really, it's, sort of, if you haven't been in the NHS for a number of years, it's very hard to recruit into the NHS, because it's a different system, the rewards are different and even our application forms make you run a mile, so in that respect it's not particularly useful. And on that front, Agenda for Change was just quite an unhelpful system for inflating pay, for clinical grades and making other things, you've ended up with a whole range of people whose job descriptions bear no relation to what they actually do, they're purely there to justify a particular pay grade which is basically unhelpful when trying to hold people to account for the performance* **(Site A PCT 2)**

> *Certainly Agenda for Change, we didn't grab the modernisation potential that Agenda for Change brought with it…although we have developed a clinical support*

worker, midwifery support worker to support the state registered professional…. it does not seem to be developing, you know, at a pace **(Site F FT Director 2)**

we have to keep an eye on the agenda for change but we also have to bear in mind that we haven't got a pension scheme that can match the NHS, and we have to look at what other benefits we can put in for our workforce… moneywise the salary is not out of kilter in a massive way. People seem to think that if it's the ISTC or the private sector that the nurses and other medical staff get paid huge amounts of money. They don't. It's just that we take into consideration that there isn't a pension and that if the staff want to pay into a pension scheme then we've got to reflect that in their salary **(Site F ISTC Manager)**

A number of interviewees thought the GP contract had been too generous in the first instance. The point was made that as GPs are now in 'the attic of contentment' there are probably few levers to use in the future to encourage them to participate in change programmes.

I think QOF has enabled us to do something a bit different with them but the sooner we get on to a different contractual arrangement with GP's the better ***(Site F PCT Director 1)***

I think the GP contract has, is increasingly becoming a barrier because I think people are less inclined to engage, because they're looking at the fact they haven't had a pay rise regardless of whether you think they've had too much in the past, or not, that is starting to hamper what we're doing **(Site PCT Director 4)**

The new consultant contract was not seen as having changed anything fundamentally. It was also noted that private practice had virtually disappeared as a result of meeting 18 week targets. It was also noted that the number of consultants had increased in order to address the requirements of the Working Time Directive.

5.3 Transactional

5.3.1 Payment by Results

PbR had polarised the systems and adversely affected the relationship between the acute sector and PCTs. For providers, PbR had been the main catalyst for change. It provided an incentive to increase activity, and encouraged them to be entrepreneurial by improving quality to attract more patients and being proactive to expand services. FTs believed the transactional reforms had worked well. The move to tariff provided a tool for transparency. From the acute perspective, PbR has made the FT look at its strategy to ensure it is delivering the right range of services. It was noted that good FTs will scrutinise their contracts with PCTs and will manage their business accordingly.

> *It's the level playing fields, it's opened up all the entrepreneurial spirit of our doctors and our managers… Now what we're saying to people is be entrepreneurial, improve the quality so that we attract more patients, provide a service that patients want and see where we can expand our services further so that we can actually get into the areas where in the past there was no incentive. And PbR actually gives us a proper driver in terms of cost because people can now see where they are service level reporting, assessed to see where we are meeting cost and income or whether we're below the PbR tariff or above it. It's been a huge driver for change, far more so I think than anybody is really accepting* **(Site B FT Director 2)**

> *the transactional reforms I think have worked and worked well. The movement to tariff and Foundation Trusts movement to legal binding contracts has really been quite a good tool for being very clear about where organisational responsibilities sit and we have moved I think from - in the old system, before we were an FT, before we went onto PbR, you would spend a lot of time passing the parcel to make sure at year end the problem didn't sit with you. With the PbR and the transaction system that's around that - it is very clear which party is responsible for what and therefore your focus is on delivering your part of the system and that certainly works* **(Site E FT Director 1)**

> *PbR actually gave us quite a benefit and because we went through a year earlier and*

the PCT got transitional relief there was money in the system in order to be able to fund some of that work, so we are very efficient in terms of coding whenever we've had coding reviews we are seen to be fair, not over coding at all but actually that we do capture the majority of information that is required in terms of first and second diagnosis and the like, that actually, you know we do good work there. So we believe that PbR has been a real benefit for us in terms of money truly following patients. I don't think the PCT would necessarily see it in that way because I think it's caused them quite a whole in their financial arrangements but you know we've been able to invest what additional money we've received in improving the quality of services for patients **(Site E FT Director 3)**

Some were frustrated that PbR was only half rolled out. Half of one system was still negotiating local prices. PbR should have been rolled out the whole way. It was also claimed that despite supposedly recognising specialist work, HRG 4 still penalised it.

I think it was a very good exercise… money follows the patient, no it doesn't, PbR is only half rolled out. You still, so actually we've got the, you end up with half of one system half of another so you've still got as much work in negotiating local prices as you did before. PbR should have been rolled out the whole way, I don't see why, how, why it's become so hard, I really don't **(Site B FT Director 1)**

For commissioners PbR created a negative impact. PCTs and GPs believed it created a financial hole as it sucked resources into FTs. The combined impact of PbR and FT Status meant PCTs were unable to manage demand.

it's in their interest to ensure that they have maximum number of throughput coming through… To give you an example we have patients who used to go in to A&E and all they've had is a minor injury, they get stitches, they get, so being discharged, they are asked to come back to A&E outpatients again for removal of stitches. Now PCT has been paying us to remove stitches and we're wound managing and all that. So that's duplication because as they get an outpatients fee. So these factors are happening which did not happen before **(Site B GP 4)**

One of the issues we have had in the transaction analysis issue is the providers, because they are there to maximise their income, they have got a PbR system now which allows them to do that. The natural inclination is - and I am not saying it is fraudulent, the natural inclination is you pick up the work that you are doing, so you get this creep from the lower - the A - G coding. You get a creep from HRGs to HRGs that are more complex - to try and maximise the income and of course, there is only so much money in the system, so that bounces back on us as the commissioners. At the end of the day, although it is said that we have the budget for probably commissioning 75 - 80% of healthcare - well actually our influence on a lot of it is minimal really, we could only influence a small proportion of that **(Site C PCT Director 2)**

I'm sure their activity [main FT provider] had gone through the roof and that yeah they're incentivised to admit people, to follow them up in outpatients, so you know to refer from one consultant to another and primary care trusts all the time are trying to work on service redesign and reinvent systems to stop outpatient follow ups, you know, stop us referring patients, stop patients attending any, all these things to stop secondary care sucking the money in. It's you know, a sort of logical systems where the tail wags the dog, you know, secondary care you know although theoretically commissioned by primary care and by general practice is in a position where we can't stop it sucking all the money in **(Site B GP 3)**

we had a first rate foundation trust and certainly our perception was that payment by results when it was first introduced, that cost the health economy five million pounds for no additional activity and the predictions are with HRG4, it might not be quite so much money but there'll still be additional costs for no extra activity. And this is all supposed to be about driving people to have care elsewhere. And it's had the exact opposite effect ***(Site F PCT 2)***

PbR had become reduced to activity rather than quality. PbR worked in contexts with short, sharp interventions like cataract operation or hip replacements. The PbR model did not work for long term conditions or co-morbidities required self management. In this sense, it acted as a specific barrier to shifting care into community as it not provide any incentive for providers *not* to treat or move care closer to home.

under PbR that the money has been sucked into secondary care and community services have not been developed really to tilt back the balance away from secondary care which means that PCT's last financial year has a hole of about £x to y million **(Site E GP 2)**

I think the transactional reforms have brought with them too much unintended consequence and they're not organised for quality, they're organised for finance in some cases **(Site E SHA 1)**

the elements of PBR which have just fallen by the wayside and never really been implemented are the quality standards in it… it describes what it is but you never actually get that, you just get activity and whatever can be churned out. The capacity of PCTs to change their activity is minimum. And I don't think it's had a huge effect particularly on referral behaviour within general practice, but that's possibly more a failure of PCTs to, or the failure PBC should be a driver for demand management but it hasn't really been effective **(Site A PCT 2)**

We've often seen huge reported rises in activity, which are not supported by any evidence of more clinics, for example, but are really just changes in coding practice and it's become like an arcane skill set which has been developed within Trusts around the coding, so in that way it's not been desperately helpful **(Site A PCT 2)**

The closer link between activity and funding entailed by PbR had fuelled income-maximisation behaviour on the part of providers. A lack of detailed understanding of plans and contracts and insufficient information systems meant PbR mechanisms favours FTs efficient coding led to low reference costs. Commissioners did not have the sophisticated IT systems necessary to maximise the gains of PbR, nor the infrastructure to monitor transactions.

it favours people who are good at coding and have got good IT systems and the PCT has got a crap IT system … I think that is proving more costly and the PCT doesn't have an infrastructure to monitor the transactions properly so we don't know if we're being ripped off and where you do a bit of spot analysis you often find discrepancies

and so I think … I think clearly the Foundation Trusts are probably playing fairer than they used to but I still think they're a mistake on the system. They always seem to favour the FT rather than the PCT **(Site E GP 3)**

Where it is less helpful is where you want to look at the whole pathways of care and that's partly because we have got fairly immature commissioning arrangements in place… we haven't really got people that have moved beyond - who have looked at the bigger picture… the whole pathway from a lead organisation and then have that lead organisation sub-contract with other players and we are not yet into that mechanism **(Site E FT Director 1**)

There were some differences in the explanation for these different provider and commissioner perspectives.

Where it is less helpful is where you want to look at the whole pathways of care and that's partly because we have got fairly immature commissioning arrangements in place… we haven't really got people that have moved beyond - who have looked at the bigger picture… the whole pathway from a lead organisation and then have that lead organisation sub-contract with other players and we are not yet into that mechanism **(Site E FT Director 1)**

Even the Trusts admit that they've gone too far **(Site G PCT Director 1)**

Nevertheless, all this could mean significant financial consequences for PCTs.

where you get a level of activity and referrals that are slightly higher than you planned for, the way that PbR works is you can start to see providers eagerly get into super profits and commissioners go broke in a very, very short period of time **(Site E SHA 1)**

Tariff … has tended to create an incentive on the supply side … So I could see in the next two years, some people merrily bankrupting their commissioner **(Site E GP 3)**

5.3.2 Management Information

NHS Data was generally not fit for purpose as the information was too disparate to be helpful. Despite this, the impact of transactional reforms had focused the mind on efficiency and innovation. For providers, it was important to know "what is making money and what isn't".

> *we introduced service line management then realised that actually what was making the money was cataracts, retinal surgery which was losing us money, a lot. But because they were doing so many cataracts it was never noticed. They immediately looked to what they were doing and realised that they actually didn't need to do it as an inpatient, they just did. And so they changed it to day case, you know and it was a much more profitable department. And as long as you can build in the benefits to that department of that sort of change that gives people real incentives* **(Site E FT Director 2)**

5.4 System Management and Regulation

Care standards and the achievement of core targets remain significant levers in driving behaviours.

Providers believed SMR needed further clarification. The pitch was too crowded with the (then) Healthcare Commission, (and later) Care Quality Commission, Monitor, SHA, Quality Observatory, networks, peer review and the Royal Colleges. SMR exhibited duplication and inconsistency, with some confusion about the demands and roles of the regulators. More co-ordination was needed and greater clarity about who is regulating for what.

> *You know it's becoming very confusing to us. The system management and regulation seems to be an industry in itself, although it seems to have lost the plot a bit as far as I can see in that we hear now that they're looking at outcomes and they're looking at approximately five hundred different outcomes. If you're*

regulating a private industry, you would not come up with five hundred outcomes, you just can't do it **(Site B PCT Director 1)**

it seems to me that we do need much greater co-ordination between the regulators and be clear about who's regulating for what and I think, in a way, we've left Monitor too much space to expand into and provide too little by way of specification for the Healthcare Commission and it needs just doing once, but I'm sure they'll do that when CQC comes in **(Site C FT Director 1)**

For Foundation Trusts, there was the threat of double jeopardy from the Healthcare Commission doing one thing, Monitor doing something else and PCTs focusing on other issues. The new combined health and social care commission was welcomed and the focus on quality, patient safety and governance was positively received.

Monitor clearly wants to take a more holistic view of Trust performance beyond financial performance and what we are not comfortable with is having to kind of deal with two different regulators trying to do the same thing in different ways **(Site B FT Director 1)**

FTs were aware of commissioner criticism that they bypassed the system but they stressed they were accountable to the whole community as well as Monitor. The problem was more to do with tensions in the way that FTs and PCT had separate reporting measures to the SHA. As FTs 'P45' was with Monitor, they would naturally look nationally rather than locally.

I always think about what's going to get me sacked and actually what's going to get me sacked is if Monitor aren't happy with us… so I go with what's the national funds first of all and best endeavours towards whatever's the local contracting arrangements **(Site E FT Director 3)**

A number of interviewees felt CQUIN and Quality Accounts has the potential to change behaviour and drive the quality and innovation agenda and can act as another counterbalance to PbR, providing what is being measured is achievable and appropriate for the local health economy. In F, it was noted that reporting on these initiatives has added an

extra six pages to the monthly Board report. The PCT had built quality standards into all contracts.

5.5 Darzi – Next Stage Review

The Darzi agenda on quality was generally quite well understood in its broadest sense by most interviewees (DH, 2008). Most agreed with a move to an emphasis on quality and its sense of being a continuation from Next Step reforms (DH, 2005a). The emphasis on clinical effectiveness and clinical engagement, as opposed to the financial and management structures that underpin it, was welcomed.

Commissioners believed Darzi complemented the Next Step Reforms by putting patients and clinicians at the centre. Some believed Darzi brought with it a paradigm shift to quality and leadership, giving commissioners clout over how to measure quality and engage clinicians as leaders. Where the NHS Plan (DH, 2000) did not press the buttons for clinicians raising suspicion and distrust, Darzi was proactively working with their interests and concerns.

> *I do welcome this drive towards clinical engagement. I mean, I've been doing clinical engagement the whole of my ten years career in management and it's never been an easier time to do it. Because everybody accepts that it is required, whereas most of my career it's been 'well, why do you need clinicians involved', but Lord Darzi has persuaded everybody that clinicians do need to be involved at every level and you must do it. So that's got to be a good thing* **(Site B PCT Medical Director)**

> *The introduction of the quality schedules, quality frameworks, CQUIN, it's too soon to say what benefits they're having, but I think it, well it has had the benefit of pushing quality up the agenda. I think the CQUIN initiative has got potential, provided we're allowed to develop it locally, because it ought to be about what's required locally and not centrally driven* **(Site F PCT 2)**

The emphasis on quality at the heart of everything was perceived as feeling different, though there were questions as to whether the 'right tools' were being used to achieve

these aims. The emphasis on quality and patient outcomes was seen as moving healthcare away from an overtly medical model.

However, some claimed that the Darzi impact would be limited, as they were already moving care closer to home, and establishing redesigned pathways, the local emphasis on quality predated national directives, and some organisations were well ahead in developing hard metrics for quality.

> *I think there needs to be some hard metrics and I'm not certain that the infrastructure of the NHS can support the hard metrics that you need. So, if you look at what they've done in the States, they've got systems that give them information, it will give them information on individual consultants' rates… appropriateness of prescription, timeliness of prescription and administration. I can measure all of this in this organisation but I don't know that many other trusts can* (**Site B FT CE)**

However, others felt that by being focused on secondary care, Darzi potentially disenfranchised commissioning as CQUIN, Quality accounts and PROMS acted as incentives focused on acute care rather community care. It also imposed 'one size fits all' solution on areas that did not require them.

> *Darzi is a real, I suppose, political cat among the pigeons, in some areas. I think his Reforms are based on a lot of thinking and hard work that's gone on, looking at how to reform general practice, particularly, amongst other things. I think it was done in a very specific area. I think the initial looking at things like polyclinics was done in an area of London which was under-doctored, certainly it has created a huge political stink locally here, because it's been seen as having to be delivered by a Primary Care Trust that is distant from the population of GPs it covers, and been driven through without asking them* **(Site B GP 4)**

Darzi was 'was all things to all people', however its vision reflected an urban perspective, and might work well in large urban areas like London but was not the right model for rural contexts. It did not make sense to have Darzi walk in centres in the area as it already a network of community hospitals and two walk in centres.

5.6 System updates: reform in a cold climate?

The second round interviews across our case study sites sought to capture any internal and external change in the impact of system reforms since the round one interviews. The following section presents these findings. Initially, it presents contextual changes brought about an impending economic downturn and a renewed emphasis on quality and safety. It then presents findings revisiting Next Stage Review and Next Steps reforms.

5.6.1 'Lean Times'

The economic downturn brought a change in mindset towards cost improvements, productivity and efficiency.

> *If not next year … but in years after that, the NHS is likely to have a lot less money, how much, whether it's zero growth, whether it's a minus figure, nobody yet knows, but regardless of political party, that is likely, or that's the writing on the wall. Now, this is going to put some of our things around quality, productivity, efficiency, we're going to have some tensions* **(Site C PCT commissioner 3)**

Across all sites, funding and investment became the most significant issue as systems were preparing themselves for financial crisis. The economic context had driven system wide efforts in scenario and contingency planning for 'lean times' ahead. On the whole, systems were in agreement that economic situation required collective action between acute sector, PCT provider services and clinical groups.

> *A year ago we would have been talking about the future being about competition and markets for healthcare … I do think it is moving into an entirely different conversation about how we create a sustainable system…* **(Site C PCT commissioner 3)**

> *Well, what we've tried to do in– it's just been getting it going over the last few months really, is to bring all of the organisations together… and just try to put the*

bits back together and try to get those working as more of a joined up system really. So I think it's about giving encouragement, permission to do that and to move away from the kind of bone headed focus on targets really and it's rewarding systems for joining up **(Site E PCT Commissioner 1)**

the view we've taken in our patch, is you know, we've got to actually have some agreement at a very senior level across organisations about working together and a sustainable health economy, because at the end of the day, I think, you know, what will help us deliver is not the transactional things it's actually the behaviours and the, you know, and leadership actually. I mean I think it does come down to leadership… if we carry on with some of the behaviours we've got in the system, you know, foundation trusts just wanting to maximise their income. I mean I have to say in terms of the sort of the behaviours in the system I think Monitor have still got a bit of catching up to do **(Site B PCT Commissioner 2)**

For providers, a shift to cooperation around revised system objectives was accepted but it potentially created a loss of purpose and confusion over objectives, particularly for FTs. Such cooperation was going against the FT ethos of commerciality, growth and business development. From the FT perspective this was the time to push reform through.

from where we're sitting, it is the time to give the Foundation Trust more freedom, because if we're to find new and innovative ways of riding through what are going to be very lean financial times **(Site B FT Director 2)**

For non FTs, potential cuts had catastrophic consequences. Without surplus and CQUIN payment their future remained uncertain with options on the table that included being taken into provider arm, becoming a social enterprise, or merging with a local FT. In the current climate community hospitals no longer financial viable, however, the possibility of merger or closure could lose local focus and autonomy and create bigger monopoly.

It's almost catastrophic and one cannot sort of comprehend the implications if Government doesn't decide that they've got to say stop doing something. It can't all be delivered through efficiency **(Site E Trust Director 1)**

This shift of emphasis on to productivity and efficiency brought with it an increasingly proactive role of SHA within systems. The introduction of 'QIPP' (quality, innovation, productivity and prevention) was described as a response to the downturn in providing a greater emphasis on changing ways of working and creating transformational change. QIPP was seen as focusing attention on the economic downturn. The focus on quality, priority setting, return on investment was welcome but created local dilemmas about how to improve systems with less money whilst improving quality of service.

> *the whole QIPP agenda is really starting to focus our attention. Obviously QIPP is being seen by the Department of Health as the way to ease the pressures in terms of the economic downturn. So we've got to demonstrate that we're positively impacting on the Quality, Innovation, Productivity and Prevention* **(Site C PCT Commissioner 2)**

> *I think we're going to see a period of further reformation. But I think you could argue that the whole QIPP agenda is about introducing more reform. Well it doesn't come out, it's not badged in terms of the national policy or framework. It's more about a way of working. I think that the reform is very much more about needing to do things in a different way, you know, the old adage about if you always do what you've always done, that sort of springs to mind really and I just don't think that the NHS will survive without us taking a long hard look at where else we need to reform* **(Site C PCT Commissioner 3)**

> *I suppose people don't quite yet understand what QIPP is in terms of well what is it in terms of programme or something. I think what it has done is brought together the agendas for us, because we're very sighted at the moment. I mean we're doing a lot of work on priority setting. … the challenge for us is cutting costs whilst improving quality and to me, you know, the QUIP framework brings that together in a way that, you know, we can use in the service* **(Site B PCT Commissioner 2)**

The Competition and Cooperation Panel was also impacting. The outcome of financial constraints was awareness that greater cooperation and integration of services was needed. However, CCP's drive for competition was in tension with collaboration and integration necessary in economic downturn, and recent announcements of the NHS as 'preferred provider' (Burnham 2009) left systems lacking clarity about the direction, whether

competition or collaboration. For FTs, greater clarity was needed about how a collaborative model sits alongside market testing. FTs accepted a move from competition to cooperation but the implication of being 'reigned in' went against the FT principle of 'freedom to innovate'.

> *When David [Nicholson] said it's collaboration and competition, I think he understood that this model they'd created was not going to solve their problems, but I don't think that adds clarity, I think if they picked it up and ripped it up and said well what is the answer, I can sort of live with that. If they said well, you know, for right or wrong this is the road we've taken we're going to have to make it work, we're going to have to make it a smarter, refined system, but to say well that's the system, but we want you to collaborate, I don't think it's helping* **(Site E FT Director 1)**

> *Going to the market place isn't always the right answer and I think it's making sure that PCTs are mindful of what all of the options are without just going, you know, full steam ahead on to competition* **(Site C MHT Director 1)**

> *I struggle to see the role of a Foundation Trust whose ethos is surplus creation… in an environment where there is shrinking resource level. My general overall view is that an FT on that basis doesn't have a role, and I don't see what the benefit to the economy of a new FT would be, of even existing FTs* **(Site G PCT Commissioner 2)**.

This was mirrored in some differences whether to push forward with or pull back from PbR (cf Corrigan, 2010).

> *This isn't the time to revisit, this is the time to actually use what PbR was there to do, which was to drive forward the changes you need to happen* **(Site B FT Director 2)**

> *I would push the competition much, much further than it has been. But then I would say that as a big, aggressive acute trust who are sorting themselves out…you've got to allow trusts to go to the wall, you've got to, if you take the politicalisation out it and we have got y major hospitals in X, do you really need y major hospitals in X? No you don't is the bottom line* **(Site B FT Director 2)**

I'm not advocating for it to be scrapped altogether, because I don't think that's feasible. What I think we probably need is the reasonable flexibility so that PbR, the tariff becomes the recommended retail price, rather than the price **(Site C PCT Director 1)**

We've negotiated with some of the Trusts, for example beyond certain levels, marginal increase so they're not getting the full tariff and actually what we've said to them now is almost we don't care as a PCT whether – whatever the level the activities are, we cannot afford to pay you, so we're not going to pay you. What we need to do rather than the Acute Trusts focusing ever more on how they can generate more activity, once it becomes clear that they're not going to get paid anymore it then becomes 'how do we work with you in order to minimise financial pressure and minimise demand?' Now that runs counter to the approach hitherto, but we've got to be a incentive to them to want to reduce demand or all there is an incentive for them to continue to fuel demand and you end up with ridiculous situations whereby supply are fuelling demand, they've then got to bring in extra theatres, consultants working at weekends, paying loads of money to get waiting times ever lower to do activity that we all know is a waste of bloody time. It's just like – it's the economics of the madhouse (**Site E PCT Director 1)**

There is a deal going on at the moment where E PCT is currently saying to the Acute Trusts that it basically can't afford the PbR next year and we're going to set a block contract…. And that the capacity basically has to match the money available and there will be no variance outside of that. Now whether they can actually hold the Acute Trusts to that I'm not so sure and in truth again all that does is it just – I mean I just think that's a bad move anyway because all it does is nullify everything, it's very difficult to get activity out of Secondary Care if you can't disentangle money from the contract to make that activity from the outside. So block contract effectively just keeps everything in status quo for a year **(Site E GP 1)**

5.6.2 Quality and Safety

Systems placed greater emphasis on performance monitoring and quality measures. SHAs were more involved and focused on working with Trust management boards on quality alongside performance targets. Site C suggested the quality drive 'switched the SHA light bulb' on to form community health improvement group and gain clinical involvement.

> *SHAs have a duty now to innovate… this duty to innovate has stimulated better conversations between clinicians and the clinical networks again that I think we were in danger of losing through some of the NHS reforms that were becoming very focused on management, very focused on processes and very focussed on finance in particular* **(Site C SHA 1)**

> *There is without doubts a lot more push from the SHA to try and drive pretty well all of the main policy themes out in the local communities. So on that same point of productivity and efficiency the SHA is setting up a group quality improvement, productivity and prevention equip group and they're requesting or demanding that the community set one up as well* **(Site C FT Director 1)**

SHA perspectives believed that 'Mid Staffs' had made regulators dramatically look at responsibilities and accountabilities, providing a catalyst for boards to engage with the patient safety and quality agenda. Commissioners described how Mid Staffs led to increased interest in quality and safety. Contract meetings now paid greater attention to audits, evidence, and unannounced visits.

> *I think the impact Mid Staffs has had on the service has been quite dramatic… it's made the regulators look at their line of sight responsibilities and accountabilities and that in itself has been a test for the service, because the service doesn't always appreciate, who's regulating them and how's it being worked… I think the other issue around Mid Staffs just to focus on that is the economic and the belief that Mid Staffs fought very hard to become an FT and get their finances in balance against quality. … There's very little evidence for lack of quality. There was a lot of evidence of lack of leadership and good management… we've got to remember what the core business*

is, and the core business is patient service, patient care and giving the patient a decent experience. And when we move people in to positions where they lose sight of that, that's where the service starts to falter. So I think the big landmark in the last year has been the Mid Staffs review and the outcomes and the necessary changes to systems in there that's happened before that **(Site C SHA)**

I think Mid Staffs in terms of both the role of the board and the role of the non executives in particular has really come to the fore. But coupled with that has been the whole patient safety and quality agenda and I think there's been, if you look at the weight of quality issues that are now on our agenda it changed and it's much heftier now in terms of the quality agenda (**Site C PCT Director 2)**

The increased emphasis was welcome but it did raise the danger that SHA visits could distract organisations from day to day motivation to ensure quality and safety. Providers feared the regulatory backlash to Mid Staffs could lead to kneejerk reactions that overlaid CQC measures that were still bedding down. Separate regulation systems – CQC, Monitor and now QIPP – could mean organisations get bogged down in information giving. PCT raised the point that emphasis on quality of care in hospitals was driving care and attention away from community setting.

For acute providers, the danger that quality and efficiency reduced to micro management, standardised averages and inputs would be at the expense of quality outcomes. FTs were confident they already had information systems that were quality focused. Much of the work was already being done (e.g. Quality Accounts). The current emphasis on quality and safety represented a codification of work from FTs to the wider NHS (learning from the vanguard organisations). FT questioned whether regulators properly dealt with failure and persistent offenders. Improvements were still needed such as making organisations compulsory fully registered with CQC.

5.7 Examining the reforms as combined Levers

5.7.1 Targets and outcomes

The 18 week target in elective services, infection control and delivery of local priorities were the main goal for the system. Access targets were perceived as the highest priority. Targets were criticised for unintended consequences on choice and clinical priorities, with some providers perceived as gaming in order to hit targets. Targets were treated as absolutes within the system and many noted the tension between national and local priorities. While national targets remained 'must dos', it was considered that 'bottom up' targets encouraged more patient-focused, quality-focused, and involved 'buy in' from clinicians. A perceived unintended consequence was an increase in demand due to the 4-hour A&E waits, people going to hospital guaranteed to be seen within four hours rather than use an out-of-hours service. Referral to treatment in 18 weeks increased difficulties of introducing demand side triage services in GP practices because of GP access targets. An unintended consequence of 18 weeks was the way it combined with PBR and FT status was to increase supply side capacity

> *… we pulled in huge amounts of money into secondary care to deliver access targets which undoubtedly needed to be addressed. But unfortunately, what that has done is removed demand management and I don't think that was fully understood, or if it was, then we're now paying the consequences. Because … waiting lists created a demand management and now we've taken off that demand management stop, if you like, and we have got … raising expectations by population and by doctors, let's be honest about that, and we've ended up with a change in thresholds. And it's almost unlimited and bottomless* **(Site G Trust Director 3)**

Improving outcomes in public health, such as chronic diseases and diabetes, were at the forefront of commissioner activity, but there were some uncertainties about how the reforms, which were regarded as more associated with achieving the reduction of HCAI and

waiting times, would contribute to these aims. . While QOF was broadly welcomed, it was seen as potentially reinforcing structural inequality, as the payment was triggered at a compliance mark of around 70% which may still result in 30% of patients not getting optimal management. GPs attained QOF targets fairly easily but it had resulted in PCT policing QOF rather than it being a high trust contract. In one site, the PCT was setting up something more challenging for GPs – such as a balanced scorecard, drawing on appropriate QOF measurements, the results of patient surveys and financial and commissioning performance.

5.7.2 'Mutually supporting'?

It was felt that the reforms were not generally mutually supporting, forming a coherent whole. Rather, reforms were out of kilter, with some perverse incentives and some contradictions. With commissioning reforms developing later than FTs, the fragmented implementation of reforms meant 'the left leg and right leg have been run by different brains'.

> *Because some of these things have been around for longer than others and I think that because they arrived first, they've skewed some behaviours. So I think if that's what the Department of Health are thinking about initially, then I'd love them to have articulated that at the beginning rather than having giving us that one last year, that one this year and that one in stages, because, because of that some of these things are better developed but I think also they, some of the behaviours that some of these push people towards have skewed the, I'd say the power base in the wrong way if you like* **(Site E GP 2)**

> *It's my believe that an awful lot of that money has gone into additional administration that actually if the return on investment was right, we wouldn't be where we are today. So I have some strong suspicion that, you know, we've added an awful lot of cost without an awful lot of benefit…. It's a bit like leaving a different, somebody else's brain to run your left leg and somebody else's brain to run your right leg and expect to be able to run a mile in under four minutes, it's not likely to happen* **(Site E FT Director 4)**

It was felt that the reforms did not contain strong levers to achieve demand side reform and care closer to home, as they were weighted towards the acute care as the combined impact of PbR and supply side drive for quicker waiting times had increased demand and been achieved at the expense of PCT financial deficit. Reforms created conflicting pressures between markets, choice and control, with a lack of clarity about the particular model they were pushing. Commissioners struggled to develop integrated pathways of care.

> *it's not always felt as though actually this is encouraging people to work together across organisational boundaries … but I think sometimes the reforms seem to set us up to be completely separate….* **(Site E FT Director 1)**

> *In terms of the care of chronic conditions there's no doubt that we could deliver a lot more of that out there, it's just a matter of working with primary care and not in competition to get the pathways right* (**Site E FT Director 2)**

> *I think they need to decide whether they're going to allow devolution markets and choice really to happen and let that drive everything and accept the consequences of that, which would be destabilisation, which could be well actually things get done a lot better in some parts of the UK, or England, than others. Or, to kind of continue to hang on and set targets and go with this very detailed measurement stuff and I still think they don't quite know which way they're trying to do it. I suspect we're never going to get there in all honesty* **(Site B FT Director 3)**

> *I think the reforms are in the wrong direction. I think we need to take a good look at what's going on in some other countries where they're developing more integrated, whole systems, move away from the market and do something about empowering organisations on the ground and addressing the way that some middle tier organisations disempower local systems* **(Site E PCT Director 1)**

It was often argued that the transactional reforms needed to be revisited. The widely accepted view was that PCTs lacked financial clout or incentives to change systems as PbR financial flows had acted as provider incentives to increase activity. Further work on tariff splitting was needed along with greater focus on building quality in transaction payments.

Some advocated that some form of fundholding arrangements or total purchasing or vertical integration systems could accelerate change.

> *I think the transactional reforms could deliver if they actually put the incentives in at Primary Care. Primary Care and General Practice in particular in Primary Care, is really good at responding quickly and changing the business model almost overnight to respond to a different environment. The further up the ladder you go, the bigger the organisation becomes, the harder it is to do that…*
>
> *….You can adopt a purely financial model, a la fund holding, total purchasing whatever and then let the market rip or try and get some constraints, but basically turn it into a financial model. Or you can try and make changes happen purely by clear pathway redesign where you actually just say 'OK, we're going to shift services out of community hospitals and allow people to sort of just adopt policy rather than actually stick some pragmatic, financial models in place…. At the moment we seem to have a sort of mixed economy between those two.*
>
> ***…****I suppose for me the dilemma is that one part of the system the Foundation Trusts are operating on piece work and the other part of the system is trying to operate purely on a pathway redesign model. So you know the PCTs don't seem to have any financial clout at all and there's no real incentive there to make things work financially any differently*
>
> *….In my opinion total purchasing worked and it worked better than the system that currently exists and I think if you are prepared to do that and keep a sort of relatively light regulatory hand on it then I suspect you'd see some huge changes happening a lot quicker than you will if you just allow the model to sit as it is… if you really wanted to make a change in terms of hospital care and keeping people out of hospital and making Acute services more streamlined and more efficient, you've actually got to put those financial drivers back in there for General Practitioners, community nurses and therapists. … And at the moment I don't think those financial drivers exist, I genuinely don't think – the Government may feel that they do, but I just don't think they're being implemented because by and large PCTs and Strategic Health Authorities are scared of letting that model run* (**Site E GP 1**)

To date, the lack of impact of reform had been largely due to too much emphasis and energy taken up by transactional reform rather than transformational change. Systems were tied up in transactional and bureaucratic arrangements that prevented them from responding to local populations.

> *All the other pieces of paper I need to feed the beast. I don't have time to be empowered and come up with new ways of doing things*
> *…We need to focus more on the quality of the care we provide, and less micro-management. That's what I'd like to see coming in the future, not more bureaucracy, this desire to always centrally control things. They'll never get there, because the NHS is a political animal. But as far as I'm concerned, the more freedom they can allow us – and make us accountable more directly to the public – then the better* **(Site B FT Director 2)**

> *I think some of the sort of reforms and particularly the sort of transactional ones I think will change significantly actually in the next 12 months. I think I'd go back to what I said earlier which is I think, you know, for me what will make or break this is the sort of, you know, real leadership and behaviour rather than the reforms as such* **(Site B PCT Director 5)**

5.8 Conclusion

Unpicking the collective impact of the reforms in local health economies was difficult. Most individual respondents appeared to be engaged with utilising or responding to their separate elements, but struggled to articulate how and why they were 'mutually enhancing'. Reforms were individually, rather than collectively, developed over time. Implementation was more akin to a post hoc rationalisation (cf Audit Commission and Healthcare Commission, 2008) rather than having mutually supporting effect. They had been created at different times by different people with different agendas. However, a few respondents claimed to see the full picture.

it feels like we are, you know, doing a bit of post-hoc rationalisation to show that these things really are connected and there really is a bigger sort of plan than us mere mortals understand **(Site E SHA 1)**

I largely think the last 10 years has been coherent and I think has been very effective. Over the last 10 years I think there's been the odd blind alley and I think there are the odd bits where once you get in to the detail things don't tie up very well. And I think we are now at a phase where a lot of the dividends from the last 10 years of reform, need re-looking at **(Site G Community Services Provider 1)**

Parts of the reforms had led to improvements over the last ten to fifteen years, but implementation had been too fast and too fragmented. The timescale was unrealistic as 'changing a dinosaur' in five years was difficult. It would need up to 7 years before systems could assess impact.

Whether it's by happenstance or not, you know some people might say well it's all part of the big plan. I think there's probably truth in both. I think opening up the NHS to more competition has been very effective. We have driven down waiting times, targets, whichever way you but its targets have achieved what the NHS plan wanting them to achieve in 2001. If people now do not wait longer than five weeks for their outpatient appointment. Ninety percent of our patients get their treatment within eighteen weeks and eighteen weeks is still too long **(Site B FT Director 2)**

Greater clarity was needed about the sorts of behaviours and activities the DH wished to see in the system. For some, quasi market reforms are not the answer as attention to profit discarded certain customers and created inequitable systems. However if a market model was the preferred option then the centre needed to follow a consistent line of policy. Seeing changes through rather than diverting attention was needed. Further structural change could create further misalignment to the priorities being faced, diverting more energy into reorganising rather than delivery. Stability was needed in order to look at financial management and performance, and to maximise efficiency.

if there is a change of government if there is going to be a fundamental change of direction which actually I think would be a nightmare. Because you know, I know it's an old cliché, but the NHS is such a huge oil tanker that you know, you take a decision next year that you're going to stop with this policy and change another one, it would, just unpicking all of that and trying to change direction takes a huge amount of time and effort **(Site B PCT Director 5)**

The chapter presented above has examined the impact of health reform in six local health systems in England. In the following chapter, we examine the impact of reforms across three tracer conditions – Orthopaedics, Diabetes and Early Intervention Mental Health- within those health systems.

Chapter Six: the impact of reforms on Orthopaedics, Diabetes and Early Intervention Mental Health

This chapter presents a summary of findings about the combined impact of health reform across three tracer conditions – orthopaedics, diabetes and early intervention in psychosis. It beings with an overview of each condition before going on to present findings for these tracer conditions under the reform streams as presented in the Next Steps Reform diagram. Within each, the chapter presents a summary discussion of the influence of local contexts and mechanisms before a concluding assessment of the extent to which the 'Next Steps' reforms provided a mutually supporting set of levers and incentives.

6.1 Orthopaedics tracer service

Introduction

Trauma and Orthopaedics is a specialty-level consultant-led service, and traditionally elective orthopaedic care is accessed by GP referral. It is associated with comparatively long waiting times, and as a result has been a target of a range of initiatives (Appleby et al, 2005). Orthopaedics was the subject of one of the first NHS Collaboratives (Bate, Robert et al, 2002) and a Modernisation Agency Action On programme (Action On Orthopaedics and the Orthopaedic Services Collaborative, 2002). Nevertheless, it "was clear to the government that a more determined effort was required" and this led to the National Orthopaedic Project in 2004 (Harrison and Appleby, 2005, p29): "Despite good progress, as well as an unprecedented level of investment and reform, it was recognised that orthopaedics could pose a threat to the commitment in the NHS Plan that no patient will wait longer than six months for an operation by December 2005".

The Musculoskeletal Services Framework (MSF) was published in 2006 to support the delivery of 18 weeks by proposing a model of good practice examples of working from the NHS, as well as suggesting new ways of working (DH, 2006b). The approach is based on

'International evidence' showing that better integration and collaboration between, primary, secondary and social care can reduce hospitalisation and yet, crucially, provide better care and a better service to patients and carers alike'. Familiar to the management of many conditions, including diabetes, the approach is structured around the patient journey or integrated care pathways (ICPs). ICPs form the basis of redesigned musculoskeletal services proposed in the Framework.

Orthopaedics was also chosen as one of the six specialties included as national 'Closer to Home' demonstration sites because of the perceived potential to improve access (DH, 2006b; Sibbald, Pickard et al, 2008).

6.1.3 The policy objectives

The overriding policy objective as been to improve waiting times for treatment. Orthopaedics has historically had comparatively long waiting times and has been a focus of concern as a high volume specialty that has struggled to meet national waiting time targets. Nationally, despite improvement over time, trauma and orthopaedics was one of two specialities not to reach the 18-week target by the deadline of 1 January 2009.

The dominant role of waiting times was subject to some dissent, particularly from orthopaedic surgeons:

> *At the moment the only targets that we are beaten with are nothing to do with quality … only to do with waiting times. And in the treatment of chronic pain and disability those are pretty poor targets frankly. They're not the targets I would choose. … We worship 18 weeks, because it's a tangible thing that we can deliver. So we do* **(Site G: Orthopaedic surgeon)**

Characteristics of the case-study sites

As noted in Chapter 2, two of the rural PCTs are considerably larger than the other case-study PCTs. Case study G accounted for 42% of the total population covered by the six case studies in 2008/9, compared to 25% for rural PCT E and 11% for the largest urban PCT (B).

The comparatively larger rural PCTs are served by geographically dispersed providers, such that on average they have less than one hospital Trust available within 30 minutes travelling time.

The three urban PCT case studies can be characterised in terms of having a main provider undertaking the majority of orthopaedic admissions, despite scoring comparatively highly on our 'choice' criterion.

Waiting times for treatment

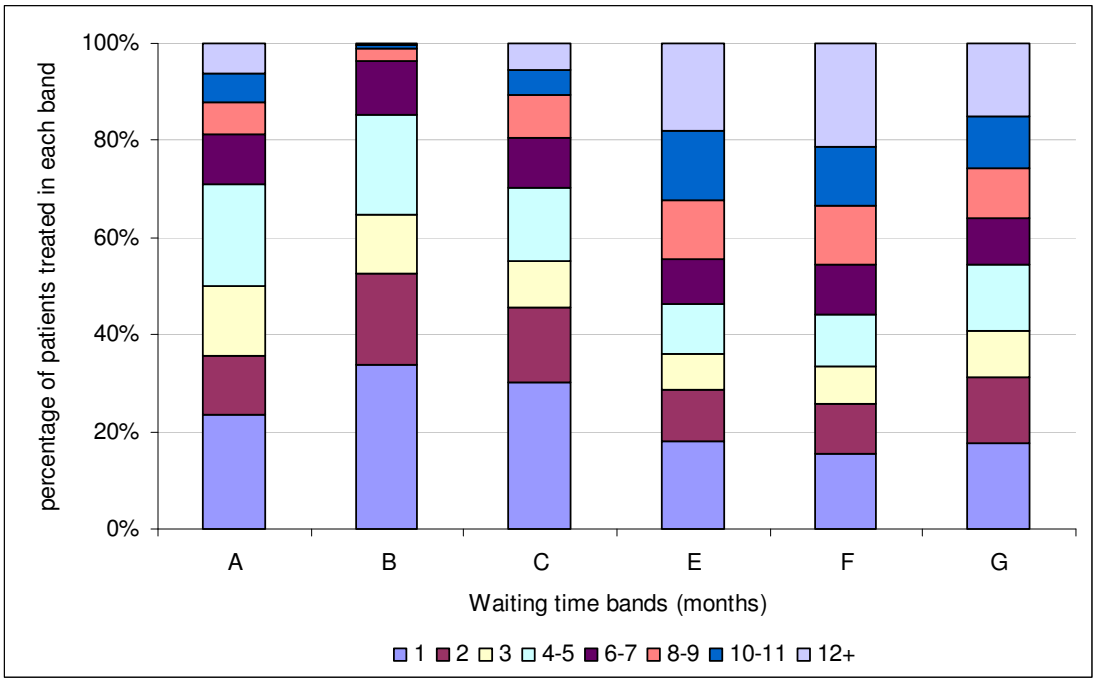
Our case-study PCTs illustrate considerable variation in waiting time experience. In general, the urban PCTs have experienced better waiting time performance than the rural PCTs (figure 6.1). For example, in 2003/4, 60% (6,478/10,814) of patients were admitted within three months of the decision to admit across the urban PCTs (B, C and A) compared to 39% (11,216/28,979) across the rural PCTs (G, E and F).

By 2008/9, both urban and rural experienced much better waiting time performance (figure 6.2). Eighty-one percent (10,737/13,241) of patients were admitted within three months of the decision to admit across the urban PCTs compared to 70% (28,177/39,988) across the rural PCTs, with the urban PCTs' performance significantly stronger ($p<0.01$).

Figures 6.3 and 6.4 illustrate the change in mean and median waiting times, respectively, from the decision to admit for elective orthopaedic inpatient admissions for the case-study PCTs over the seven years to March 2009. These figures illustrate how the rural PCTs (E, F and G) made progress towards closing the gap in terms of waiting time performance compared to the urban PCTs. (The inter quartile range for inpatient waiting times is shown in figure A2.1 in appendix 2).

Waiting times were longer for inpatient admissions compared to day cases. Figures 6.5 and 6.6 show the change in mean and median waiting time from the decision to admit for elective orthopaedic day case admissions over the same period. (The inter quartile range for day case waiting times is shown in figure A2.2 in appendix 2).

Figure 6.1: length of time spent waiting from decision to admit for elective orthopaedic admissions in 2003/4



Note: the 2002/3 data are not shown because in that year 65% of decision to admit records were set to the date of admission for PCT F.

