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ARE ENGLISH HOSPITALS DOING LESS?

John Appleby examines the numbers behind recent claims about activity in English hospitals

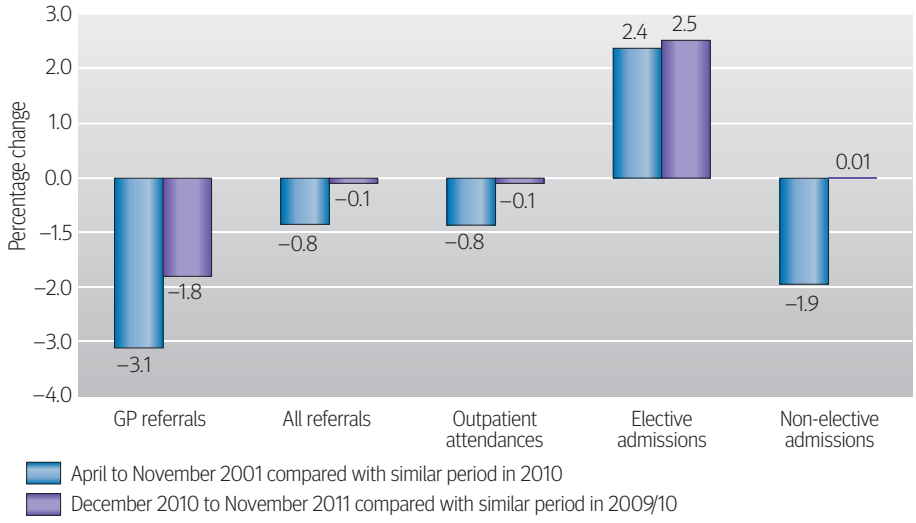

Fig 1 | Changes in hospital referrals, outpatient attendances, and elective and non-elective admissions in England[1]

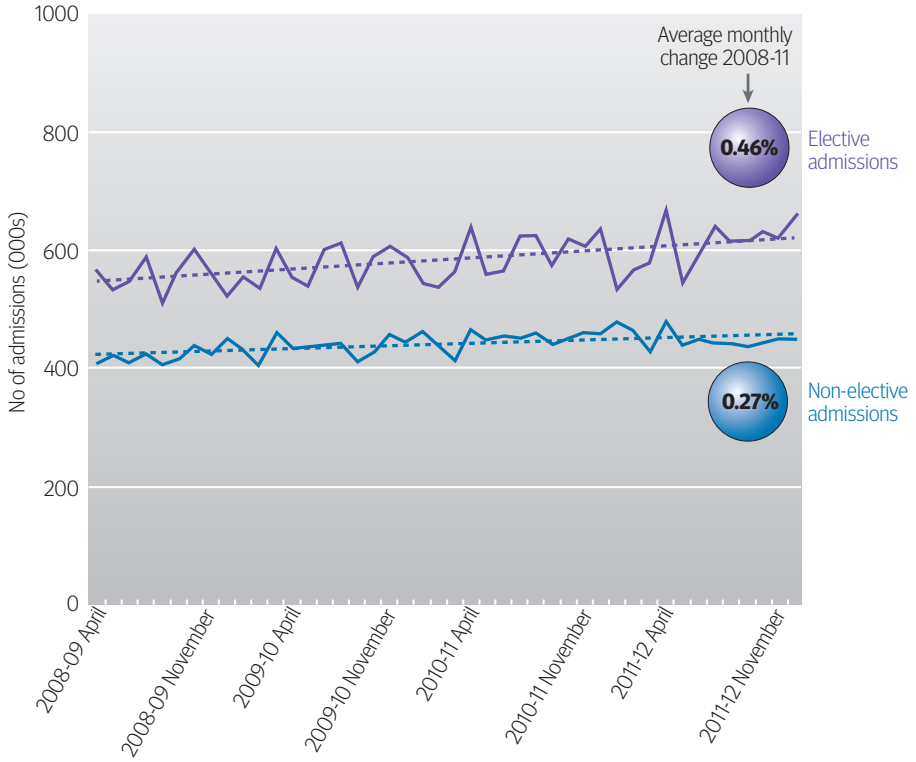

Fig 2 | Trends in elective and non-elective admissions, England, 2008-11[1]

Rather than "doing more with less" or, if we are slightly more optimistic about the money, "doing more with the same," English hospitals seem to be doing less (possibly with less or the same). Yet the secretary of state for health, Andrew Lansley, told BBC Radio 4's *Today* last week (24 January) that the figures were positive. What is going on?