Figure 6.2: length of time spent waiting from decision to admit for elective orthopaedic admissions in 2008/9

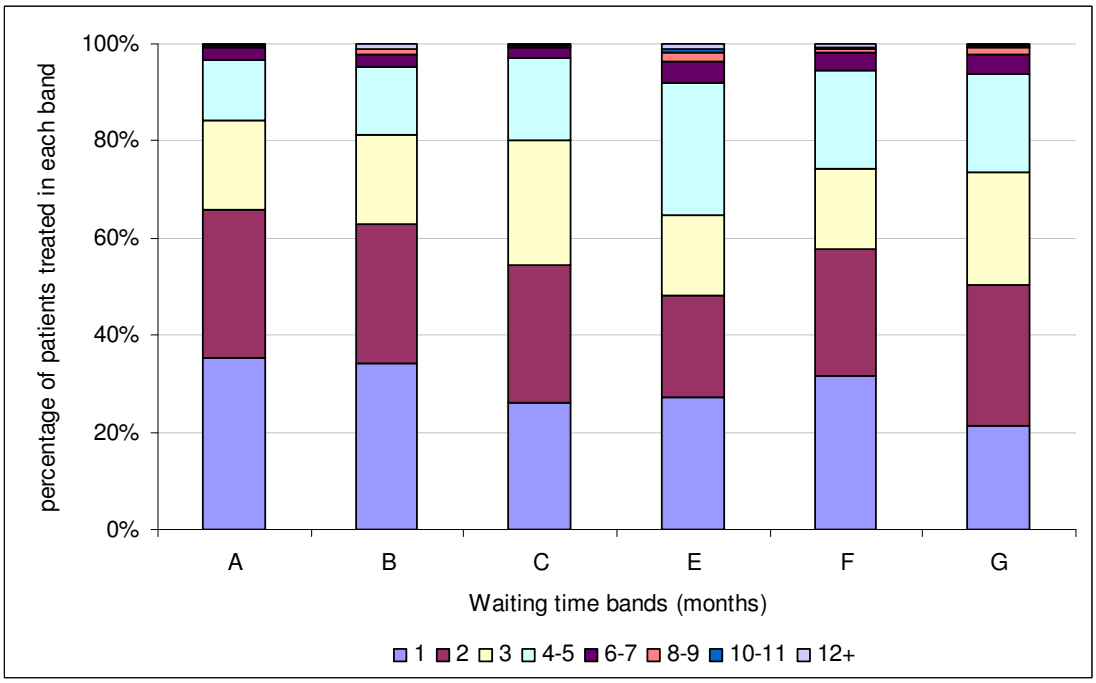
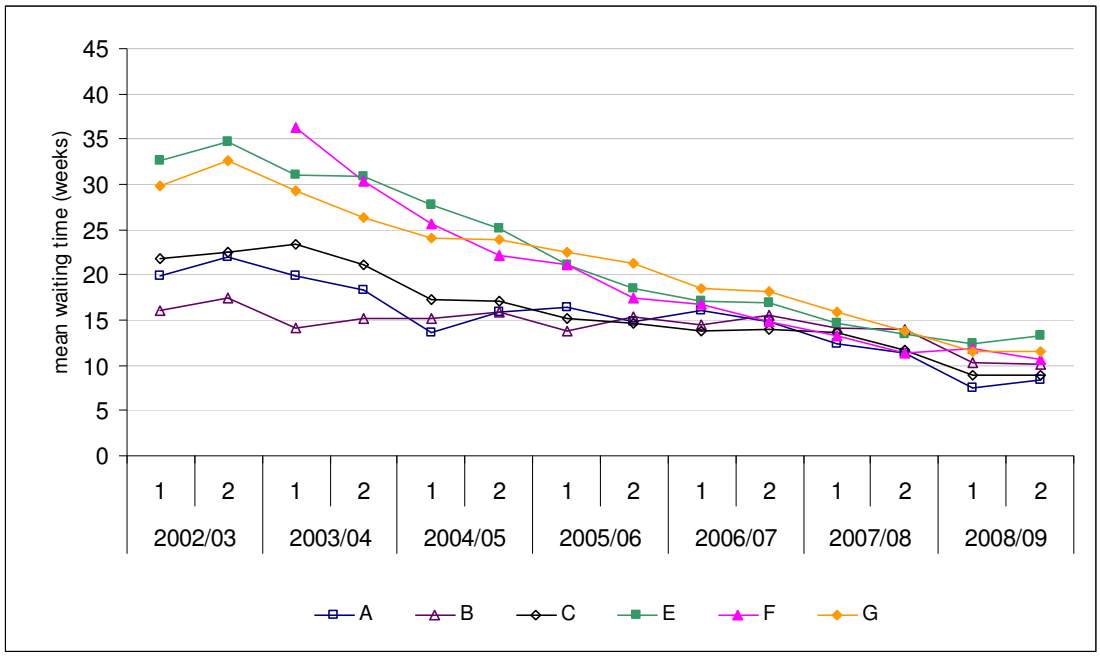
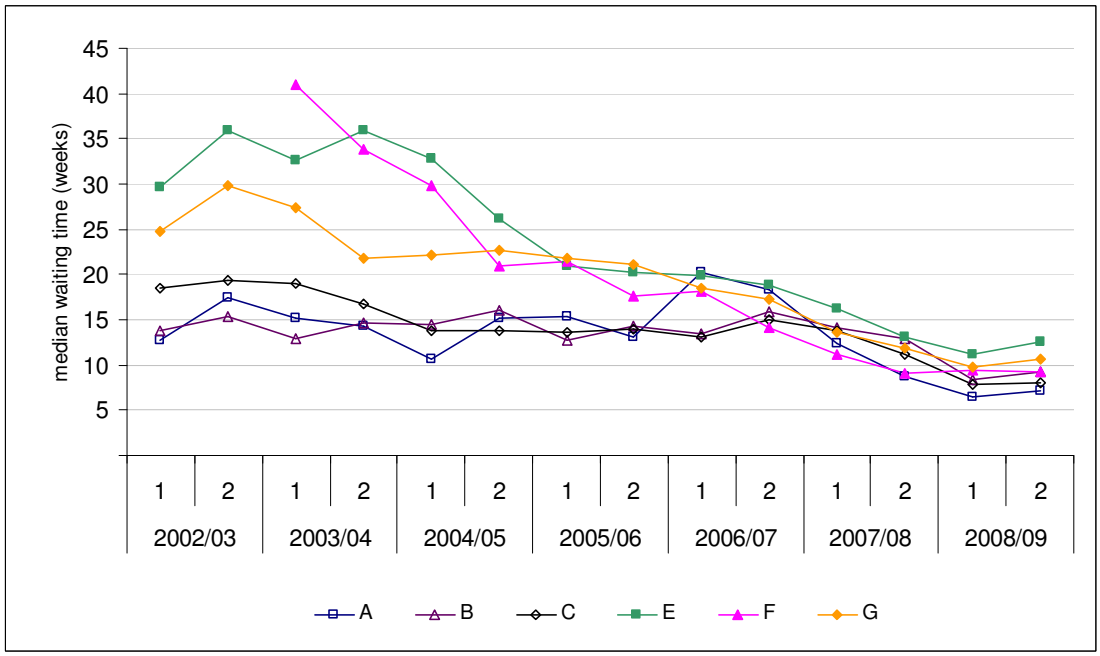


Figure 6.3: Mean waiting time from decision to admit for elective orthopaedic inpatient admissions



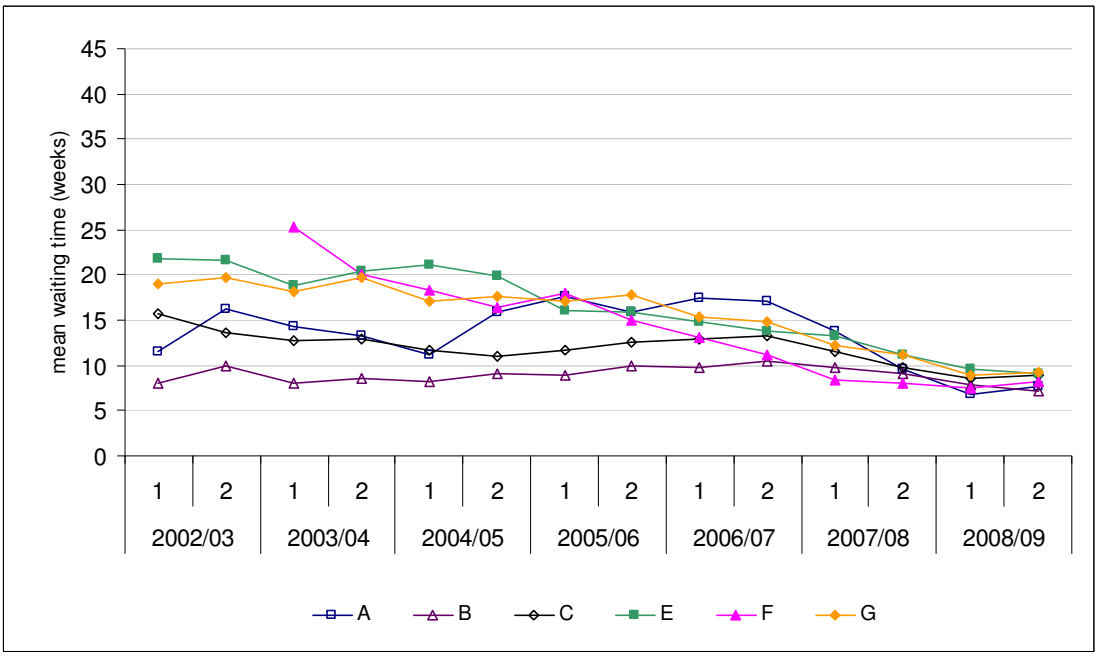
Note: the 2002/3 data for PCT F are excluded because 65% of decision to admit records were set to the date of admission.

Figure 6.4: Median waiting time from decision to admit for elective orthopaedic inpatient admissions



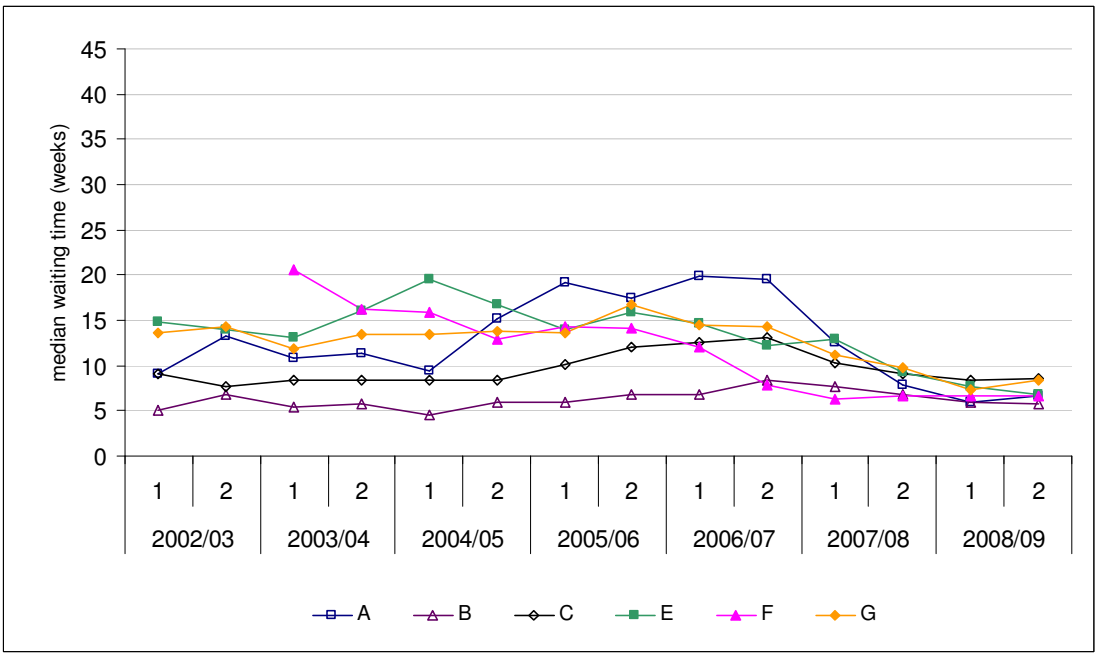
Note: the 2002/3 data for PCT F are excluded because 65% of decision to admit records were set to the date of admission.

Figure 6.5: Mean waiting time from decision to admit for elective orthopaedic day cases



Note: the 2002/3 data for PCT F are excluded because 65% of decision to admit records were set to the date of admission.

Figure 6.6: Median waiting time from decision to admit for elective orthopaedic day cases



Note: the 2002/3 data for PCT F are excluded because 65% of decision to admit records were set to the date of admission.

In order to explore the factors associated with variation in waiting time, a regression analysis using a multilevel linear mixed-effects model was undertaken. Data on admissions in each of

the six years to 2008/9 were included. The model was run separately for inpatients (137,208 admissions) and day cases (130,481 admissions). The model used the square root of waiting time (from the decision to admit to the date of admission) as the dependent variable. Patient age and year of admission were included as fixed-effect explanatory variables and PCT was as a random-effect explanatory variable. All these variables were found to be statistically significant predictors of waiting time.

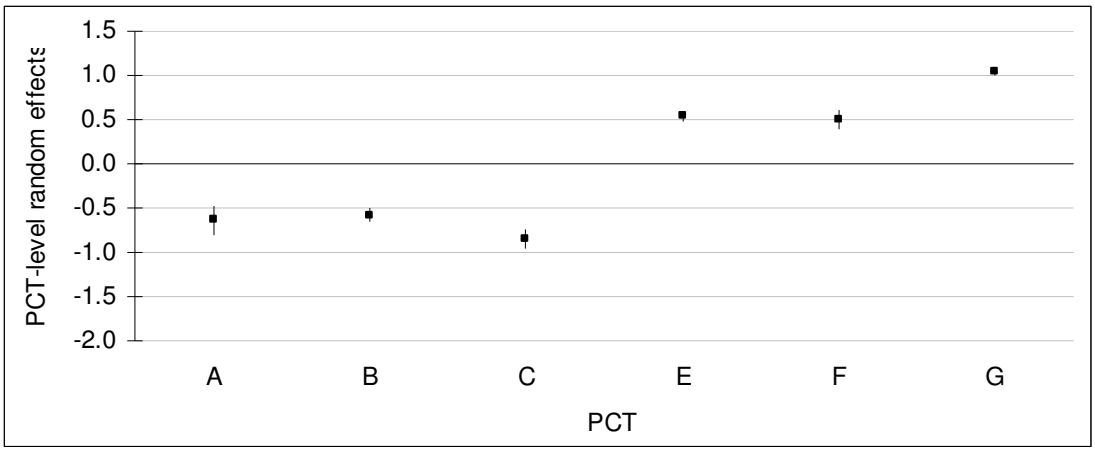
Interpretation of the coefficients based on the square root of waiting time is not straightforward beyond determining whether the association between explanatory variables and waiting time is positive or negative, and, when comparing their relative size in the inpatient and day case results. The fixed-effect coefficients are summarised in table 6.2. Patient age is positively associated with waiting time, with a larger impact on inpatient admissions compared to day cases. The year of admission is negatively associated with waiting time, with a larger impact on inpatient admissions compared to day cases.

Table 6.2: regression model fixed effect variable coefficients

Admission type	Fixed effect variables	Coefficient	Standard error	t value
inpatients	intercept	9.885	0.322	30.68
	age	0.046	0.001	65.87
	year	-0.823	0.008	-103.57
Day cases	intercept	9.929	0.364	27.31
	age	0.007	0.001	11.86
	year	-0.496	0.006	-77.99

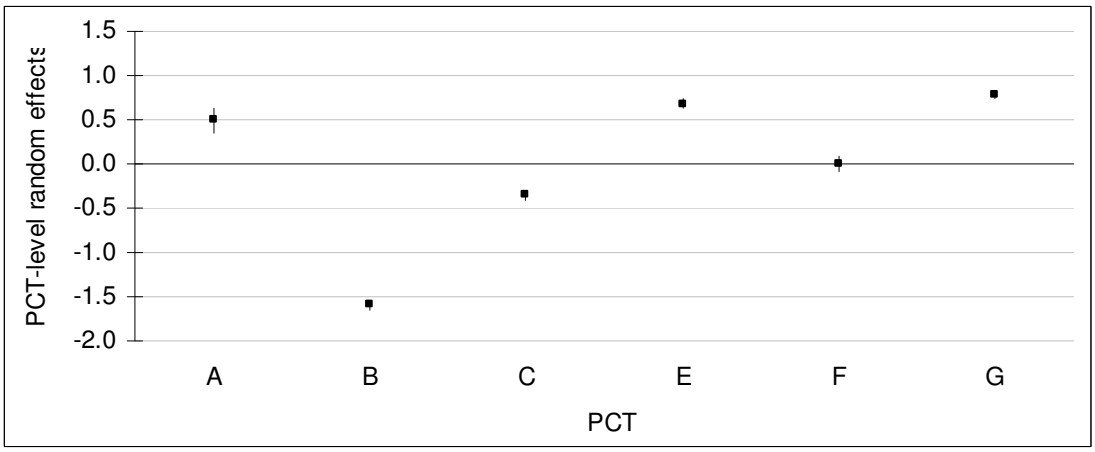
The PCT-level random effects are shown in figures 6.7 and 6.8 for inpatient and day case admissions, respectively. Figure 6.7 shows that the three urban PCTs (A to C) are associated with significantly shorter waiting times than the average. Similarly, the three rural PCTs are all associated with significantly longer waiting times than the average.

Figure 6.7: Inpatient waiting time PCT-level random effect coefficients and 95% CIs



The results of the day case model are similar, with the urban PCTs B and C experiencing shorter waiting times than the three rural PCTs (figure 6.8). However, PCT A's experience was not as good as that of PCT F.

Figure 6.8: Day case waiting time PCT-level random effect coefficients and 95% CIs



Focusing on 2008/9, PCTs A, B and C experienced lower median and mean waiting times for inpatient admissions, compared to PCTs E, F and G (see figures A2.2b and A2.2c in appendix 2). The regression model described above found that having controlled for patient age, the PCT effects for PCTs E, F and G were all significantly above average in 2008/9 (figure A2.2d in appendix 2). In 2008/9, day case waiting times were subject to comparatively little variation across the six case studies. The general trend for the urban PCTs to experience lower waiting times than the rural PCTs was maintained, with two of the urban sites (A and B) experiencing lower waiting times than two of the rural sites (E and G) (see figures A2.2e and A2.2f in appendix 2). The regression model found that having controlled for patient age, the

PCT effects for PCTs E and G were significantly above average, and those for PCTs B and C were significantly below average in 2008/9 (figure A2.2g in appendix 2).

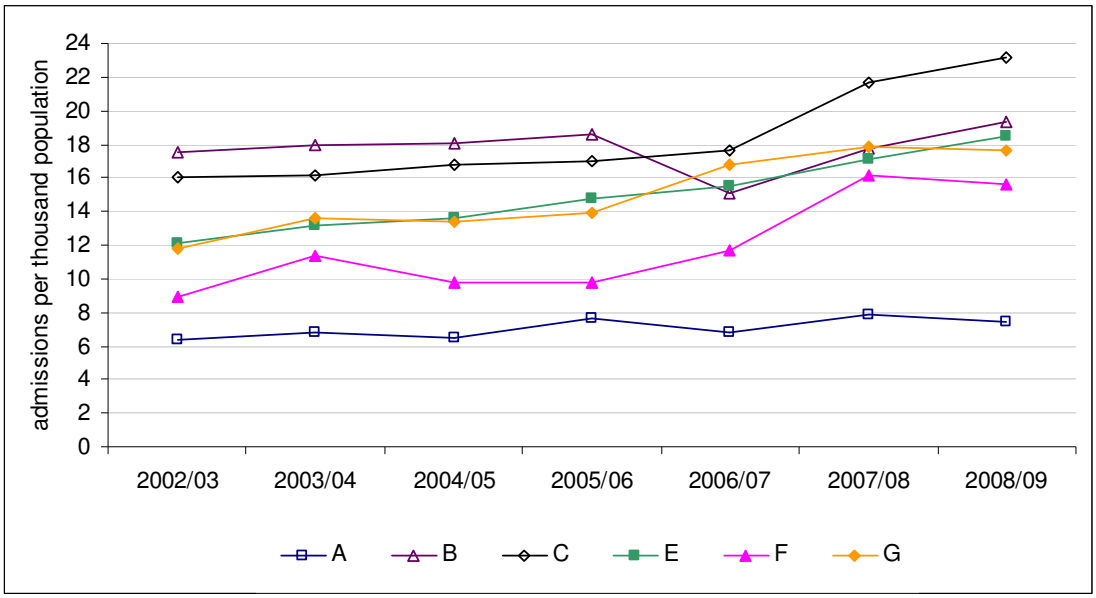
Table 6.1 summarises the performance of the case study PCTs in terms of the percentage of orthopaedic patients admitted within the 18 week target during the first three months of 2009. The three urban PCTs met the target of at least 90% of patients admitted within 18 weeks of referral, while the rural PCT fell short. Table 6.1 compares the performance of each case study with the performance of comparator PCTs, which were those identified as comparators for PCT-level programme budget data.

Table 6.1: Performance in orthopaedics against the 18 week target

Case study	Percentage of orthopaedic patients admitted within the 18 week target during the first three months of 2009	
	PCT	Comparator PCTs
A	90	88
B	95	88
C	92	85
E	77	86
F	85	84
G	87	90

The case-study PCTs experienced a wide range of admission rates (figure 6.4). In 2002/3, the two PCTs with the highest rates were both urban (figure 6.4). In general, the trend has been for increases in admission rates across the rural case-study PCTs of more than 50%, compared to smaller increases across the urban case-study PCTs (table 6.2).

Figure 6.4: Orthopaedic admission rates per thousand population between 2002/3 and 2008/9



The urban PCT A has the lowest orthopaedic admission rate and as noted in Chapter 2 a younger resident population compared to the other case studies (figure 2.5). In 2008/9, the mean age of patients with an orthopaedic admission was 49.1 years for urban PCT A, compared to 53.3 years and 53.6 years for the other urban PCTs and the range 54.2 years to 55.8 years for the rural case studies (see figure A2.3 in appendix 2).

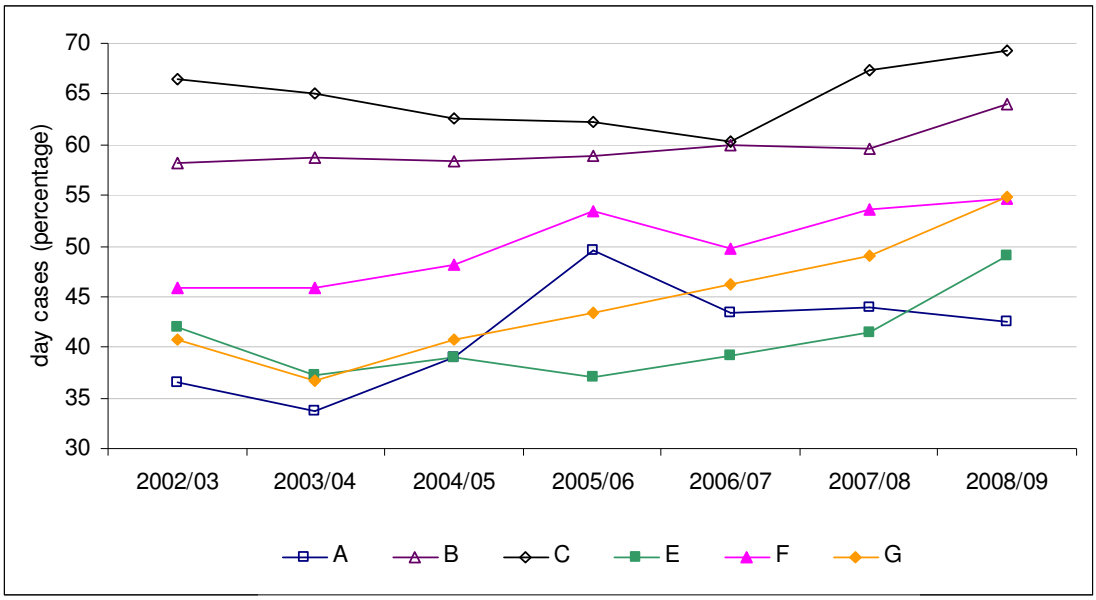
Table 6.3: Summary changes in elective orthopaedic admission rates

	2002/03		2008/09		Difference in rate between years	95% CIs for the difference in rate	% change between years
	Rate PTP	no	Rate PTP	no			
All							
A	6.4	1088	7.4	1276	1.0	0.5 to 1.6	15.9
B	17.5	5847	19.3	6525	1.9	1.2 to 2.5	10.7
C	16.0	3715	23.1	5527	7.1	6.3 to 7.9	44.3
E	12.1	8577	18.5	13929	6.4	6.0 to 6.8	52.8
F	8.9	2065	15.6	3684	6.8	6.1 to 7.4	76.0
G	11.8	14728	17.8	22768	6.0	5.7 to 6.3	50.8

Inpatients							
A	4.1	690	4.3	734	0.2	-0.2 to 0.6	5.1
B	7.3	2445	7.0	2351	-0.3	-0.7 to 0.1	-4.6
C	5.4	1246	7.1	1695	1.7	1.3 to 2.2	31.9
E	7.0	4981	9.4	7102	2.4	2.1 to 2.7	34.2
F	4.8	1119	7.1	1672	2.3	1.8 to 2.7	47.4
G	7.0	8733	9.1	11603	2.1	1.9 to 2.3	29.6
Day cases							
A	2.3	398	3.1	542	0.8	0.5 to 1.2	34.5
B	10.2	3402	12.4	4174	2.2	1.7 to 2.7	21.7
C	10.6	2469	16.0	3832	5.4	4.7 to 6.0	50.5
E	5.1	3596	9.0	6827	4.0	3.7 to 4.3	78.7
F	4.1	946	8.5	2012	4.5	4.0 to 4.9	109.9
G	4.8	5995	8.7	11165	3.9	3.7 to 4.1	81.6

Figure 6.5 shows the very substantial range in day case rates across the PCTs despite the large increase in day case admissions, particularly in the rural PCTs (table 6.1).

Figure 6.5: Day case rates for orthopaedic elective admissions between 2002/3 and 2008/9



In each of the three urban Sites a single provider accounted the majority of orthopaedic admissions in 2008/9, despite the presence of alternative suppliers (figure 6.6). In contrast, in the rural Sites admissions tended to be more widely distributed between providers and the opportunity for competition tended to be more limited. Further details about the case studies' experiences of activity and waiting times are provided in appendix 2.

Street et al (2010) illustrate multiple measures which suggest that ISTCs treat less complex cases than hospitals across a range of treatments. The ISTC in PCT F undertook more total knee replacements (TKRs) than the PCT's main provider in 2008/9 (154 and 101, respectively). The mean age of patients undergoing a TKR was 66.5 years at the ISTC compared to 79.9 at the main provider, and the difference in mean was significant at the 5% level (-13.4 years, CIs -14.8 to -12.0 years). Similarly, the mean length of stay was lower at the ISTC compared to the main provider (4.5 days and 6.7 days respectively), and the difference in mean was significant at the 5% level (-2.2 days, CIs -3.2 to -1.2 days). Histograms for these measures are shown in figures A2.15 and A2.16 in appendix 2. These findings also suggest that the ISTC was treating less complex patients than the main provider.

Figure 6.6: percentage of orthopaedic admissions by site and main providers in 2008/9

Site	Main provider (year gained FT status if applicable) and % of admissions in 2008/9	Comments
A	NHS Trust, 60%. NHS Trust, 30%	The main provider ran a treatment centre between 2002 and 2006 which was closed due to insufficient activity.
B	specialist FT (2007), 71% FT (2004), 18%	Some additional activity was reported to have been undertaken at a local private hospital, data not available
C	FT (2004), 95% ISTC in another PCT, 2%	Another ISTC was operational in 2004/5 and 2005/6 before being closed
E	FT (2004), 40% NHS Trust, 23% FT (2007), 13% ISTC, 6%	Viewed as 'low diversity' because of the large distances between providers
F	FT (2004), 42% NHS Trust, 11% ISTC, 26%	This Site is unusual because of the comparatively high proportion of admissions at the local ISTC
G*	NHS Trust, 28% FT (2006), 19% NHS Trust, 15% NHS Trust, 9% FT (2005), 12% ISTC, 1% ISTC in another PCT, 4%	Despite the distances between providers which limit choice, there is a sufficient range of providers for the Site to be viewed as 'high diversity'

* percentages for 2007/8 admissions are shown for Site G as data for one of the ISTCs were not available for 2008/9

6.1.4 Impact of health system reforms on orthopaedics

6.1.4.1 System Management and Regulation

Waiting time targets and quality measures

Waiting time targets have dominated policy objectives relating to orthopaedics because of historical poor performance at national level. From an operational perspective, meeting the

increasingly demanding maximum waiting time targets has been a clear priority. However, its status among senior clinicians has been widely questioned:

> *… to reduce the waiting times to what was thought to be acceptable, down to 18 weeks …[was] a noble aspiration; I think patients did wait too long, but it was a very blunt tool in orthopaedics* **(Site G consultant orthopaedic surgeon)**

Some voiced concern over the practical challenges of using resources efficiently, particularly as patients' expectations change:

> *… the waiting targets in general are good, a good concept in that people shouldn't have to wait two years, three years. ... But as the waiting time becomes shorter, it becomes harder for units to work efficiently. So if you have somebody who cancels, you can't get anybody to fill that because they think 'well actually if I wait for a week or so I'll get the date that I wanted'* **(Site E consultant orthopaedic surgeon)**

Equally, concern was expressed about the overall approach taken to delivery on waiting times:

> *… we've only hit the target by throwing a humungous amount of money at it and … I cannot understand how they can't learn that if they set a target, and they threaten the managers with death if they don't meet the target, and they throw money in to the system at the same time, that the money gets wasted!* **(Site B consultant orthopaedic surgeon)**

The reduction in waiting times is also linked to a consequential increase in the number of patients presenting for surgical treatment:

> *I would have to say one of my best treatments used to be a waiting list, the fact that people are seen and treated so quickly means that in fact we treat more, a higher proportion because in the days when I had a six to 12 month waiting list, I probably had at least 10, 15% of patients who for one reason or another came off the list, the majority of those were reported that their symptoms had got better* **(Site F consultant orthopaedic surgeon)**

The impact of changes in service delivery on private practice was cited by many stakeholders across the case study sites. Most obviously, "private practice has gone down now ...

because of 18 weeks … you've got quick access. Would you pay £10,000-£12,000 for a hip if you can have it done in six weeks' time?"

Other senior clinicians were unwilling to engage with the reduction of waiting times as an appropriate objective: "… in the treatment of … chronic pain and disability … 18 weeks is just the wrong target I would say".

Instead, they pointed to the need to focus on quality measures relating to disease severity and clinical outcomes:

> *[There are] two big, big issues in our world. There's the … diagnosis inflation issue, so trying to get objective measures of disease severity … the bigger the diagnosis the bigger the operation, the bigger the remuneration.*
> *…So there's the diagnostic quality and then there's the therapeutic quality and at the moment we have no national guidelines for either … So my aspiration there is that the patient should … be able to receive a lifetime guarantee, a sort of kite mark procedure that has been done to a certain standard. And as the purchaser I would expect to purchase that. …We don't have that at the moment* **(consultant orthopaedic surgeon)**

> *PROMs … is good. The National Joint Registry which ought to be compulsory, I don't know why the Department of Health hasn't made that compulsory* **(Site E)**

6.1.4.2 Supply side reform

FT Status

The system requirement to meet maximum waiting time targets has provided a dominant imperative for orthopaedics. Both NHS Trusts and Foundation Trusts share an incentive to maximise revenue. The drive for FT status in combination with PbR has typically incentivised NHS providers to treat more patients where access has been problematic. FTs have often been successful in using PbR to secure additional revenue to increase capacity and activity and help deliver waiting time targets. In isolation, the policy was widely reported to have facilitated better management and quality within FTs. However, the FT policy was also viewed as highly contentious, having "fragmented the health service and to get the best

value out of the healthcare system, we need to bring it back together". This issue was both expressed by PCT commissioners and acknowledged by the FTs themselves.

From a system perspective, it has been increasingly recognised that some localities have cost pressures, driven in part through increases in capacity in specialties including orthopaedics, that can only be addressed by PCT commissioners managing the local economy by using surpluses generated by providers to offset deficits at others. In this context, FT status is most challenging. In one large PCT, action has already been taken, with the PCT starting moving away from PbR in order to fund deficits. "We're now closer to block contacts, or less variable contracts, than we were before".

Staff working in NHS Trust or FT orthopaedics departments were typically concerned by the implications for profitability of PbR tariffs and changes in case-mix associated with the introduction of ISTCs.

Independent Sector Treatment Centres

The presence of ISTCs has been viewed as highly controversial in some localities. The way in which the initial contracts were centrally agreed, where revenue was largely disconnected from volume, and at premium to national tariffs, led to significant criticism:

> *it makes a lot of people grit their teeth … because of the way it was handled … very much out of our hands, it was handled centrally and that was the problem ... But the idea, as a concept, is great and it can work* **(PCT commissioner)**

The quality of treatment provided by ISTCs has been questioned. In one case study PCT, an ISTC was reported to have been closed after "very high" complication rates occurred. In other PCT, an ISTC manager reported commissioning an independent review of their readmission rates, in response to "some mutterings from the local trust consultants that our outcomes for the joint surgery were quite poor". The readmission rate was found to be "much lower … than the rest of the NHS within that area. … . I'm not saying it did a huge amount of good for our reputation with the other orthopods because … I think they were a bit pig sick about that". Several PCT managers described this ISTC's outcomes as excellent.

The impact of ISTCs has undoubtedly been wider than their contribution to capacity. NHS stakeholders have commented on the impact of local ISTCs in prompting changes in working practices and reassessment of the potential for competition between providers: the ISTC

> *really is shaking up the health economy. … on the positive side it did make the surgeons think in the NHS perspective* (**Site G manager**)

For example, in October 2008 a big ISTC opened close to a Trust serving PCT G; "that's the first time … we've ever had any competition [here]". In some areas, such as hernia repair, the Trust seconded staff to the ISTC to provide the activity: "I think we'd all recognise that's actually much better for patients to have what is routine surgery in … a much better …, dedicated elective environment". For three specialties the Trust chose to compete; the Trust is the major regional trauma centre and for the ongoing recruitment of consultants, management of junior doctors' rotas, and the financial consequences of the inevitable change in case-mix, it was viewed as important to maintain orthopaedics.

The impact of ISTCs leaving other providers "with a rump of complex high co-morbidity patients" was consistently viewed negatively by staff from affected providers.

> *… we tend to get the patients that they wouldn't take so we get the higher risk patients both medically and orthopaedically. They are more demanding in terms of nursing care and … the type of surgery that they require. That usually means that it works out more expensive because we are having to put in more expensive prosthesis, … and they take longer to do, so we do fewer cases and generally they are in hospital longer, so that there's been a major sea change* **(Site F consultant orthopaedic surgeon)**

In the two largest rural PCTs, the role of ISTCs in contributing additional orthopaedic activity has been modest. However, the ISTC in the other rural PCT (F) has made a substantial contribution, accounting for 26% of orthopaedic admissions in 2008/9. In this case, the local FT main provider acknowledged that it had faced a problem "as some waiting lists started to stretch", but was critical of the design of the ISTC contract which left the FT with a more complex case-mix, and reports of underused capacity in the ISTC. However, despite the unusually extensive use of the ISTC, this FT's waiting time performance was one of the weakest of all the main providers across the six case-study PCTs. Furthermore, it appeared that the FT had not responded to this exposure to competition by challenging its own working practices. Despite the unusually large proportion of total activity undertaken by

the ISTC in this locality, an orthopaedic consultant from the PCT's main provider noted: "in fact, … it hasn't actually reduced the amount of work that we are doing, we are still working to capacity".

In several case studies, the PCTs and ISTCs expect contracts to be renewed, but in a different format i.e. on same basis as any other provider without guaranteed activity. ISTCs may therefore look at increasing the specialties offered to compensate. In one case it is also reported likely the ISTC will be required to take more complicated cases as part of any new contract.

In a sense, it was too early to evaluate the impact of ISTCs before competition for renewed 'pay as you go', rather than guaranteed workload contracts, come into play. In the short term, they have increased capacity for orthopaedics and we can infer that NHS providers would have been under greater pressure to meet waiting time targets in their absence. However, if ISTCs tend not to survive once they have to compete for activity, the value for money of their introduction may be open to question.

Workforce

Modernising Medical Careers was "born of good intentions but it was implemented in a disastrous way" (Site C)

> *… they've destroyed the hopes, dreams, aspirations of a whole generation of junior surgeons. … we never ever struggled to get juniors and now because of the way that the system is, we can't get post filled, there's nobody to do them, nobody wants to do them, nobody's qualified to do them they're all working 40 hour week which … they don't particularly want to do* **(Site E)**

Contract negotiations for consultants:

> *fantastic home goal by politicians in that we're now all contracted for hours and more units of time. So instead of just doing a job which was care for your patients it's now 'you will work these hours'; for all of us that's the least hours we've ever worked in our entire lives*

… no one is denying that doctors need to be managed but it's how you manage doctors which is the crucial thing and I think they completely underestimated what it would take in order to get doctors to go along with it. And the way they did it was to try and de-professionalise and doing the profession down has completely back fired on them

… we can't be told by managers what we're going to do and these are the standards which we are going to apply to you. It's ruined or is ruining the profession

Do you have any sort of view on how the modernisation agency engaged with your department?

Well there was a chap …, utterly useless, a DOH Stooge who came … and said you guys need to be doing more operating. Well thanks very much, thanks for the support. ... So there's been no engagement, a huge mistrust of the modernisation agency. And it's all part and parcel of how I think we, as doctors, perceive what's going on that the government has had an agenda to bring through these reforms by hook or by crook and one of the big things they've got to do in order to make it work is to smash the medical profession, to de-professionalise us. Bring in all this reform of training so it's competency based so the skill mix can be diluted such that they can say well this person's competent to do X, Y and Z doesn't matter if it's doctor or a nurse. So that was the sort of first phase in how we see the reforms happening is remove the medical profession from the equation and then roll in the reforms into a demoralised and compliant workforce

6.1.4.3 Transactional reform

Payment by Results

PbR has been positively viewed by senior managers in NHS acute providers. It has typically incentivised providers to increase orthopaedic admissions and by so doing reduce pressure on waiting times. However, there are instances where admissions have not increased. In one case this was attributed to fixed available capacity: "more patients mean waiting lists [which] mean being beaten with sticks, so there's no incentive at all to, it's a disincentive in fact to see more patients".

Several factors relating to the tariffs were cited, particularly by staff working in orthopaedics. There was a widely held belief that when the case-mix had become more complex, due to

some activity being seen in ISTCs, the profitability of orthopaedics had been impaired. For example, one senior NHS Trust manager cited this issue as a reason for attempting to compete with a local ISTC: "we didn't want to get left with a very complicated case mix … because we felt we wouldn't be able to sustain ourselves financially … [and] make money under the tariff" (Site G). A consultant working in Site E noted "we're left with the rump of the complex cases [because of the local ISTC]. We can't turn people away and because the HRGs don't reflect that we are losing money on most of the patients that we treat".

Some PbR tariff levels were criticised for promoting inappropriate incentives. An orthopaedic consultant gave an example of inflexibility in the tariffs which led to surgeons being "berated" for using a high cost prosthesis which was viewed as being cost-effective as it was less likely to wear out. At the same time, this interviewee also noted that PbR was fuelling consideration of treatment options with cost saving consequences:

> *we're very keen on … only doing a smaller operation if we possibly can, so a partial knee replacement being the classic, as opposed to a total knee replacement, and that's actually going to be a really interesting contributor to delivering service on tariff because you can do that for less money*

However, the orthopaedic consultant also emphasised pressure to undertake profitable surgery of doubtful efficacy:

> *the obscenity of a purely cost-based system [is] that we are being strongly incentivised … to do procedures that are of limited or negligible benefit … and that's terrible isn't it? So … HRG4 strongly rewards us to do arthroscopic surgery on arthritic joints which is cheap but doesn't work and that's barmy isn't it?*

For some, there was a sense of PbR contributing to greater efficiency: "there isn't the real scope for any more innovation really, we're all treating patients much more quickly, we're all much more aware of the cost of what we do. I don't see how it can be paired more from the bone that it is already". However, there was also appreciation of a bigger picture which the providers should not ignore:

> *I think we're quite lucky in our management structure of leadership is very good and therefore we as clinicians don't get … harangued by the financial implications … . … our Trust has done very well, financially the Trust is making a great profit but the PCT is*

making a great loss and for us, financially, if the PCT go bust, whatever that means, that puts us as their main provider in a rubbish situation **(Site E)**

6.1.4.4 Demand Side reform

Commissioning

Commissioning in relation to orthopaedics has played a minor role compared to the acute sector's response to the DH-led cocktail of access targets and PbR funding and additional ISTC capacity. In this environment, stakeholders have expressed doubt about the ability of the commissioning function to manage demand.

There are examples of community-based triage services being implemented across some of the case-study PCTs, but in general they are focused on changing access to orthopaedic consultants in order to improve their conversion rate (so that they can spend a greater proportion of their time undertaking surgery). Explicit management of treatment thresholds has typically not been implemented by PCT commissioners.

In the absence of widely implemented robust demand management tools, it appears likely that treatment thresholds have changed, and PCT commissioners are not well placed to counter the incentives of providers.

Nevertheless, some PCT commissioners expressed some confidence in being able move beyond 'payment by activity' towards 'payment by results' and establish more direct links with measures of impact on health outcomes.

The PCTs' experience of community-based orthopaedics triage services is mixed. The level of engagement of orthopaedic consultants has been a key issue. In some schemes, they are not involved at all and in others they may see selected patients in isolation. In one well established service, the consultants see themselves as part of a multidisciplinary team:

… there's usually a GP with special interests there … and then there's a couple of physio type practitioners and we all know each other and they will very often come in to see me and say, look I've got this one what do you think? So ... it has evolved … or devolved really

back to how it always was which was a consultant who's the most experienced person there who can actually make the decisions, the clinical management decisions, having a team of people who are seeing cases and who would come to consultants for advice. … So it's come back to how it always was just the location has changed **(consultant orthopaedic surgeon)**

In this scheme, consultants are paid on a sessional basis to see selected patients. Here, the NHS provider Trusts are willing to forgo some outpatient revenue, so long as 'their' consultants encourage patients requiring surgery to book their treatment with them. In one case this was reported to have resulted in an NHS Trust agreeing especially short waiting times for admission for a particular surgeon who was offering patients a choice between the Trust and a private hospital.

In general

it works … very efficiently in terms of the bureaucracy of it. The patients turn up, I see the number of patients I have agreed to see, they're all relevant to my practice and I think I deliver a good service … . It does feed in patients back into … [Trust] because the patients once they've seen me will often elect to go to … [there] to have their treatment done by me. So the Trust is winning, the Trust doesn't have to pay me to go there because the PCT pays me to go there. So the Trust is getting … an appropriate case mix really for nothing **(consultant orthopaedic surgeon)**

Other orthopaedic consultants did not accept that triage by another type of clinician could work.

There are wider consequences too: "the downside of it is that we as a Trust have lost that clinical workload with all the opportunities there are for training, training the registrars and developing a cohesive service". Registrars now may see three new patients per clinic instead of seven or eight.

One scheme reported undertaking a study which suggested an increase in treatment thresholds had occurred compared to other localities, but in that PCT the commissioners were assessing performance on conversion rates rather than treatment rates. Hence, there was no direct attempt to manage the growth in surgical activity.

I do a 100-150 shoulder procedures that my senior colleagues 20 years ago, did maybe 10 of and that development is continuing. Every time we appoint someone with a special interest … it attracts more work. I don't know, I really don't know how the mechanism happens **(Site F consultant orthopaedic surgeon)**

Practice based commissioning

In the context of demand management, practice based commissioners have the potential to play a key role, which

is very much to look at pathways, to look at … the change that they think their patients need. … I think the principles were brilliant … let's get those who are buying the service to understand how much they cost, really looking at mapping of pathways and to have an effect on what we're going to offer our patients **(Community Services manager)**

In practice, however, the initiative appeared to be far from the grasp of PBC.

Choice

The choice agenda was often raised in relation to orthopaedic services. Not surprisingly, orthopaedic consultants have tended to see themselves as the key criterion for choice:

the most important thing … is the person who's actually wielding the knife …. I think most patients want to know that the person doing the operation is someone who has a vested interest in making that operation go as well as possible and that would be someone who is a local surgeon within a community who has a reputation to protect

In this case, the alternative was characterised as "somebody coming in for six weeks from Sweden or South Africa hacking their way through a list of patients and then clearing off again".

The tension for PCTs between allowing patient choice and ensuring that ISTC contracts were utilised was often cited. For example, it was reported that patients were "bullied" via repeated phone calls from referral management centres into changing their choice to the

local treatment centre. This situation is one of the clearest examples of a "dichotomy between commissioning and choice" (manager). More generally, orthopaedic triage services inevitably "steer" patients along particular pathways which entail assumptions about patient choice.

Tension was also noted between the paucity of information available to patients on which to make choices and the difficulty of coping with increased demand associated with having a good reputation or comparatively short waiting times:

> *some people just want to be seen in the shortest space, even though it may be entirely incorrect for them to be seen in that unit. You get people … who will come … here for the day just to be seen even though they … need their treatment locally … . I think choose and book is probably the worst thing that anyone's ever introduced* **(consultant orthopaedic surgeon)**

6.1.5 Conclusion

The case studies' experiences of activity

A broad distinction can be drawn between the experience of the urban and rural case-study PCTs. The urban PCTs have experienced historically better waiting time performance compared to the rural PCTs over the last seven years.

Overall, the rural PCTs have reduced the size of the gap in waiting time performance with the urban PCTs. With one exception, this has been achieved by substantially larger increases in activity across the rural case-study PCTs compared to the urban sites. The rural PCTs experienced increases in admission rates between 2002/3 and 2008/9 of between approximately 50% and 76%.

Two of the urban PCTs (B and A) have experienced comparatively small increases in admission rates over time. However, they also mark the extremes in terms of admission rates. PCT B had the highest admission rate during the four years from 2002/3 and strongest waiting time performance, and would arguably have incurred least pressure to subsequently

increase activity. PCT A has also had strong waiting time performance for inpatient admissions. PCT A has a markedly younger resident population compared to the other case studies along with the lowest admission rate since 2002/3.

The PCTs show considerable variation in admission rates and the proportion of day cases undertaken.

Policy levers

Several policies have directly facilitated the response to comparatively poor waiting time performance of increasing admissions. Both NHS Trusts and Foundation Trusts share an incentive to maximise revenue. PbR introduced a stronger link between activity and funding and so long as the marginal cost of additional activity has been less than the national tariff, providers have been incentivised to treat more patients.

Hence, in the case of orthopaedics, the system regulation imperative of maximum waiting time targets has provided a clear context in which the transactional infrastructure (PbR) has enabled supply-side players (predominantly NHS Trusts and Foundation Trusts) to further their interests and increase capacity and activity.

ISTCs have also played a role. In the two largest PCTs, the role of ISTCs in contributing additional activity has been modest. However, the ISTC in the other rural PCT (F) has made a substantial contribution, accounting for 26% of orthopaedic admissions in 2008/9. The presence of ISTCs has been viewed as highly controversial in some localities. The way in which the initial contracts were centrally agreed, combined with local resistance to their use, and the implications for other providers having to work within the PbR tariff structure, have prompted much comment. ISTCs have also illustrated the tension between patient choice and role of commissioners to influence resource utilisation.

The impact of ISTCs has undoubtedly been wider than their contribution to capacity. NHS stakeholders have commented on the impact of local ISTCs in prompting changes in working practices and reassessment of the potential for competition between providers.

The evidence from the case studies is that in general waiting time performance has improved, particularly in those localities with the weakest initial experience. Although the rural PCTs nearly 'closed the gap' with the urban PCTs over time, it remains the case that during the first quarter after the deadline for achieving the 18 week target, the three urban sites met the target and the three rural sites did not (table 6.1). Moreover, the key concern has been that demand-side control has been weak, such that stakeholders have expressed doubt about the ability of the commissioning function to manage demand. In the absence of widely implemented robust demand management tools, it appears likely that treatment thresholds have changed, and PCT commissioners are not well placed to counter the incentives of providers.

In the few examples of large-scale demand management initiatives, such as community-based triage services, one objective has been to change the flow of patients to orthopaedic consultants, so that they can spend a greater proportion of their time undertaking surgery (ie improve their conversion rate). Explicit management of treatment thresholds has not yet been undertaken by PCT commissioners. Nevertheless, some PCT commissioners expressed some confidence in being able move beyond 'payment by activity' towards 'payment by results' and establish more direct links with measures of impact on health outcomes.

In those PCTs with comparatively weak waiting time performance, the policy levers have supported a supply-side led response, which has to a great extent delivered more rapid access to treatment. However, the growth in capacity has been unprecedented, and it remains to be seen whether the rapid increase in activity is sustainable. There is increasing recognition that as overall funding is constrained, a greater emphasis on system-level management is required. In theory, PCT commissioners have a key role to play, but their history is chequered, particularly in the rural localities, and it is not clear that they can provide the leadership necessary to counter the strong instincts for self-preservation associated with the acute sector and FTs in particular.

6.2. Diabetes

Introduction

Diabetes is a chronic and progressive disease that describes a group of disorders characterised by elevated blood glucose caused by the inability to produce and/or respond to insulin (Department of Health, 2002b). The prevalence of diabetes is on the increase. In 2008, it was estimated that nearly 2.5 million people in England had diagnosed or undiagnosed diabetes, with a forecast that this number would rise to about 3.6 million (or 6.5% of the population) by 2025 (YHPHO, 2008). Health complications associated with diabetes are more likely to occur in areas with greater levels of deprivation (3.5:1 between social class V and social class I), and amongst people of South Asian and African-Caribbean descent (6:1 and 3:1 respectively; Department of Health 2007). Whilst diabetes is most likely to affect people over 40 year of age, a growing problem with childhood obesity has been uncovered. In the long-term, diabetes is associated with enhanced risks of a range of health problems including heart disease, stroke, retinopathy, circulation problems and depression (YHPHO, 2008).

The impact of diabetes on the health care system is substantial. Total NHS spend on the diabetes care programme in 2006/7 was £1,043 million with over half the cost associated to prescription costs. Diabetics are twice as likely to be admitted to hospital and tend to have prolonged hospital stays (Sampson, Brennan et al,., 2007).

Tackling and preventing diabetes has been a priority of the Department of Health for many years. In 2002, the *National Service Framework for Diabetes* set national standards for the prevention, detection and management of diabetes (Department of Health, 2002b, 2003d). NICE clinical guidance for the management of both type 1 and type 2 diabetes were published in 2004 and 2008 respectively (NICE, 2004, 2008). Such guidance has been supported by the work of NHS Diabetes within the Department of Health that has been highly pro-active in seeking to raise the quality of diabetes care in the NHS by developing a range of support tools for providers and commissioners to encourage them to redesign diabetes services to become more integrated and personalised - for example, through *Year of Care Programme* (NHS National Diabetes Support Team, 2008). Since 2004, pay for performance indicators in general practice through the Quality and Outcomes Framework

have also incentivised the routine monitoring and management of persons with, and at risk of, diabetes.

6.1.2 Overall progress

As Figure 6.7 shows, the six case sites in the study had different ratings in terms of the care quality of their diabetes services. This was based on Healthcare Commission ratings and represented the baseline position of the case sites prior to the interview process. A variation in diabetes prevalence, based on April 2008-March 2009 QOF data, also existed for our case sites and represented the prevalence during the period of first-round interviews.

Figure 6.7 site ratings of care quality of diabetes services

Site	Spearhead PCT	Adults with diabetes are looking after their condition	Adults with diabetes feel supported to self care through care planning, information and education	Adults with diabetes have key tests and measurements carried out	% Prevalence of Diagnosed Diabetes (versus expected)
A	Yes	Fair	Weak	Weak	3.1 (3.6)
B	Yes	Fair	Good	Fair	4.0 (4.3)
C	No	Fair	Fair	Fair	4.6 (4.3)
E	No	Fair	Excellent	Good	4.0 (4.0)
F	No	Good	Excellent	Good	3.9 (4.0)
G	No	Fair	Fair	Fair	3.8 (4.0)

Figure 6.7: Case sites diabetes service characteristics (source: Healthcare Commission, 2007b) and prevalence (source: The Information Centre for Health and Social Care, 2008-9 QOF registers). Prevalence for diagnosed diabetes among people aged 17 years and older and expected prevalence compares value to that of PCTs with similar diabetes risk factors.

Each of these quality contexts appears to have had some bearing on the local interactions between commissioners and providers. For example, inequalities in the prevalence rate of diabetes in Site A and knowledge that the PCT's comparative performance with others was poor (based on QOF ratings) was reported to have led to some concerted local strategies for improvement in primary care to better manage diabetes patients. Conversely, the two sites with the best initial ratings (Sites E and F) were reported by respondents in the study to have poorly developed clinical relationships between primary and secondary care providers. One might hypothesise, therefore, that the context of being within a poorly performing site at the outset was a motivator for change.

Evidence to support this can be seen in Figure 6.8 that shows changes in the level of expenditure for each PCT within their diabetes programme budgets between 2004/5 and 2008/9. (In some sites, such as Site C, there may be uncertainties around data reporting particularly in the earlier years. For example, the 2005/6 figure is a for site C is missing value). Despite high diabetes prevalence, Site A expenditure on diabetes was consistently below the national average from 2004/5-2007/8 but increased substantially in 2008/9. However, association between performance and spend cannot be directly made. Whilst the general trend across the case sites has been for spend on diabetes to increase (albeit, mostly under the national average) it is less likely that this trend reflects pro-active investment (or non-investment) decisions and reflects more directly the trends in increasing hospital activity and cost.

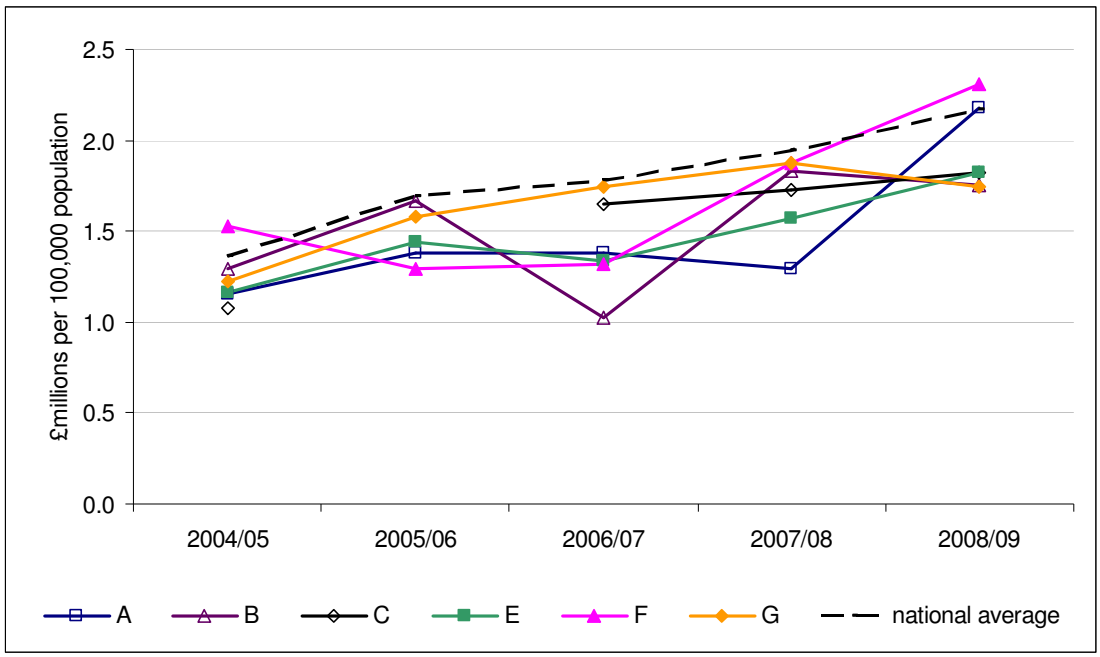


Figure 6.8: Annual PCT Spending for diabetes care for the years 2004-2009 for selected case study sites. Data derived from the annual DH Programme Budgeting Benchmarking Tool (National Programme Budget project, DH 2004-9)

A further analysis on performance trends across the six sites was undertaken using an assessment - based on aggregated practice scores within each PCT - of three selected diabetes outcome indicators in the QOF: two measures indicating effective blood glucose management (DM6/20 and DM7) and one measure of blood pressure management (DM12). The overall trend in each case site was for improved year-on-year performance amongst general practices, though with evidence of a levelling-off of improvements over time (Figure 6.9).

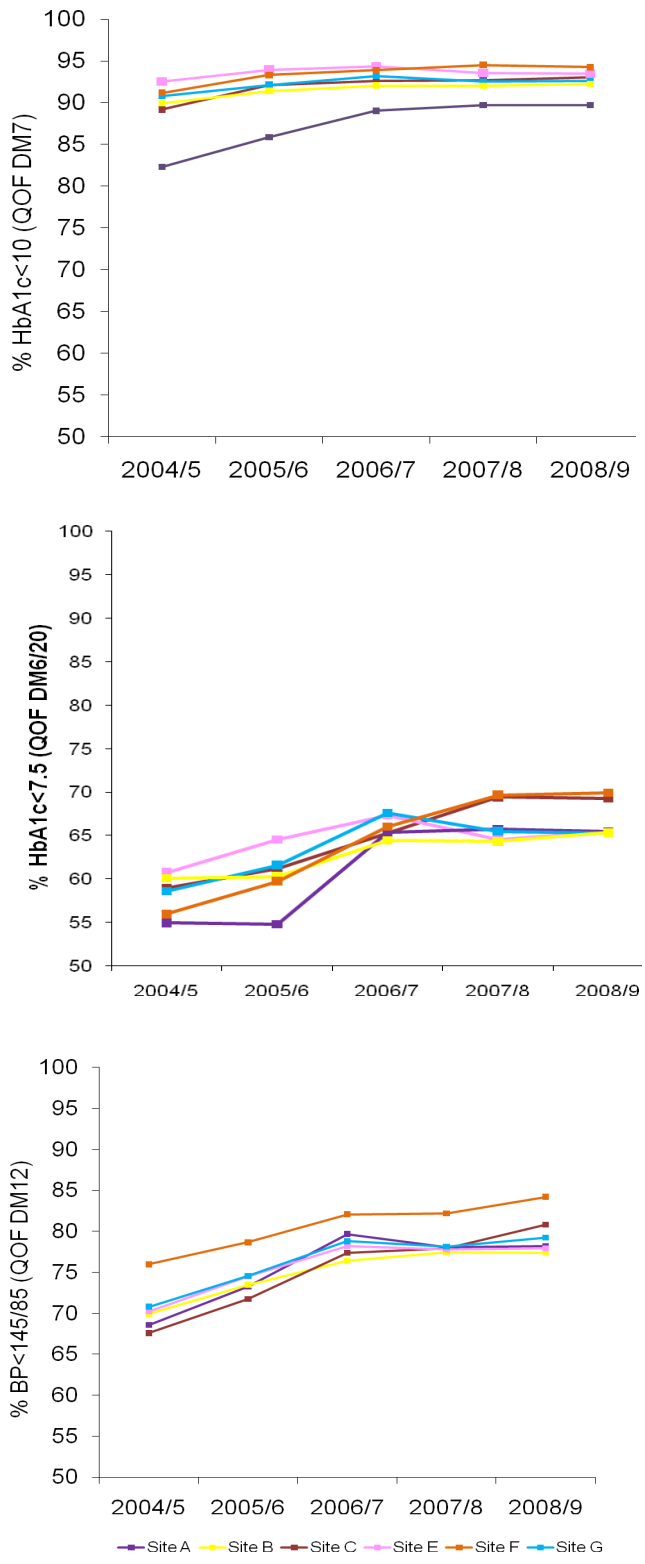


Figure 6.9: Achievement of QOF scores DM 7(HbA1c ≤ 10), DM6/20 (HbA1c ≤ 7.5) and DM 12 (BP<145/85) for the years 2004-2009 for case site (Source data: QOF database).

This correlates with national studies that have shown how QOF was initially associated with improved quality of care (Campbell, Reeves et al., 2007, Tahrani, McCarthy et al., 2007) but

that the rate of improvement had not been sustained post-2007 (Campbell, Reeves et al., 2009). There was also a tendency for the selected QOF indicators performance to not go much beyond the upper threshold for payment (threshold for payment: DM 7 (40-90%), DM6/20 (40-50%) and DM 12 (40-60%). Both these attenuation effects could reflect either the difficulty of target attainment in some diabetics or the lack of further incentive after attainment of the upper payment thresholds – ceiling effect (Calvert, Aparna Shankar et al., 2009).

Whilst the results for five of our sites showed a clustering of performance (for example, between 0.88 and 0.93 for indicator DM7) one site - Site A - was performing below the others suggesting some key deficiencies in disease management practices within certain practices of the PCT. This is related to the context of the Site A itself being an urban PCT with significant areas of deprivation; a higher proportion of ethnic groups more susceptible to the disease; and a high number of single-partner GP practices and validated by comparator PCT sites for Site A showing similar underperformance (data not shown).

The Diabetes Community Health Profiles and the Diabetes Outcomes and Expenditure tool (DOVE; attempts to relate spending in diabetes care (using the DH Programme Budgeting Benchmarking Tool) to diabetic outcomes (using QOF DM6/20 HbA1c ≤7.5 and diabetic emergencies in acute care (source data from National Diabetes Audit Dashboard, Information Centre for Health and Social Care) in diabetes care. Case site PCT relevant data were extracted and shown in Figure 6.10

Site	Expenditure (per person with diabetes)	% of people with diabetes with a HbA1c ≤ 7.5%	Rating	Change in Programme Budgeting total spend	% Change in HbA1c (≤7.5)	Rating	Emergency admissions for ketoacidosis and coma/ 100 registered patients (compared with similar PCTs)
A	£459.30	65.70	low costs poor outcomes	-£49.62	0.30%	lower change in costs better change in outcomes	7.4 (5.6)
B	£460.16	64.3*	low costs poor outcomes	£189.21	-0.10%	higher change in costs worst change in outcomes	4.4 (6.0)
C	£362.09	69.8+	low costs good outcomes	-£19.35	4.50%	lower change in costs better change in outcomes	5.2 (6.0)
E	£386.36	64.5*	low costs poor outcomes	43.3	-2.80%	higher change in costs worst change in outcomes	4.3 (5.7)
F	£467.64	69.7+	low costs good outcomes	£116.94	3.60%	higher change in costs better change in outcomes	5.9 (4.7)
G	£444.62	65.4*	low costs poor outcomes	£8.33	-2.20%	higher change in costs worse change in outcomes	4.8 (4.7)

Figure 6.10: Outcome versus Expenditure for diabetes care – data extracted from Diabetes Community Health Profiles and the Diabetes Outcomes and Expenditure tool. Expenditure (source data Programme Budget Benchmarking Tool) and HbA1c (source data QOF) for the year 2007/08 and as changed from 2006/07 values. Emergency admissions for ketoacidosis and coma (per 100 registered patients) in 2007-09 compared with PCTs with similar diabetes area classification. *Significantly lower than England. +Significantly higher than England.

Whilst there are limitations to attributing outcomes simply to one measure of diabetes management and emergency admission for diabetic complications, and no knowledge of how diabetes budget is being spent, the benchmarking does indicate that whilst all case site had low costs/spending in 2007-08, they were not necessarily reflected in poor HbA1c values (Site C and F) nor high emergency admission for ketoacidosis compared to sites with similar

diabetes characteristics (Sites B, C, and E). Site C had better outcomes despite lowering costs compared to the previous year (2006-07). The other urban sites fared worse, Site A especially not only had poor patient support and detection of diabetes to be lower than expected (Figure 6.7), there were poor results in QOF measures (Figures 6.9-10), and a very high rate of emergency admissions for ketoacidosis indicating some (undetected) patients with very poorly managed diabetes. The rural sites rate better for patient support and have good detection of diabetes (Figure 6. 7) but Site E and G had worsening outcomes in HbA1c management in 2007-08 despite increased budgeting for diabetes care from the previous year (Figures 6.9-10). Site F had excellent support for patients (Figure 6.7) and good outcomes for QOF measures (Figure 6.9), however emergency admissions for ketoacidosis was high. This could be reflective of the poor primary and secondary care diabetes pathway we found at this site impacting on the more complicated diabetic patients.

6.2.3 Impact of the health system reforms on diabetes care

We now turn to examine the impact of the four streams in relation to diabetes care.

6.2.3.1 Demand-side reforms

Patient Choice

There was a commonly held view from respondents - both commissioners and providers - that patient choice of provider was not a lever for change that had much impact or relevance in enabling high quality care services to be provided for a long-term chronic condition such as diabetes. In most sites it was acknowledged that the majority of patients would wish to choose their local hospital out of convenience. Where multiple entry points to diabetes care existed (particularly for secondary care) it was reported that this had the potential to fragment, or undermine, the potential to develop a pathway of care.

> *" Yeah. Well it's just stupid. Here, we don't want patient choice for diabetes because if you've got choice, you can't run an integrated service, But you're not going to get better outcomes if you go here for one thing and you go to Boots to get your feet done and you go somewhere else to have your eyes done, it's not going to deliver the outcomes "* **Site C GP 1**

Hospital clinicians, for example, commonly argued that choice was not an important lever for improving care but that 'easy access to quality local services' was more important, particularly in helping to reduce health inequalities.

" Patient choice! I'm going to have another little rant. Patient choice! My personal view is that patient choice on the whole now I'm going to sound like a dinosaur, a complete dragging me down dinosaur person in that actually patient choice, what's that about for chronic disease? Fine if you want your hip replaced,… for chronic, You go out and ask patients what they want is a reasonable service with good access that they can get to easily and they can see someone quickly and that they can get help when they need it. That's what people want. **Site C Diabetes Consultant**

" People want to be seen locally and want continuity of care and those are probably the key issues " **Site B GP Diabetes special interest**

Patient Voice

Patient voice, particularly in making personal decisions about the nature of the care and treatment they received, was regarded as a more relevant issue - and one that had more impact, for example, during the consultation process with GPs. In responding to the question about patient voice, many respondents also equated that to the need to enable or support patients in the self-management of their diabetes - as set out in best practice guidance. Voice was also identified with individual patient knowledge and empowerment (e.g. the Expert Patient Programme) and sometimes with wider collective structures for patient participation and engagement. Most clinicians welcomed patient empowerment as a core aspect of good diabetes care:

" Patient empowerment is important, particularly in diabetes… We see patients for 15, 20 minutes two or three times a year, then there's 24 hours a day, 7 days a week for the rest of the year the patient's got to look after themselves and be highly motivated. They can only do that if they're knowledgeable and educated and indeed one of the major investments here in diabetes is structured patient education and patients do learn a lot more about the disease " **Site B FT Consultant Diabetes**

However, many respondents also recognised that the strength of the patient voice - and the nature of how to connect with it - would vary between individuals and groups, particularly so in areas such as Site A with large pockets of hard-to-reach groups:

I think yes that you've got two extremes. You've got very wealthy, middle class people and [elsewhere] you've got a lot of deprivation, you've got a lot of ethnic minorities unemployment, … in [Site A] it'd be straightforward and very highly intellectual and smart and all the nice sort of IT stuff and where then I have to change my cap when I go down to [Y] because I've got people there who don't know how to read and write. ***Site A Diabetes Nurse***

Other respondents also suggested that voice was not the strongest lever for change locally in comparison with other imperatives (such as meeting targets and service standards) since the process of developing fully engaged patients was problematic - the underlying subtext to such arguments in some cases appearing to be the lack of belief (primarily amongst some rural clinicians) to the value of the patient's viewpoint:

" I think empowered patients are great. Informed patients are great, We have lots of really good patient representation … and they were great at shaking lethargy out of the system … So I think, you know, well informed patients can certainly make a change... [but enabling] *stronger voices is a bit of a problem ..."* ***Site*** **E FT Diabetes Consultant**

' [I am] *not sure how much the patient can voice, they can say.* **Site G Diabetes Consultant**

Two sites (Site B and E) in the study appeared to claim that voice was particularly strong locally in influencing diabetes care provision. The engagement strategy was encouraged through support, tools and information from national support bodies such as NHS Diabetes and Diabetes UK:

I think we've got a very strong voice in [Site B] for patients on diabetes. We work with Diabetes UK as our main network locally to disseminate some of the outcomes. … we had an event from the public consultation event which was over seventy people came and it

was because we were all linked in to Diabetes UK locally.. **Site B PCT Head of Strategic Commissioning**

A*s part of the* [NHS] *Diabetes toolkit, one of the first steps is to go to the public and say 'what do you want', and I have to say we were rather smug, we went and thought, well we know what they want, and we'll just hear it and then go on, and we didn't, they came back with ideas that we had no idea of.* **Site B GP Diabetes Clinical Lead**

I think we were one of the first areas in the country to have annual retinal screening for diabetes. Delivered in advance of the NSF target. Partly because we were interested in it but partly because we had really effective patients on the group. **Site E FT Diabetes Consultant**

Commissioning

There has been a tendency in the wider literature to describe PCT commissioning as the 'weakest link' in the reform architecture - particularly in terms of its ability to influence the way services are designed and delivered to better meet patient needs (Smith et al, 2010). However, our analysis showed that some PCT commissioners were pro-active and ahead of others in taking forward the best practice guidelines from national policies and developing a strategic plan for integrated, community based diabetes service - and shifting care out of hospitals.

What we currently have are diabetes type services commissioned in silos. So you've got service commissioned for podiatry, service commissioned for dietetics, service commissioned for [16.24] screening. Service commissioned for in patient care. Ok and that's how we operate. It's not fully integrated. **Site A PCT Commissioning and Strategy Directors**

Diabetes I'm really excited about … I mean it's actually one of our service redesign priorities this year and we are talking about having a completely different model in the city and a community based model. I suppose where that gets difficult in terms of the reform agenda is the complexity of taking a service that's currently provided by three different sets of providers – GPs, our own provider arm and [the main FT] – and turning it

into an integrated service. I don't underestimate how difficult that's going to be. **Site B PCT Director of Commissioning**

PCTs stated that their vision was for more than 80 or 90% of diabetes provision to be based in the community. In enabling this shift towards community-based and integrated services, PCT commissioners were impacting at different levels both between and within the case study sites, a factor very much related to the way services had been developed historically. Consequently, many PCTs were seeking ways to grow the model:

each locality has a slightly different area or interest. So you have to sort of, you know, you've got to nurture those ones and work with them a little bit more. **Site B PCT Head of Strategic Commissioning**

really, I suppose, it should across the whole of [Site G]. If we're going to provide an equitable service then we should all be delivering the same, you know, the same care, the same education to patients but whether it'll still be two, I mean, Site G is one PCT so in theory it should be the same across the PCT shouldn't it? But it is a big PCT so and it's a big county, yeah, but things are delivered very differently in X than they are down here….. **Site G Diabetes Nurse**

In responding to questions about the strength of the PCT commissioner, many respondents across all the case sites had concerns about commissioning knowledge, skills and capacity:

I think the problem is people don't actually understand what is provided in a community setting and commissioners at the moment don't understand the complexity of community provision and how that contributes to the health and wellbeing of an individual on an ongoing long term basis and I mean even if you use diabetes as an example you know the consultants that sit in the hospital think the best way to provide diabetes care is for them to come out and provide a clinic in the community and in their perspective that's providing the local clinic, you know service in the community. **Site B PCT Provider Services**

A common response from many sites was that PCT commissioners had little power (or inclination) to really enforce change locally - PCTs had little control over referrals made by

GPs whilst the transactional and governance regimes meant that primary, community and secondary care providers had little incentive to respond to strategic calls for integrating diabetes care.

However, in at least one PCT [Site A], significant progress had been made in incentivising the development of better diabetes management within primary care through the deployment of a QOF+ scheme that rewarded the sites for being more pro-active in case finding of at-risk diabetes patients linked to an educational process led by hospital consultants. The development of a clinical network linked to performance related pay in primary care suggests that commissioners can and have influenced care delivery in the direction of what one might call 'best practice' in primary care, despite having relatively few levers to enable vertically integrate care.

Practice-based commissioning

Across the sites PBC was not generally perceived as having significantly impacted on diabetes care and there were mixed feelings towards its potential:

> *And so they appear to be wanting to commission exactly what we've always provided. I'm not convinced that it's changed things very much* **Site E Diabetes Consultant**

> *Now certainly some of the practice based commissioning in theory could help with that and in theory practice based commissioning is a really good idea for chronic diabetes.* **Site G Diabetes Consultant**

The presence of a number of different PBC groups locally was reported to be associated with a greater fragmentation of pathways and inequity of services - particularly if different components of services were commissioned by different PBC group, with PBC itself seen as a barrier to integrated pathways. Indeed, one of the facilitating factors to the PCT in Site A in influencing diabetes care provision was the presence of a single local PBC consortium willing to work in partnership with the PCT to take forward these innovations.

The two sites where practiced based commissioners had progressed most in commissioning and delivering diabetes services, albeit in limited localities, had support from the PCT and good clinical relationships between primary and secondary care.

> *We try and see them as co-commissioners, so what we'd want to develop is a culture where, which we are doing, where you know the ideas are being generated from the practise based commissioners, through needs assessment that's being done on patch and their seen as partners in the commissioning process. And obviously some of them have freed up resources where they commission for their local population. With some of the bigger projects like the diabetes, what we have is some [PBC] consortium are doing pieces of work around the diabetes, quite bespokely, but it does strategically fit with our agenda* Site B PCT Head of Strategic Commissioning

> *We've had a much more positive relationship with the diabetic department. Certainly our practise based commissioning and consortium group have in terms of looking at their, on the cusp of, in fact I think it's just started, of having a diabetes that really spans primary and secondary care and a truly joint partnership working between primary and secondary care. That is completely different to the system that we had, you know, in the past. Why has that worked in diabetes? Well certainly a lot of it is to do with the consultants, their willingness to look at things differently…., we've had some new consultants coming in fairly recently which has transformed the relationship.* **Site C PEC Chair**

6.2.3.2 Supply-side reforms

Diverse providers

There was a common perception across the six sites that competition for patients between diverse providers was not necessarily a good thing for people with diabetes since the ability to manage an individual across their care pathway required a high degree of collaboration and co-ordination. Hence, there were concerns that competition among diverse suppliers would lead to service fragmentation:

Now the problem requires a concerted planning cooperation across all of the different sectors of the health service. Competition in the NHS I don't think has encouraged that at all, in fact it actually is pulling in the opposite direction, because it is encouraging Acute Trusts to focus more on the role of the diabetic specialist in management of diabetics, which is actually against where we really need to go - in both the evidence base, point of view and from common sense to be honest with you. So it means we have to set up models that fight against the natural drivers in health reforms to improve the quality of care and we are doing that. PBC to a certain extent you see, was developed as a kind of a counter value balance to this Acute Trust. But GPs are busy people and not many of them can give the time and effort to developing a PBC system which is going to be as strong as Acute Trusts are. **Site C PCT Director of Public Health**

a lot of what we've heard about in the NHS … has been designed almost from an acute services point of view and isn't necessarily best for chronic disease. I don't believe that having a whole variety of providers with different aspects of diabetes care in different parts of a locality actually give the patient better care. I can understand the theory behind it and the potential advantages but there are major disadvantages in that what you develop is a fragmented care, so you have no continuity and we have seen that in [Site B] that doesn't mean that it has to be one provider, but the real danger here is that you have so many providers providing smaller, different aspects, there's not a critical mass. **Site B Consultant Diabetes FT**

However, there was some support for some discrete elements of diabetes care - such as retinal screening - where diversity could be good. In Sites A and E, for example, it was argued that contracts for discrete service elements could potentially improve cost-effectiveness of the service.

Foundation trusts

The study could not find any definitive conclusions about the impact of FT-status on the ability to integrate diabetes services or in its effect on relationships with primary and secondary care. However, some consultants reported that it had become more difficult to engage with their primary care colleagues - though this was put down to pressure of work and increased activity.

6.2.3.3 Transactional reforms

The Quality and Outcomes Framework

The development and impact of pay for performance through the QOF, with its particular focus on diabetes care management, was viewed very differently across the respondents in the study. Some, particular those in PCTs and general practice, suggested that it had significantly 'upped their game' in the pro-active management of diabetes. Others, particularly consultants, felt that QOF was a rate limiting step, had not 'stretched' the boundaries of quality, and led to a reduced quality in the holistic appreciation of patients' needs. In Site A, the introduction of a QOF+ scheme was targeted at poorly performing practices with high exception reporting and high unmet needs. They reported that the behaviours of GPs and their practice teams were significantly influenced through incentive payments, but that such an approach needed to be developed in conjunction with better education and training.

> *Well I think the one that has had the greatest effect on our practice is the use of QOF targets. For ourselves, now that has lead to good things and to bad things because QOF targets have made GP's provide a better service [but] it has reduced them to a trade because people are now getting paid for items of service which otherwise they wouldn't get paid for, I think that's disappointing in a profession but what happens with QOF targets is that GP's are more thorough and they achieve a great deal more.* **Site E Diabetes Consultant 1**

Payment by Results

The impact of PbR in rewarding and enabling more productive and cost-efficient care within a hospital setting was supported by many consultants within Foundation Trusts. In Site E, for example, a consultant reported that it had 'raised everybody's game' whilst in Site A the tariff-based system was described as having led to higher volumes, fewer follow-ups, and greater scrutiny of care quality.

However, in terms of integrating care for people with diabetes, PbR was seen as a significant barrier in its 'destructive ability' to divide primary and secondary care despite widespread clinical support of community-based pathways.

… payment by numbers works absolutely fine if you have a short, sharp intervention. So it's absolutely fine if you're having a cataract operation or if you're having a hip replacement. It's a rubbish model for long term conditions and diabetes is one of the very good examples of a long term conditions **Site C Diabetes Consultant**

But that whole sort of ethos of moving the care from the hospitals to the community is definitely one that's been messed about by payment by results….Stopped yeah, well we're trying to get them going again, but you get to a point you've got clinical consensus about that's the right pathway and we don't seem to be able to get over the barrier of well how are we going to implement it? Because it will mean loss of income and all the rest of it. So that's been a real issue…Not by the clinicians. Clinicians are absolutely clear, but the policies thing seems to have got in the way of it **Site F PCT Medical Director**

The articulation of PbR being a barrier to care integration was particularly strong amongst PCT and GP respondents. There was a broad agreement amongst this group that PbR needed to be more sophisticated for services such as diabetes:

we will charge you at £100 a year or something' - now some of them might hardly use any of it but you will have some very expensive people… I think PBR needs to be more sophisticated, far more sophisticated **Site C FT Medical Director**

Yet others, such as the PBC consortia lead in Site F suggested that diabetes care would significantly benefit from 'being taken out of the tariff and returned to a service level agreement'.

6.2.3.4 System management and regulation

Guidance, support and various toolkits to strengthen the commissioning and care management of people with diabetes has played a significant part in influencing how care was being provided. In particular, the NSF, NICE, and Year of Care initiatives were recognised as key levers for improving diabetes services both locally and nationally. Such guidance was considered as 'vital' in providing PCTs with the underlying tools, knowledge and

empowerment to commission services differently whilst care providers 'trusted' the implied changes since they come from a respected source:

> *I think the NSF under NICE guidelines are to be supported and congratulated … it's a good enterprise if you link properly the NSF and NICE to QOF points and practice and practice based commissioning and educate the patient such as they understand what's available and where it's obtainable then yes I think it is. And over long time since I've been in the Health Service I've seen staggering improvements. So I would say some of them are due to those policies.* **Site E SD Diabetes Consultant**

> *The commissioning tool kit for diabetes - which is what we've used to do our redesign on - has been really helpful in giving us a guide on what steps to take ... I think the Year of Care … [will] be a good lever that will as long as we can get it embedded and get the cultural change happening, because that's really saying to practices, you take up the model in terms of care planning that actually we value the behaviour of relationship changes with the patient rather than just getting round their medical statistics better*. **Site B PCT Head of Strategic Commissioning**

Within a hospital setting, the 18 week target in diabetes - in conjunction with the tariff - was recognised as a force in driving productivity generally but that 'door to needle' time in diabetes met such targets quite easily. It was also felt that, for a chronic condition such as diabetes, that the 18-week target lacked relevance given that the nature of the intervention would vary based on individual needs:

> *But with chronic disease management, I think it's rather different. And I think well, you know, sometimes time is an appropriate part of the diagnostic process. Sometimes you need time to respond to the treatments that you're being exposed to. Sometimes you need time for it to be clear, you know, how this whole problem is going to pan out. You know, whether it's just an acute problem that's going to, you know, it isn't severe and is going to be self limiting or whether it's going to be a persistent and progressive problem. I think also you need the ability to prioritise who you review in terms of chronic disease on the basis of clinical need rather than just timescale.* **Site E FT Diabetes Consultant**

6.2.3.5 The Influence of Local Contexts and Mechanisms

The local context played an important part in determining how progress in improving diabetes care provision played out. For example, in Site A, the 'burning platform' of high diabetes prevalence and poor QOF performance galvanised the PCT into making it a programme priority leading to the development of a local incentive scheme and educational programme with specialists from local hospitals that was not seen elsewhere. In rural PCTs, less emphasis was placed in personalising diabetes services and enabling patient voice and choice due to the inherent difficulties in managing a remote population and where little variety in care options was available. The historical nature of the way PBC developed was also a factor - larger collectives across a PCT enabled a collaborative response whereas PCTs with a number of smaller PBCs did not. In all of the case sites, despite each developing specific strategies for quality improvement and care integration for diabetes services, there had to date been an inability to create effective mechanisms for vertical care integration - a case of 'stifled' achievements since the strong 'push' of regulatory guidance came up against various barriers in system architecture (such as payment incentives and targets). This was despite a common understanding of where better care for people with diabetes needed to develop supported by central guidance on best practice diabetes care that was an accepted norm from all stakeholders across all sites.

6.2.3.6 Conclusion

Understanding the collective impact of the NHS Reform elements was problematic for the individuals that were interviewed as part of the sub-study on diabetes. The reform forces that impacted individual behaviours were often invisible and unseen. Hence, there was a perception that whilst change had been achieved in diabetes care - and for the better in most cases - interviewees found it difficult to ascribe changes to specific reforms or reforms in general. Indeed, in some sites, it seems that the reform levers were never really implemented locally since pathways of diabetes care could potentially be developed better independent of certain reform drivers such as competition and choice. In other words, research from the diabetes tracer suggests that the reform architecture was never intended to be used in a collective fashion to improve diabetes care.

What is clear from the research into the diabetes tracer is that the strongest forces of reform (as perceived by those working on the ground) have been central regulation and guidance mixed with the nature of the payment and reward system - a combination that could be synergistic (for example, in encouraging care management in general practice) but also in conflict (for example, in enabling vertical integration). The strength of commissioning to encourage more integrated diabetes care appears to depend on the combination of these forces - hence, PCTs could (though few did) utilise best practice guidance and payment levers to enable change in primary care; but were unlikely to enable better integration between primary and secondary care settings except through significant engagement in the development of clinical networks (aided by larger PBC consortia and a history of good relationships between primary and secondary care). Choice, competition and provider diversity were not reform levers that were actively encouraged.

6.3. Early intervention Mental Health

Introduction

Early intervention in psychosis services support people aged 14 to 35 with a first presentation of psychotic symptoms. In the 1990s evidence amassed suggesting that many people in the early stages of a psychotic illness experienced significant delays between the first onset of psychotic symptoms and the provision of treatment, and further, that the length of this 'duration of untreated psychosis' strongly affected long-term outcomes (Birchwood 1997).

In response to these concerns, the National Service Framework for Mental Health announced the intention to establish 50 new Early Intervention in Psychosis (EI) services (DH 1999). These services would provide high-intensity support to a small caseload of patients for up to three years. The configuration of the new services was specified by national guidance, which stated how many patients each service should support by a 2004 deadline (DH 2001). Subsequent targets directed EI teams to reduce the duration of untreated psychosis experienced by their patients, and gave revised caseload trajectories.

Successful delivery of EIMH services requires close coordination across a number of agencies - child and adolescent mental health services; crisis resolution teams; primary care; education; youth agencies; and others. From a commissioning perspective, EIP also requires coordination at SHA level, with SHAs having responsibility for reaching the target number of patients.

6.3.1 Overall progress

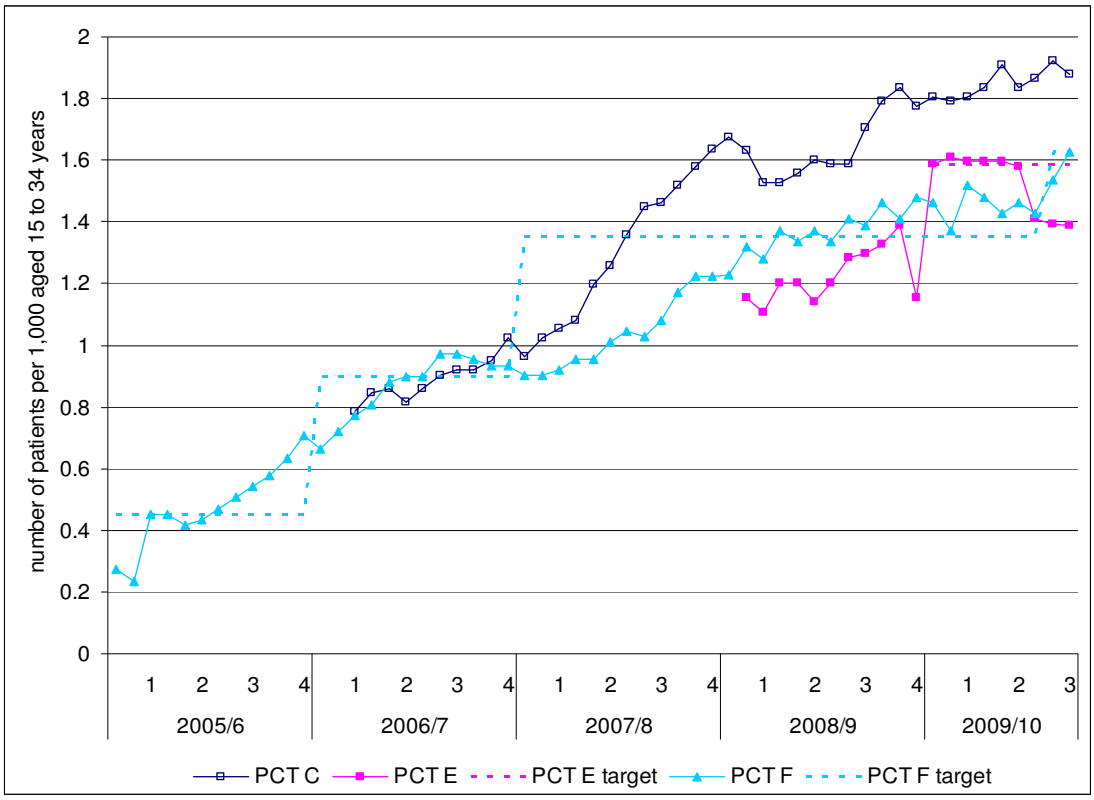
The 50 EIP services have now been established, but original targets for implementation were not met. In 2006 the Department of Health instructed SHAs to develop one year recovery plans to put delivery of EIP services back on track (DH, 2006c).

A major study evaluating the early development and impact of EIP services raised a number of concerns. The research suggested that the development of the services had not been as high a priority as other demands within PCTs, with EIP services having to "justify their funding and demonstrate their value more clearly" than other services (Lester et al., 2007, p47). Inexperience amongst mental health commissioners; the low status given to them in PCTs relative to other commissioners; and poor quality relationships between the different agencies involved in developing EIP services were identified as important factors explaining the implementation delay.

Some data on the number of patients in the EI service caseload were provided by the mental health service provider for three of our case study PCTs. These data are expressed as the number of patients per 1,000 PCT population aged 15 to 34 years in figure 6.11. The data for PCT E include 'consultation cases' from April 2009, and as the target caseload included these patients, the target is shown from April 2009. No data were available for the service covering PCT E before May 2008. The target caseload for PCT F has increased over time as the EI service has become more established (figure 6.11). Figure 6.11 provides some insight into how the EI service caseload has grown over time in half of the case study PCTs. The choice of three of our sites not to provide data may be due to a number of factors including reservations about the quality of the locally available data and/or the merits of sharing performance-related data.

Some data on DUP were supplied by the mental health service provider for PCT F. The cumulative median DUP increased from 52 days in July 2007 to 63 days in December 2009. In general, the providers were unable to provide data relating to DUP, and uncertainty about this measure appeared to have inhibited local data collection.

Figure 6.11: Early Intervention caseload by PCT



6.3.2 Impact of health system reforms on EIMH

This section examines the impact of the four streams on EIMH.

6.3.2.1 Demand-side reforms

Patient choice

Patient choice of provider was not seen as a major driver for service improvement in EIP services. Mental health services are typically organised on a geographical model, and the EIP model in particular emphasises the importance of strong collaborative working between multiple agencies within a defined local area. Giving patients choice of provider was therefore seen as neither practical nor desirable by professionals. Patients may be offered choice in the sense of being involved in constructing their own personalised care plans, for example, choosing between antidepressant medication or psychological therapy. Some research participants suggested this type of choice is more important for individual patients. However, in the logic of market reform it is not the kind of choice that would be expected to drive wider service improvement.

For a minority of mental health service users, choice is further limited by the use of compulsory treatment.

> *I do struggle somewhat with the paradox that is choice in mental health. I am going to compel you to treatment, but where would you like me to treat you? … what we see as choice and what we are trying to bring into kind of life here, is something around personalisation and how we personalise care for people and accepting that there are constraints and there are limited choices* **(Site E Mental Health Trust Director 1)**

Patient voice

The involvement of service users and carers in operational decision-making has become increasingly common in mental health services, driven by a highly vocal service user movement. In our case study sites, the role of patient voice in mental health trusts was

often viewed as being "streets ahead" of that in the acute sector. Services users and carers were involved in interview panels and represented on operational boards. One site suggested there were 100-150 service users who were very active within the mental health trust.

> there is absolutely no doubt that mental health trusts are, even now, light years ahead of acute providers in terms of actually meaningful service user carer input **(Site F Mental Health Trust Director 2)**

Voice was seen as being central to the early intervention approach, which rests on the premise of articulating and empowering people in delivering services built around needs. Customised care plans, involvement on partnerships and user and carer groups were all examples of voice in EIMH.

> *there is a sense within, within the whole philosophy of early intervention that part of what we're trying to do is, even for people who may go on to use longer term services, hopefully by the time they've gone through an early intervention service they're much more empowered to be able to be articulate about what their needs are* **(Site E EIMH Team Member 2)**

However, the extent to which this involvement was seen as having real impacts on the delivery of EIMH services was variable. In DV there were concerns that voice had limited impact in practice, and was captured by a minority of service users who may not be representative of others.. .