Comparing the first eight months of this financial year (April to November 2011) with the same eight months in 2010, it is true, as Andrew Lansley has said, that non-elective (emergency) admissions fell by 1.9% and that general practitioner (GP) referrals also fell—by 3.1% (fig 1). This, he implied, was a good thing. Emergency admissions had been rising for some years (fig 2), and this has been seen as a bad thing—implying failure in other parts of the health system, such as general practice, and possibly some perverse behaviour by hospitals to ensure they met maximum waiting time targets in emergency departments by admitting patients unnecessarily, even if only for a few hours' observation.

The fall in GP referrals—counter to general trends over the past few years (fig 3)—could also be seen as good if it represents a more appropriate routing of patients to, say, less intensive or more cost effective forms of care. Unfortunately, data do not exist to support or deny this; fewer referrals may mean less demand from patients (or their GPs), treatment elsewhere, or simply delays for patients. But these sorts of delays will not show up on hospital lists because these include only referred patients. So, the fact that median waiting times were generally lower in November last year compared with May 2010 (fig 4) does not really tell us much about the possible causes or consequences of the drop in referrals.

But have referrals really fallen by as much as Andrew Lansley says? If we take a full year to November 2011 and compare it with the previous year GP referrals still fell, but by 1.8% (compared with 3.1% for April-November 2011). And if we take other referrals into account—around 37% of all

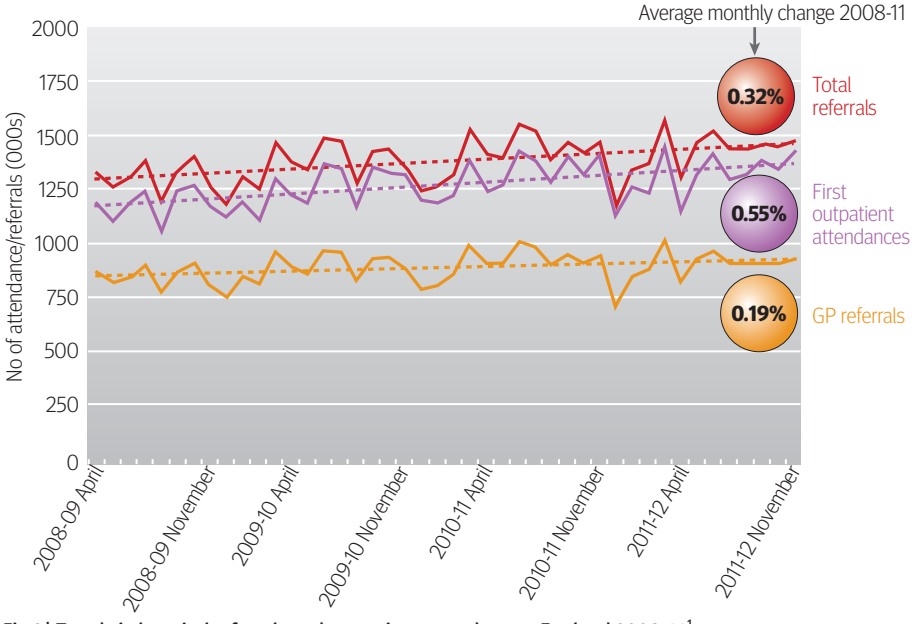

Fig 3| Trends in hospital referrals and outpatient attendances, England 2008-11[1]