> *I am very much in favour of this, but I'm not so sure about its potency and particularly if you are talking about a 17year old person who might be feeling weird… one of the problems is that you get a sort like more of a professionalisation of a certain sort of patient user group, because a lot of people who have a bit of trouble then they want to go away and get on with their lives* **(Site E EIMH Team Member 3)**

Commissioning

Commissioning had a variable impact on the evolution of EIMH services. All sites adhered to commissioning approaches based on collaboration and joint service planning between the PCT and the mental health trust rather than competitive tendering. For example in Site A, Commissioners debated the merits of tendering for EIMH. On balance it was seen as more important to develop relationships and services that were integrated and joined-up. Going out to tender the various parts of EIMH could potentially lose that continuity.

Despite this collaborative ethos across systems, EIMH teams were beginning to feel threatened by what they saw as the increasing power of commissioners and the growth of market testing and tendering. It was anticipated that tendering would be increasingly common in future.

> I think that over the last year, this is perhaps what I feel has begun to change most noticeably, there has been a significant increase, in our experience, of market testing and tendering **(Site C Mental Health Trust Director 1)**

> I think the power has shifted from the providers more to the purchasers… And so that's probably not a bad thing for our services. I think there's a bit of paranoia… People are feeling a little bit uneasy, you know and as the commissioners didn't commission this service and someone else gets it in the private sector **(Site B EI Team Member 1)**

In sites (A, B and C), mental health providers reported that commissioners had played an important role in facilitating the development of EIMH in the direction of extra funds, ensuring accountability and involving service providers in commissioning support EIMH services. In Site B, commissioners were actively promoting the goal of achieving a holistic youth service appropriate for 14+.

> *Brilliant, they [the commissioner] have been really good… I am quite happy to have that sort of feedback structure where I need to go back to the commissioners on a quarterly basis with reports and figures and the statistics and say 'this is what we have done, this is where we are at in the past 3 months…' and that's also helped us identify areas - you know, the shortfall, an unmet need and it is a clear structure for*

me to feedback areas of unmet need, whereas in the past I have never had that opportunity as a clinician or a manager **(Site C CAMHS 1)**

In contrast, other sites described how contrary to the stated priorities of local PCTs, mental health was a lower priority for commissioners. EIMH practitioners reported little contact with commissioners. It was felt that the lack of attention directed towards mental health services by commissioners was to the detriment of services, since commissioning "does make a difference":

I mean if you asked them if you asked our PCTs they'll all say mental health is very high on their agenda; if you ask PBC groups they'll all say mental health is very high on their agenda; if you look at what they actually discuss it isn't **(Site F Mental Health Trust Director 2)**

I have never seen a commissioner. I have often said, you know, commissioners should be around, commissioning. Sitting down, going out with people, finding out what services they have commissioned. How they could improve on it… I am sure there is a lot of money wasted… **(Site E EIMH Team Member 4)**

It may not be the Cinderella perhaps so much as it used to be in terms of resources, but in terms of where the attention goes - And we suffer, I think, you know, because I think good commissioning actually does make a difference, really **(Site E Mental Health Trust Director 2)**

In some cases practitioners believed service managers may be uncomfortable that close interaction between practitioners and commissioners could place future contracts at risk:

they [Mental Health Trust] talked about the importance of us all having good relationships with commissioners and knowing our commissioners… I think it's been very difficult for managers above me to allow that because we've been so close to not achieving our targets so I guess there's a fear of what we might say that could jeopardise next year's contract **(Site E EIMH Team Member 1)**

Practice based commissioning

There was little evidence that PBC had made any impact on the development of EIMH services. In general PBC was perceived to be poorly developed, and where PBC groups were driving some change in the local health economy they were focused primarily on acute care rather than mental health services.

> I think the PBC groups are more focused on acute care rather than mental health services. But perhaps if they knew a little bit more about them they would start to engage **(Site C Mental Health Commissioner 1)**

The level of GP interest in and knowledge regarding mental health was variable. There was seen to be more scope for PBC to have a positive impact on the development of EIMH services where clinical relationships between GPs and mental health professionals were historically stronger.

6.3.2.2 Supply-side reforms

Diverse providers

There remained little diversity of provision of mental health services across our case study sites, even in those sites selected for having highly diverse acute services provider markets. There is a strong tradition of using voluntary and private sector services in mental health but this is often limited to particular areas such as residential accommodation, day services and low-volume, high-values services such as secure care. The provision of most core mental health services in our sites was largely monopolistic.

> *I think the supply side reform in terms of counting more flexible response of innovative service providers has applied more in the acute sector than it has in mental health. But I think that's because diversity of provision in mental health in terms of interest from the independent or private sector is very much focused on a niche market* **(Site C Mental Health Trust Director 1)**

Commissioners saw it as a defensible strategic choice to maintain continuity with established providers rather than encouraging diversity.

There is no competition, because it's unlikely that we would withdraw that element of service from our local mental health trust. I think we would work with them to try and improve it rather than withdraw it. That's how I feel. Whether you call that weak commissioning or whether that's taken a pragmatic approach, because to pull a service, the amount of concern, workers leave, patients get jittery, you know, all that has to be taken in to consideration **(Site C Mental Health Commissioner 1)**

EIMH services were provided exclusively by NHS mental health trusts. Some argued that the specialised, intensive nature of EIMH made it unlikely that private sector or third sector providers would have the necessary skills to present serious competition to the NHS for these services. On this view, the nature of the service tends to create a natural monopoly. The competitive threat was not therefore currently seen as being a significant driver for quality improvement in EIMH.

There were indications, however, that service providers in several areas felt that this was changing - that competition with other providers was beginning to pose a bigger threat to NHS providers. In site C, a contract forming part of the national Improved Access to Psychological Therapies programme had recently been won by a non-NHS provider, providing a shock to the entire mental health system (Site C). Some providers were concerned that competition would not stimulate quality improvements within the NHS in the absence of set national tariffs (see 'transactional reforms', below).

I think the whole focus on market management and opening up the market to new providers is having an impact, both on commissioning and on provision. We've seen more contracts being let now than ever before… And new providers are coming in and we've within this organisation we've lost work as a result of that… We had opportunity to tender for some new business which was around improving access to psychological therapies with [City C]. And we didn't get that contract and it's a contract that was worth about £6 million over 3 years. So quite significant. Well more than quite, that would have been 6% of our income, so you know, very significant **(Site C PCT Director 2)**

Across the sector it is happening that the percentage that has been spent outside the public sector is rising every year **(Site F Mental Health Trust Director 2)**

Subcontracting from MHTs to third sector providers was likely to be a future trend. The IAPT agenda was a good example of the third sector tendering for services with the MHT working in collaboration. In Site E, the creation of a coordinated network with third sector looked to encourage diversification. This was very much the limits to diversification so far, however future competition to deliver services was not ruled out.

Organisations like Rethink for example, you know they could probably be in quite a good position to bid for a service like this. Yeah I think there is a worry about that. I'd be worried **(Site E EIMH Team Member 5)**

it have heard lots of fantasy conversations amongst staff about splitting off and setting up their own organisation... I don't know where it's actually happened but that's interesting, I guess that's an interesting possibility **(Site E EIMH Team Member 2)**

Foundation trusts

There was evidence that achieving foundation trust status had taken on an important priority for the mental health trusts in our case study sites. This was seen as being a valuable process to go through at a managerial level, but it was not clear that this had led to improved care for people using EIMH or other services.

Obviously the foundation trust reform agenda we see that's a major focus for us. Unless we become a foundation trust the management board of this organisation will be taken over, merged or split up somehow **(Site C PCT Director 2)**

I think the process of becoming a foundation trust was extremely valuable to us. Because it made us think about a whole range of things in a different way and exposed us to external scrutiny and challenge in a different way… But if you ask most people whether they be staff or service users or whatever, what difference has it made, not a lot **(Site G Mental Health Trust Director 2)**

Some EIMH teams believed that foundation status was good for the trust overall, but did not have a direct impact on EIMH. Others went further than this, suggesting that the application process had caused the trust to lose focus and energy.

> *You know the trust is trying to achieve foundations status… And I sometimes think that that's to the detriment of the services on the ground. You know there's a lot of managers, a lot of, a lot of groups and forums… I think sometimes it's easy for a trust to lose focus and lose where there energy should be spent* **(Site E EIMH Team Member 1)**

6.2.3.3 Transactional reforms

An important difference between EIMH and our other tracer conditions, diabetes and orthopaedics, is that Payment by Results has not been implemented for mental health. The nature of mental illness and mental health services makes transactional reforms highly difficult to achieve in this area. Major challenges exist around defining the episode, currency and transaction, and then around measuring the quality of care. The general perception amongst our research participants was that a national set of tariffs would not be implemented for mental health in the near future, although some progress may be being made at local and regional levels.

> It's not affecting us at all… I think we're still a long way off being able to establish anything approaching a national tariff, there's some discussion about a more local, regional basis **(Site C Mental HealthTrust Director 1)**

Some mental health trusts in our research had a number of contracts based on cost and volume, but the majority were still block contracts. While there was concern around the applicability of Payment by Results to mental health, there was an equal measure of concern regarding the negative consequences of holding block contracts. There was concern that in the absence of a national tariff, competition with private and third sector providers was occurring on the basis of price rather than quality. That is to say, NHS providers feared that they were being undercut by alternative providers who were "cherry picking" patients or

offering services which were ostensibly of an equivalent standard, but which in reality were of poorer quality.

> *The third sector has been able just to say whatever they do, we will match it and be cheaper. But what they didn't have to do was match what we had to do in terms of quality and they didn't have to contribute to emergency planning. They didn't have to provide 24 hour cover. They could just cherry pick and under cut in price… once there is a tariff it is the same for all of us and then we compete on quality* (**Site F Mental Health Trust Director 2)**

The absence of transactional reform in mental health was seen as a potential problem as the NHS enters a period of financial hardship. The fear is that as acute care providers use the national tariff as a means of protecting their income, those service areas relying on block contracts will come under increasing and disproportionate pressure.

> *Because we don't have tariff, we've got no protection* (**Site F Mental Health Trust Director 2)**

Those working in EIMH believed PBR would be difficult in contexts that lacked the necessary information systems. It was not clear how the transaction would be defined and measured and how would assess the outcome. Unlike the acute sector, mental health was not as easily defined and categorised.

> *Payment by Results will make us much more adherent to recording our work on the IT systems that we have… we are going to have to be much tighter in terms of who we take on and when we are working with suspicion of psychosis… it's really hard at the outset to be that tight because we have to, by definition, work with uncertainty* **(EIMH Team Member 5)**

Although PBR was not due to be implemented until 2014, EI practitioners believed that a cluster based model providing minimum and optional sets of interventions could become the future mechanism for PBR in mental health. They believed that tariffs or currencies that were able to benchmark and compare quality e.g. South Yorkshire clusters of care model would be advocated as a preferable model. The particular approach to pricing provider types

of care was seen as potentially incentivising clinicians to innovate in making efficiency savings. However, there was still work to be done in defining what such a model would look like

> *It is not so much the tariff but it is the actual currency that you use. How will we know that, how will we be able to benchmark and compare quality? But I can see that it is so difficult… all that work has been done in South Yorkshire, those clusters of care are really good, but nobody has actually, as yet put the money around it in any meaningful way* **(Site B Commissioner)**

6.2.3.4 System management and regulation

The strongest drivers for service development in EIMH were targets, guidance and regulations from the Department of Health, regulatory agencies and other bodies - and in particular the National Service Framework for Mental Health (DH, 1999) and Mental Health Policy Implementation Guide (DH 2001) and NICE Guidance. This was a consistent message from across our case study sites. The number of EIMH services established and their internal configuration were determined directly by national targets and the ongoing evidence base about adolescent MH services.

> *I think that the NSF represents a sort of systems framework which is extremely useful* **(Site E EIMH Team 2)**

> *if nice guidelines produce good evidence based practice for working with early psychosis. That's the stuff that I'm going to filter down to practitioners, to say hey you need to know about this, it's evidence based, it's good practice. At the end of the day the stuff on this chart, I have to pick it apart. It's hard, it's hard to understand* (**Site E EIMH Team 1)**

The targets that EIMH teams worked towards were seen as a mixed blessing. They were positive in that they were clearly a potent mechanism for introducing the EIMH model across the country. However, targets were often regarded by clinicians as a cloud hanging over

EIMH teams rather than a means to facilitate improvement. On this view, targets bureaucratised EIMH, causing a great deal of energy to be spent on reaching required caseloads at the potential expense of delivering high quality care and achieving good outcomes for patients.

Practitioners described perverse behaviours resulting from targets. The target focus on confirmed cases excluded the important work that went on in the three month assessment before confirmation of case. Confirming psychotic symptoms within three months and deciding whether symptoms were drug induced traumas, depression or bipolar was difficult in such a time frame. The drive to reach target caseloads potentially reinforced a medical model of treatment and led to people being unnecessarily labelled as 'psychotic'. By focusing on inputs rather than outcomes in terms of social inclusion and getting people back into society, the National Service Framework and Policy Implementation Guide may have caused EIMH services to deviate away from the original EIMH model, which stressed the importance of focusing on raising awareness levels, promoting social inclusion and preventing labelling and medicalisation.

> *The thing I struggle with is targets. It can be medicalised sometimes, in that you have got to achieve targets… as we got better in our job, we would actually pick up earlier signs and symptoms and more of those that are not experiencing a psychotic episode but actually could be at severe risk of doing so. But what we can't do is we can't quantify what we are doing, because the only way we can quantify is reaching targets of saying someone has a psychotic experience, which is really to my mind deviating from why early intervention is set up* **(Site EIMH Team Member 4)**

> *it works throughout the year up until about February and suddenly everybody is going, 'Oh, God, target, target, target,' so we have to then maybe push through assessments quicker than what we would ideally like to in a clinical way* **(Site E EIMH Team Member 5)**

> *the problem it causes is if you're not counting the assessments, you're not counting a huge amount of the work … [the caseload target] does then introduce kind of perverse incentives about not doing certain pieces of work, not because they don't need doing but because they're not counted* **(Site E EIMH Team Member 2)**

Several service providers reported that Monitor, the Healthcare Commission and more recently the Care Quality Commission have all had an influence on their activities and have driven increased quality of care in general. However, no examples were given illustrating the impact of these regulatory agencies on EIMH services specifically. Regulation was reported to have encouraged an increased focus on quality, in particular by giving providers the ability to benchmark their performance against each other.

> *There is no doubt that having something like the Healthcare Commission and CQC did improve the focus on quality and has started to give us… some sort of benchmarking so at least you've got some idea of where you might be and enabled you to say well, you know, "OK are we good enough"? "Are we not good enough?" "Are we better than good enough?" Which, compared to where we were, say 10 years ago, I mean really no-one knew at all* **(Site F Mental Health Trust Director 2)**

> *[Monitor] do push you and push you and push you to understand your business. And that was really good. So I think that that has had a huge impact on the organisation* **(Site F Mental Health Trust Director 1)**

6.2.3.5 Darzi – The Next Stage Review

The Next Stage Review was supported by MHTs in its call for a move to quality and prevention in mental health. The recognised push towards personalised services and individual budgets with more scope for local authority and voluntary sector services was also welcomed.

> *I think probably the plan was ready for a refresh and I think the impact of Darzi has been probably to gather even more ambition across the service* **(Site E Mental Trust Director 1)**

Other perspectives questioned the relevance of Darzi reform to MH. The fact that MH was left out in the first instance was taken to be symbolic of how much of priority was placed on MH.

As usual mental health was a bit behind, [Darzi] was pretty much acute focused. In fact there was hardly any mention of mental health at all until about two weeks before it was published… It really was utterly last minute that anything was even put in the Darzi report about mental health services **(Site A Mental Health Director 1)**

EI teams reported little impact from the Next Stage Review so far, and some managers and clinicians had not heard of it. Social care and social work reforms such as those resulting from the Butler Inquiry and the Laming Inquiry generally had a higher profile.

6.2.3.6 Influence of local contexts and mechanisms

In general, the impact of the system reforms on EIMH appeared to be similar across the case study sites. In a sense this is not surprising, as the Department of Health guidance which drove the establishment of EIMH services prescribed what form they should take. Moreover, our starting hypothesis was that EIMH would be affected less strongly by market-based reforms than the other tracer conditions.

There were however some differences between sites. Most strikingly, commissioners seemed to have taken a more active role in the development of EIMH services in some sites than others. Commissioning appears to have been a stronger lever in those sites with more competition in provider markets. However, even in these sites the means by which commissioners have wielded their influence has not primarily been through competitive tendering. Rather, they have concentrated on working in partnership with their existing provider base and the fostering of clinical leadership. A possible interpretation is that the existence of potential competition, even if not utilised directly, gave commissioners more power and encouraged providers to cooperate. Alternatively, the finding may be a consequence of the fact that the sites with more competition were also more urban areas, with higher rates of psychosis and other mental health problems. This may have given mental health and EIMH a higher profile on commissioners' agendas.

EIMH had contributed to significant improvements in transition across adolescent and adult services. Despite this, sites experienced difficulties integrating services with other agencies

involved in the EI pathway. More information was needed around referral pathways to make sure agencies understood and cooperate across the system. For example, the relationship between EI and CAMHS pathway looking after 14-16 on occasions got duplicated and diluted.

> *It's like we're missing a piece and that is the sort of the clarity the transparency and some of that is around it being one of the last perhaps areas in the NHS to have that kind of spotlight shone into it around what are its processes and how it actually operates* **(Site B CAMHS 1)**

> *The clarity provided around functional teams like the early intervention teams or the crisis resolution teams or whatever - has been really helpful. What it has resulted in I think in some cases is a fairly incoherent system. So you have got very clear functions but sometimes those functions are exclusive to the point of - for this bit of the service, but actually not for this. And what we have done over the last couple of years is we have created networks of care that are essentially whole and one system with individual functions within them* **(Site E Mental Health Trust Director 1)**

Local strategies were resolving these tensions by looking to create networks of care containing all the functional teams. Site E compared their network approach to South Yorkshire cluster model, with EIMH one the clusters. Site B were looking to implement a redesign programme that used the EI approach as a gateway model to fit with a multitude of MH presentations.

> *We've got this new system… called the network functions. So we used to have community mental health teams but we have network functions now and they're broken up into various functions… that's a single point of entry for anybody experiencing any kind of mental health problems really… where there would be somebody would triage the referral and make a decision about what they might need and then they would assess and then they go through a process of stepped care* **(Site E Mental Health Trust Director 2)**

Relationships between commissioners, clinicians and MHTs were a key feature to the management and delivery of EIMH. What facilitated this relationship were local champions and knowledge brokers who promoted EIMH and raised awareness about the service.

> *Sometimes that's all it needs, isn't it. One champion. But I think the ease for South has been that they clustered very early on in quite big clusters and so the champion was quite vocal and was able to say 'actually, these people are having a massive effect on your list or on your costs or on, you know'… the ferocity of the consultant in charge of South who's very keen on making sure that happens* **(Site B EI Commissioner)**

Levels of funding also affected EI service development. Under resourcing acted as a barrier to the EIMH aim of developing multidisciplinary teams. For DV, teams did not have the resources to deliver early detection as part of the EIMH package as their remit only stretched to dealing with those people with first signs of psychosis. In site SB and DV, PCT funding cycles prevented forward planning in staff recruitment and workforce planning.

> *I also think for Early Intervention we are stuck in a position that sort of sits between the Children's Trust, Adult Mental Health, PCTs in this sense of who owns which bit and who is going to contribute what monies to what part of the resource and I think that quite often because it's such a complex mix, those conversations don't actually happen and for example we are funded primarily through Adult Services' money, well completely actually through Adult Services' money and yet 25% of our client caseload is under 18* **(Site E EIMH Team Member 3)**

> *The reason why I think a lot of services have even not followed the policy implementation guides or have, have followed the guide but chosen to, to allocate things in different ways, has, has ultimately been about money. The psychology issue, particularly psychology is quite an expensive… in relation to other professions, so choosing to spend part of your budget, a limited budget on, on psychology means that you have to forego other things in other places, particularly when the targets around early intervention have been about bums on seats and caseload capacity and that sort of thing* (**Site E EIMH Team Member 2)**

it's been very stop/start/stop/start and because the NHS is the way it is, the money might be released today, for an extra two care co-ordinators, it's going to be six months minimum before you get anybody in post, and I don't think that that's ever really been appreciated **(Site B EIMH Member 1)**

6.2.3.7 Conclusions

The development of EIMH services has been driven first and foremost by targets and guidance, and the pressure to adhere to them. This pressure has had both positive and negative consequences, but it is unlikely that the 50 new EIMH services would have been established over the last decade without some form of top-down direction. Overall we found that the strongest drivers for service development in EIMH were targets, guidance and regulations from the Department of Health - in particular the National Service Framework for Mental Health (DH, 1999) and Mental Health Policy Implementation Guide (DH 2001). This was a consistent message from across our case study sites. The number of EIMH services established and their internal configuration were determined by national targets and the ongoing evidence base about adolescent MH services.

Choice and competition appear to have had little impact on EIMH services or on mental health services generally. The scope for patients to choose is limited under current service configurations. There was no direct financial reward for providers to attract patients since Payment by Results was yet to be implemented.

There is evidence that in some sites commissioners have played an active role in the development of EIMH services. This depends on levels of interest and mental health expertise within PCTs and PBC groups. Commissioners may have more power to influence providers where there is a credible threat of competition, although the means in which they are choosing to exert this power is primarily through cooperative partnerships with existing providers rather than through competitive tendering processes. This may however be changing with time. Patient voice was perceived as being important in operational decision-making in mental health services, but the extent to which the involvement of service users

and carers at this level leads to real changes and improvements in the quality of care is not clear.

Overall, the evidence presented above suggests limited impact of the Next Step reforms. In relation to EIMH, the main policy drivers have been the NSF and the PIG and the ongoing evidence base supporting the need for such a service.

The Next Steps Reform reforms were positive in raising the profile for EIMH but they also led to a burgeoning of targets and teams that did not always integrate within wider MH systems. Sites were aware that more needed to be done on to address the quality and experience across the patient pathway. Greater emphasis was placed on social inclusion, education and the need to develop engagement and outcomes criteria.

The future of EI remained uncertain for EI as the policy agenda and commissioner attention moved on to something else. The IAPT agenda was something that potentially could take over from EIMH however; the emerging consensus was that the EI approach provided a model for future services. The end of NSF potentially created a void in terms of an operating framework for EI however the New Horizons policy agenda (DH 2009) was largely seen as its successor in providing a framework to support EIMH. The NH vision of a 'Youth Mental Health Service' appeared to be largely supported with many of its principles already being worked towards.

This chapter has examined the impact of the reforms on our three tracer conditions. In the next chapter, we bring together this material and the case study material from chapter 5 to form a wider discussion.

Chapter 7: Synthesis and Discussion

This chapter brings together the main findings of the research to examine the collective impact of the NHS reforms as set out in the framework of programme theory. It also reflects on how the reforms played out across the case study sites by exploring the links between context, mechanisms and outcomes (Pawson and Tilley, 1997).

7.1 Programme theory

The basic elements of programme theory were set out in Chapter 2. As Pawson and Tilley (1997) point out, social programmes are based upon explicit or implicit theories about how and why the programme will work. The task of evaluation is to surface those theories, identify the key assumptions and test their validity. We adopt *Realistic Evaluation* as a conceptual framework to examine 'generative causation' (see Figure 2.1): how organisational outcomes are triggered by the interplay between mechanisms operating in a particular context. More simply, the theory can be summarized by the basic equation: Context + Mechanism = Outcome. Pawson and Tilley (1997) stress the importance of context-mechanism-outcome (CMO) configurations. Theories must be framed in terms of propositions about how mechanisms (M) are fired in contexts (C) to produce outcomes (O): what might work for whom in what circumstances (pp. 84-5). In other words, the relationship between causal mechanisms and their effects is contingent rather than fixed (p. 69).

As we revealed in Chapter 3, the reform journey was not based on some commonly articulated strategy either in chronological or system terms. Some of the reform narratives began in 1997 with the 'New NHS' (DH, 1997), whilst others began with the 'NHS Plan' (DH, 2000). However, some respondents saw some points of continuity from the Conservative 'internal market', especially with GPFH and PBC, and 'NHS Trusts' and FT respectively. Our documentary analysis shows that although some of the reform streams of the 'Next Steps Reforms' (DH 2005a) can be found in earlier documents, there is little explanation of this 'fit' beyond the diagram. It remains unclear why there are four streams rather than, say, three or five. There are few clues as to how the mechanisms fit with each other or with the

outcomes. In particular, outcomes appear to be regarded as 'global' in the sense that *all* of the streams contribute to *all* of the outcomes rather than a clearer specification of programme theory. Neither is it clear whether 'one size fits all' in terms of specialty or geographical area. In other words, it is not clear whether the reforms were intended to apply to areas beyond acute, elective conditions, or to all parts of the country. In short, we appear to have one global MO configuration (ie ignoring context) rather than specific CMOs. For example, it could be argued (see below) that (say) specific mechanisms such as choice might lead to particular outcomes such as responsiveness in certain contexts (such as competitive or at least contestable markets). While similar rhetorical policy 'ends' feature in most of the documents, it is easier to see the links with policy 'means' in some cases rather than others (cf Le Grand 2007). Economic theory indicates how competition might lead to outcomes such as efficiency, quality responsiveness under certain conditions (eg Le Grand 2007; Propper et al 2008; Cooper, Gibbons et al 2009; Bloom et al 2010). Similarly, 'administrative theory' indicates how 'targets and terror' might lead to outcomes such as reducing waiting lists (at least in the short term) (eg Bevan and Hood 2006; Le Grand 2007). However, it is more difficult to see how stated ends such as reducing health inequalities can be achieved by the identified means of the Next Steps Reforms (cf Hunter 2008). Moreover, as we can see below, it is clear that some outcomes were perceived as being more 'must do' or 'P45' targets than others. This is reinforced by some targets being seen as longer-term 'procrastination' or 'tomorrow' targets, summed up in the words of one NHS manager: 'no one loses their job over health inequalities' (see Exworthy and Powell 2004). Some of these issues were recognised in the policy documents. For example, the NHS Plan (DH 2000: 94) states that financial rewards for trusts will be linked to the results of the annual National Patients Survey (p. 94). This did not appear to happen in the short term, but the idea seems to have been later revisited with CQUIN (see below). In this sense, the documents display some conception of policy learning (and see below), but even towards the end of the period, it is difficult to detect clear CMO for issues such as health inequalities.

The policy interviews in Chapter 4 clarified some of these issues, but did not fill all the gaps in programme theory. It was recognised that the reforms displayed some problems in policy formulation (or system architecture) in terms of both individual streams and the fit between them, and others in policy implementation (cf Wolman 1981; see below). There were some differences in 'programme theory' among stakeholders for institutions such as Foundation

Trusts, with some having concerns over some of their key features. For example, according to one stakeholder:

> *Most of the problems with the reform architecture were entirely predictable and could have been resolved at the time. I failed to spot that we were not resolving them because we sat in meetings and everybody agreed that they needed to be done and then no-one did it*.

There were concerns about the chronology and balance of reform streams. For example, it was broadly agreed that commissioning had developed more slowly and was weaker than the supply side. There were some concerns over the capacity of PCTs as commissioners, partly due to reasons of structure, personnel and potential destabilisation. In other words, commissioning was broadly regarded as the weak link of the reforms (cf House of Commons Health Select Committee 2011). It was clearly recognised that the reforms were not 'set in stone', and that changes were necessary. For example, from early on it was clear that tariff needed to be refined so that the incentives were not only for more activity but also to ensure best practice care and care outside hospital. Some predictable but unwanted outcomes were also identified, including the expenditure growth associated with the strength of providers and the incentives from PbR. It is also clear that some policy evolution was necessary due to apparent problems - some later elements aiming to restore balance to system - for example, practice-based commissioning to balance payment by results, and World Class Commissioning to challenge the dominance of Foundation Trusts. Some see Darzi's Next Stage Review as a further policy evolution, while others regard it more as a revolution.

A number of informants stressed the importance of context, recognising that one size does not fit all and that a different set of mechanism may be required for different conditions.

> *[The Reforms were] designed really around elective surgery … I don't think that we have fully completed the jigsaw of what the right blend of policy mechanism has been for different pathways.*

> *There has been a tendency for some in the department to view the NHS as just one very large hospital*

On the other hand, it was broadly held that geographical context, such as the extent to which choice can operate effectively in rural areas, was not of great significance.

> *There are concerns about rural areas, but only about 10% of Britain is rural, so actually there was always this great danger of letting the rural tail wagging the urban dog*

> *The fact that you couldn't make it work in Cumbria or rural East Anglia or Cornwall was not an argument for failing to apply those principles for the majority of the population*

In short, then, there was some recognition of context, but still few clear CMOs. There was little evidence of clear programme theory among the stakeholders that we interviewed, nor to any evidence for conscious use of the reform levers as a mutual set of levers to improve the cost-effectiveness of care or patient satisfaction.

There was some agreement on the problem of implementation. For example, some regarded the roll out of ISTC as too limited, and insufficient to 'shake up' the system. A number of reasons were identified including changes in personnel at the Department of Health (including among Ministers and key advisers), the complexity of the reforms and inaction, and lack of commitment or 'buy in' (locally and among civil servants):

> *There was an implementation failure throughout the system.*

> *Implementation has been a messier, slower process that it ought to have been*

> *I think that great chunks of the DoH has never bought into the reforms*

> *But the challenge is getting buy-in on the ground'*

System reform in the six case study sites was explored in Chapter 5. Two main broad points emerged. First, the overall perception of the reforms varied from extremely positive to very negative, with senior managers broadly being more favourable and clinicians being more

negative (see below). There was no clear pattern between case study sites, although on the whole providers were more positive than commissioners. This may be due to a feeling that the reforms have favoured providers, with some successful FTs seeing themselves as 'winners'. There was a general perception shared by providers and commissioners that the reforms were unbalanced in the sense that providers such as FT saw earlier and stronger reform levers. It is also possible that it relates to a broader reorganisation fatigue among PCTs. In particular, two of the rural sites were large PCTs that were still feeling the effects of the 2006 amalgamation of PCTs. In this sense, some PCTs felt that they were disadvantaged by a 'double whammy' of attempting to play 'catch up' on two fronts: generally with the supply side, and in comparison with other PCTs that witnessed less structural change. Second, the broad understanding of the reforms as a whole was low, with the exception of senior managers. While respondents were well aware of the reform levers that affected their day-to-day activities, the mutually reinforcing nature of the reforms was not clear, with many not being able to fit the pieces of the jigsaw together. Indeed, some pieces of the jigsaw- such as workforce and management information- were largely lost from view. In other words, there was limited understanding of programme theory.

Turning to stated outcomes, most providers regarded the access and HCAI targets as most important, with the 18 week target as the main 'must do'. Some respondents, particularly in PCTs, named health gain and the reduction of health inequalities as their main purpose. However, there was less certainty in how outcomes were related to mechanisms. Few implementers at the periphery saw the full picture. They understood their 'patch', but not how it related to the wider reform themes. In other words, they understood the trees but not the wood.

7.2 Discussion

This section aims to set the above findings on programme theory in a wider context. The importance of clear programme theory may be linked with wider perspectives on policy formulation and implementation (Wolman 1981; see also Exworthy and Powell 2004). We will focus on the policy implementation literature, but it is difficult to draw a hard and fast line between formulation and implementation (Buse et al 2005; Exworthy and Powell 2004; Hill and Hupe 2009; Wolman 1981). The policy implementation literature tends to examine

‘top down’ and ‘bottom up’ perspectives. The top down perspective is closely linked with the rational model of the policy process which sees it as a linear sequence of activities with a clear division between formulation and implementation. Policies are handed down a chain of command to subordinate levels which are charged with putting them into practice. Many early studies pointed to an implementation ‘gap’ or ‘deficit’. This led to the notion of ‘perfect implementation’ with allied prescriptive recommendations. Pressman and Wildavsky (1973) regarded the key to effective implementation in the ability to devise a system in which the causal links between setting goals and the actions to achieve them were clear and robust. Goals had to be clearly defined and widely understood, the necessary political, administrative, technical and financial resources had to be available, a chain of command had to be established from the centre to the periphery, and a communication and control system had to be in place to keep the whole system on course. In short, failure was caused by adopting the wrong strategy and using the wrong machinery. Later theorists drew up lists of conditions for effective implementation. According to Sabatier and Maznanian (1979), there should be:

- Clear and logically consistent objectives
- Adequate causal theory
- An implementation process to enhance compliance by implementers
- Committed, skilful, implementing officials
- Support from interest groups and legislature
- No changes in socio-economic conditions that undermine political support or the causal theory underlying the policy.

Similar conditions were outlined by other theorists (eg Hogwood and Gunn 1984; Hood 1976; Van Meter and Van Horn (1975), but all stress to varying degrees the importance of causal theory and the disposition of the implementers. For example, Van Meter and Van Horn (1975) point to the importance of the ‘disposition’ or ‘response’ of the implementers, which involves three elements: their cognition (comprehension, understanding) of the policy, the direction of their response to it (acceptance, neutrality, rejection) and the intensity of that response.

The ‘bottom up’ perspective is generally associated with Lipsky (1980) who stresses the importance of ‘street level bureaucrats’ whose discretion essentially allows them to re-make

policy at local level. It can be argued that professionalised settings make health care systems a classic example of street level bureaucrats. However, this very different perspective reinforces the top down perspective in one vital sense: the importance of focusing attention on the actors in the implementation process, their goals, their strategies, their activities and their links to one another. In another sense, both top down and bottom up perspectives focus on the vertical (centre-periphery) dimension, and tend to neglect the importance horizontal (different local agencies; different groups) dimension (Exworthy and Powell 2004).

Matland (1985) points to two factors that have a key impact on implementation: ambiguity and conflict. He uses these factors to produce a 2x2 matrix. 'Administrative implementation' occurs where this is low ambiguity and low conflict. 'Political implementation' occurs in situations of low ambiguity and high conflict. 'Experimental implementation' is characterised by high ambiguity and low conflict. Finally, 'symbolic implementation' occurs where there is high ambiguity and high conflict. While there are many elements to the Next Steps Reforms, very few are likely to be characterised by administrative implementation, which is the ideal situation for a top-down approach. For political implementation, implementation outcomes are decided by power. In the case of experimental implementation, contextual conditions, or environmental influences on outcomes, are likely to be important. Programme mutations arise as different organisations implement different policies in different environments. There are complex feedback and learning issues to consider, and bottom-up approaches to analysis are especially likely to be applicable. Finally, symbolic implementation involves high conflict, and the strength of coalitions and professional values and allegiances, particularly at the local level, tends to determine outcomes. It is this cell, which arguably fits much of the reforms, that shows many of the 'wicked problems' of implementation. In the next section, we explore some aspects of disposition to programme theory from both vertical and horizontal dimensions.

In vertical terms, there are indications that there may be limited 'buy in' to the reforms among staff 'in the field'. According to Hunter (2008: 77), the contradictions and incoherence of the reform agenda underlaid a highly critical capability review of the DH (2007), which was critical of the failure to convince either DH staff or those in the field of the purpose of the changes and how they related to each other (see also Greer and Jarman 2007). It concluded that the DH had not set out 'a clear articulation of the way forward for the whole of the NHS, health and well-being agenda' and it operated as 'a collection of silos

focused on individual activities' (Cabinet Office 2007: 17-18). Moreover, the department 'generates too many initiatives without properly considering the interactions or offering any clarity on prioritisation' and 'policies tend to be developed in organisational silos and cross-boundary integration issues are not routinely thought through. Sometimes insufficient attention is paid to the impact these issues will have on delivery agents' (Cabinet Office 2007: 19-21). The Review urged the department to consider the need for more consistent engagement with front-line staff, 'enabling them to make an effective contribution to the development of policy and build common ownership of outcomes' (Cabinet Office 2007: 22).

There is more recent suggestions that some NHS staff are not fully engaged with or supportive of current reforms (see Chapter 8). With respect to the Coalition Government's NHS reforms, Sir David Nicholson has stated that there were three types of people currently in the NHS. The first included 'those who hate' the reforms and should leave as they would be a 'drag on the system' (Santry 2010). Moreover, a significant number of 'health leaders' have concerns over the on Coalition Government NHS reforms (Nuffield Trust 2011).

In horizontal terms, there are some indications of differential 'buy in' among managers and clinicians. In the period since the formation of the NHS, the system has moved away from 'benign producerism' (Hunter 2008: 53), clinical autonomy has been reduced, but with some increasing conflicts between managers and clinicians (Greener 2004, 2005; Greener et al et al 2011; Harrison et al 1992; Harrison and Ahmad 2000). Hunter (2008) uses the work of Alford (1975) to explore how reform strategies based on either markets or bureaucratic models are unlikely to succeed because they neglect the way in which groups within health care systems develop vital interests that sustain the present system and vitiate attempts at reform. Alford (1975) regards clinicians or 'professional monopolists' as 'dominant interests' who are challenged by the managers or 'corporate rationalisers'. Hunter (2008: 191-2) sees an unhealthy stand-off between the 'two tribes' of clinicians and managers which has come to act as a major fault line.

The appointment of an eminent cardiac surgeon, Ara Darzi, as a junior health minister, with a brief to lead a review of the NHS, saw moves to ensure that change would be locally driven and clinically led. In his Interim Report (2007b), Darzi observed that staff felt that they 'had been ignored, that their values had not been fully recognised, and that they had not been given credit for improvements that had been made'. He reported clinicians saying that 'they

feel constrained and undervalued by managers', but balanced this by acknowledging that 'managers sometimes see clinicians as stubborn and slow to change' (DH 2007b: 49). The Darzi approach (DH 2007b, 2008) appears to recognise the problems of micromanaging such a complex system from the centre, and that a uniform approach to change driven from a remote centre in a 'one size fits all' approach was inappropriate (Hunter 2008: 56-57). Hunter (2008: 194) concludes that top-down reform initiatives imposed on a highly professionalised workforce by a hierarchical authority are destined to fail.

However, while the emphasis on clinical effectiveness and clinical engagement, as opposed to the financial and management structures that underpin it, was broadly welcomed by the informants in our case study areas, there was a feeling that Darzi was 'was all things to all people', with perhaps a vision reflecting an urban perspective, and might work well in large urban areas like London but was not the right model for rural contexts. It did not make sense to have Darzi walk in centres in areas that already had a network of community hospitals and walk in centres. This was perhaps an example of health policy being reflected through the distorting prism of London.

7.3 Hypotheses and CMO Configurations

Our main hypothesis was that the impact of the reforms would vary across the case study sites with some potentially being located in more receptive contexts for their application than others. In general, and certainly for our tracer condition of orthopaedics, the urban areas should be more receptive contexts, with more potential competition and diversity, than the rural areas. It may be hypothesised that integration would be of greater importance for the tracer conditions of diabetes and EIMH, and this would be reinforced by choice and competition being of less significance for these areas. However, in global terms, at the extremes, we would expect a more receptive context in Site A (where competition and diversity of provider types present; integrated) compared with Site F (not competitive; not diverse; not integrated).

In broad terms, there seemed to be relatively limited impact of patient choice on activity patterns. It was felt that it would be fairly difficult for patients to 'switch' in the rural areas as there were few local alternatives providers. However, there also appeared to be relatively

little switching in the urban area where choice was more 'real' due to broad satisfaction, reputational effects, 'brand loyalty', general unwillingness to be active' choosers' and limited information on which to choose (cf Robertson and Dixon, 2009). Indeed, in two sites, respondents reported patients being 'encouraged' to choose ISTCs. However, providers claimed that they were aware of the threat of choice, particularly from younger and more mobile groups, but it is unclear whether a 'critical mass' of 'active choosers' or 'market mavens' existed in order to significantly make markets. In this sense, the main effect of choice might not be an end in itself, but a means to an end of making providers feel that they were in contestable markets. Although patient voice was seen to be a driver for change in service delivery, few of the interviewees could give *specific* examples of how patients, public, governors or members of Foundation Trusts had shaped local strategy. Providers broadly felt that commissioning was relatively weak. The impact of Practice Based Commissioning (PBC) was very much seen as 'work in progress'. Most of these factors did not appear to be significantly contextual: providers stated that they were aware of the threat of competition, even in uncompetitive markets, and factors such as PBC did not seem to make great headway in any context. Our CMO proposition, then, is that more choice should lead to greater responsiveness. However, as noted above, programme theory was unclear about the importance of context, and CMOs tended to be de facto MOs.

CMO: choice → responsiveness

The impact of supply-side reform varied across sites. The impact of ISTCs was shaped by the size of contract and the extent to which systems were able to meet the agreed capacity. Beyond ISTCs, wider private and third sector involvement was limited, although there was some evidence of 'sub contracting' to the private sector by FTs in order to achieve the 18-week waiting time target.

Providers supported FT status because it gave them greater autonomy- to be more in control of their own destiny. There is a greater focus on financial strength which has provided the incentive to innovate, which has been directly facilitated by PbR. Hence FT and PbR are strongly mutually reinforcing. Providers also supported FT status which they felt brought improvements in governance and accountability. In contrast, commissioners felt the incentives and autonomy granted by FT status limited collaboration. This became more of an

issue in the second round interviews, where it was felt that future financial constraints might provide a greater driver towards collaboration.

CMO: ISTC→responsiveness

CMO: FT→responsiveness, innovation, governance, but FT > reduced collaboration

The main transactional reform, PbR, was designed as a universalistic mechanism, although tertiary providers claimed that it adversely affected them. Moreover, providers complained that the initial ISTC contract was based more on block contract than PbR, and that they were therefore competing on an unlevel playing field, particularly because of the consequences of the change in case-mix. Most providers stated that PbR provided incentives for increasing activity, but commissioners felt that it might contain some perverse incentives. It was felt that PbR had yet to have much impact on quality, although there are moves to increase the link between tariff and quality (eg CQUIN). PbR had greatest impact in orthopaedics. It had a significant impact in diabetes, both in terms of increasing productivity and activity, but acted as a barrier in the pursuit of vertical integration (but best practice and unbundled tariffs may have a future impact) and EIMH (where it is yet to apply).

CMO: PbR→activity, but blocked care closer to home.

CMO: PbR affects orthopaedics more than diabetes and EIMH.

The SMR stream was criticised for its focus on targets and inputs rather than on patient experience and clinical and organisational outcomes, although PROMS should have some impact (Devlin and Appleby, 2010). In the view of local participants, SHA's and Monitor's focus on targets and the drive to meet the 18-week waiting time target came at a cost of strained relations across systems.

CMO: SMR →18 weeks

The Darzi 'Next Stage Review' and subsequent White Paper 'High Quality Care For All' was supported for bringing in a new focus on quality, patient experience and better outcomes. However, it was sometimes claimed that these reforms symbolised continuity, as implementation of quality and care closer to home was already underway. The emphasis on

clinical leadership and ownership of service change was welcome, but it was also perceived as 'disenfranchising the commissioner' and reinforcing the power of the supply side.

CMO: HQCFA → quality

CMO: HQCFA →provider power

7.4. The impact of reform across tracer conditions

7.4.1 Orthopaedics

As an acute elective, orthopaedics is an obvious test case for the NSR as programme theory appears to base the reforms on 'cold' surgery. Moreover, orthopaedics has struggled to meet the 18 week targets.

Hypotheses and CMO Configurations

We had two main hypotheses for orthopaedics. First, orthopaedics would be most affected by NSR. As we see later, this was largely confirmed. Certainly, it was felt that all of the reform streams had some relevance to orthopaedics. Second, the impact of NSR would vary across the case study sites. In particular, we expected more impact in Site A (competitive; diverse; integrated) than in the 'control' of Site F (not competitive; not diverse; not integrated).

This was partially confirmed as the urban PCTs were more successful in hitting their 18 week targets than the rural PCTs. However, the urban PCTs were closer to the target at the beginning of the period, and the rural PCTs were more successful in reducing their waiting lists than the urban PCTs, but it can be argued that – given their original position- reducing waiting times was easier for them to do. By 2009, the urban PCTs all performed better than

the average of their comparator PCTs, while two of the three rural PCTs fared worse. However, the 'control' PCT (F) was slightly above the average for its comparator PCTs.

Part of the reason for this complex picture is due to the crudity of our context variables. The 'potential competition' index is based on the number of hospitals within 30 minutes at the level of Department for Transport Lower Super Output Areas (LSOAs) (see Chapter 2). While there was more *potential* competition in our urban PCTs as compared with our rural PCTs, *actual* competition was limited with the main provider treating some 60% (A) 71% (B) and 95% (C) compared to 63% (two trusts, E), 70% (F) and 48% (two trusts, G). However, while the percentage share of the main providers for the PCT as a whole was less in the rural areas, it is likely this masked the degree of *local* monopoly within the rural PCTs.

There were some changes in market share over time, which largely reflected differential growth in activity. In all areas, the main provider tended to see least growth (with a small fall in B), but despite some large percentage changes in treatments at other providers, it would take a long time to significantly change overall patterns. For example, FT B in area B saw a 194% increase in admission rate, but it was still a relatively minor player compared with the dominance of the main provider. Much of this increased activity was the result of an increase in day cases. It is by no means certain that these changes will continue into the future. First, past patterns of competition within the context of an increasing size of 'cake' may not reflect future behaviour in a period of competition for a more static or even decreasing cake. Second, it is not clear how much more scope there is for increasing day cases.

Similarly, the 'diversity' variable was crude as diversity has a number of dimensions such as FT, private providers, third sector providers, and ISTC. Indeed, our control area (F) had few FTs and private hospitals, but over a quarter of its orthopaedics treatments carried out in ISTC. To the extent that ISTCs were introduced into localities that were thought to be at risk of failing to meet access targets, it is not surprising that they were used in each of our rural case studies. However, F PCT actively promoted the ISTC within the context of limited reductions in waiting times by the main FT.

Moreover, performance of Trusts within the PCTs varied. Our qualitative data shows that staff working within poorly performing orthopaedic departments were aware of challenges

to be addressed. In these cases, the introduction of competition from an ISTC was often, but not always, viewed as a catalyst for addressing historical working practices.

In terms of individual drivers, on the demand side there was little evidence of the impact of voice. Although there seemed to be relatively few active choosers (cf Robertson and Dixon, 2009), providers were aware that patients *could* chose, and the threat of patient choice certainly was clearly in the mind of providers. Providers claimed that commissioning was yet to make a major impact, with PBC not seen as a major driver. Context did not appear to be a major factor, with most providers – even those with largely monopoly positions stating that the threat of choice was important. Similarly, voice, commissioning and PBC appeared to be universalistic rather than contextual in that they did not seem to have a major impact in any of our sites.

CMO: choice→ responsiveness

On the supply side, FTs claimed that FT status led to a greater focus on innovation and a more 'business approach'. However, some PCTs argued that this came at the risk of fragmenting the LHE, and in some cases it was claimed that FT surplus was associated with PCT deficit. Providers were very much aware of the competition from ISTC. Even in areas where ISTCs treated only a few percentages of orthopaedic activity, they out-punched their weight in terms of the effect on the existing providers. However, it is difficult to evaluate the impact of ISTCs in the future as initial contracts that were weighted in favour of ISTCs as new market entrants are renegotiated. Context was more important here as the market share of FTs varied in our sites. While all providers were aware of ISTC, their presence sharpened the mind much more in sites such as F rather than C.

CMO: FT→ innovation; ISTC → responsiveness

The transactional reform, in the form of PbR, was seen as major driver in providing incentives to increase activity. However, there was awareness that early versions of tariff may have provided some perverse incentives in blocking care closer to home. There were few contextual effects here. PbR is a national policy, although providers claim that it penalises tertiary providers.

CMO: PbR→ activity

Finally, SMR were seen as important, with the 18 week target, along with other access and HCAI targets, regarded as vital. The HCC (now CQC) was seen as important, with FTs regarding Monitor as vital. SMR are national and uniform, although, the difficulties in reaching targets such as 18 weeks and HCAI depend on how far the starting point is from the target, and the impact of Monitor will depend on the level of FT in the LHE.

CMO: SMR→ 18 weeks

A range of views were expressed because the impact of Darzi. Some felt that his emphasis on quality did not represent a change in policy, while others welcomed his championing of issues such as the move to provide care 'closer to home'.

Summation

As expected, programme theory for orthopaedics was clearest the clearest of our three tracers, featuring elements from most of the streams. Moreover, the reforms were 'on the radar' of more orthopaedics stakeholders, with a greater perceived impact. Most of the drivers were consistent with programme theory of the policy, with the exception of some perverse incentives of PbR leading to increased activity in secondary settings and blocking care closer to home.

7.4.2 Diabetes

Improvements in diabetes care had been achieved but it is difficult to attribute these improvements to specific reforms.

Hypotheses and CMO Configurations

Our main hypothesis for diabetes was that integrated diabetes services ought to flourish in locations with a history of integration. There was little support for this. Based on Healthcare Commission data (see Chapter 6), Site A (high integration) had the worst 2007 scores, while site F (low integration) had the best. However, there were complex interactions with our

emergent hypotheses. Poor performance scores may have provided a catalyst for improvement, such that Site A put placed great efforts in improving its services. However, some of the next steps reforms may reduce rather than improve the ability to integrate care -a view held by many diabetes respondents.

As noted above, there is a policy-commitment to increase levels of choice for individuals with long-term conditions, including diabetes. There is also an expectation that there will be more diversity in the provision of services for long-term conditions in future. However, because the management of long-term conditions generally involves a network of care services, rather than 'one-off' interventions, choice and competition obviously cannot function in the same way as for episodic care. However, many respondents considered that that patient choice of provider was not a lever for change that had much impact or relevance in enabling high quality care services to be provided for a long-term chronic condition such as diabetes. It was claimed that most patients wished to 'stay local'. Moreover, some felt that choice had the potential to fragment, or undermine, the potential to develop a pathway of care.

In most of our case-study sites there was little real choice as alternative providers were too far away and competition for diabetes services was limited, but in Site A clinicians reported patients from a large geographical area using choose and book for their service because of short waiting times and a telephone based consultant follow-up service.

There was widespread support for integrated diabetes services to be based in community settings, but there were differences in the understanding of what constituted integrated diabetes care not just between but within case-study sites. There was acceptance of 'silos' at commissioning level and these inter-site differences were not just a factor of larger rural PCTs struggling to deliver similar services (such as practice-based nurse-led clinics) in all localities. Smaller urban PCTs with more developed PbC were working against integrated care by commissioning for separate services.

Commissioners were largely positive about the steps that had been taken whilst clinicians argued commissioning attempts at integrated care were weak and not well understood. At most sites, clinicians felt commissioning support for diabetes specific patient structured education programmes for patients to be weak or delayed. The sites which had progressed

most in their attempts to deliver community based integrated care were described as having good clinical relationships (Site B and C). Practice based commissioning for diabetes had progressed furthest in our urban sites, and was supported by the PCT, but raised questions for equity of access if all local PBC groups did not take part in the initiatives. It was felt by clinicians that patient 'voice' in terms of 'expert patients' and 'empowered patients' led to patients that were better able to manage their diabetes and thus had better outcomes.

CMO: 'voice' (empowerment) → responsiveness
CMO: choice → fragmentation
CMO: PBC →responsiveness, but at risk of increasing inequity

Turning to supply, in broad terms diverse providers were not available and competition could not develop because there was a limited skilled workforce capable of providing alternative services. There were some private providers for aspects of the diabetes care pathway, for example retinal screening, but this was thought to lead to fragmented and unsupported care and be of higher cost to NHS providers. There were therefore few significant positive impacts, but it was felt that:

CMO: diversity →fragmentation, inefficiency

In terms of transactional reforms, PbR has acted as a barrier to integrated diabetes care in the community as some commissioners felt that acute trust managers do not want to lose income of seeing patients in the hospital. PbR was also criticised for being not applicable for a chronic condition like diabetes with a complex case mix. Some case-study FTs have begun to address the PbR barrier by looking at diabetes coming off tariff or capping at a specific level of activity.

There were mixed views on the Quality and Outcomes Framework. While some interviewees felt QOF provided better structure for care, others saw it as a tick-box exercise that didn't go far enough especially for quality measures. Quantitative analysis of the QOF data for our case sites did show some evidence of a ceiling effect and this may be due to their being little incentive to improve diabetes services in primary care beyond the achievement of payment targets (Calvert, Aparna Shankar et al., 2009).

CMO: PbR →disintegration, care remaining in hospitals

CMO: QOF →responsiveness

Finally, NSF and NICE guidelines were recognised to be the strongest SMR drivers for managing and regulating diabetes services. The 18 week target was recognised as driving service delivery for the more complicated diabetes patients within acute care settings, but was not perceived as being specifically relevant to the majority of diabetic patients requiring treatment in primary and community settings.

CMO: SMR→responsiveness

The Darzi Report did not ring many bells in our diabetes tracer, so there are no clear CMO.

Summation

Although diabetes care was seen as improving, consistent with evidence from QOF and national reports (Department of Health, 2010), few respondents explicitly linked this to the mutually reinforcing streams of the reforms, although individual elements such as the NSF were seen as important. Indeed, some saw individual elements such as choice as leading to fragmentation, and PbR as preventing integration and care closer to home.

This links with wider evidence as some diabetes professionals consider similar elements of the reforms as problematic (ABCD and Diabetes UK, 2006). More generally, the Management Of Diabetes for Excellence (Matthews, 2007) state that whilst patient choice is intended to stimulate the highest quality treatment, the option is far more appropriate for elective short-stay surgery than chronic disease management. Diabetics need continuing treatment and support for life and this is ideally provided by a familiar team. PbR is also less than appropriate for treatment of a multi-factorial condition, such as diabetes, because a consultation often requires referral and input from other non-diabetes specialists. Practice-based commissioning was favourable towards multidisciplinary diabetes networks planning and monitoring local care, but this is still in early stages. The overall view of the current system changes was that a systemic overview of the whole care pathway is needed with any changes to be evidence-based (Matthews, 2007).

7.4.3 Early Intervention Mental Health

The reforms appear to have less influence in EIMH, which generally worked to different agendas and operated within different models of service delivery.

Hypotheses and CMO Configurations

We had three main hypotheses for EIMH. The first was that the NSR would have less impact on EIMH as compared with orthopaedics, as some of the main drivers such as choice and diverse providers were not regarded as particularly relevant, and transactional reforms were not present during the period of study. This appeared to be largely confirmed in that many of the potential system drivers appeared not to have any major impact.

The second hypothesis was that 'targets', best regarded as part of SMR would have the greatest impact of the NSR. This was largely confirmed in that the main drivers were seen as NSF, PIG and NICE, which we have classified as SMR, with a major target being to reduce DUP

The third hypothesis was that, as 'universalistic' SMR would have the greatest impact, then contextual effects would be minimal. This was broadly confirmed as the impact of the system reforms on EIMH appeared to be similar across the case study sites.

Overall, the Next Steps were not applicable. Choice, PBC, diverse providers, FT Status, PBR and Lord Darzi's Next Stage Review did not feature as significant drivers for EIMH services. The policy reforms that did impact on EIMH centred on demand side reform and the potential impact of transactional reform of Payment by Results.

Commissioning featured at a number of levels. The commissioning approach was one of collaboration in the way they facilitated EIMH services. However, the perception among EIMH teams was one that feared the threat of decommissioning. The use of market testing and tendering of EIMH remained a possibility and a fear for EIMH teams. Where commissioner reliance on targets to monitor performance provided the stick for service development, the message from EIMH teams was a need for greater understanding and awareness of EIMH and the issues they faced. For commissioners, their reliance on targets

was largely because they lacked knowledge and information about the specialist nature of EIMH.

With PBR to be fully implemented in 2014, clearly such a policy mechanism is likely to have a significant impact on EIMH and mental health more widely. There was much uncertainty and ambiguity as to what the mechanism would look like. Despite fears of possible perverse incentives such a mechanism could create, there was some optimism for a PBR mechanism to take the form of a benchmarking 'cluster based' approach to money following the patient. For this to happen, our findings suggest that significant improvements will be needed to existing data and information systems for such a mechanism to work. The information and data silos that appeared to exist across the EI pathway would need attention.

CMO: voice→responsiveness

Voice was a key driver of EIMH. It took the form of customised care plans, user and carer panels. Voice went to the very heart of EI approach. Clearly, it was difficult to detect the impact of voice on individual users however these findings support the view that the outcome of interaction with EIMH could make individuals more assertive about their needs when dealing with future MH services.

CMO: **SMR (NSF; PIG: NICE) →Outcomes (DUP)**.

In light of these findings, we find that the reform stream that shaped the impact of EIMH was System Management and Regulation. With contextual factors negligible, it was the policy drivers of the National Service Framework, Policy Implementation and Guide and NICE guidance that shaped the outcomes associated with EIMH. Without these policy mechanisms, it is likely that achieving EI goals of reducing DUP would not have occurred at the same rate.

The influence of other mechanisms and contexts

In relation to EIMH, our research draws attention to the influence of other contexts and mechanisms. What influenced the outcomes of EIMH service across our sites were levels of funding, the capacity for collaborative relationships and the existence of local flag bearers for the EIMH services.

The issue of funding equity across site populations influenced the scope and dynamics of EIMH services. Lack of funding limited the diversity of team members. The outcome limited EIMHs scope to promote a social inclusion model of socio-psychological intervention rather than a reliance of medicalised intervention. PCT funding cycles also limited to capacity to develop the service and introduce new roles.

The capacity for collaborative relationships across the EI pathway also shaped the impact of EIMH services. The transition from adolescent to adult services remained an ongoing issue. EIMH as an intervention had significantly improved this transition but the information systems surrounding the pathway remained an ongoing issue. Collaboration was evident across all sites however the information systems to support the process were clearly an area for improvement.

Local champions and flag bearers for the EI approach were important in raising awareness of the EI across the system. Those sites with particularly inspiring individuals created conditions that contributed to EIMHs aim to reduce DUP.

Summation

The impact of Next Steps reforms was limited however the impact of other policy reforms notably the NSF contributed to significant progress in achieving community based mental health services. Our evidence suggests EIMH supports the policy priorities in breaking down traditional barriers between professional groups, primary and secondary care and other agencies such as agencies such as education and employment (Appleby, 2007).

Our findings support the ongoing evidence that EIMH provides an essential service at a crucial point in the organisational processes between younger and adult services. They also draw attention to ongoing tensions between the demands and ethos of providing a quality service and meeting case-load targets (Lester, Birchwood et al., 2009). Such tension has led to unintended consequences that EIMH teams have struggled to wrestle with.

Overall, for EIMH to successfully reduce DUP requires addressing the ongoing issue of funding and greater attention being paid to the creation of information systems accessible to all agencies involved in the EI process. Our findings support several recent studies that illustrated problems in transition that potentially leads to disruption in continuity of care and disengagement from services (Singh, 2009). Organisational reconfiguration at commissioning levels and impending financial pressures may inhibit such integration. However, for the EI model to achieve its aims will require consistent funding and improved mechanisms to foster collaboration through information and data.

7.4 Conclusion

One of the major aims of the research was to examine programme theory, capturing how people understood, defined and perceived the combined and relative impact of the reform policies on behaviour, relationships, and social structures. This is important as it is not programmes that 'work' but their ability to break into the existing chains of resources and reasoning which led to the 'problem'.

There is little evidence of clear programme theory among the stakeholders that we interviewed. While there were no clear differences between case study sites, there was some variation between individuals and tracer conditions. Not surprisingly, senior managers appeared to have a clearer grasp of all the reform streams and how they fitted together than other respondents. Similarly, 'generalists' had a clearer overview than respondents from the tracer conditions, although respondents from orthopaedics broadly had a better grip on the reforms than those from diabetes or EIMH.

To some extent, this is not surprising as the reforms appear to be aimed at elective services. However, they are clearly also relevant to primary and community care and to LTC (DH 2006a) and it is intended that PbR will be extended to mental health services. There were some views that the reforms are contextual in that they are seen as solutions for elective services in conurbations such as London, and not relevant for other specialties and places.

In general and for orthopaedics in particular, there were significant differences in views between commissioners and providers, but there was some agreement that the reforms are unbalanced in that the centre of gravity lies on the provider side. To some extent, commissioners are attempting to play 'catch-up' (cf. House of Commons Health Committee 2008). There were also some common dogs that did not bark. Few respondents mentioned outcomes such as health gain, reducing health inequalities and prevention. Similarly, few stressed mechanisms such as voice, workforce reform, and management information. Even fewer could clearly explain how the mechanisms of reforms would lead to outcomes such as improving health and reducing health inequalities (cf House of Commons Health Committee 2009; Audit Commission 2010). Indeed, some saw the reforms as leading to negative outcomes such as the fragmentation of services. To some extent, some of these issues are the subject of more recent moves (e.g. best practice and unbundled tariff; CQUIN; PROMS etc), but there are concerns that these do not appear to be more 'on the radar'.

In conclusion, then, few respondents considered that the reforms were mutually supportive. This suggests that they tended to see reform levers working in isolation rather than in the joined-up fashion intended in the Next Steps Reform document (DH 2005a). Indeed, in some cases, it could be said that they reforms were not really implemented or tested. This suggests that our research says more about the relative impacts of the various streams and the elements within streams rather than a full consideration of the interactions between the streams.

Chapter 8: Conclusions

Introduction

Health service researchers always appear to live in interesting times, in the sense that the system that they study appears under almost continuous change. Since the bulk of the empirical data in this study was collected, health policy has seen an 'unprecedented' need to achieve efficiency savings, and a White Paper, 'Equity and Excellence' produced by a new Conservative/ Liberal Democrat Coalition Government (DH 2010c).

In this section we explore how the 'Next Steps' of the Coalition government map onto the Next Steps Reforms (DH 2005a). We then revisit the NSR, hypotheses and the main findings on CMOs. Finally, we discuss the extent to which key lessons learned from the NSR are relevant to the current government's reforms.

8.1 Next Steps under the Coalition Government

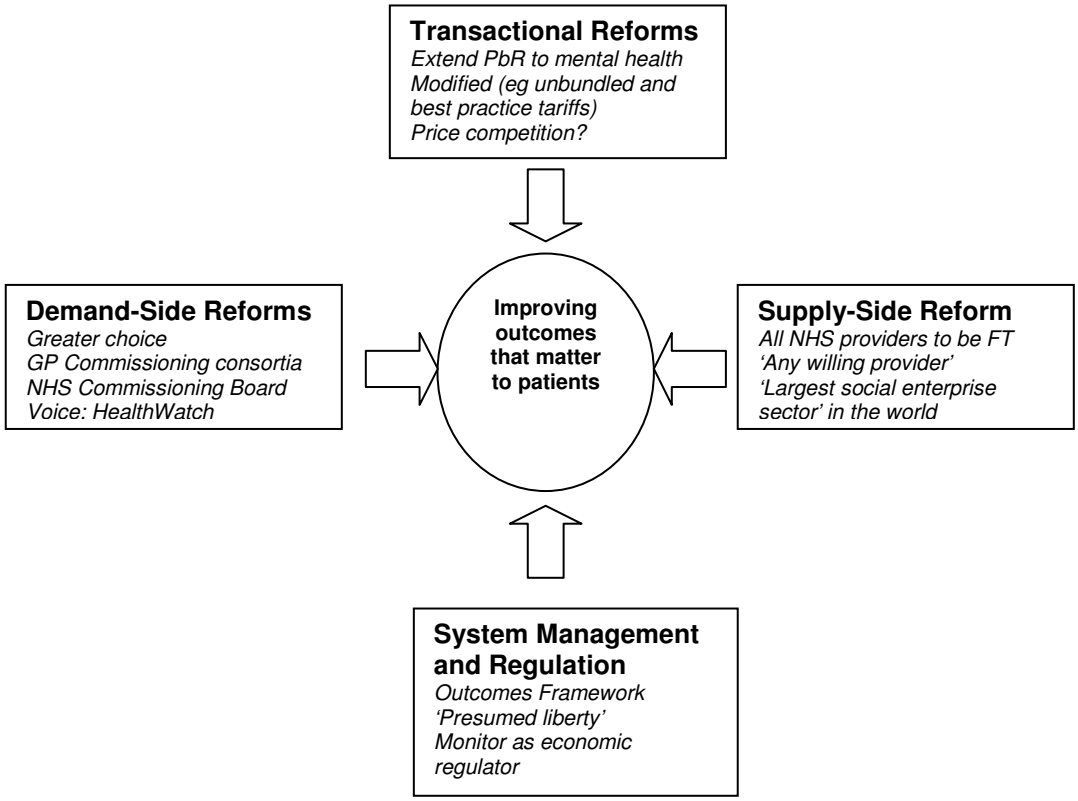
The 'Nicoholson challenge' was set out in 2009, and required the NHS to make an efficiency gain of around 4% per annum (also expressed as the need to make some £15-20 billion in efficiency savings). Although the DH is confident that substantial savings can be delivered by successfully implementing the Quality, Innovation, Productivity and Prevention (QIPP) programme throughout the NHS, the Health Committee (2011: para 25) considers the 'Nicholson challenge' to be 'without precedent in NHS history; and there is no known example of such a feat being achieved by any other healthcare system in the world'.

The main themes of 'Equity and Excellence' are that: patients will be at the heart of everything we do; there will be a relentless focus on clinical outcomes; and that we will empower health professionals (DH 2010c). The main changes can be outlined as the abolition of PCTs and SHAS, and the introduction of GP-led commissioning consortia; an

independent NHS Commissioning Board; a presumption of 'any willing provider' across all clinical settings; all NHS providers to become FTs; some changes to the roles of Monitor and Care Quality Commission; local authorities to be responsible for local health improvement and illness prevention; and a new patient and service-user involvement called HealthWatch at local and national levels (DH 2010c; Health Committee 2011; Millar et al 2011). However, the details of some of these points remain rather vague and subject to a seemingly almost continuous revision (but see DH 2010d, f).

There is debate regarding whether these changes represent evolution or revolution (eg Health Committee 2011; Millar et al 2011), The Committee was 'struck by elements of both continuity and discontinuity' (Health Committee 2011: para 39). Although the White Paper has a different structure, it can be mapped onto the four streams of the Next Step Reforms (DH 2005a).

Fig.8.1 'Equity and Excellence' modifications to Next Steps Reforms



In an echo of the NSR, it is stated that 'these plans are interconnected and mutually reinforcing' (DH 2010c: 12). In terms of the central 'box' of outcomes, there will be a move from the focus on nationally determined process targets to the improvement of healthcare outcomes in relation to mortality, morbidity, safety and patient experience. Success will be measured not through bureaucratic process targets, but against results that really matter to patients – such as improving cancer and stroke survival rates. The Government's objectives are to reduce mortality and morbidity, increase safety, and improve patient experience and outcomes for all. The NHS will be held to account against clinically credible and evidence-based outcome measures, not process targets. We will remove targets with no clinical justification (DH 2010c). The NHS Outcomes Framework is set out in a later document (DH 2010e). It consists of one framework (defining how the NHS will be accountable for outcomes), five domains (articulating the responsibilities of the NHS), ten overarching indicators (covering the broad aims of each domain), thirty one improvement areas (looking in more detail at key areas within each domain) and fifty one indicators in total (measuring overarching and improvement area outcomes). The five domains are: preventing people from dying prematurely; enhancing quality of life for people with long-term conditions; helping people to recover from episodes of ill health or following injury; ensuring that people have a positive experience of care; and treating and caring for people in a safe environment and protecting them from avoidable harm.

It is stressed that tackling health inequalities and promoting equality is central if the NHS is to deliver health outcomes that are among the best in the world. The social gradient in many health outcomes for people in disadvantaged groups and areas is a major driver of England's poor health outcomes in comparison to other similar countries. Therefore, one of the underpinning principles when developing this framework has been the need to promote equality and reduce inequalities in health outcomes. (DH 2010e, para 1.10-1). However, the objective of the first domain is to capture how successfully the NHS is playing its part in reducing the number of avoidable deaths, recognising that the NHS Commissioning Board can be accountable only for the NHS contribution to this goal. Not all deaths can be prevented through healthcare; indeed, the major impact on reducing mortality will be by preventing people becoming ill in the first place (para 2.9). This suggests a 'new era for public health' which adopts a life course framework for tackling the wider social determinants of health, which involves the creation of 'Public Health England', transferring local health improvement functions to local government, with allocated ring-fenced funding

with a new health premium which will incentivise and reward local authorities for progress made against elements of the proposed public health outcomes framework (DH 2010g).

Demand side reforms involve putting 'patients at the heart of the NHS, through an information revolution and greater choice and control' The document states that 'shared decision-making will become the norm: *no decision about me without me*.'. Patients will have access to more information, and will have choice of any provider, choice of consultant-led team, choice of GP practice and choice of treatment. Choice in maternity will be extended through new maternity networks. Choice of treatment and provider in some mental health services will begin from April 2011, and will be extended wherever practicable. The collective voice of patients and the public will be strengthened through arrangements led by local authorities, and at national level, through a powerful new consumer champion, HealthWatch England, located in the Care Quality Commission. Commissioning will be reformed with the replacement of PCT (and PBC) by GP consortia, which will give GPs overall control of NHS budgets to commission services. An independent NHS Commissioning Board will hold consortia to account against agreed outcome indicators for performance and quality. This 'lean and expert organisation' will be a Special Health Authority but with 'limited power to micro manage and intervene' (DH 2010c: 30).

Supply side reforms include all NHS trusts becoming or being part of a foundation trust. The government aims to create the largest social enterprise sector in the world by increasing the freedoms of foundation trusts and giving NHS staff the opportunity to have a greater say in the future of their organisations, including as employee-led social enterprises. The government's aim is to free up provision of healthcare, so that in most sectors of care, any willing provider can provide services, giving patients greater choice and ensuring effective competition stimulates innovation and improvements, and increases productivity within a social market.(DH 2010c: para 4.26). The Government will apply a consistent approach across all types of NHS services, ending the uncertainty and delay about the future of community health services currently provided within PCTs. We will complete the separation of commissioning from provision by April 2011 and move as soon as possible to an "any willing provider" approach for community services, reducing barriers to entry by new suppliers. In future, all community services will be provided by foundation trusts or other types of provider. (para 4.24).

Turning to Transactional reforms, providers will be paid according to their performance. Payment should reflect outcomes, not just activity, and provide an incentive for better quality (p. 4). It is claimed that the absence of an effective payment system in many parts of the NHS severely restricts the ability of commissioners and providers to improve outcomes, increase efficiency and increase patient choice. The previous administration made progress in developing payment by results in acute trusts. The mandatory scope has changed little since 2005/06, and has not incentivised results throughout the system (DH 2010c, para 3.17-8). The document continues that the Department will start designing and implementing a more comprehensive, transparent and sustainable structure of payment for performance so that money follows the patient and reflects quality. Payments and the 'currencies' they are based on will be structured in the way that is most relevant to the service being provided, and will be conditional on achieving quality goals. This includes refining the basis of current tariffs, including rapidly accelerating the development of best-practice tariff; extend the scope and value of the Commissioning for Quality and Innovation (CQUIN) payment framework; allowing commissioners to pay a 'quality increment' and impose a contractual penalty (eg proceeding with work to impose fines for an extended list of "never events", such as wrong site surgery. The government will implement the previous government's decision to extend PbR to adult mental health services.

Major changes are signalled in SMR. The document states that 'We will start by discarding what blocks progress in the NHS today: the overwhelming importance attached to certain top-down targets. These targets crowd out the bigger objectives of reducing mortality and morbidity, increasing safety and improving patient experience more broadly' (DH 2010c: para 3.2). Put another way, 'implementation will happen bottom-up' (p. 6). The Government's reforms will empower professionals and providers, giving them more autonomy, devolving power and responsibility for commissioning services to the healthcare professionals closest to patients, to strengthen democratic legitimacy at local level, local authorities will promote the joining up of local NHS services, social care and health improvement. The NHS will have greater freedoms and less political micromanagement. The headquarters of the NHS will not be in the Department of Health or the new NHS Commissioning Board but instead, power will be given to the front-line clinicians and patients. The headquarters will be in the consulting room and clinic. The Government will liberate the NHS from excessive bureaucratic and political control, and make it easier for

professionals to do the right things for and with patients, to innovate and improve outcomes (DH 2010c: para 1.12).

Greater autonomy will be matched by increased accountability to patients and democratic legitimacy, with a transparent regime of economic regulation and quality inspection to hold providers to account for the results they deliver (DH 2010c: para 4.1). Providers will no longer be part of a system of top-down management, subject to political interference. Instead, they will be governed by a stable, transparent and rules-based system of regulation (para 4.26).

Monitor will become an economic regulator, to promote effective and efficient providers of health and care, to promote competition, regulate prices and safeguard the continuity of services. Monitor's powers to regulate prices and license providers will only cover publicly funded health services. However, its powers to apply competition law will extend to both publicly and privately funded healthcare, and to social care. Monitor is likened to 'other sectoral regulators such as OFCOM and OFGEM', and will have concurrent powers with the Office of Fair Trading to apply competition law to prevent anti-competitive behaviour.

The government states that it will strengthen the role of the Care Quality Commission as an effective quality inspectorate across both health and social care. However, providers will be set free and will be in charge of their own destiny, without central or regional management or support (DH 2010c: para 5.12). Moreover, we are moving to a system of control based on quality and economic regulation, commissioning and payments by results, rather than national and regional management. Within that context, we are committed to reducing the overall burdens of regulation across the health and social care sectors. We will therefore undertake a wide-ranging review of all health and social care regulation, with a view to making significant reductions (para 5.10).

Finally, as noted above, there will be a new Outcomes Framework (DH 2010e). We will replace the relationship between politicians and professionals with relationships between professionals and patients. Instead of national process targets, the NHS will, wherever possible, use clinically credible and evidence-based measures that clinicians themselves use. The Government believes that outcomes will improve most rapidly when clinicians are engaged, and creativity, research participation and professionalism are allowed to flourish.

In future, the Secretary of State will hold the NHS to account for improving healthcare outcomes. The NHS, not politicians, will be responsible for determining how best to deliver this within a clear and coherent national policy framework (DH 2010c: para 3.4).

Although 'Liberating the NHS' (DH 2010d) does not use the term, some elements of 'programme theory' can be gathered from the document. First, it discusses 'levers' and 'incentives'. For example, the NHS Outcomes Framework is by no means the only lever for quality improvement in the new system. Robust regulation, strong commissioning and clarity of roles across the system will provide the right environment for continuous quality improvement. The strengthened inspection role of CQC and its system of registration will ensure that minimum standards are met (para 3.26). There are claims that particular levers will lead to certain outcomes (although there is little recognition of context). For example, HealthWatch England should have real influence, adding a vital dimension to CQC's work on improving services and reflecting the importance we place on the high quality regulation that CQC provides (para 2.57). On the provider side, the new system of economic regulation will promote financial discipline, efficiency, transparency and fairness in the way that resources are used (para 7.28). It is claimed that some elements build on the work of the previous government. For example, we will build on key aspects of the existing arrangements: for example, a number of GP consortia are likely to emerge from practice-based commissioning clusters and Monitor will become the economic regulator (DH 2010c: para 1.13). The Government certainly agrees that it would have been preferable for the previous administration to have completed the design and implementation of the reforms started under Tony Blair, upon which *Liberating the NHS* clearly builds: the completion of the transition to foundation trusts, freeing up the provider side to allow greater innovation, introduction of patient choice of any willing provider, the extension of payment by results, the clearer separation of commissioning and provision, and devolving power to practice-based commissioners. As a number of people have observed, the Government's plans represent a logical extension of those reforms. If the previous administration had implemented in full its own original reform plans, the scale of change envisaged in *Liberating the NHS* would seem considerably less radical (DH 2010d: para 7.22).

On the other hand, it is stressed that other elements are new. According to DH (2010d: para 7.23), the reforms comprise an extensive array of new mechanisms designed to improve quality and efficiency:

- giving patients more choice and control over their care improves quality and efficiency;
- a comprehensive set of quality standards developed by NICE and supported by the NHS Commissioning Board will help spread adoption of the most effective care;
- aligning the clinical and financial aspects of commissioning through GP consortia is a prerequisite for the QIPP agenda.;
- the new arrangements for GP consortia will also enable and incentivise successful commissioners to expand, and there will be a clear statutory failure regime. These are important advances on the current arrangements for PCTs;
- strengthening the local authority role as integrator of commissioning across the NHS, public health and social care is vital to delivering more integrated care, which is more efficient and offers a better user experience;
- giving providers freedom to innovate will drive major productivity and efficiency improvements – for example, in community services;
- the development of Monitor as economic regulator will strengthen the drive for provider efficiency through greater price transparency, increased competition, and a clear and independent provider failure regime; and
- driving and completing the foundation trust pipeline will ensure that all existing NHS trusts become clinically and financially sustainable, either as a stand-alone organisation, or as part of an existing FT or another organisational form. A forensic focus on the organisations that require the greatest development is an essential part of our plans to drive quality and productivity on the provider side.

There are some attempts to set out how the elements fit together. For example, patients will have more control over their care and, for most services, the ability to choose between any willing provider that meets NHS standards and prices. Money will follow the patient, and providers will have far greater freedoms to respond to patients' needs and preferences. This will enable the best providers to thrive and will put pressure on those providing poorer quality or unresponsive services. (DH 2010d: para 6.76). There is also some notion of balance in the system: a key lesson from previous reforms in the NHS is the need to get the balance right between progress on the commissioning side and progress on the supply side (para 7.43).

Moreover, there is the notion of system alignment. All levers and incentives will be aligned to support the delivery of the outcomes goals set out in the framework. Figure 2 illustrates how the system for delivering improved outcomes will operate, and how the levers and incentives will be aligned (Dh 2010d: para 3.27).

Figure 2

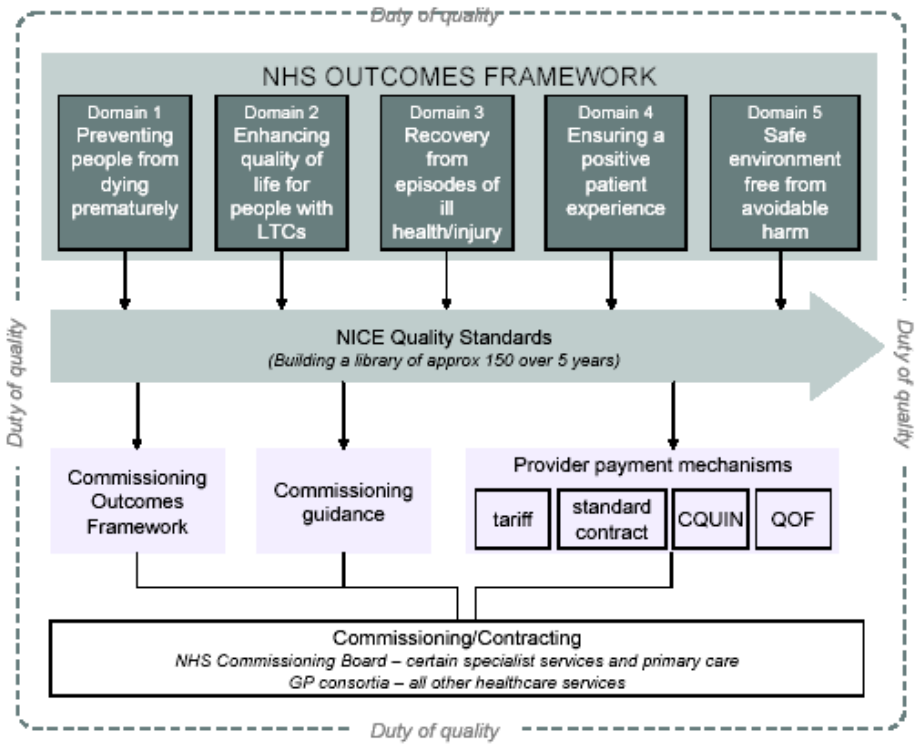


Figure 8.2: System alignment in 'Liberating the NHS' (Figure 2 from DH 2010d)

Moreover, the implementation of *Liberating the NHS* involves the management of a significant and complex set of interconnected changes (DH 2010d: para 7.58). There are also references to 'system architecture': the current architecture of the health system has developed piecemeal, involves duplication, and is unwieldy. Liberating the NHS, and putting power in the hands of patients and clinicians, means we will be able to effect a radical simplification, and remove layers of management (DH 2010c: para 1.13).

It is claimed that it is necessary to pursue system-wide reform simultaneously with achieving efficiency savings. The government acknowledges that QIPP is the single greatest challenge

that the NHS faces over the lifetime of this Parliament is to increase quality and productivity (DH 2010d: para 7.20). Moreover, many respondents have argued that implementing structural reform is incompatible with achieving the immediate quality and productivity challenge. But whilst the financial context is unarguably more challenging than it was five years ago, the scale of the efficiency challenge is such that it can only be met by system-wide reform. Successful delivery of plans to improve quality and productivity is not something separate from making early progress with structural reform. Instead it is inextricably linked with implementing reform. Plans to manage QIPP, and plans to manage transition, are in practice one and the same thing (para 7.23)

Finally, there is also an over-arching claim that organisations and structural reforms are important, but at their heart our plans for improving the NHS are all about people: giving all patients more clout in the system and increasing local voice; trusting professionals to do the right thing, and rewarding innovation, excellence and equity; and giving local leaders the responsibility that comes with increased authority. Our model of improvement is about trust and empowerment: a model of assumed liberty, not earned autonomy. The Government sees its role as creating an enabling framework to support and energise local change. And as the NHS Confederation put it: "*in general, we support the approach of confining policy to the specification of the broad frameworks and allowing local organisations to develop solutions that are appropriate to their own circumstances*" (para 7.10).

8.2 Revisiting 'Next Steps' reforms: mutually supporting levers and incentives?

The Next Step Reforms aimed to achieve positive outcomes through the right balance of four inter-related and mutually reinforcing streams. This requires that the reform streams work individually and collectively. However, two sets of main charges have been levelled against the health reforms. First, it has been claimed that they are incoherent. According to Hunter (2008: 74) if by 2002 there was a reasonably clear direction in the health system reforms in favour of markets and competition, the precise means of achieving these gave cause for concern and seemed to lack strategic coherence. In particular, the chief components of the new policy did not all mesh together in a coherent manner but seemed to push and pull against each other. Internal contradictions among these so-called 'jigsaw' policies or '5 Ps' (PFI; PbR; PBC; plurality of providers; and patient choice) were rife. According to Le Grand

(2007: 2-3) one of the criticisms of the choice and competition reforms was that they were incoherent: a contradictory mish-mash of ill thought out policy gimmicks with little basis in theory or practice. His response is that the reforms stemmed from a well-grounded understanding of the problems involved in delivering public services and, in particular, the difficulties in delivering them through forms or models of service delivery that did not involve elements of choice and competition.

We examined this charge through documentary analysis, policy interviews and service interviews. As we saw in Chapter 3, the reform journey was far from simple and linear. Although programme theory became a little clearer over time, it remains far from clear. There was some evidence of policy learning as some later policy levers were added or changed as problems emerged. For example, it became clear that 'payment by results' was more accurately viewed as 'payment by activity', and this led to discussions of 'best practice' and 'unbundled' tariffs, and to linking payment partly to quality, patient experience and patient satisfaction rather than simply to quantity. We saw in Chapter 4 that policy makers were aware of some of these perverse incentives and unforeseen consequences, and attempted to pull the appropriate policy levers. Some later elements- such as WCC- were partly an attempt to introduce system balance after tension emerged from earlier elements such as FT (cf House of Commons Health Committee 2008). Service interviews also pointed to imbalances. For example, some providers claimed that PCTs lacked capacity for effective commissioning. Conversely, some PCTs considered that FT surplus and PCT deficits were clearly linked.

Some context-mechanism-outcome (CMO) configurations were not clear to service respondents (chapters 5 and 6). This was particularly the case in three senses. First, the reform document (DH 2005a) claims that the interaction of policy streams led to improved outcomes. However, some outcomes were more on the service radar than others. Responses from the provider side almost universally stated access and HCAI rates. Although care closer to home was on the agenda for both commissioners and providers (for example, orthopaedic triage initiatives and redesign of diabetes services), in many cases increasing health, reducing health inequalities, and prevention - stated outcomes of the later policy documents- were little mentioned by PCTs, and were not on the agenda for providers. Second, there appeared to be little recognition of trade-offs between ends in service delivery. As Le Grand (2007: 13-4) puts it, it may not be possible to achieve all ends. He

claims that the recognition of trade-offs is one that many people outside the policy world often find difficult to recognise, but they are an ineluctable fact of policy formulation and development. However, few policy and service interviews appeared to recognise this. Third, while it is clear how PbR might be associated with increasing activity and reducing waiting lists, it was less clear how the original PbR tariff was associated with care closer to home.

8.3 Next Steps reforms: what works, for whom, in what circumstances?

Before turning to the main results, the main limitations of the study should be discussed. Our main aims were to:

- To explore empirically how stakeholders regard the implementation of complex policy initiatives within a range of local health economies (contexts), including how these local implementations are intended to operate (process) and their observed effects (outcomes);
- To identify the extent to which policy initiatives were proving effective in addressing nationally specified outcomes in a range of service specialties with specific emphasis on understanding the interactions and dynamics *within* organizations as well as *between* them.

The first aim was concerned with programme theory and CMO, and we feel we were successful in exploring programme theory of national and local stakeholders. We were probably less successful in our second aim. While we did make some progress on understanding the interactions and dynamics within and between organizations, we were less successful in connecting these to successful policy outcomes. This was partly due to data problems, but also due to the inherent problems in this type of analysis.

Our research design is based on six case study sites and three tracer conditions. The selection of case study sites was based on three fairly crude variables: provider market, provider diversity and the level of integration with local government. In each of the six case study sites the impact of the reforms was examined across three tracer conditions: *orthopaedics* (an elective service) *diabetes:* (a long-term condition); and *early intervention*

mental health (to represent a service requiring a complex response from health and social care providers).

The bulk of the data was derived from interviews with national and local stakeholders, and this was supported by some documentary analysis and quantitative work in the six case study sites. The national interviews provided important perspectives which added to the material from the analysis of policy documents. We carried out 175 individuals in the case study areas (with 40 phase two re- interviews, making 215 interviews in total)) which is a fairly high aggregate figure in terms of qualitative research. These interviews related to six case study sites and three tracer conditions. The number of interviews for individual case study sites and for tracer conditions remains fairly high in comparison to other qualitative work, although 16 total interviews in site A is quite low, and perhaps less stress should be placed on those findings. In one sense, this gave us eighteen case studies. The number of interviewees varied between case study and tracer conditions, and was small in some cases (eg orthopaedics in site A). However, many of the themes from the sites and tracer conditions were probably sufficient to place some confidence on the overall qualitative findings.

The quantitative research was not intended to replicate the national studies of single streams of the reforms (see http://hrep.lshtm.ac.uk/), but rather to provide some helpful context for the wider qualitative study based on local stakeholders' perceptions of the reforms. As suggested in Chapter 1, evaluating complex interventions with multiple streams in a fast moving policy environment is problematic. It proved difficult to secure the data necessary to provide a full analysis of all the streams. The difficulty in accessing data, particularly for mental health services, illustrates both the paucity of available information and the challenge in overcoming individuals' concern over sharing data when the identity of their locality could potentially be identified. Even if the data was available, specifying clear dependent and independent variables would have been difficult. The quantitative work focused on one (albeit an important, 'high level') aim of waiting lists, and orthopaedics is often regarded as one of the areas that had most difficulty nationally in achieving the waiting list targets. The quantitative analysis provides some insight into the similarities and differences between the six case-study PCTs. Although, the available data may be too limited for full or 'stand alone' quantitative analysis, they can nevertheless provide context

for stakeholders' views, and adds value by allowing the reader some insight into the local circumstances, which are subject to considerable variation across the case-study sites.

The quantitative and qualitative analysis also allowed some comparison of findings. The quantitative work suggests that the rural sites did not achieve the national target, despite the substantial increases in capacity and activity, but did close the gap on the urban sites. However, there was no clear mapping of policy context, mechanisms or outcomes from the quantitative to the qualitative work. For example, there was no clear discourse of relative success or failure in the case study sites despite their differing quantitative performance. Providers tended to be aware of the potential effects of choice and competition, even in largely monopolistic markets with few real existing threats of competition.

We now turn to discuss the main findings. While there was some recognition of the outcome and mechanism components of 'CMO configurations', insufficient attention was given to context. Beyond a few nods of recognition that emergency care was different to elective surgery, that LTC may differ from acute conditions, and that potential competition might differ between urban and rural areas, the embryonic programme theory seemed to be more universalistic than contextual.

Perhaps the most significant deficiency was the failure to engage staff at service level. According to DH (2005b), there is clearly a great deal of support for the direction of travel but some uncertainty about aspects of it and many suggestions about how to carry it forward most effectively. The document states that it is designed to address these issues, offering a description of the major changes underway and – while it cannot deal with every point – describing how some of the biggest changes will be carried forward. *It has been written primarily for the leaders of the NHS, the clinicians and managers, the Boards and everyone who is helping lead the transformation of the NHS. But it is vital that these leaders communicate its key messages – about the vision, the values and the major changes – in their own words for their patients and staff* (our emphasis). We did not seek the views of patients, but is clear that this message has not been received by some leaders, let alone all staff.

As we saw in Chapter 7, the reforms saw some problems of 'buy in' in both vertical and horizontal terms, First, there are indications that there may be limited 'buy in' to the reforms

among staff 'in the field', with a significant number of managers and clinicians either not fully understanding the reforms or being disposed towards them. To use the language of the DH Capability Review (Cabinet Office 2007), there were problems of system alignment (see also Greer and Jarman 2007; Hunter 2008). The Review urged the department to consider the need for more consistent engagement with front-line staff, 'enabling them to make an effective contribution to the development of policy and build common ownership of outcomes' (Cabinet Office 2007: 22).

It seems that this situation has continued as there is more recent suggestions that some NHS staff are not fully engaged with or supportive of current Coalition Government reforms (Santry 2010; Nuffield Trust 2011). While three quarters of the 60 or so 'health leaders' who replied to a survey in early 2011 felt that services had improved in the past three years, two thirds 'fundamental' stated that change in the NHS was necessary. However, two thirds considered that the current pace of reforms was too fast. A large majority did not think that the reforms were essential to achieving the efficiency savings in the NHS. A majority was in favour of more competition, but also considered that altruism was the most important motivator of professional behaviour. When asked to choose between different levers to achieve the efficiency savings, 47% favoured 'stronger local performance management', 26% pointed to 'control of prices for clinical care', the same figure of 13% suggested 'stronger central performance management' and 'more provider competition' and only 1% favoured GP commissioning.