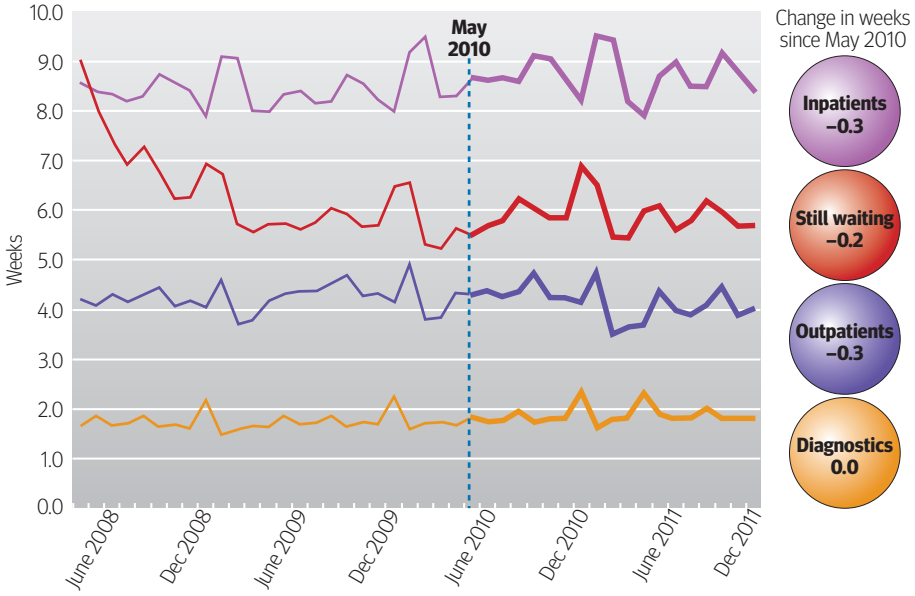

Fig 4| Trends in median waiting times (weeks)[2 3]

referrals, including, for example, consultant to consultant referrals—the change over one year (rather than eight months) drops to −0.1%.

Changing the comparator period to one year also cuts the reduction in non-elective admissions to 0.01%. Essentially, no change.

Such statistical fiddling does not, however, significantly change a further observation from the secretary of state that elective admissions increased by 2.4% (or 2.5% over a full year, fig 1). This, it might be assumed, is a good thing, showing that despite tough financial times and with hospitals being squeezed in terms of the fixed prices they can charge, they are managing to do more with the same or less.

Well, possibly. But it is hard to see how reducing GP referrals and increasing hospital elective work are both seen as good; were all these extra patients treated appropriately? Did they need to be admitted?

What all this illustrates is the general rule that broad brush and highly aggregated data tend to allow only broad brush and highly qualified interpretation.

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Are you a future clinical commissioning team of the year?

The proposed health and social care bill will result in substantial changes to the way the majority of healthcare services are commissioned in England should it become law later this year.

Although controversial, the bill does represent an opportunity for general practitioners and other clinicians to shape the way healthcare is provided in their local area, using their unique insight into local needs to set future service priorities.

To reflect this changing healthcare landscape, the 2012 BMJ Group Improving Health Awards will feature a clinical commissioning team of the year award.

This award is designed to recognise a pathfinder clinical commissioning group (CCG) that has demonstrated real achievement in 2011.

This could either be through the work it has done to become an established commissioning organisation, or through an initiative that has resulted in service redesign, leading to demonstrable improvements in patient care.

CCGs are in their infancy and the past 12 months have seen GPs and other primary care staff come together to create organisations that will be responsible for commissioning the majority of acute, community, and mental health services.

This award is looking to acknowledge a group that has shown significant organisational development in this time.

In particular, we will be looking for groups that have successfully engaged constituent practices and local clinical communities in developing their constitutions and commissioning plans.

We are also looking for strong clinical leadership and significant public and patient engagement in the work of the group to date.

Some CCGs are already involved in service transformation activities, often building on the foundations laid down by practice based commissioning groups.

We welcome applications from CCGs that have developed plans on commissioning or/ QIPP (quality, innovation, productivity, and prevention) plans that are based on population needs and represent new and innovative service delivery.