In horizontal terms, there are some indications of differential 'buy in' among managers and clinicians. Many clinicians displayed various degrees of hostility to competition and to externally imposed targets. There was some indication of greater understanding and 'buy in' from managers from higher managerial levels, and from providers rather than commissioners. While the emphasis on clinical effectiveness and clinical engagement, was broadly welcomed by the informants in our case study areas, there was a feeling that Darzi was 'was all things to all people', and it was clear that one single clinician will not necessarily engage all types of clinicians, with comments that Darzi did not understand (insert almost any type of clinician apart from cardiac surgeons!).

Moreover, while there are evaluations of individual policies (Chapter 3), there are few examinations of the whole reform agenda. According to Ham (2009: 72-4), early (up to 2003)

assessments of the reforms offered a broadly positive verdict, but later assessments delivered more cautious and in many ways more critical judgements. Moreover, they consider that progress had resulted mainly from increases in funding and the use of national targets rather than market-orientated reforms. The 'Civitas' review concluded that there is a danger of a 'lose-lose situation' (Brereton and Vasoodaven, 2010). However, we consider this to be both not fully clear from the evidence presented by the review, and unduly pessimistic. Our view is similar to the Audit and Healthcare Commission s(2008) that the NHS has made significant progress in some areas but more limited progress in others, and the potential of the reforms has not been fully realised. The problem in such a complex and fast moving policy environment is establishing causality in what works, or more precisely what works for whom in which ways.

As we saw in Chapter 7, the reforms have had more impact in some of our case studies and tracers than others. However, there seems to be no simple reason for this and, as we shall see, some of our hypotheses were not confirmed. Health economies that were more advanced with implementing the reforms were not performing at a clearly higher level than those that had limited reform levers in place, and service improvements in some contexts have been delivered without using the interaction of reforms (cf Audit and Healthcare Commission 2008).

Similarly, the reforms appear to have worked for some objectives but not others. For example, there has been increased activity and reduced waits, and some evidence of a greater focus on innovation and a business culture. On the other hand, there has been little progress towards care closer to home and prevention. It is difficult to attribute progress to the interaction of the reforms rather than to already existing components. For example, there had been clear progress in reducing waits through 'targets' and increased funding before the Next Step Reforms framework (DH 2005a). However, at least there is fairly clear programme theory to support this: respondents saw how a combination of PbR, targets, diverse supply and choice might contribute to reduced waits. Conversely, they found it difficult to see how the unreformed tariff could contribute to moving care closer to home (as recognised by DH 2006a).

Moreover, the reforms seemed to work for some better than others. Very broadly, in extreme cases, PCTs saw a 'zero sum game' in which FT surplus was associated with PCT

deficit. It could be argued that in some cases it was difficult to determine whether reforms had succeeded or failed as they had not been tried. For example, it was generally seen that PBC had not developed as originally expected. Finally, it was too early to tell for other policies. For example, ISTCs had produced some gains but also some problems stemming from their original contracts, but policy success can only be determined if and when renegotiated contracts are in place.

8.4 Revisiting hypotheses

This section reviews the main hypotheses explored in Chapter 7. Our main hypothesis was that the impact of the reforms would vary across the case study sites with some potentially being located in more receptive contexts for their application than others. While the impact of individual reform streams and elements varied across sites, it was difficult to identify any significant overall contextual variation. Certainly, there was no clear pattern between the extremes of Site A (competitive; diverse; integrated) and Site F (not competitive; not diverse; not integrated).

We had two main hypotheses for orthopaedics. First, orthopaedics would be most affected by reforms, which was largely confirmed. Second, the impact of reforms would vary across the case study sites, which was partially confirmed. In particular, historically the urban PCTs experienced better waiting time performance than the rural PCTs, and the rural PCTs have been able to reduce the size of the gap in performance. However, this progress was supply-side led, and it remains unclear whether the commissioning function will be able to take a more proactive role as resources become more constrained.

Our main hypothesis for diabetes was that integrated diabetes services ought to flourish in locations with a history of integration, but there was little support for this. However, this may be due to the problems of measuring 'integration' with the rather crude proxy variables available. Moreover, , there were complex interactions with our emergent hypotheses: poor performance scores provided a catalyst for improvement, which saw some support, but some of the reforms may reduce rather than improve the ability to integrate care, which was held by many diabetes respondents.

We had three main hypotheses for EIMH. The first was that the reforms would have less impact on EIMH as compared with orthopaedics, which was largely confirmed. The second, that SMR would have the greatest impact of the reforms, was largely confirmed. The third, that the significant impact 'universalistic' SMR would lead to minimal contextual effects, was broadly confirmed.

8.4.1 CMO Configurations

This section summarises the main CMO from Chapter 7. The table shows that system and orthopaedics CMO were fairly similar, but clear CMO were fewer, and to some extent different (more negative), for diabetes and for EIMH in particular.

Table 8.1: Summary of CMO

	System	Orthopaedics	Diabetes	EIMH
Demand	**choice→ responsiveness**	**choice→ responsiveness**	**'voice'→ responsiveness choice→ fragmentation PBC→ responsiveness, but at risk of increasing inequity**	**voice→ responsiveness**
Supply	**ISTC→ responsiveness FT→ responsiveness, innovation, governance. FT→ reduced collaboration**	**FT→ responsiveness, innovation ISTC→ responsiveness, innovation**	**Diversity→ fragmentation, inefficiency**	
Transactional	**PbR→ activity, but blocked care closer to home. PbR affects orthopaedics more than diabetes and**	**PbR→ increased activity**	**PbR→ disintegration, care remaining in hospitals QOF→ responsiveness**	

	EIMH			
SMR	**SMR→ 18 weeks**	**SMR→ 18 weeks**	**SMR→ responsiveness**	**SMR→ Outcomes (DUP)**
Darzi	**HQCFA→ quality HQCFA→ provider power**			

8.4.2 Receptive Contexts

There were fewer contextual differences between the case study sites than expected. In particular, while there were differences between the urban and rural sites in reducing waiting lists and hitting the 18 week target (based on our potential competition dimension), most interviewees were aware of the potential of choice and the threat of competition, even in largely monopolistic markets. Some factors such as PBC were said to have made limited impacts in most sites. The most important factor- PbR- is a universalistic mechanism, although it was seen as producing different local impacts (eg on tertiary providers). It can be seen that the CMO configurations were very different between the tracer areas. For example, PbR had not been implemented for mental health. NSFs were seen as important, and voice was regarded as more important than choice for diabetes and EIMH. There were some differences between organisations. In particular, PbR was broadly regarded positively for providers, but with much greater caution for PCTs. Finally, there were some differences between clinicians and managers, with clinicians generally more hostile to competition.

However, it is difficult to see multi-dimensional CMOs. A receptive context for one mechanism may not be receptive for another (cf Mannion, Davies et al., 2004). For example, a contestable market may lead to a greater stress on innovation and responsiveness, but a previous history of collaboration might lead to greater integration. PBC may flourish in areas that had well developed GPFH.

This suggests that the conditions for policy success may be additive or multiplicative. There are a number of conditions that must hold for quasi-markets or competition to work (Le Grand and Bartlett, 1993; Le Grand, 2007; Powell, 2003). Le Grand (2007: 95) writes that the

model will only achieve desirable ends of quality, efficiency, responsiveness and equity under the right conditions. Competition must be real, choice must be informed, and cream-skimming must be avoided (p. 105). If these conditions are additive or multiplicative, the reforms will work ONLY in areas that have real competition AND informed choice: in other words, where the demand and supply side come together. Although information is improving, we are a long way away from informed consumers (Robertson and Dixon 2009), but it is not clear if there is a critical mass of active consumers or 'market mavens' to focus the minds of producers. Moreover, even if the 'competition' conditions are present, it is far from clear that receptive contexts for the other reform streams are present. For example, conditions for targets to work may be seen as those of 'perfect implementation' (Hogwood and Gunn, 1984; Hood, 1976). Conditions for effective collaboration are more difficult to establish, but it is often argued that competition drives out trust, making collaboration more problematic. For example, many of our respondents- particularly in diabetes and EIMH- saw conflicts between competition and integration.

Neither is it clear that mechanisms that worked in the recent past of resource growth will work in the forthcoming period of scarcity. DH (2009c) gives a number of 'austerity' measures such as zero uplift on tariff. The Operating Framework for 2010/2011 (DH 2009d) allows a temporary suspension of PbR. There was already talk of block contracts in two of our case study areas, which may be exacerbated by future austerity. Paul Corrigan (2010) claims that it is common knowledge that there is a battle going on within the NHS between those who want to mainly use incentives to improve quality and productivity and those who mainly want to use the old style of instruction from the top. He argues that the place where productivity most needs to be improved is in the most inefficient hospitals. Yet it is precisely those hospitals that will find working to a deflated tariff the most difficult. If a SHA can say a hospital is too inefficient to work to tariff, then it will be allowing the most inefficient hospitals to opt out of the main way in which they could be made more efficient. However, our analysis suggests that it is PCTs rather than Trusts that find tariff most problematic.

8.5 Key Policy Messages

As we saw above, we are now in a rather different policy environment to the one in which most of the empirical data was collected in, with a more challenging funding regime and the introduction of new policies from the current Coalition government. In the language of programme theory, we have seen some changes in context, mechanism and (intended) outcomes. The key policy message is that programme theory and context-mechanism-outcome (CMO) configurations remain unclear, both 'on paper' and more importantly to many 'on the ground' implementing the reforms (cf Cabinet Office 2007). This meant that implementation was problematic, both in vertical and horizontal terms. There was limited and differential understanding and engagement or 'buy in' from the 'street level bureaucrats', or those 'in the field' to use the term of the Cabinet Office (2007). This could be seen, to varying degree, in some differences between the perceptions of organisations (eg FT and PCT), managers and clinicians, and in levels of seniority. It is clear that while some of the individual reform streams and elements have had significant positive impacts, they are not widely regarded as mutually reinforcing, with some perceptions of perverse incentives, unforeseen consequences, imbalances and negative impacts.

The reforms of the current government bring new contexts, mechanisms, and outcomes. This means that lessons relating to specific issues (such as PCTs or PBC) are of limited value. However, a number of lessons for policy makers can be drawn from the research that has relevance for current and future policy. A good starting point may be some lessons for policy-makers from a former Director of the Strategy Unit in the DH (Ham 2009):

- **Policy-making in Opposition is often weak**

Ham argues that the Blair government did not have a master plan for the NHS in 1997, and the evolution of NHS reforms can be seen as an example of policy making on the hoof, or in the language of policy analysts, an example in policy learning. His first lesson is therefore the weakness of policy-making in Opposition and the failure of political parties to invest time and effort in working through their thinking to enable them to put their ideas into place when elected into government.

Andrew Lansley became Shadow Health Secretary in 2004, and so has had the space to invest significant time and ideas into policy development. However, being in government was probably more of a surprise to the Liberal Democrat partners in the Coalition government. Some elements from both parties Election manifestoes can be seen in 'Equity and Excellence' , which was said to be 'a blend of Conservative and Liberal Democrat ideas' (DH 2010c: 1). Moreover, the Health Select Committee (2011) pointed to a 'significant policy shift between the Coalition Programme, published on 20 May 2010 and the White Paper, published on 12 July 2010'. It continued that 'the unexplained change in approach between the Coalition Programme and the White Paper has led to considerable uncertainty about whether the Government intends to build on existing experience within the NHS or create a major discontinuity'.

- **Politicians are inexperienced in leading large scale change**

Ministers have little track record of management and leadership in other sectors. This means that people with relevant backgrounds may be used as advisors, or ennobled to allow them to enter government (for example, Lord Darzi as Health Minister).

Following from the last point, it is not fully clear yet who the Government's main health 'policy entrepreneurs' are. However, the Health Committee (2011) stated that 'it was striking how limited the consultation was by the Government in the preparation of the policies set out in the White Paper.' It continues that while such a 'surprise' approach is not necessarily wrong, it does increase the level of risk involved in policy implementation. It allows less time to understand complexity and detail, and less time to develop and explain policy; and it leads to less understanding of objectives by staff, patients and local communities. A successful 'surprise' strategy requires clarity and planning, but the Committee does not think that the White Paper reflected these qualities. There appears to have been insufficient detail about methods and structures during the transitional phase. In terms of our report, programme theory and CMOs are not clear, and these need to be communicated successfully to the implementers in the field.

- **It takes time to deliver change**

Politicians generally wish to see 'quick wins', but it often takes time for the results of reform to become evident. This accounts for changes in policy direction often a year or so into 'ten year plans'. Ham gives the example that with the benefit of hindsight, targets and performance management, together with increased investment, made the biggest contribution to the improvement in the NHS, but this was not apparent in the summer of 2001 when ministers decided to change course.

This strikes a chord with some of our research. As the literature review (Chapter 3) shows, it is generally only more recent studies that show some positive effects of competition. The Government appears to to understand this. 'Learning the lessons of other sectors, we recognise that full reform of the provider side and the introduction of greater competition where appropriate will take time to embed over many years' (DH 2010d: para 7.44). Moreover, 'our strategy is about making changes for the long-term; not just for this Parliament, but beyond' Experience in other sectors and abroad shows that embedding change takes time, and requires ongoing adaptation. The Department is committed to evidence-based policy-making and a culture of evaluation and learning (DH 2010c: para 1.23).

- **Things may get worse before they get better**

Turning around an organisation as large and complex as the NHS may involve a deterioration to performance before the effects of increased spending and reform are felt. Ham cites Rosabeth Moss Kanter's observation that everything can look like a failure in the middle of organisation transformations.

This relates to the previous point, and poses the question of if things are getting worse, how we know whether this is a prelude to improvement, or to continued deterioration. The contextual issue is important here, as it will be difficult to determine whether any deterioration is due to the unprecedented scale of efficiency savings or to the new policy mechanisms.

- **Improvement is rarely linear**

As improvements are rarely linear, there is a need to focus both on established priorities and to be constantly alert to the likelihood that new challenges will emerge. This requires well-developed intelligence systems that connect those responsible for steering reform at a national level with managers and clinicians delivering services on the ground to provide feedback on major operational issues as they arise. It also demands a capability for strategic policy-making in government focusing on scanning the horizon for new threats and opportunities.

Our research stressed the importance of connecting with those delivering services on the ground. However, there are problems in differentiating any negative perceptions in terms of understanding or disposition. Is any hostility of implementers to reform due to limited understanding, to an informed and considered position, or simply to a dislike of change? A greater discussion between centre and periphery may allow these questions to be answered.

- **Changes in leadership may impede progress**

Changes among the guiding coalition that is leading reform almost invariably impede progress. In particular, continuity of ministers and advisers is important.

We saw (Chapter 3) that the Next Steps Reforms was, at least in part, due to the need to explain policy development to an incoming Minister. It was clear that change of Ministers led to some changes in policy direction (Ham 2009). Continuity should allow a clearer policy direction to develop.

- **NHS reform requires a combination of approaches**

In the messy reality of public service reform, a combination of approaches is always likely to be necessary. Each approach has weaknesses as well as strengths.

Our research was underscored by this view, as it was the basis for the Next Steps Reforms (DH 2005a). However, a simple combination of approaches is insufficient. Each approach may have weaknesses as well but strengths, but these must be related to context. It is

important to specify which approaches are likely to work for which groups under what circumstances. It is also important to be clear about any likely side effects. Moreover, different approaches may 'work' in isolation, but the 'mix' or 'fit' is important. The NSR specified mutually beneficial interactions between streams, However, the fit was far from clear. In some cases, different approaches may have a positive relationship (eg provider plurality and transactional reforms); a negative relationship (eg unreformed tariff which increased secondary activity and undermined 'care closer to home') or simply not mix like oil and water (e.g. the market reforms appeared to have few links to reducing health inequalities). In some cases, adversarial competition may 'drive out' the 'trust' of collaboration (cf Ham 2009; Le Grand 2007). It is not clear whether some forms of 'collaboration' may be deemed anti-competitive by an economic regulator. New Labour did appear to have a policy mix, although their balance changed over time. However, the current government appears to be placing more of its eggs in the choice and competition basket. While some positive effects were detected for New Labour's competition regime, it is not clear that these conclusions will hold for a different regime (eg with the possibility of price competition).

- **Regulation and inspection are likely to become increasingly important**

With more providers becoming FTs, the government's influence over the NHS will be exerted primarily through PCTs as commissioners. FT will be regulated by Monitor and CQC.

While regulation and inspection may have become more important under New Labour, examples such as Stafford Hospital suggest some degree of regulatory failure. The future of the SMR stream under the current government is unclear. It will clearly change focus and character with, for example, Monitor becoming an economic regulator. However, while it is claimed that CQC will be 'strengthened', it is also claimed that there will be an increased stress on internal governance and a reduced regulatory burden. The government claims that there will be less micro management and top down control. However, this may result in fewer central levers available. Given the political nature of the NHS, central politicians may still be blamed for issues over which they claim to have given up control. It is important that regulators and inspectors should focus on, in the terms of the government, the issues that matter to patients and the public.

- **Levers and incentives are needed to support collaboration alongside competition**

Different approaches to reform need to be matched to different services. For example, policies on choice and competition were develop primarily in support of the government's main aim of reducing waiting times for treatment. It is much les clear that these policies will help support improvement in other priority areas such as improving the quality of care for people with chronic diseases and improving the health of the population. Indeed, it can be argued that some fragmentation has resulted from the use of ISTCs and FTs operating with limited regard to the wider health care system. The levers and incentives to support networks and increased collaboration between providers are much weaker than those used to promote choice and competition.

This may be problematic. As Ham (2009) notes, collaborative levers tend to be weak. However, if the stress on competition increases, there will be less space to develop collaboration. We stress again the importance of specifying clear CMOs. It was seen in Chapter 3 that the NSR were developed largely with secondary elective care in mind, and the application of NSR to other contexts (eg our other tracer conditions) was more problematic. As we note above, a receptive context for one mechanism may not be receptive for another. Moreover, it was argued strongly by some respondents that competitive mechanisms were not appropriate for some spheres. Smith and Charlesworth (2011) have recently argued that while a tariff system would bring clear benefits to mental health services, they do not consider that the pricing system has sufficient accurate and reliable information in the short term. They conclude that there are significant risks associated with extending PbR to mental health services and a phased approach would be more appropriate.

- **Frontline staff, especially doctors, need to be fully engaged in reform**

Many reform ideas have not lived up to expectations because they failed to make a significant difference in the day-to-day decisions of frontline staff. The ability of managers,

politicians and others to influence decision-making is more constrained and contingent than in other organisations. Thus, ways have to be found of generating change bottom-up, not just top-down, especially by engaging professionals in the reform process. These ideas really came to the fore in the Darzi Review in the argument that reform should be driven locally and led by clinicians.

We stressed the importance of taking account of bottom-up perspectives. The current government stress a continuation of the Darzi agenda of empowering health professionals. According to DH (2010c: 1), doctors and nurses must to be able to use their professional judgement about what is right for patients. We will support this by giving frontline staff more control. Healthcare will be run from the bottom up, with ownership and decision-making in the hands of professionals and patients. However, we noted that not all 'bottom-up' perspectives are the same, with some differences between organisations, clinicians and managers, between groups of different clinicians, and levels of seniority. While it is important to engage clinicians, there may be cases where this conflicts with managerial perspectives. Moreover, as we note, some on the ground are far from convinced of the benefits of competition.

- **The NHS needs to build capacity for change and improvement**

The final lesson is the need to build capability for change and improvement throughout the NHS. Devolution to the frontline will lead to improvement being slow and uneven unless priority is given to equipping staff with the project management and service redesign skills that are needed in order to take reform forward.

There is a danger of reducing capability for change and improvement, with the reduction in management costs and the abolition of PCTs and SHAs. Reorganisations result in a loss of talent and 'organisational memory'. According to Smith and Charlesworth (2011: 12), evidence from research and practice underlines the vital, and typically underestimated, importance of significant and senior management and other infrastructure support for devolved approaches to health commissioning. Some GP consortia may decide to rely on private sector management support, suggesting that building capacity for change and improvement may be problematic. The Health Committee (2011) reported that it has been

widely claimed that many PCTs are 'imploding' as a result of so many staff leaving and those who remain feeling demoralised and uncertain about their future. In a response to the Committee's point about organisational 'turbulence', 'upheaval' or 'meltdown', , Sir David Nicholson stated that we cannot sustain 152 independent PCTs between now and the date of their planned abolition.

In addition to exploring the relevance of Ham's (2009) lessons, we draw on perspectives on programme theory and implementation (Chapter 7) to offer further lessons:

- **Programme theory is important**

A clear specification of programme theory- what works for whom in what circumstances- or context-mechanism-outcome configurations is important. Diagrams (eg DH 2005a; DH 2010d) are a good starting point, but they need to be developed. In particular, simply linking all streams to (vague) global outcomes (such as improved health) is insufficient. More clarity is needed on the ways in which (say) tariff will lead to increasing secondary activity. Ham (2009: 323) cites Peter Hyman, former Head of the PM's Strategic Communication Unit, who argues that what the front line requires is a policy framework and goals, not hundreds of micro-announcements. However, this framework must be clear and specific.

- **Context is important**

Much existing work tends to assume universalistic rather than contingent processes. In short, we tend to have mechanism-outcome (MO) configurations rather than context-mechanism-outcome (CMO) configurations. Do not assume that mechanisms that work for acute, elective procedures will work for long term conditions, or that mechanisms that work in urban areas work in rural areas. Moreover, it is far from clear that reform levers that worked in the context of expanding budgets will continue to work in a period of unprecedented efficiency savings (cf Thorlby and Maybin 2010).

- **Implementation is important**

Many policy makers tend to take a 'Webbsian' perspective. The Fabian writers, Sidney and Beatrice Webb considered that a policy was complete when it hit the statute book. However, policy implementation is as important as policy formulation. 'Perfect implementation' is

unlikely to occur, and apparent 'implementation failure' is often linked to 'formulation failure'. Ham (2009: 325) points out that one of the hardest and earliest lessons ministers learn is that the levers at their disposal are not always well connected to the delivery of care on the ground.

- **Do not assume that central programme theory is shared in vertical or horizontal terms**

Central policy makers need to make further efforts to ensure the people implementing the reforms have a wider knowledge and greater commitment or 'ownership' of the system (Cabinet Office 2007). There are clearly different views 'on the ground' about whether increased competition or more integration achieves better results. There are also some differences between perspectives between organisations, between clinicians and managers, between different types of clinician, and in terms of level of seniority. It is also important to be more receptive to views 'from the ground'. The main 'bottom-up' wish was to 'live in less interesting times'. While this may not always be possible, especially for institutions that are seen as not performing to expectations, it is clear that one factor contributing to the relative weakness of demand-side reforms was the organisational upheaval of PCT amalgamation after 2005. There is a need to refine policies, adapting them to changing context and feedback from implementers

- **System alignment is important**

As the Next Steps Reforms (DH 2005a) recognised, the reform streams are inter-connected. Changes in one part of the policy 'ecosytem' have implications elsewhere. However, it is unwise that assume that all connections are beneficial, as there may be some negative connections, for example incentives to increase secondary activity means that it is more difficult to achieve 'care closer to home'. Some unintended consequences and perverse incentives should be expected, and it is important to amplify the positive factors and try to mitigate the negative factors.

- **Policy Learning is important**

Policy makers have been alert to these issues and some later reforms are intended to rebalance the system by providing stronger levers and eliminating perverse incentives. For

example, world class commissioning was introduced to balance provider power (but see Health Committee 2011). Changes to PbR have involved unbundled and best practice tariffs, and there are now some mechanisms to reduce emergency hospital admission and hospital re-admission (see e.g. Smith and Charlesworth 2011).

8.6 Conclusions

There was some variation on views on the Next Step Reforms between sites, tracers, organisations (eg providers and PCTs) and clinicians and managers, but all agreed that the reforms had 'focused the mind'. It was generally held that transactional reforms and SMR were stronger than demand and supply reforms. Moreover, many felt that the reforms are imbalanced in the sense that the centre of gravity lies on the provider side. However, it was clear that few had a clear grasp of programme theory as a whole, being clear on the trees but not on the wood. In particular the links between mechanisms and outcomes were not clear, with many struggling to see how, for example, the reforms would lead to health improvement, reducing health inequalities, care closer to home, and prevention. Moreover, some argued that it was difficult to see the relevance of the reforms to areas beyond elective conditions.

Millar et al (2011) discuss the relevance of New Labour's health reforms for the current government's reforms. They point out that the extent to which 'Liberating the NHS' achieves its policy goals will depend on its implementation. Implementation of reform under New Labour was complex and contingent on a range of factors. Despite some evidence of an overall positive effect associated with these reforms, implementation created an imbalance of incentives across demand and supply. The resulting imbalance meant that some local health systems struggled to engage and break historical patterns and pathways. The implementation of Liberating the NHS is likely to come up against similar internal and external dynamics that will affect and challenge its mutually reinforcing nature. Of particular note, local economic constraints and the potential turmoil brought about by local organisational restructuring will potentially limit the interconnected nature of the reform programme. Such contextual circumstances are likely to create uncertainty and resistance in some parts of the service. When we analyse some of the published responses to the reform proposals they do provide some indication of concerns in relation to its reliance on market

mechanisms in the context of the NHS system. Scepticism centres on the continued and accelerated 'commercialisation' of NHS services Whilst some support the new freedoms, greater recognition is needed in achieving a balance between service reconfiguration and system efficiency and stability.

In short, is clear that the Next Steps Reforms, while having achieved much positive impact, has not delivered the full promise of mutually enhancing streams. As we move into a period of constrained resources, it is vital that the reform engine is fully tuned to ensure that it is firing on all cylinders.

Bibliography

Abbott, S. Procter, S. and Iacovou, N. (2009) 'NHS Purchaser-Provider Relationships in England and Wales: The View from Primary Care', *Social Policy & Administration*, 43(1): 1-14.

ABCD and Diabetes UK. (2006) *Survey of diabetes specialist services*.

Action On Orthopaedics and the Orthopaedic Services Collaborative (2002) *Improving Orthopaedic Services - a guide for clinicians, managers and service commissioners*. NHS Modernisation Agency, London.

Alford, R. (1975) *Health Care Politics*, Chicago, Ill: Chicago University Press.

Allen, P. (2006) 'New localism in the English National Health Service: What is it for?', Health Policy, 79(2): 244-52.

Allen, P. Wright, J. Dempster, P.G. Hutchings, A. and Townsend, J. (2010a) *Investigating the governance of NHS foundation trusts*, Final report to NIHR Service Delivery and Organisation Programme.

Allen, P., Bartlett, W., Pérotin, V., Zamora, B., and Turner, S. (2010b) 'New forms of provider in the English National Health Service', *Annals of Public and Comparative Economics*, in press.

Allen, P. and Jones, L. (2011) 'Increasing the diversity of NHS providers', in N. Mays, A. Dixon and L. Jones (eds) *Understanding New Labour's market reforms of the English NHS,* London: King's Fund, forthcoming.

Anderson, E. Shepherd, M. and Salisbury, C. (2006) ''Taking off the suit': engaging the community in primary health care decision-making', *Health Expectations,* 9(1), 70-80.

Appleby, J. Boyle, S. Devlin, N. Harley, M. Harrison, A. Locock, L. Thorlby, R. (2005) *Sustaining reductions in waiting times: identifying successful strategies*. London, King's fund

Appleby, L . (2007) *Mental health ten years on: progress on mental health care reform,* London, Department of Health.

Audit Commission (2005) *Early lessons from Payment by Results*. London: Audit Commission.

Audit Commission (2006) *Early lessons in implementing practice based commissioning*. London: Audit Commission

Audit Commission (2007) *Putting commissioning into practice: Implementing practice based commissioning through good financial management*, London: Audit Commission.

Audit Commission (2008) *The right result? Payment by results 2003-07*. London: Audit Commission

Audit Commission and Healthcare Commission (2008) *Is the Treatment Working? Progress with the NHS System Reform Programme*. London: Audit Commission

Audit Commission (2010) *Healthy balance: A review of public health performance and spending*. London: Audit Commission

Badrinath, P. Currell, R.A. and Bradley, P.M. (2006) 'Characteristics of Primary Care Trusts in financial deficit and surplus - a comparative study in the English NHS', *BMC Health Services Research*, 6(64).

Barsam, A. Heatley, C.J. Sundaram, V. and Toma, N. (2008) 'A retrospective analysis to determine the effect of independent treatment centres on the case mix for microsurgical training', *Eye,* 22(5):687-90.

Bartlett, W. Allen, P. Perotin, V. Turner, S. Zamora, B. Matchaya, G. and Roberts, J. (2010) *Provider diversity in the NHS: impact on quality and innovation,* Report to Department of Health Policy Research Programme.

Bate, P. Robert, G. and McLeod, H. (2002*) Report of the breakthrough collaborative approach to quality and service improvement within four regions of the NHS*. Health Services Management Centre, University of Birmingham, Birmingham.

Bevan G. (2009) 'Head to Head: Have targets done more harm than good in the English NHS?', *BMJ,* 338:a3129.

Bevan G and Hood C. (2006) 'What's measured is what matters: targets and gaming in the English public health care system', *Public Administration*, 84(3): 517–38.

Bloom, N. Propper, C. Seiler, S. and Van Reenen, J. (2010) *The impact of competition on management quality: evidence from public hospitals,* Discussion paper 2010/09, London: Imperial College Business School.

Boyne G. (2003) *Evaluating public management reforms: principles and practice*, Open University Press, University of Michigan.

Brereton, L. and Vasoodaven, V. (2010) *The Impact of the NHS market*, London: Civitas.

Brereton, L. and Gubb, J. (2010) *Refusing treatment: the NHS and market-based reform,* London: Civitas.

British Medical Association (2005) *Impact of treatment centres on the local health economy in England*, Health Policy and Economic Research Unit.

British Medical Association (2009) *Choose and Book: Learning Lessons from Local Experience*.

Browne, J. Jamieson, L. Lewsey, J. Meulen, J. Copley, L. and Black, N. (2008) 'Case-mix & patients' reports of outcome in Independent Sector Treatment Centres: Comparison with NHS providers', *BMC Health Services Research,* 8(78).

Burnham, A. (2009) *NHS as preferred provider: Dear Colleague Letter*. Department of Health, Gateway Reference Number: 12774.

Burge, P. Devlin, N. Appleby, J. Gallo, F. Nason, E. and Ling, T. (2006) *London Patient Choice Project Evaluation*, RAND Europe, City University & the King's Fund.

Buse, K. Mays, N. and Walt, G. (2005) *Making Health Policy*, Maidenhead: Open University Press.

Cabinet Office (2007) *Capability Review of the Department of Health*, London: Cabinet Office.

Calvert, M. Shankar , A. McManus, R. Lester, H. and Freemantle, N. (2009) 'Effect of the quality and outcomes framework on diabetes care in the United Kingdom: retrospective cohort study', *BMJ,* 338:b1870.

Campbell, S. Reeves, D. Kontopantelis. E. Middleton, E. Sibbald, B. and Roland, M. (2007) 'Quality of primary care in England with the introduction of pay for performance', *The New England Journal of Medicine*, 357: 181-90.

Campbell, S.M. Reeves, D. Kontopantelis, E. Sibbald, B. Roland, M. (2009) 'Effects of pay for performance on the quality of primary care in England', *The New England Journal of Medicine,* 361(4): 368-78.

Checkland, K. (2004) 'Management in general practice: the challenge of the new General Medical Services contract'*, British Journal of General Practice,* 54(507): 734–739

Checkland, K. Coleman, A. Harrison, S. Hiroeh, U. (2009) ''We can't get anything done because...' making sense of 'barriers' to Practice-based Commissioning', *Journal of Health Services Research & Policy*, 14(1): 20-6.

Clamp, J. Baliu, D. Copas, D. Hutchinson, J. and Rowles, J. (2008) 'Do independent sector treatment centres (ISTC) impact on specialist registrar training in primary hip and knee arthroplasty?', *Annals of the Royal College of Surgeons of England*, 90(6):492-6.

Coleman, A. Checkland, K. Harrison, S. and Dowswell, G. (2009) *Practice-based Commissioning: theory, implementation and outcome. Final report*. NPCRDC, University of Manchester.

Cookson, R. and Laudicella, M. (2010) 'Do the poor cost much more? The relationship between small area deprivation and length of stay for elective hip replacement in the English NHS from 2001/2 to 2007/8', *Social Science and Medicine,* 72(2):173-84.

Cookson, R. Laudicella, M. and Li Donni, P. (2010) 'Trends in socio-economic equity in hospital care in the English NHS from 2001 to 2008: small area analysis of administrative data', Work in progress draft.

Cookson, R. Dusheiko, M. Hardman, G. Martin, S. (2010) 'Does hospital competition increase health care inequalities? Evidence from the English National Health Service 1991-2001', *Journal of Public Administration Research and Theory*. (in press)

Cooper, Z. Gibbons, S. Jones, S. McGuire, A. (2009) 'Does Hospital Competition Save Lives? Evidence from the English NHS Patient Choice Reforms', SERC and LSE Health working paper.

Cooper, Z. McGuire, A. Jones, S. Le Grand, J. (2009) 'Equity, waiting times, and NHS reforms: retrospective study', *BMJ,* 339 (32): b3264.

Cooper, Z. Gibbons, S. Jones, S. and McGuire, A. (2010a) 'Does hospital competition save lives? Evidence from the English NHS patient choice reforms', *Working Paper 16/2010*, London: LSE Health, London School of Economics.

Cooper, Z. Gibbons, S. Jones, S. and McGuire, A. (2010b) 'Does hospital competition improve efficiency? An analysis of the recent market-based reforms to the English NHS', *CEP Discussion Paper No 988*, *London: Centre for Economic Performance*, London School of Economics.

Connolly, S. Bevan, G. and Mays, N. (2010) Funding and Performance of Healthcare Systems in the Four Countries of the UK Before and After Devolution, London: Nuffield Trust.

Corrigan, P. (2010) 'Paul Corrigan on suspending NHS incentives', *Health Services Journal* , 11 March 2010.

Curry, N. Goodwin, N. Naylor, C. Robertson, R. (2008) *Practice-based commissioning: reinvigorate, replace or abandon?,* The King's Fund: London.

Damiani, M. Propper, C. and Dixon, J. (2005) 'Mapping choice in the NHS: cross sectional study of routinely collected data', *BMJ*, 330(7486): 284.

Department of Health (1997) *The new NHS: modern, dependable*. Stationery Office: London

Department of Health (1999) *National Service Framework for Mental Health*. Stationery Office: London

Department of Health (2000) *The NHS Plan: a plan for investment, a plan for reform*. Stationery Office: London

Department of Health (2001) *Mental Health policy implementation guide*. London. Stationery Office: London

Department of Health (2002) *Delivering the NHS Plan: next steps on investment, next steps on reform*. Stationery Office: London

Department of Health (2002b) *National Service Framework for Diabetes: Standards*. Stationery Office: London

Department of Health (2003a) *Building on the best: Choice, responsiveness and equity in the NHS - response document*. Stationery Office: London

Department of Health (2003b) *Building on the best: Choice, responsiveness and equity in the NHS – Mental Health Task Group Report*. Stationery Office: London

Department of Health (2003c) *Building on the best: Choice, responsiveness and equity in the NHS – Long Term Conditions Group Report*. Stationery Office: London

Department of Health (2003d) *National Service Framework for Diabetes: Delivery Strategy*. London: Department of Health.

Department of Health (2004) *The NHS Improvement Plan: Putting people at the heart of public services*. Stationery Office: London

Department of Health (2005a) *Health reform in England: update and next steps*. Stationery Office: London

Department of Health (2005b) Cr*eating a patient-led NHS: Delivering the NHS Improvement Plan*. Stationery Office: London

Department of Health (2005c) *Supporting people with long term conditions: An NHS and social care model to support local innovation and integration*. Stationery Office: London

Department of Health (2006a) *Our health, our care, our say*. Stationery Office: London

Department of Health (2006b) *The Musculoskeletal Services Framework*. Stationery Office: London

Department of Health (2006c) *Local delivery plans – mental health early intervention services*, Stationery Office: London.

Department of Health (2006d) *Health reform in England: update and commissioning framework,* Stationery Office: London.

Department of Health (2007a) *Who gets diabetes - Health inequalities*. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4899972 (accessed 23rd March, 2010)

Department of Health (2007b) *NHS Next Stage Review Interim Report*. London: The Stationary Office.

Department of Health (2008) *High Quality Care for All: NHS Next Stage Review final report*. Stationery Office: London

Department of Health (2009a) *The handbook to the NHS Constitution for England*. Stationery Office: London

Department of Health (2009b) *Report of the National Patient Choice Survey*, England. Stationery Office: London

Department of Health (2009c) *NHS 2010 - 2015: from good to great. Preventative, people-centred, productive*. Stationery Office: London

Department of Health (2009d*) The NHS operating framework for England for 2010/11*. Stationery Office: London

Department of Health (2009e) *Archive - Commissioner Based Hospital Waiting Lists and Waiting Times*
http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/HospitalWaitingTimesandListStatistics/DH_087742

Department of Health (2010) *Six years on: delivering the Diabetes National Service Framework*. Stationery Office: London

Department of Health (2010b) *Programme budgeting tools and data* http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Programmebudgeting/DH_075743

DH (2010c) *Equity and Excellence. Liberating the NHS*, London: The Stationery Office

DH (2010d) *Liberating the NHS: Legislative Framework and Next Steps*, London: the Stationery Office.

DH (2010e) *The NHS Outcomes Framework 2011/2*, London: the Stationery Office.

DH (2010f) *The Operating Framework for England 2011/12,* London: the Stationery Office.

DH (2010g) *Healthy Lives, Healthy People*, London: The Stationery Office.

Department for Transport (2007) *Department for Transport Annual Report 2007*. Stationery Office: London

Devlin, N. and Appleby, J. (2010) *Getting the most out of PROMs*. London: The King's Fund.

Diabetes UK (2009) *The National Service Framework for diabetes: Five years on... are we half way there?,* Diabetes UK.

Dixon, A .Storey, J .and Alvarez-Rosete, A. (2009) 'Accountability of Foundation Trusts in the English NHS: views of directors and governors', *Journal of Health Services Research and Policy,* 15:82-9.

Dixon, J. Glennerster, H. (1995) 'What do we know about fundholding in general practice?', *BMJ,* 311(7007):727-30.

Dixon, A. Robertson, R. Appleby, J. Burge, P. Devlin, N. and Magee, H. (2010) *Patient choice: how patients choose and how providers respond,* London: King's Fund.

Dixon, A. Storey, J. and Arturo- Alvarez, R. (2010) 'Accountability of foundation trusts in the English NHS: views of directors and governors', *Journal of Health Services Research & Policy,* 15(2): 82–89.

Dusheiko, M. Goddard, M. Gravelle, H. Jacobs, R. (2008) 'Explaining trends in concentration of healthcare commissioning in the English NHS', *Health Economics*, 17(8): 907-26.

Exworthy, M. Powell, M. and Mohan, J. (2000) 'Quasi-hierarchies, quasi-networks and quasi-markets in the NHS ', *Public Money and Management*, 19(4), 15-22.

Exworthy. M/ and Frosini. F. (2008) 'Room for manoeuvre? Explaining local autonomy in the English National Health Service', *Health Policy,* 86(2-3): 204-12.

Exworthy, M. and Powell, M. (2004) 'Big windows and little windows': implementation in the 'congested state', *Public Administration*, 82(2): 263-81.

Farrar, S. Sussex, J. Yi, D. Sutton, M. Chalkley, M. Scott, T. and Ma, A. (2007) *National Evaluation of Payment by Results Report to the Department of Health*. Health Economics Research Unit, University of Aberdeen.

Farrar, S. Yi, D. Sutton, M. Chalkley, M. Sussex, J. and Scott, T. (2009) 'Has payment by results affected the way that English hospitals provide care? Difference-in-differences analysis', *BMJ*, 339:b3047.

Forster, R . and Gabe, J. (2008) 'Voice or Choice? Patient and Public Involvement in the National Health Service in England under New Labour', *International Journal of Health Services*, 38(2): 333-356.

Fotaki ,M. Roland, M. Boyd, A. McDonald, R. Scheaff, R. and Smith, L. (2008) 'What benefits will choice bring to patients? Literature review and assessment of implications', *Journal of Health Services Research & Policy,* 13(3): 178-84.

Foundation Trust Network (2010) *Quality Accounts 2 – Reviewing NHS foundation trusts' experiences and plans*. The NHS Confederation.

Gaynor, M.S. Moreno-Serra, R. and Propper, C. (2010) *Death by market power: reform, competition and patient outcomes in the National Health Service*, NBER Working Paper 16164, Cambridge, Mass: National Bureau of Economic Research.

Goodwin, N. Mays, N. McLeod, H. Malbon, G. and Raftery, J. (1998) 'Evaluation of total purchasing pilots in England and Scotland', *BMJ,* 317: 256-9.

Goodwin, N. (2007) 'Developing effective joint commissioning between health and social care: prospects for the future based on lessons from the past', *Journal of Care Services Management*, 1(3):279-93.

Graham, J. Timmis, A. Cooper, J. Ramdany, S. Deaner, A. Ranjadayalan, K. and Knight, C. (2006) 'Impact of the National Service Framework for coronary heart disease on treatment and outcome of patients with acute coronary syndromes'*, Heart*, 92:301-6.

Gray, K. and Bailey, M. (2008) 'Non-price competition in NHS secondary care contracting: empirical results', *Journal of Health Organisation and Management*, 22(5): 480-95.

Green, J. McDowall ,Z. and Potts, H. (2008) 'Does Choose & Book fail to deliver the expected choice to patients? A survey of patients' experience of outpatient appointment booking', *BMC Medical Informatics and Decision Making*, 8(36).

Green, J. and Tones, K. (1999) 'Towards a secure evidence-base for health promotion', *Journal of Public Health Medicine,* 21, 133–9.

Greener, I. (2008) 'Decision Making in a Time of Significant Reform: Managing in the NHS', *Administration Society*, 40(2):194-210.

Greener, I. (2007) 'Are the assumptions underlying patients choice realistic? A review of the evidence', *British Medical Bulletin,* 83(1):249-58.

Greener, I. (2004) 'Talking to health managers about change: heroes, villain and simplification', *Journal of Health Organisation and Management*, 18, 321-35.

Greener, I. (2005) 'Health Management as Strategic Behaviour: Managing Medics and Performance in the NHS', *Public Management Review*, 7, 95-110

Greener, I. and Mannion, R. (2009) 'Patient choice in the NHS: what is the effect of choice policies on patients and relationships in health economies?', *Public Money & Management,* 29(2): 95 -100.

Greener, I. Harrington, B. Hunter, D. Mannion, R. Powell, M. (2011) *A realistic review of clinico-managerial relationships in the NHS: Final Report of Project 08/1808/245*, London: NIHR Service Delivery and Organisation Programme, HMSO.

Greer, S. and Jarman, H. (2007) *The Department of Health and the Civil Service: From Whitehall to department of delivery to where?,* London: Nuffield Trust.

Gubb J. (2008) *Why are we waiting? An analysis of waiting times in the NHS*. Civitas

Gulliford, M, Ashworth, M, Robotham, D. and Mohiddin, A. (2007) 'Achievement of metabolic targets for diabetes by English primary care practices under a new system of incentives', *Diabetic Medicine,* 24(5): 505–11.

Ham, C. (2009) *Health Policy in Britain*, 6th edn, Basingstoke: Palgrave Macmillan.

Ham, C. and Hunt, P. (2008) *Membership Governance in NHS Foundation Trusts: A Review for the Department of Health.* Health Services Management Centre, University of Birmingham.

Harrison, A. Appleby, J. (2005) *The War on Waiting for Hospital Treatment*. London, King's Fund

Harrison, S. Hunter, D. Marnoch, G. and Pollitt, C. (1992) *Just Managing: Power and Culture in the National Health Service*, Basingstoke: Macmillan.

Harrison, S. and Ahmad, W. (2000) 'Medical autonomy and the UK state 1975 to 2025', *Sociology*, 34 (1): 129-46.

Healthcare Commission (2005) *NHS performance ratings 2004/2005,* London: Healthcare Commission.

Healthcare Commission (2007*) Independent sector treatment centres: a review of the quality of care.* London: Healthcare Commission.

Healthcare Commission (2007b) *Managing diabetes: Improving services for people with diabetes,* London: Healthcare Commission.

Healthcare Commission. (2005) *The Healthcare Commissions review of NHS foundation trusts,* London: Healthcare Commission.

Heins, E. Price, D. Pollock, A.M. Miller, E. Mohan, J. and Shaoul, J. (2010) 'A review of the evidence of third sector performance and its relevance for a universal comprehensive health system', *Social Policy & Society,* 9 (4) pp 515-26.

Hill, M. and Hupe, P. (2009) *Implementing Public Policy*, 2nd edn, London: Sage.

Hogwood, B. and Gunn, L. (1984) *Policy Analysis for the Real World*, Oxford: Oxford University Press.

Hood, C. (1976) *The Limits of Administration*, London: Wiley.

House of Commons Health Committee (2008) *Foundation trusts and Monitor. Sixth Report of Session 2007-08*. London: The Stationery Office.

House of Commons Health Select Committee. (2008) *Foundation Trusts and Monitor*, Sixth Report of Session 2007-08, London: The Stationery Office.

House of Commons Health Committee (2009) *Health Inequalities. Third Report of Session 2008–09,* London: The Stationery Office.

House of Commons Health Select Committee (2011) *Commissioning*, London: The Stationery Office.

Hughes, D. Mullen ,C. and Vincent-Jones, P. (2009) 'Choice vs. voice? PPI policies and the re-positioning of the state in England and Wales', *Health Expectations*, 12(3): 237-50.

Hughes, E. (2007) 'Payment by results—a model for other diabetes healthcare systems?', *Primary Care Diabetes*, 1(2): 111–113.

Information Centre for health and social care (2009) *Compendium of Clinical and Health Indicators,* available at*:* www.nchod.nhs.uk

Ipsos MORI Social Research Institute (2008) *Survey of Foundation Trust Governors: Research Study Conducted for Monitor,* Ipsos MORI Social Research Institute.

Jones L and Mays N. (2009) *Systematic review of the impact of patient choice of provider in the English NHS*, London School of Hygiene and Tropical Medicine.

Kazi, M. (2003) 'Realist Evaluation for Practice', *British Journal of Social Work*, 33:803-18.

Khunti, K. Gadsby, R. Millett, C. Majeed, A. and Davies, M. (2007) 'Quality of diabetes care in the UK: comparison of published quality-of-care reports with results of the Quality and Outcomes Framework for Diabetes ', *Diabetic Medicine,* 24(12): 1436-41.

Le Grand, J. and Bartlett, W. (eds.) (1993) *Quasi-Markets and Social Policy*. Macmillan, London.

Le Grand, J. (2007) *The other invisible hand: delivering public services through choice and competition*, Princeton University Press, Princeton, NJ, USA.

Le Grand, J. Mays, N. and Mulligan, J-A. (1998) *Learning from the NHS internal market: a review of the evidence*, London: King's Fund.

Lester, H. Birchwood, M. Bryan, S. Jones-Morris, J. Kaambwa, B. *et al*. (2007) *Evaluating the development and impact of Early Intervention Services (EIS) in the West Midlands*. Report for the NIHR Service Delivery and Organisation Programme, London.

Lester, H. Birchwood, M. Bryan, S. England, E. Rogers, H. and Sirvastava, N. (2009) 'Development and implementation of early intervention services for young people with psychosis: case study', *The British Journal of Psychiatry*, 194: 446-450.

Lewis, R. and Dixon, J. (2005) *The Future of Primary Care: Meeting the challenges of the new NHS market.* London: The King's Fund.

Lewis, R. and Hinton, L. (2008) 'Citizen and staff involvement in health service decision-making: Have National Health Service foundation trusts in England given stakeholders a louder voice?', *Journal of Health Services Research and Policy* , 13(1): 19-25.

Lewis, R. Smith, J. Harrison, A. (2009) 'From quasi-market to market in the National Health Service in England: what does this mean for the purchasing of health services?', *Journal of Health Services Research & Policy*. 14(1): 44-51.

Lipsky, M. (1980) *Street-Level Bureaucracy*, New York: Russell Sage Foundation.

Mannion R, Davies H, Marshall M (2004) *Cultures for Performance in Health Care*. Open University Press

Mannion R. (2005) 'Practice based commissioning: a summary of the evidence', *Health Policy Matters,* 11.

Mannion, R. Goddard, M. Kuhn, M. Bate, A. (2005) 'Decentralization strategies and provider incentives in healthcare: evidence from the English National Health Service', *Applied Health Economics and Health Policy*, 4(1):47-54.

Mannion, R. Harrison, S. Jacobs, R. Konteh, F. Walshe, K. Davies, H.T. (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,* 102 (8): 332-6.

Marmot, M. (2010) Fair Society, Healthy Lives - The Marmot Review Final Report

Marshall, M. Mannion, R. Nelson, E. and Davies, H. (2003) 'Managing change in the culture of general practice: qualitative case studies in primary care trusts', *BMJ*, 327(7415): 599–602.

Marini, G. Miraldo, M. Jacobs, R. and Goddard ,M. (2007) *Foundation Trusts in the NHS: does more freedom make a difference?,* Health Policy Matters, Centre for Health Economics, University of York.

Marini ,G. Miraldo, M. Jacobs, R. and Goddard, M. (2008) 'Giving greater financial independence to hospitals – does it make a difference? The case of English NHS Trusts', *Health Economics*, 17(6):751-775.

Marini, G. and Street, A. (2006) *The administrative costs of payment by results*. CHE Research Paper 14. University of York.

Matland, R. (1995) 'Synthesising the implementation literature: the ambiguity-conflict model of policy implementation', *Journal of Public Administration Research and Theory*, 5(2): 145-74.

Matthews, D. (2007) 'Why we need a new model for diabetes care', *The British Journal of Diabetes & Vascular Disease*, 7: 130 -1.

Mays, N. (2011) 'The English NHS as a market: challenges for the Coalition Government'. In: Holden C, et al, eds. *Social Policy Review 23: Analysis and Debate in Social Policy.* Bristol: The Policy Press, forthcoming

N. Mays, A. Dixon and L. Jones (eds) (2011) *Understanding New Labour's market reforms of the English NHS,* London: King's Fund, forthcoming.

Mays, N. Mulligan, J-A and Goodwin, N. (2000) The British quasi-market in health care: a balance sheet of the evidence, Journal of Health Services Research and Policy, 5(1): 49-58.

Miles, M. and Huberman, A. (1994) *Qualitative Data Analysis: An expanded sourcebook,* (2nd edn.) Sage: London & Thousand Oaks, California

Millar, R. Snelling, I. and Brown, H. (2011) *Liberating the NHS: orders of change*, HSMC Policy paper 11, Birmingham: HSMC.

Millett, C. Car, J. Eldred, D. Khunti, K. Mainous, A. and Majeed , A. (2007) 'Diabetes prevalence, process of care and outcomes in relation to practice size, caseload and deprivation: national cross-sectional study in primary care', *Journal of Royal Society and Medicine,* 100(6):275–283

Miraldo M, Goddard M and Smith P. (2008)*The Incentive Effects of Payment by Results*, Dr Foster Intelligence.

Monitor (2009) *NHS foundation trusts: review of six months to 30 September 2009*

Naylor, C .and Goodwin, N. (2009) *Building world class commissioning: what role can external organisations play?*, The King's Fund.

NHS National Diabetes Support Team (2008) *Getting to grips with the Year of Care: A practical guide*, London: NHS National Diabetes Support Team, Diabetes UK and The Health Foundation

NICE (2004) *Type 1 diabetes: diagnosis and management of type 1 diabetes in children, young people and adults*.

NICE (2008) *Type 2 diabetes: National clinical guideline for management in primary and secondary care (update).*

Nuffield Trust (2011) *Snapshot Survey of Health Leaders on the Government's NHS Reforms*, London: Nuffield Trust.

Ojiako, U. Maguire, S. Koh, L. Grainger, T. Wainwright, D. (2010) 'Softer perspectives on enhancing the patient experience using IS/IT', *International Journal of Health Care Quality Assurance,* 23(2): 187 -208.

Orendi, J. (2008) 'Health-care organisation, hospital-bed occupancy, and MRSA', *Lancet,* 371: 1401-2.

Parkinson, N. (2009) *Practice-based commissioning: Group and Independent Leads Survey: Wave 1 Results (December 2009,* Department of Health.

Parkinson, N. (2010) *Practice-based commissioning: Group and Independent Leads Survey: Wave 2 Results (March 2010),* Department of Health.

Patiar, S. Lo, S. Duvvi, S. and Spraggs, P. (2006) 'Patient satisfaction with NHS elective tonsillectomy outsourced to the private sector under the Patient Choice Programme', *Journal Of Evaluation In Clinical Practice*, 12(5): 569-72.

PatientView (2009) *Local healthcare commissioning: grassroots involvement? A national survey of health advocacy groups*. National Voices and the Royal College of Nursing.

Pawson, R. and Tilley, N. (1997) *Realistic evaluation*, London: Sage

Pérotin, V., Zamora, B., Reeves, R., Bartlett, W. and Allen, P. (2010) *Does hospital ownership affect patient experience? An investigation into public-private sector differences in England*, under review.

Pettigrew, A. (1992) 'The character and significance of strategy process research', *Strategic Management Journal*, 13; 5-16.

Picker Institute Europe (2009) *Patient and Public Engagement: The Early Impact of World Class Commissioning: A Survey of Primary Care Trusts*.

Pollock, A. and Godden, S. (2008) 'Independent sector treatment centres: evidence so far', *BMJ*, 336(7641): 421-4.

Powell, M. (1999) *New Labour, New Welfare State?* (ed) Policy Press: Bristol.

Powell, M. (2002) *Evaluating New Labour's Welfare Reforms* (ed), Policy Press: Bristol

Powell, M. (2003) 'Quasi-markets in British health policy: a long duree perspective', *Social Policy and Administration*, 37(7): 725-41.

Pressman, J. and Wildavsky, A. (1973) *Implementation*, Berkeley, Cal: University of California Press.

Propper, C. Damiani ,M. Leckie, G. and Dixon, J. (2007) 'Impact of patients' socioeconomic status on the distance travelled for hospital admission in the English National Health Service', *Journal of Health Service Research and Policy*, 12 (3): 153-9.

Propper, C. Wilson, D. Burgess, S. (2006) 'Extending choice in English health care: The implications of the economic evidence', *Journal of Social Policy,* 35(537-57).

Propper, C. Wilson ,D. Simon, B. (2006) 'Extending Choice in English Health Care: The Implications of the Economic Evidence', *Journal of Social Policy*, 35(04):537-57.

Propper, C. Bugess, S. and Gossage, D. (2008) 'Competition and quality: evidence from the NHS Internal Market 1991-1999', *Economic Journal*, 118: 138-70.

Propper, C. Sutton, M. Whitnall, C. and Windmeijer, F. (2010) 'Incentives and targets in medical care: evidence from a natural experiment', *Journal of Public Economics*, 94: 318-335.

Rashid, M. Abeysundra, L. Mohd-Isa, A. Khan, Y. Sismeiro, C. (2007) 'Two years and 196 million pounds later: where is Choose and Book?', Informatics *In Primary Care*, 15 (2): 111-9.

Robertson, R. and Dixon, A. (2009) *Choice at the point of referral*. London: King's Fund.

Roland, M. (2007) 'The Quality and Outcomes Framework: too early for a final verdict', *British Journal of General Practice*, 57(540): 525–7.

Rogers, R. Williams, S. Jarman, B. and Aylin, P. (2005) '"HRG drift" and payment by results', *British Medical Journal*, 330 (563).

Rosen, R. Florin, D. Hutt, R. (2007) An Anatomy of GP Referral Decisions: A qualitative study of GPs' views on their role in supporting patient choice. London: The King's Fund.

Sabatier, P. and Mazmanian, D. (1979) 'The conditions of effective implementation', *Policy Analysis*, 5(4): 481-504.

Sampson, M. Brennan, C. Dhatariya, K. Jones, C. and Walden, E. (2007) 'A national survey of in-patient diabetes services in the United Kingdom', *Diabetic Medicine*, 24 643–9.

Santry, C. (2010) 'Top staff to move into community services, says Nicholson', *Health Service Journal*, 19 November.

Sibbald, B. Pickard, S. McLeod, H. Reeves, D. Mead, N. Gemmell, I. Coast, J. Roland, M. Leese, B. (2008) 'Moving specialist care into the community: an initial evaluation', *Journal of Health Services Research and Policy,* 13(4): 233-9.

Singh, S. (2009) 'Transition of care from child to adult mental health services: the great divide', *Current Opinion in Psychiatry*, 22:386-90.

Smith, J. and Charlesworth, A. (2011) *NHS Reforms in England: Managing the Transition*, London: Nuffield Trust.

Smith, J. Mays, N. Dixon, J. Goodwin, N. Lewis, R. McClelland, S. McLeod, H. Wyke, S. (2004) *A Review of the Effectiveness of Primary Care-led Commissioning and its Place in the NHS*, The Health Foundation.

Smith, J. Dixon, J. Mays, N. McLeod, H. Goodwin, N. McClelland, S. Lewis, R. Wyke, S. (2005) 'The NHS revolution: health care in the market place: Practice based commissioning: applying the research evidence', *BMJ,* 331(7529): 1397–99.

Smith, J. and Goodwin, N. (2006) *Towards Managed Primary Care: The role and experience of primary care organizations*. Aldershot: Ashgate Publishing.

Smith, J. Wood, J. and Elias, J. (2009) *Beyond Practice-Based Commissioning: the local clinical partnership*, Nuffield Trust, London.

Stevens, S. (2004) 'Reform Strategies For The English NHS', *Health Affairs*, 23(337-44).

Storey, J. and Holti, R. (2009) 'Sense-making by clinical and non-clinical executive directors within new governance arrangements', *Journal of Health Organization and Management,* 23(2): 149-69.

Street, A. and Maynard, A. (2007) 'Activity based financing in England : the need for continual refinement of payment by results', *Health Economics, Policy and Law*, 2(4): 419-27.

Street, A. Sivey, P. Mason, A. Miraldo, M. and Siciliani, L. (2010) 'Are English treatment centres treating less complex patients?', *Health Policy*, 94:150-7.

Sussex J and Farrar S. (2009) 'Activity-based funding for National Health Service hospitals in England: managers' experience and expectations', *The European Journal of Health Economics*, 10(2): 197-206.

Tahrani, A. McCarthy, M. Godson, J. Taylor, S. Slater, H. Capps, N. Moulik, P. and Macleod, A. (2007) 'Diabetes care and the new GMS contract: the evidence for a whole county', *British Journal of General Practice*, 57(539): 483-5.

Thorlby, R. and Maybin, J. (eds) (2010) *A high-performing NHS? A review of the evidence 1997-2010*, London: The King's Fund.
http://www.kingsfund.org.uk/publications/a_highperforming_nh.html

Van Meter, D. and Van Horn, C. (1975) 'The policy implementation process: a conceptual framework', *Administration and Society*, 6(4): 445-88.

Vincent-Jones, P. and Mullen, C. (2009) 'New Labour's PPI Reforms: Patient and Public Involvement in Healthcare Governance?', *Modern Law Review,* 72 (2): 247-71.

Wallace, A. and Taylor-Goodby, P. (2008) *New labour and reform of the NHS*. Economic and Social Research Council, 2008

Wanless, D. Appleby, J. Harrison, A. and Patel, D. (2007) *Our Future Health Secured? A Review of NHS Funding and Performance*, The King's Fund.

Weir, N. Kotecha, M. and Goel, K. (2007) 'Expanding choice options for older patients in relation to practice-based commissioning: A qualitative study of older patients in a small GP surgery', *Quality in Primary Care*, 15(6): 331-6.

Wilson, E. Sussex, J. Macleod, C. and Fordham, R. (2007) 'Prioritizing health technologies in a Primary Care Trust', *Journal of Health Service Research and Policy*, 12(2) 80-85.

Wolman, H. (1981) 'The Determinants of Program Success and Failure', *Journal of Public Policy*, October 1981, pp. 433-464.

Wright, J. Martin, D. Cockings, S. and Polack, C. (2006) 'Overall Quality of Outcomes Framework scores lower in practices in deprived areas', *British Journal of General Practice*, 56(525): 277–279.

Appendix A: Interview guides

First Round Interview Guide

1. Can you describe your current role?

How long have you been at the authority/organisation?

How long have you been in your current role?

2. Can you describe the recent history of your organisation?

Are there events or circumstances of note?

How is the (tracer) service set up? Get an overview of the particular service –is there anything of note concerning the service within the locality?

3. What do you consider to be your organisation's main outcomes and targets?

Have these changed over time?

4. What policies do you consider to be the main health reforms? How are they impacting on your organisation?

Present the reform diagram taken from: **'Health Reform in England: Update and next steps' (DH 2005)**

In light of the diagram:

7. What is your understanding of the different health reform streams? How have they impacted on the organisation or tracer?

(If participant has already discussed reforms in opening questions… would they like to add anything further?)

8. How do the different reforms interact with each other?

Do you see any connections between the reform streams?

9. In what ways do they act as levers or incentives? Are there any disincentives or perverse incentives?

Are there any contradictions or tensions between the policies?

Do you see any unintended consequences?

10. Do these reforms interact with the Next Stage Review – Darzi? If so, how?

How does Darzi impact on organisation and/or delivery?

Does it connect with any or all of the 'Next Steps' diagram?

11. Are there any other enablers or barriers that you feel impact on your organisation or tracer?

Are there any wider organisational factors?

12. How far has your experience of implementing the reforms been due to local factors?

Do you think they might have a different impact elsewhere?

13. Overall, have the reforms helped or hindered your organisation to achieve its desired goals/outcomes?

14. Do you have a take-home message for the DH?

Second Round Interview Guide

We only have 30 minutes so we need to ask quite direct questions. I think these should be based on three lines of questions

1. **Updating the research in changes that have impacted since our last conversation**

Probing areas

- Changes to priorities of targets & outcomes
- Changes (or lack of) as the result of economic context
- Change (or lack of) as the result political context
- Change as a result of greater attention to quality and safety (external shocks of mid staffs etc)

2. **Testing the programme theory of the combined impact of health reform**

- We were interested in the extent to which the reforms acted as a mutually supporting set of levers that combined to produce better services and outcomes for patients.

In our first round we found that (probe will change depending on who we are speaking to)

Commissioner perspectives

The impact of commissioning struggled in the context of combined levers of PbR and FT Status. In some cases this was reinforced in those PCTs that were involved in the 2006 *Commissioning a Patient Led NHS* reorganisation.

Do you agree this is the way health reforms have impacted in your health community? If so why, if not why?
Has this opinion changed since we last interviewed you? What has driven this change?

Provider perspectives

The combined impact of PbR, FT Status (if applicable), 18 weeks has seen demand rise? This combined impact of reforms has 'improved services' but has come at a cost in that commissioners have struggled to make changes to existing services. Do you agree with that? If so why, if not why?

Do you have any examples of how the combined impact of reforms has worked?
Has this opinion changed since we last spoke to you? What has driven the change?

Tracer specific lines of questioning

Diabetes

Reforms have been a barrier to models of diabetes services built on integrated pathways. To what extent has this been the case?
What levers do diabetes services need to improve services?

Orthopaedics

Whenever a good or a bad thing, the combination of 18 weeks, payment by results and supply reform (FT status, ISTC competition) have provided the combined levers to drive service delivery? Is this combined impact of levers been applicable to your experience? In what ways?

Commissioning community services is still in its infancy: has this changed since we last interviewed you?

Early Intervention in Mental Health

NSF and the EI PIG have been the main policy drivers for reform: have any of the reforms we were interested in had any significant impact in EI services. In particular has Competition, commissioning, regulation driven any changes in services?

What needs to be done to increase the integration of services (as we still found fragmentation of delivery across youth agencies)?

What about the future of EI? What is likely to impact on the service?

Asked across all groups

Has the Darzi reforms driven any of changes since we last interviewed you?
If not, what has?

3. **The future**

How do you feel the reforms will impact in the future?

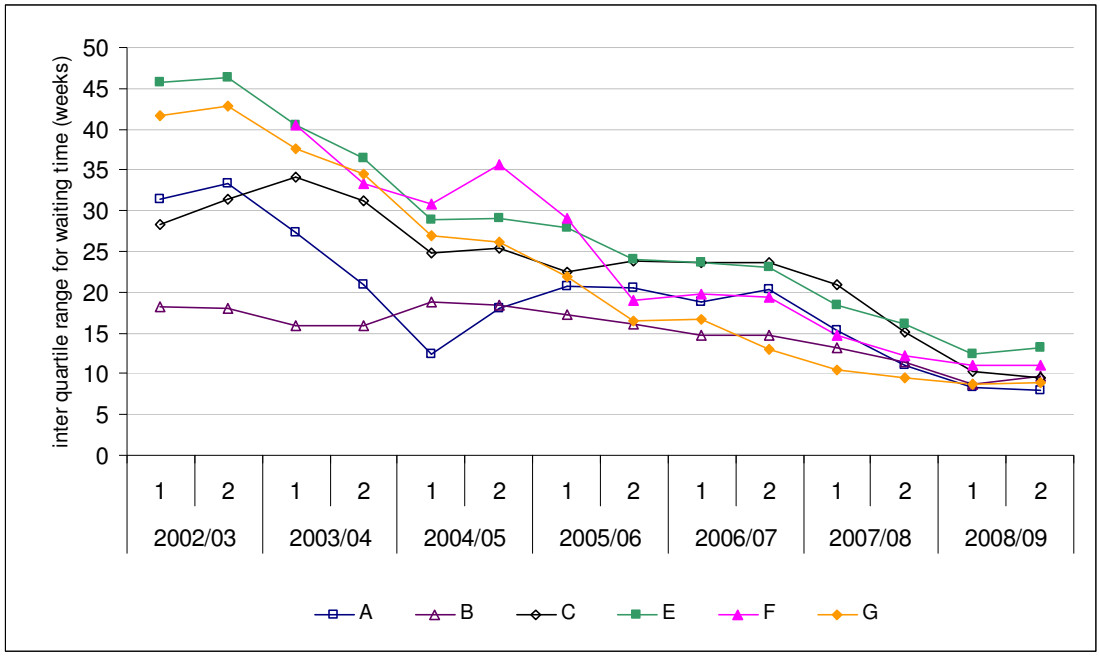
Do you have a take home message for the government, or the next government about way to reform the NHS?

Appendix B: Orthopaedics

This appendix includes three figures referred to in chapter 6 and further information about case studies' experiences of activity and waiting times at provider level.

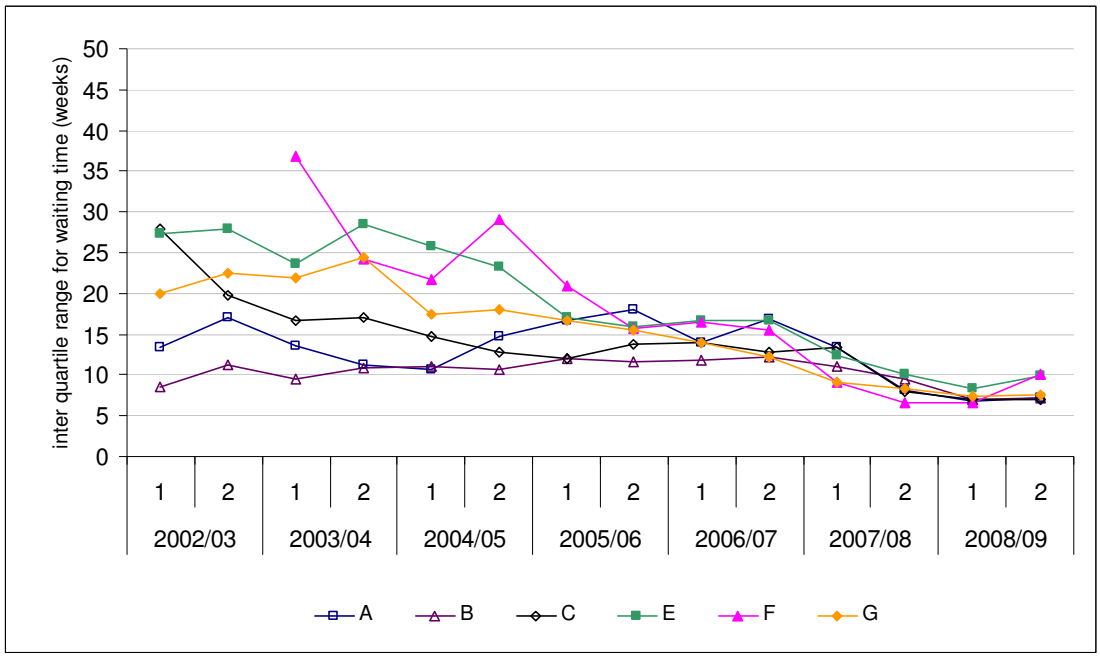
Figures referred to in Chapter 6

Figure A2.1: The inter quartile range for inpatient waiting times



Note: the 2002/3 data for Rural PCT F are excluded because 65% of decision to admit records were set to the date of admission

Figure A2.2: The inter quartile range for day case waiting times



Note: the 2002/3 data for Rural PCT F are excluded because 65% of decision to admit records were set to the date of admission

Figure A2.2b: Mean waiting time and 95% CIs from decision to admit for elective orthopaedic inpatient admissions in 2008/9

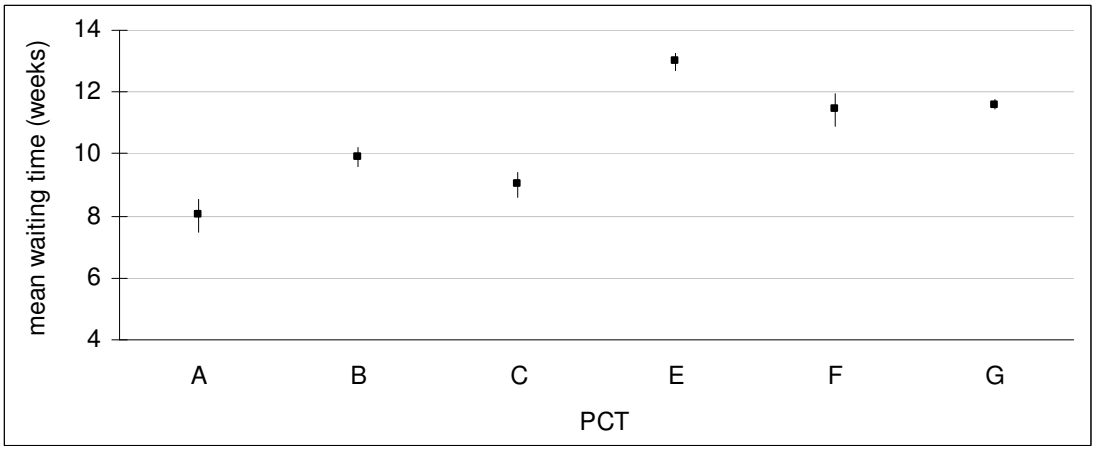


Figure A2.2c: Median waiting time and 95% CIs from decision to admit for elective orthopaedic inpatient admissions in 2008/9

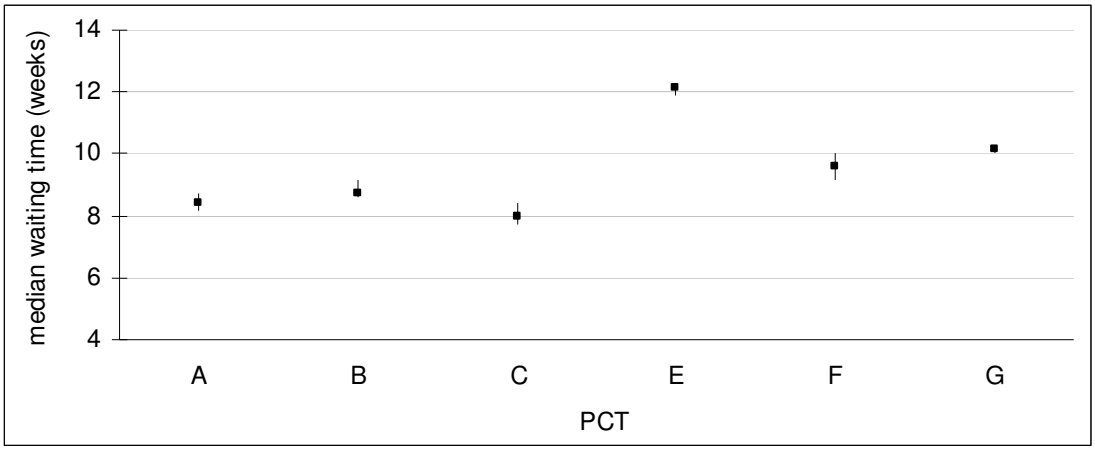


Figure A2.d: Inpatient waiting time PCT-level random effect coefficients and 95% CIs in 2008/9

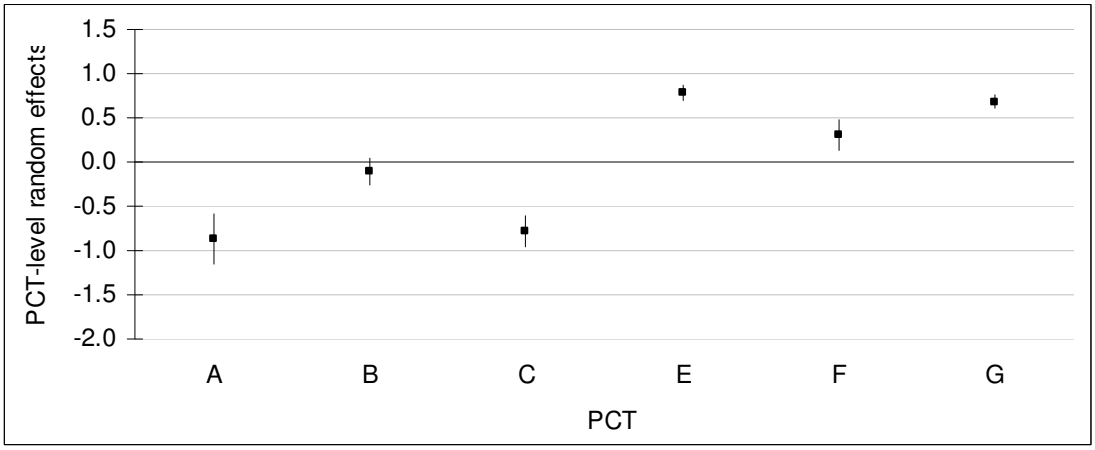


Figure A2.2e: Mean waiting time and 95% CIs from decision to admit for elective orthopaedic day cases in 2008/9

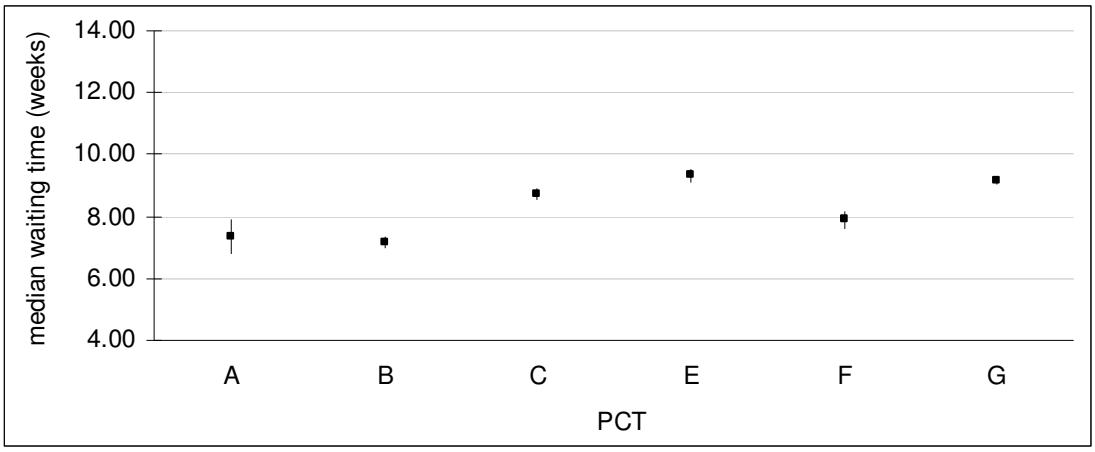


Figure A2.2f: Mean waiting time and 95% CIs from decision to admit for elective orthopaedic day cases in 2008/9

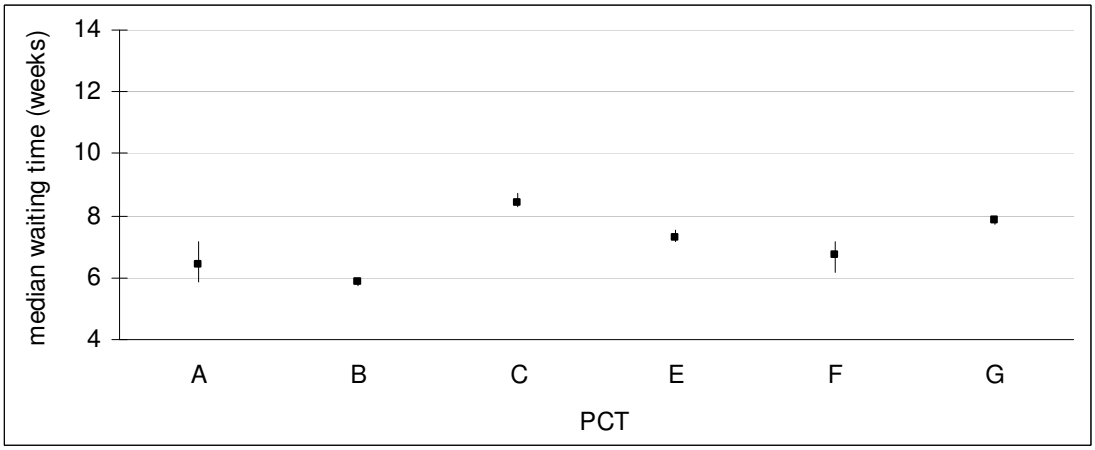


Figure A2.2g: day case waiting time PCT-level random effect coefficients and 95% CIs in 2008/9

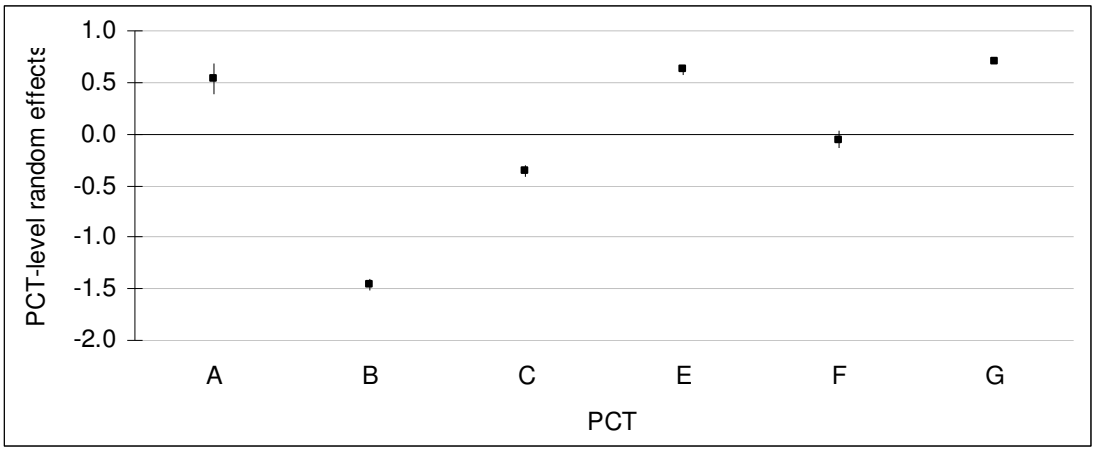
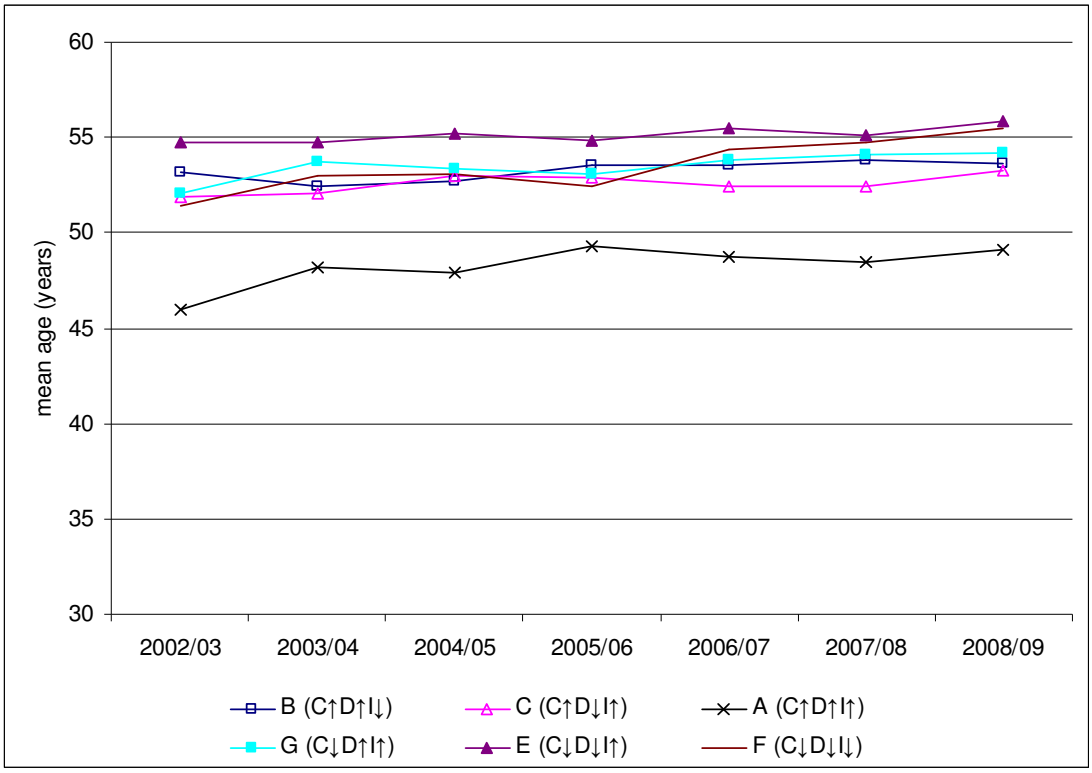


Figure A2.3: Mean patient age for orthopaedic admissions between 2002/3 and 2008/9



Case studies' experiences of activity and waiting times at provider level

Site B

The provision of orthopaedics for this urban Site is dominated by a specialist orthopaedic provider, which accounted for 70.6% of its elective orthopaedic admissions in 2008/9 (figure A2.4). Between 2002/3 and 2008/9, overall elective orthopaedic admissions for the PCT's residents increased by 10.7% from 17.5 to 19.3 per 1,000 population, and this change is significant at the 5% level (table A2.1). The increase in admissions was due to increased day case activity of 21.7% (table A2.1). Between 2002/3 and 2008/9, the proportion of day case elective orthopaedic admissions increased from 58.2% to 64.0% ($p<0.01$).

Providers B and C experienced increased admissions over this period, in contrast to no change for the main provider A and a reduction for Provider C (table A2.1).

The largest change in provider-level activity was the increase in admissions to Foundation Trust B, which accounted for 18.1% of admissions in 2008/9. The increase in activity at this

provider was mainly for day case hand procedures and soft tissue or other bone procedures (HRGs H13, H17 and H19).

Table A2.1 Site B Changes in elective orthopaedic admission rates

	2002/03		2008/09		Difference in rate between years	95% CIs for the difference in rate	% change between years
	Rate PTP	no	Rate PTP	no			
All							
A FT	13.9	4635	13.6	4604	-0.2	-0.8 to 0.4	-1.5
B FT	1.2	399	3.5	1184	2.3	2.1 to 2.5	194.3
C HT	0.5	162	0.8	260	0.3	0.2 to 0.4	59.2
D FT	1.0	326	0.7	232	-0.3	-0.4 to -0.1	-29.4
Others	1.0	325	0.7	245	-0.2	-0.4 to -0.1	-25.2
Total	17.5	5847	19.3	6525	1.9	1.2 to 2.5	10.7
Inpatients							
A FT	5.6	1875	5.0	1686	-0.6	-1.0 to -0.3	-10.8
B FT	0.6	190	1.0	347	0.5	0.3 to 0.6	81.2
C HT	0.2	76	0.3	106	0.1	0.01 to 0.2	38.3
D FT	0.6	200	0.3	114	-0.3	-0.4 to -0.2	-43.5
Others	0.3	104	0.3	98	0.0	-0.1 to 0.1	-6.5
Total	7.3	2445	7.0	2351	-0.3	-0.7 to 0.1	-4.6
Day cases							
A FT	8.2	2760	8.6	2918	0.4	-0.04 to 0.8	4.9
B FT	0.6	209	2.5	837	1.9	1.7 to 2.0	297.2
C HT	0.3	86	0.5	154	0.2	0.1 to 0.3	77.6
D FT	0.4	126	0.3	118	0.0	-0.1 to 0.1	-7.1
Others	0.7	221	0.4	147	-0.2	-0.3 to -0.1	-34.0
Total	10.2	3402	12.4	4174	2.2	1.7 to 2.7	21.7

During the first three months of 2009, 95% of admitted orthopaedic patients in this urban case-study PCT were admitted within the 18 week target, compared to 88% of patients in the six comparator PCTs (table 6.1). Figure A2.5 illustrates the orthopaedic waiting time experience for the PCT's top four providers. The PCT's main provider performed strongly against the 18-week target during the first three months of 2009, with 94% of patients treated within 18 weeks, compared to 94% for Provider B, 83% for provider C and 94% for provider D.

Figure A2.4: Site B urban: elective orthopaedic admissions by provider

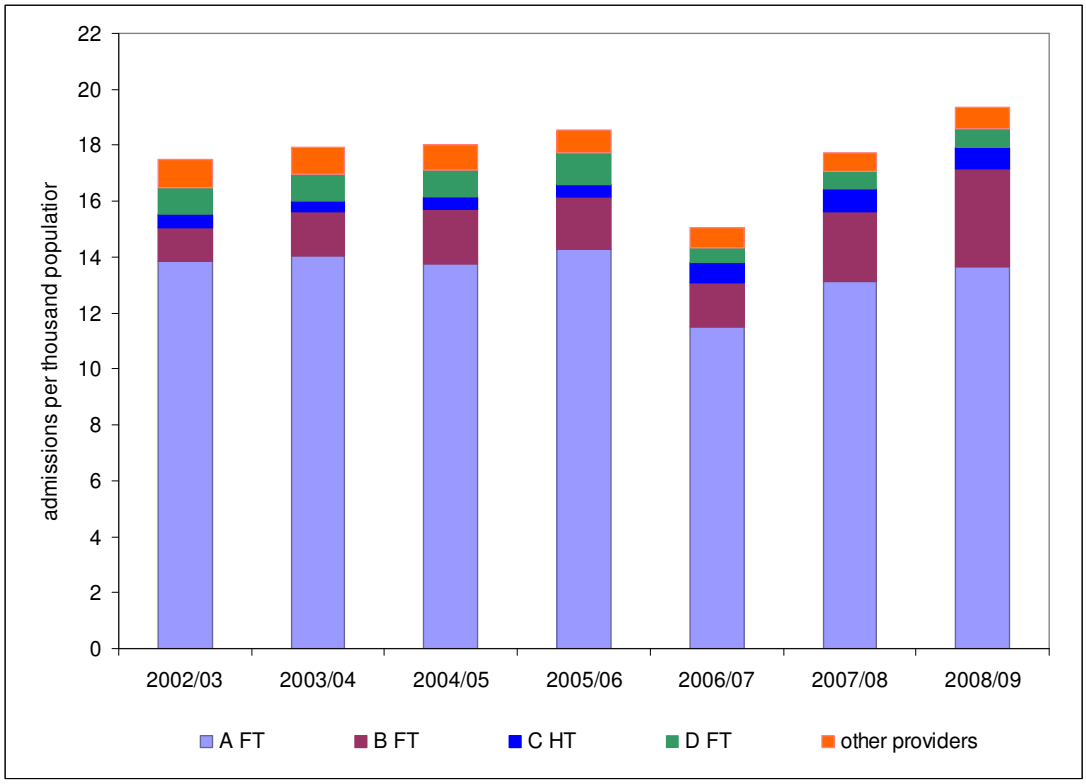
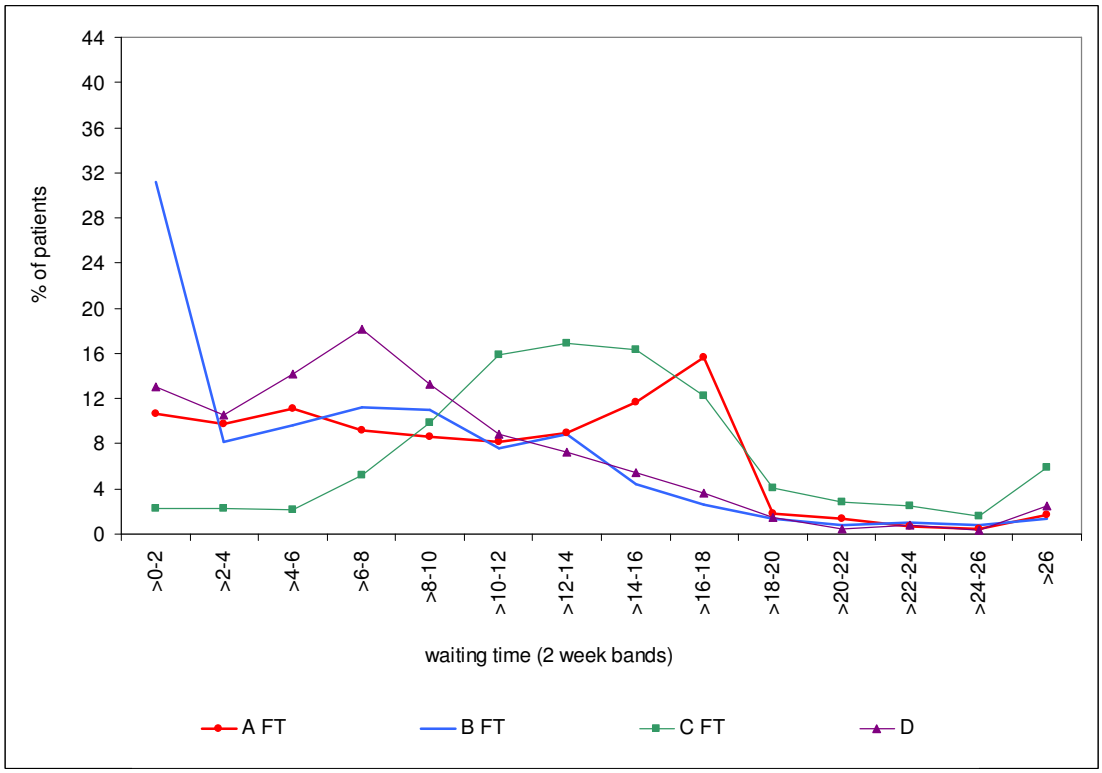


Figure A2.5: Site B urban: waiting time for elective orthopaedics by main provider in the three months to March 2009



Site C

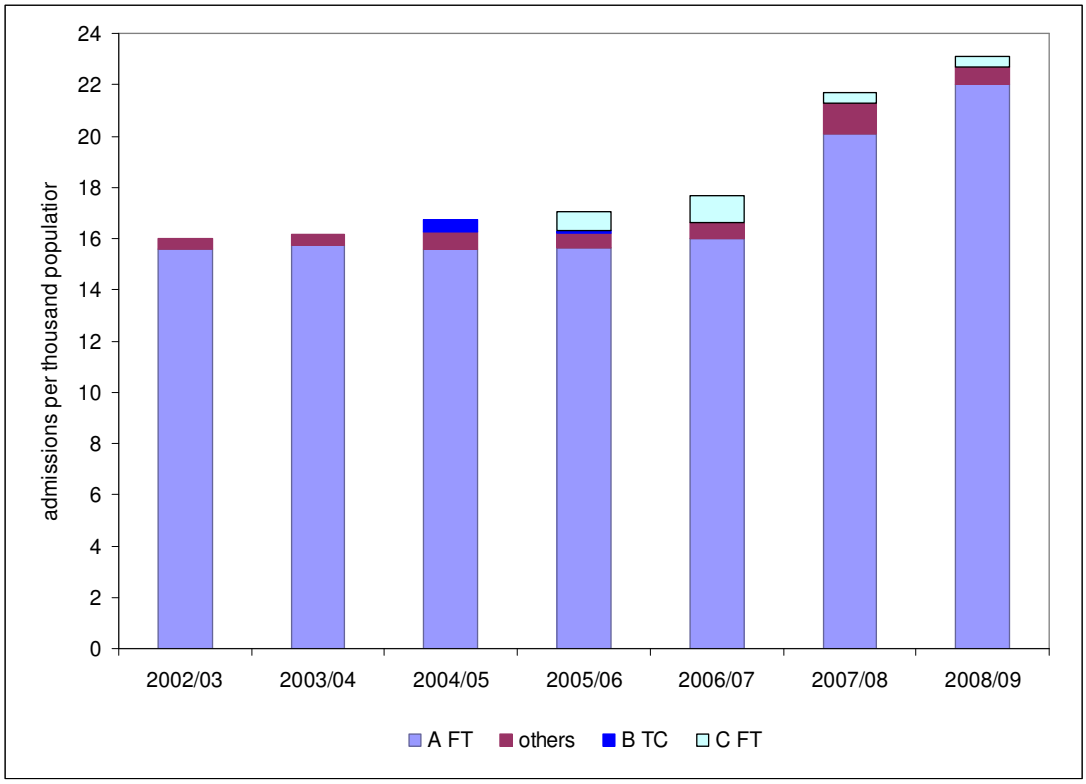
The provision of orthopaedics for this urban Site is dominated by a Foundation Trust, which accounted for 95.4% of its elective orthopaedic admissions in 2008/9 (figure A2.6). Between 2002/3 and 2008/9, overall elective orthopaedic admissions for the PCT's residents increased by 44.3% from 16.0 to 23.1 per 1,000 population, and this change is significant at the 5% level (table A2.2). The increase in admissions was largely due to increased activity at the main provider.

Table A2.2: Site C changes in elective orthopaedic admission rates

	2002/03		2008/09		Difference in rate between years	95% CIs for the difference in rate		% change between years
	Rate PTP	no	Rate PTP	no				
All								
A FT	15.6	3621	22.0	5271	6.4	5.6	7.2	41.2
C TC	0.0	0	0.4	99	0.4	0.3	0.5	
others	0.4	94	0.7	157	0.3	0.1	0.4	62.0
total	16.0	3715	23.1	5527	7.1	6.3	7.9	44.3
Inpatients								
A FT	5.1	1186	6.5	1548	1.4	0.9	1.8	26.6
C TC	0.0	0	0.2	44	0.2	0.1	0.2	
others	0.3	60	0.4	103	0.2	0.1	0.3	66.5
total	5.4	1246	7.1	1695	1.7	1.3	2.2	31.9
Day cases								
A FT	10.5	2435	15.6	3723	5.1	4.4	5.7	48.3
C TC	0.0	0	0.2	55	0.2	0.2	0.3	
others	0.1	34	0.2	54	0.1	0.001	0.2	54.0
total	10.6	2469	16.0	3832	5.4	4.7	6.0	50.5

An ISTC was active in 2004/5 and 2005/6 before being closed. Another ISTC in a different location opened in 2005/6 accounted for 1.8% of recorded orthopaedic admissions for the PCT population in 2008/9. Between 2002/3 and 2008/9, the proportion of day case elective orthopaedic admissions increased from 66.5% to 69.3% ($p<0.01$).

Figure A2.6: Site C urban: elective orthopaedic admissions by provider



During the first three months of 2009, 92% of admitted orthopaedic patients in this urban Site were admitted within the 18 week target, compared to 85% of patients in the six comparator PCTs (table 6.1).

Site A

The majority of orthopaedics for this urban Site is provided by an NHS Trust, which accounted for 60.0% of its elective orthopaedic admissions in 2008/9 (figure A2.7). Between 2002/3 and 2008/9, overall elective orthopaedic admissions for the PCT's residents increased by 15.9% from 6.4 to 7.4 per 1,000 population, and this change is significant at the 5% level (table A2.3). The increase in admissions was due to increased day case activity across providers. Between 2002/3 and 2008/9, the proportion of day case elective orthopaedic admissions increased from 36.6% to 42.5% ($p<0.01$).

Figure A2.7: Site A urban: elective orthopaedic admissions by provider

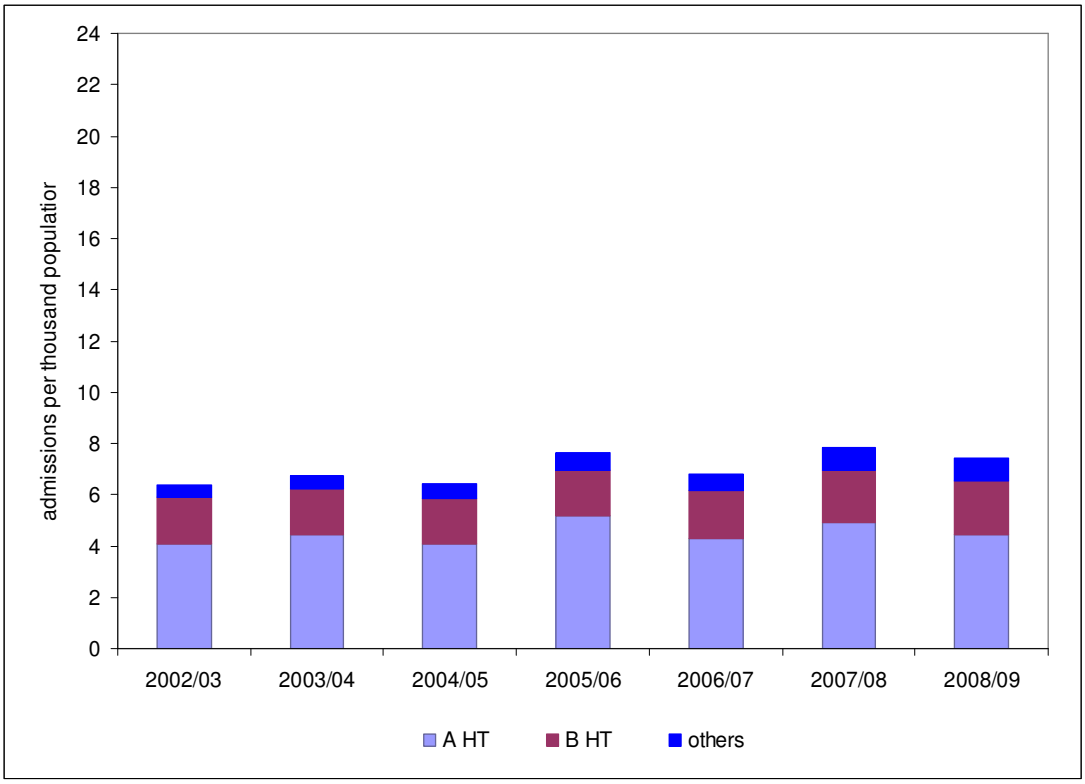


Table A2.3: Site A Changes in elective orthopaedic admission rates

	2002/03		2008/09		Difference in rate between years	95% CIs for the difference in rate		% change between years
	Rate PTP	no	Rate PTP	no				
All								
A HT	4.1	690	4.4	765	0.4	-0.1	0.8	9.5
B HT	1.8	314	2.1	357	0.2	-0.1	0.5	12.3
others	0.5	84	0.9	154	0.4	0.2	0.6	81.1
total	6.4	1088	7.4	1276	1.0	0.5	1.6	15.9
Inpatients								
A HT	2.7	451	2.7	461	0.0	-0.3	0.4	1.0
B HT	1.1	190	1.1	198	0.0	-0.2	0.3	3.0
others	0.3	49	0.4	75	0.1	0.02	0.3	51.2
total	4.1	690	4.3	734	0.2	-0.2	0.6	5.1
Day cases								
A HT	1.4	239	1.8	304	0.4	0.1	0.6	25.7
B HT	0.7	124	0.9	159	0.2	0.002	0.4	26.7
others	0.2	35	0.5	79	0.3	0.1	0.4	123.0
total	2.3	398	3.1	542	0.8	0.5	1.2	34.5

During the first three months of 2009, 90% of admitted orthopaedic patients in this PCT were admitted within the 18 week target, compared to 88% of patients in the five comparator PCTs (table 6.1). Figure A2.8 illustrates the orthopaedic waiting time experience for the PCT's top two providers. At provider A, 83% of admissions were within the 18-week target during the first three months of 2009, compared to 95% of patients treated within 18 weeks at Provider B.

Figure A2.8 Site A urban: waiting time for elective orthopaedics by main provider in the three months to March 2009

Site G

Orthopaedics for this rural Site is provided by five main providers, two of which are Foundation Trusts. Two ISTCs have provided some orthopaedic activity since 2006/7. As routine HES were not available for one of these ISTCs in 2008/9, the analysis shown in table A2.4 focuses on the period 2002/3 to 2007/8.

Table A2.4: Site G changes in elective orthopaedic admission rates

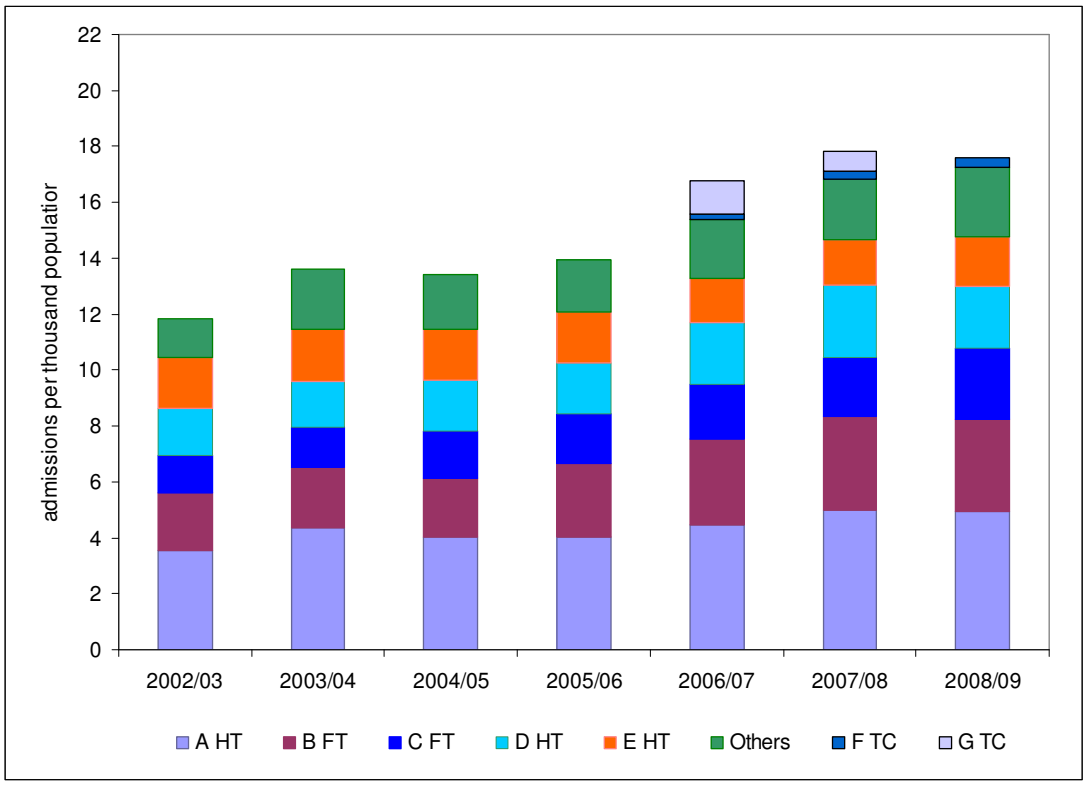
	2002/03		2007/08		Difference in rate between years	95% CIs for the difference in rate		% change between years
	Rate PTP	no	Rate PTP	no				
All								
A HT	3.5	4409	5.0	6336	1.4	1.3	1.6	40.1
B FT	2.1	2598	3.4	4285	1.3	1.1	1.4	60.8
C FT	1.3	1621	2.1	2719	0.8	0.7	0.9	63.6
D HT	1.7	2091	2.6	3333	0.9	0.8	1.0	55.4
E HT	1.8	2297	1.6	2073	-0.2	-0.3	-0.1	-12.0
F TC	0.0	0	0.3	337	0.3	0.2	0.3	
G TC	0.0	0	0.7	950	0.7	0.7	0.8	
Others	1.4	1712	2.1	2735	0.8	0.7	0.9	55.8
Total	11.8	14728	17.8	22768	6.0	5.7	6.3	50.8
Inpatients								
A HT	2.2	2684	2.6	3374	0.5	0.4	0.6	22.6
B FT	1.0	1299	1.7	2119	0.6	0.5	0.7	59.1
C FT	0.7	898	0.9	1167	0.2	0.1	0.3	26.7
D HT	1.0	1307	1.1	1439	0.1	0.0	0.2	7.4
E HT	1.2	1498	1.0	1284	-0.2	-0.3	-0.1	-16.4
F TC	0.0	0	0.0	4	0.0	0.0	0.0	
G TC	0.0	0	0.6	821	0.6	0.6	0.7	
Others	0.8	1047	1.1	1395	0.3	0.2	0.3	29.9
Total	7.0	8733	9.1	11603	2.1	1.9	2.3	29.6
Day cases								
A HT	1.4	1725	2.3	2962	0.9	0.8	1.0	67.5
B FT	1.0	1299	1.7	2166	0.7	0.6	0.7	62.6
C FT	0.6	723	1.2	1552	0.6	0.6	0.7	109.3
D HT	0.6	784	1.5	1894	0.9	0.8	0.9	135.6
E HT	0.6	799	0.6	789	0.0	-0.1	0.0	-3.7
F TC	0.0	0	0.3	333	0.3	0.2	0.3	
G TC	0.0	0	0.1	129	0.1	0.1	0.1	
Others	0.5	665	1.0	1340	0.5	0.4	0.6	96.5
Total	4.8	5995	8.7	11165	3.9	3.7	4.1	81.6

Between 2002/3 and 2007/8, overall elective orthopaedic admissions for the PCT's residents increased by 50.8% from 11.8 to 17.8 per 1,000 population, and this change is significant at the 5% level (table A2.4). During this period, the fall in the proportion of admissions to the

PCT's two main providers from 47.6% (7,007/14,728) in 2002/3 to 46.6% (10,621/22,768) was not significant (p=0.08).

The increase in admissions was due to increases in day case (81.6%) and inpatient (29.6%) rates (table A2.4). Between 2002/3 and 2007/8, the proportion of day case elective orthopaedic admissions increased from 41.9% to 49.0% (p<0.01), and all of the PCT's main four provider Trusts experienced increased admissions over this period (figure A2.9 and table A2.4). The two ISTCs accounted for 5.7% (1,287/22,768) of all orthopaedic admissions for the PCT's residents in 2007/8.

Figure A2.9: Site G rural: elective orthopaedic admissions by provider

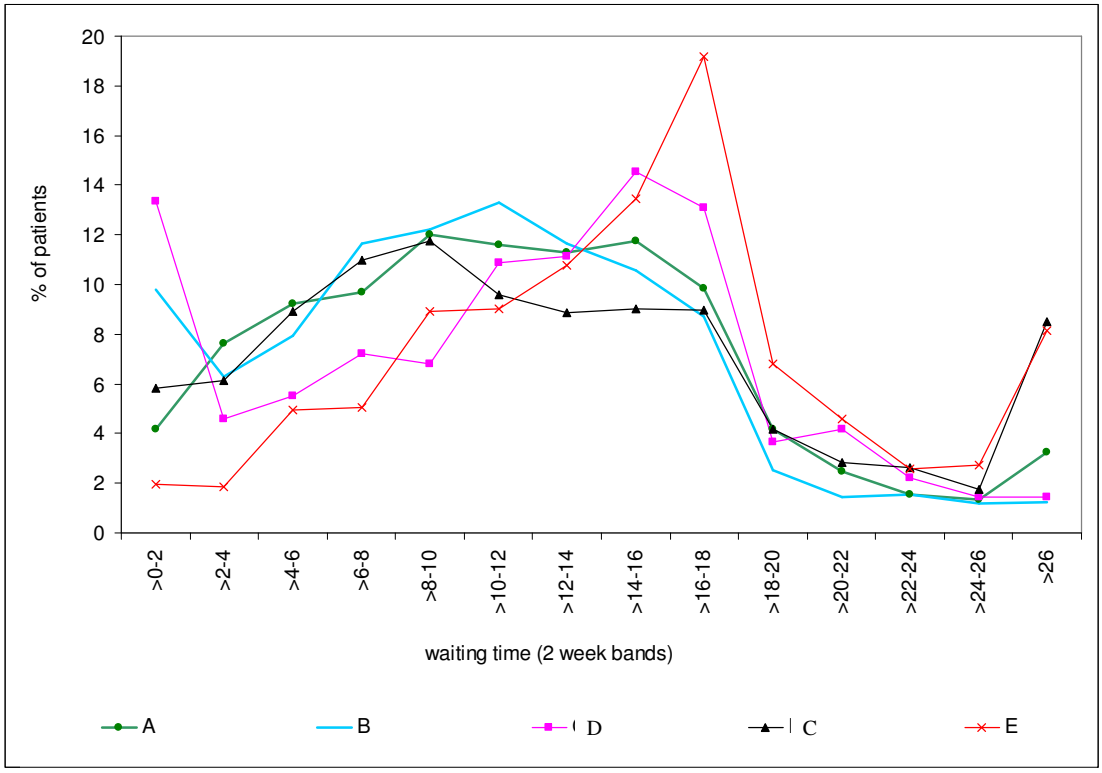


During the first three months of 2009, 87% of admitted orthopaedic patients at NHS providers in this Site were admitted within the 18 week target, compared to 90% of patients in the comparator PCTs (table 6.1).

During the first three months of 2009, performance against the 18 week target varied with 92% of orthopaedic admissions at provider B taking place within the 18 weeks, compared to 87% at providers A and D, 80% at provider C and 75% at provider E (figure A2.10). Figure

A2.10 illustrates provider C's propensity to admit patients shortly before the 18 week target. Both providers C and E admitted a relatively high proportion of patients after 26 weeks waiting.

Figure A2.10: Site G waiting time for elective orthopaedic admissions by main provider in the three months to March 2009



Site E

The majority of orthopaedics for this rural Site is provided by two Trusts, which accounted for 63.5% of its elective orthopaedic admissions in 2008/9 (figure A2.11). Between 2002/3 and 2008/9, overall elective orthopaedic admissions for the PCT's residents increased by 52.8% from 12.1 to 18.5 per 1,000 population, and this change is significant at the 5% level (table A2.5). The increase in admissions was due to increases in day case (78.7%) and inpatient (34.2%) activity (table A2.5). Between 2002/3 and 2008/9, the proportion of day case elective orthopaedic admissions increased from 41.9% to 49.0% ($p<0.01$).

Table A2.5: Site E Changes in elective orthopaedic admission rates

	2002/03		2008/09		Difference in rate between years	95% CIs for the difference in rate		% change between years
	Rate PTP	no	Rate PTP	no				
								All
A FT	6.2	4433	7.4	5616	1.2	0.9	1.5	19.2
B HT	2.9	2027	4.3	3229	1.4	1.2	1.6	49.9
C FT	1.4	1028	2.5	1859	1.0	0.9	1.2	70.2
D TC	0.0	0	1.1	862	1.1	1.4	1.8	
Others	1.5	1089	3.1	2363	1.6	1.1	1.2	104.2
Total	12.1	8577	18.5	13929	6.4	6.0	6.8	52.8
Inpatients								
A FT	3.7	2657	4.4	3334	0.7	0.5	0.9	18.1
B HT	1.3	908	1.9	1436	0.6	0.5	0.8	48.8
C FT	0.9	614	1.2	935	0.4	0.3	0.5	43.3
D TC	0.0	0	0.4	336	0.4	0.4	0.5	
Others	1.1	802	1.4	1061	0.3	0.2	0.4	24.5
Total	7.0	4981	9.4	7102	2.4	2.1	2.7	34.2
Day cases								
A FT	2.5	1776	3.0	2282	0.5	0.4	0.7	20.9
B HT	1.6	1119	2.4	1793	0.8	0.7	0.9	50.8
C FT	0.6	414	1.2	924	0.6	0.5	0.7	110.1
D TC	0.0	0	0.7	526	0.7	0.6	0.8	
Others	0.4	287	1.7	1302	1.3	1.2	1.4	327.0
Total	5.1	3596	9.0	6827	4.0	3.7	4.3	78.7

All three main Trust providers experienced increased admissions over this period (table A2.5). The ISTC accounted for 6.2% (862/13,929) of all admissions for the PCT's residents in 2008/9. The largest change in provider-level activity was the increase in day case admissions at providers other than the three main Trust providers and the ISTC. Hence, the majority of the increase in admissions is due to an increase in activity across the range of providers, rather than the introduction of the ISTC.

During the first three months of 2009, 77% of the PCT's patients were admitted within 18 weeks, compared to 86% of patients in the nine comparator PCTs (table 6.1). Figure A2.12 illustrates the orthopaedic waiting time experience for the PCT's top three providers; comparable data for the ISTC are not available. The PCT's main provider has performed

relatively weakly against the 18-week target during the first three months of 2009, with 59% of patients treated within 18 weeks, compared to 88% for the other two providers.

Figure A2.11: Site E elective orthopaedic admissions by provider

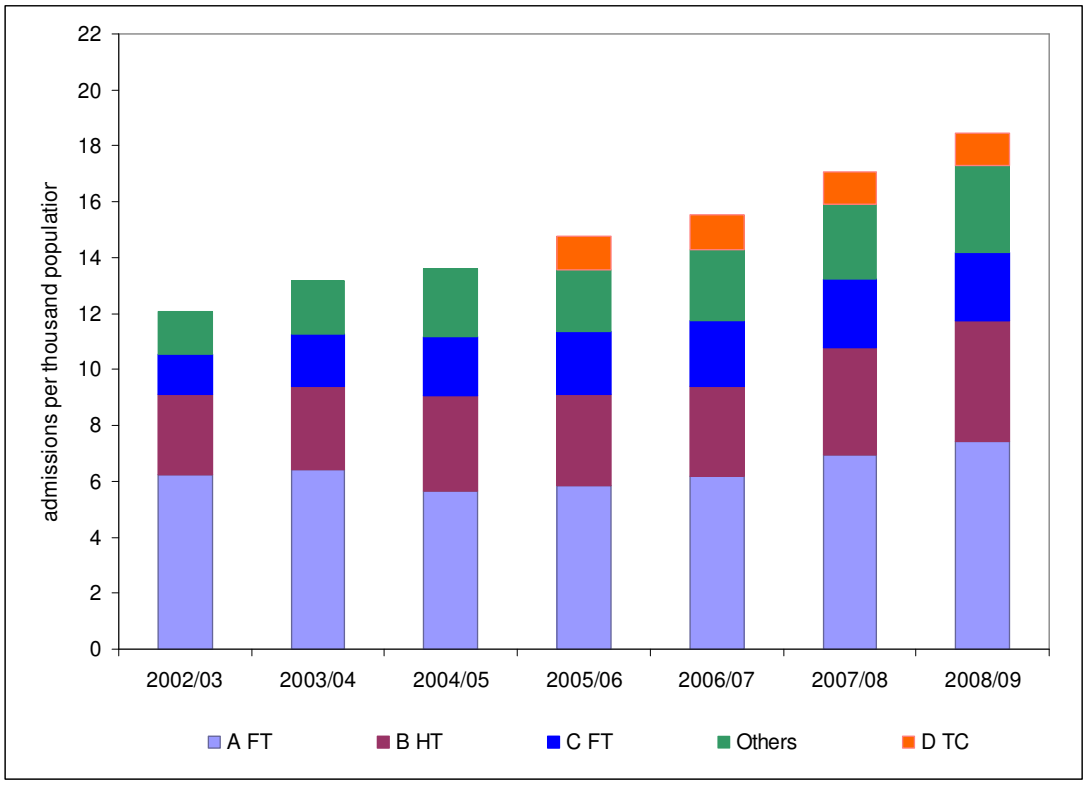
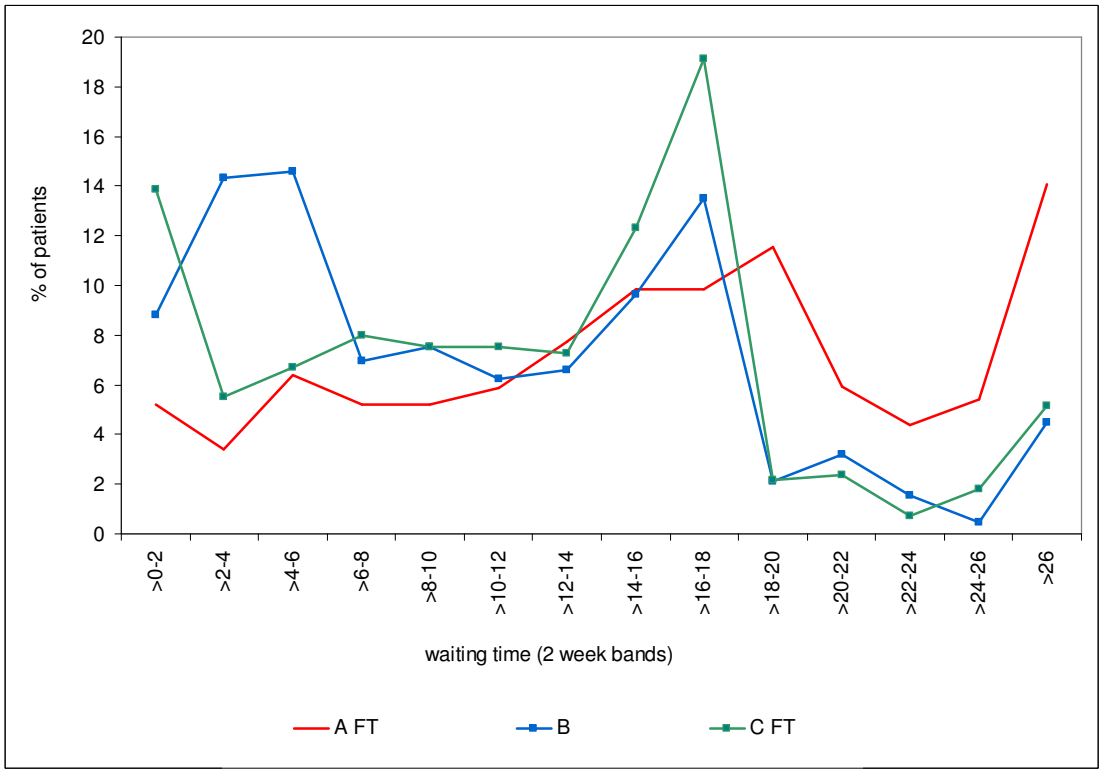


Figure A2.12: Site E waiting time for elective orthopaedics by main provider in the three months to March 2009



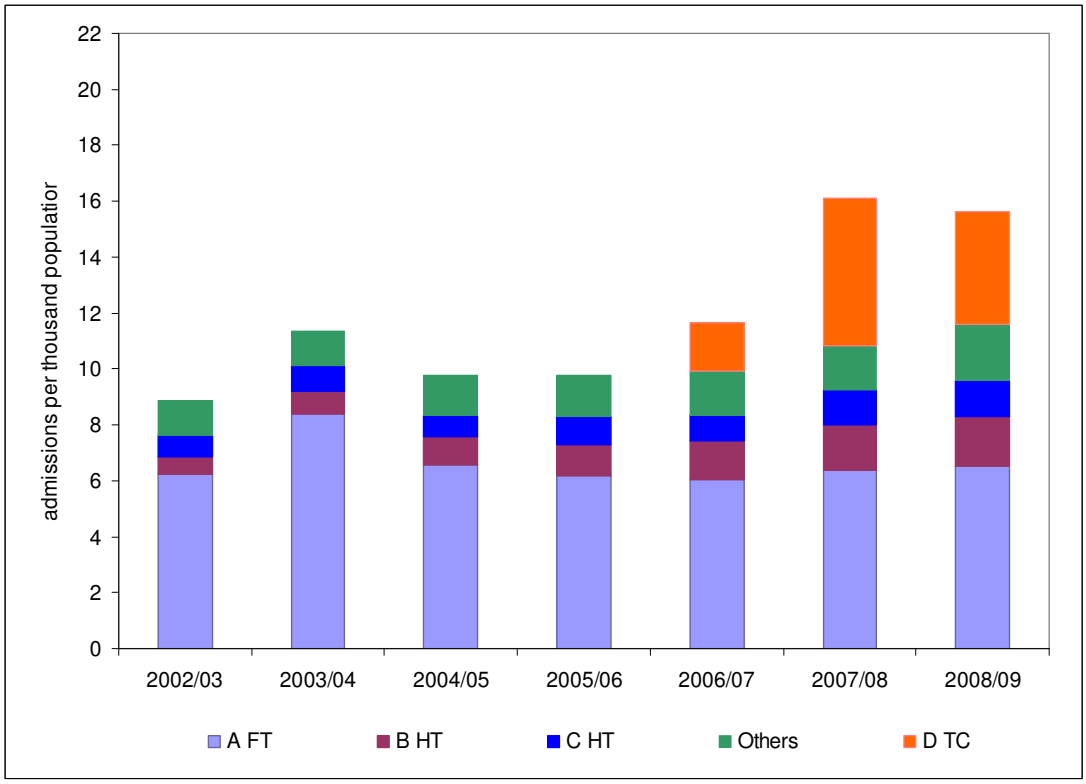
The overall performance of these providers in terms of CQC ratings is subject to considerable variation, both in 2008/09 and over time. It is interesting that Provider A's overall performance is the strongest, and it has Foundation Trust status, in light of its relatively weak orthopaedic waiting time performance.

Site F

The provision of orthopaedics for this rural Site has historically been dominated by a Foundation Trust, which accounted for 70.2% (1,450/2,065) of its elective orthopaedic admissions in 2002/3 (figure A2.13). However, between 2002/3 and 2008/9, overall elective orthopaedic admissions for the PCT's residents increased by 76.0% from 8.9 to 15.6 per 1,000 population, and this change is significant at the 5% level (table A2.5). This overall increase in admissions was not due to a change in the number of admissions at the main provider, but was due to increases in other Trusts and, in particular, the activity undertaken at the ISTC (table A2.6). In 2008/9, the ISTC accounted for 25.8% (952/3,684) of orthopaedic admissions for the PCT (figure A2.13). Between 2002/3 and 2008/9, the proportion of day case elective orthopaedic admissions increased from 45.8% to 54.6% ($p<0.01$).

In 2008/9, the ISTC undertook more primary knee and hip replacements and more day case arthroscopies than the PCT's FT main provider (262 verses 191, and 205 verses 195, respectively).

Figure A2.13: Site F elective orthopaedic admissions by provider



During the first three months of 2009, 85% of admitted orthopaedic patients in this case-study PCT were admitted within the 18 week target, compared to 84% of patients in the nine comparator PCTs (table 6.1).

Figure A2.14 illustrates the orthopaedic waiting time experience for the PCT's top three NHS providers; comparable data for the ISTC are not available. The PCT's main two providers (A and B) performed relatively weakly against the 18-week target during the first three months of 2009, with 75% and 79% of patients treated within 18 weeks, respectively, compared to 95% for provider C. Provider C is a specialist orthopaedic hospital and its performance is unusual with 42% of admissions within two weeks of the maximum waiting time target.

Table A2.6: Site F changes in elective orthopaedic admission rates

	2002/03		2008/09		Difference in rate between years	95% CIs for the difference in rate		% change between years
	Rate PTP	no	Rate PTP	no				
All								
A FT	6.2	1450	6.5	1538	0.3	-0.2	0.7	4.7
B HT	0.6	138	1.8	417	1.2	1.0	1.4	198.2
C HT	0.8	189	1.3	302	0.5	0.3	0.7	57.7
D TC	0.0	0	4.0	952	4.0	3.8	4.3	
Others	1.2	288	2.0	475	0.8	0.5	1.0	62.7
Total	8.9	2065	15.6	3684	6.8	6.1	7.4	76.0
Inpatients								
A FT	3.3	770	2.5	599	-0.8	-1.1	-0.5	-23.2
B HT	0.3	75	1.1	256	0.8	0.6	0.9	236.8
C HT	0.5	123	0.8	200	0.3	0.2	0.5	60.4
D TC	0.0	0	1.6	368	1.6	1.4	1.7	
Others	0.6	151	1.1	249	0.4	0.2	0.6	62.7
Total	4.8	1119	7.1	1672	2.3	1.8	2.7	47.4
Day cases								
A FT	2.9	680	4.0	939	1.1	0.7	1.4	36.3
B HT	0.3	63	0.7	161	0.4	0.3	0.5	152.2
C HT	0.3	66	0.4	102	0.1	0.04	0.3	52.5
D TC	0.0	0	2.5	584	2.5	2.3	2.7	
Others	0.6	137	1.0	226	0.4	0.2	0.5	62.8
Total	4.1	946	8.5	2012	4.5	4.0	4.9	109.9

Figure A2.14: Site F waiting time for elective orthopaedics by main provider in the three months to March 2009

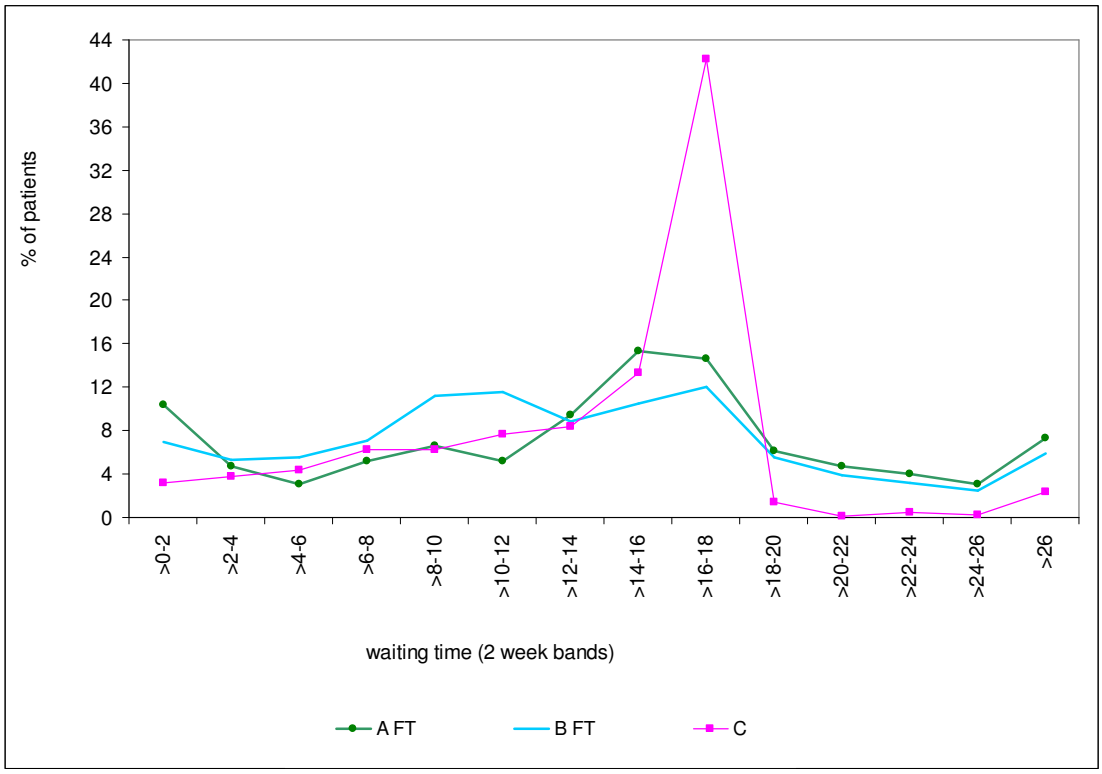


Figure A2.15: Site F age bands for TKR patients at the ISTC and main provider in 2008/9

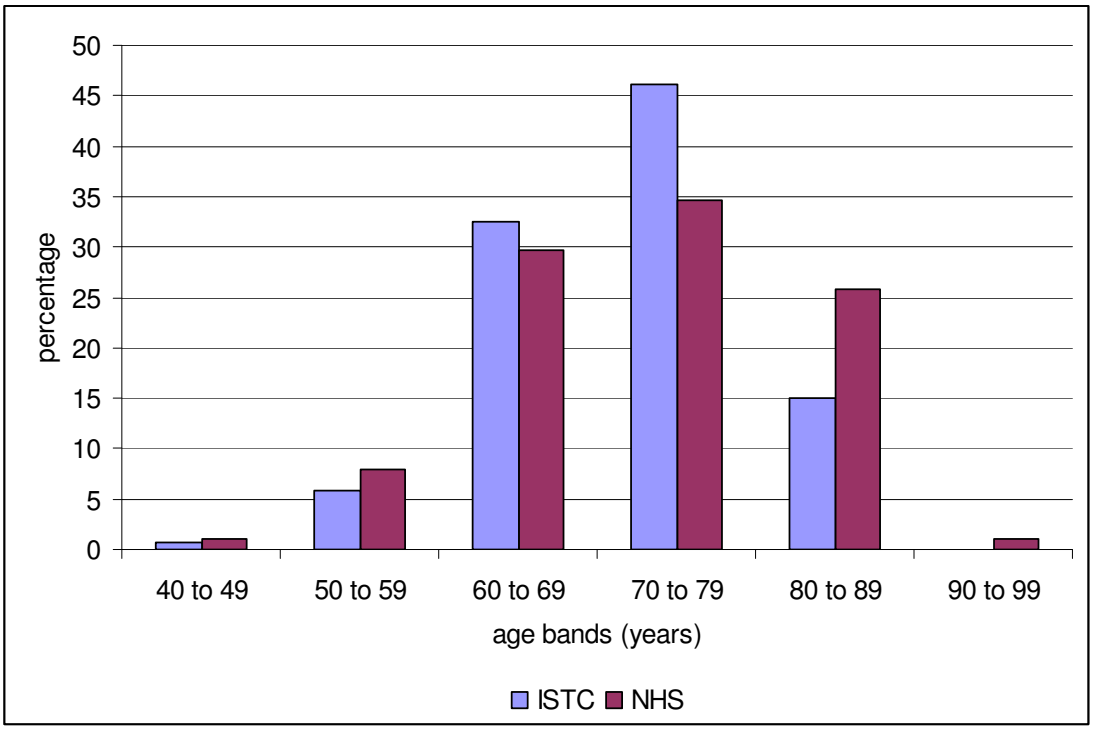
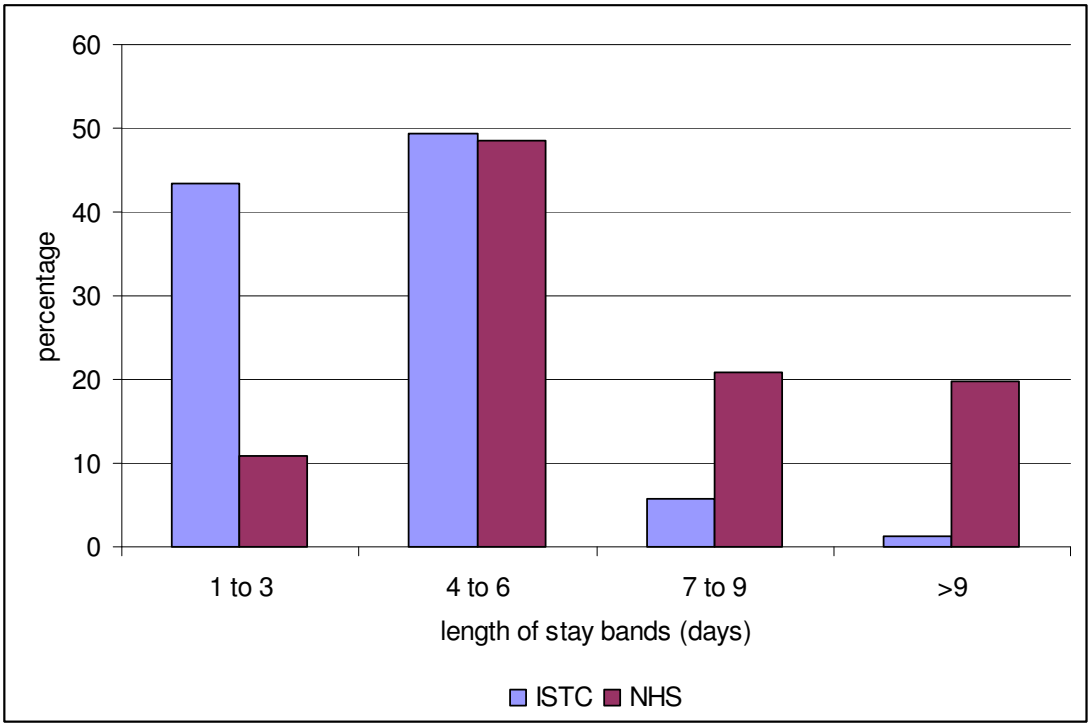


Figure A2.16: Site F length of stay bands for TKR patients at the ISTC and main provider in 2008/9



Appendix C The health reform journey

Date of publication	Main system reform document	Demand	Supply	Transactional	System Management Reform	Tracer Areas
1992-1997	Health of the Nation					
1997	The New NHS		PMS pilots			
1998		Our Healthier Nation				
1999					Saving Lives - Our Healthier Nation, Quality and performance in the NHS – performance assessment framework	NSF – Mental Health (Adults)
2000	The NHS Plan					
2001		From Vision to Reality – progress on tackling health inequalities	Shifting the Balance of Power – an H.R. framework			The expert patient: a new approach to chronic disease management for the 21st Century
2002	Delivering the NHS Plan	The Wanless Report				
2003		Building on the Best, Choice, responsiveness and equity in the NHS and Social Care: a national consultation, Strengthening Accountability – Section 11 of the Health and Social Care Act 2001	Modernising Medical Careers			NSF - Diabetes
2004	NHS Improvement Plan – Putting People at the Heart of Public Services	Choosing Health, Choose and Book	The NHS workforce in England 2003: More staff, working differently,			NSF – Mental Health (Children)

			Agenda for Change			
2005		Delivering Choosing Health, Creating a Patient-led NHS, Now I feel tall: What a patient-led NHS feels like			Health reform in England. Update and next steps	Supporting People with Long term Conditions – NHS and Social Care Long term Conditions Model
2006	Our Health, Our Care, Our Say	Tackling Hospital Waiting 18 weeks Implementation Framework			Simplification Plan (to reduce regulatory burden), PCT and SHA roles and responsibilities	Turning the corner: improving diabetes care
2007				World Class Commissioning		
2008	High Quality Care for All					Year of Care - Diabetes