The panel of judges will be looking to see how commissioners have used evidence to underpin their commissioning decisions and how the local community and other stakeholders have been involved.

Examples of innovative commissioning decisions that have led to new ways of service delivery are particularly welcome.

We look forward to receiving your entries at http://groupawards.bmj.com/.

Anita Jolly is a public health physician and clinical specialist at BMJ Group.

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INTO THE ABYSS? How the health bill affects the NHS

The Health and Social Care Bill already seems a reality out in the heartlands of the NHS, so what effect will its passing have, says **Rebecca Coombes**

JOE CUMMINGS

It's one year since the Health and Social Care Bill was published and you could be forgiven for thinking the UK parliament and the English NHS are living in parallel universes. While MPs and Lords wrangle over the enormous 350 page bill, and lobbyists, including doctors, fight to improve on the initial offering, out in the health service radical reform is already well underway. Transition to clinician-led commissioning has progressed so quickly that it's as if the actual passing of the bill were a mere incidental detail. As one commentator told the *BMJ*, "we've taken a running jump into the abyss." The NHS has already laid waste to huge amounts of management capacity, undermining its ability to cope as the previous years of public sector largesse begin to recede. So when the bill finally receives royal assent, what difference will it make to the health service?

Without it general practitioners can't legally commission health services

The bill is vital if general practitioners are to get the legal right to commission health services. The bill transfers these statutory powers to the clinical commissioning groups (CCGs) and the NHS Commissioning Board. Although the bill is not yet law, there are already 257 pathfinder CCGs, covering 97% of the population in England. The vast majority have been cleared to take on shadow budgets from April in advance of becoming fully operational next year. So, if the bill were scrapped now, there would be a serious question mark about whether primary care trusts (PCTs) could revert to their previous role of commissioning the bulk of health services. PCTs have already been wound down to just 50 clusters—and many of their skilled managers have jumped ship. The *Health Service Journal* reports that one region has already lost two thirds of its commissioning staff.[1] Many have joined the brain drain to the acute sector, especially foundation trusts, and in whole areas of the NHS commissioning is being driven by deputies. To prevent chaos if the bill were withdrawn CCGs would probably still need to be put on a legal footing to shoulder some commissioning responsibilities alongside the depleted PCTs. But with no overall commissioner, this would present a serious risk to the provision of services for patients. It creates a structure in which confusion and duplication would reign.

It gives Monitor important new powers to regulate the NHS and its healthcare providers

The plan to transform Monitor into a super-regulator is proof in many critics' eyes that this government is hell bent on further marketisation of the NHS. If the bill passes, Monitor will indeed morph from mere regulator of foundation trusts to regulator for all NHS funded providers. It will regulate prices for NHS services and prevent anticompetitive behaviour that acts against patients' interests. Monitor will also license NHS providers jointly with the Care Quality Commission—although there remains great uncertainty as to how these two bodies will work together.

Monitor's new role in preventing anticompetitive behaviour gives the NHS a dedicated competition regulator for the first time—the NHS will no longer share a regulator with sectors such as transport or credit card companies. It will be subject to the same competition rules as before but a different body, Monitor, will be enforcing them, and compliance will also be part of the licensing regime. Opinion is split about whether this will give commercial companies greater access to billions of pounds of public contracts to provide healthcare. A specific health regulator could lead to a more sympathetic and more appropriate system of competition, say some. "Monitor might look not just at the financial objectives but also at the social ones. One social objective is the need to maintain access for all people, and that is a reason why a service should attract a subsidy," says Jennifer Dixon, director of the Nuffield Trust. Others worry that a dedicated regulator will divert attention on to procurement rules to an extent that could impede some sensible decision making.

It's worth mentioning that unlike the abolition of PCTs and setting up of CCGs, plans to transform

the role of Monitor have so far not advanced to the point of no return. It still doesn't have a chief executive, and many of its duties remain to be fleshed out in post-bill regulations. The planned joint licensing role with the Care Quality Commission has yet to be worked out, as have the details of the transfer of tariff setting responsibilities from the Department of Health. So if the bill were withdrawn, Monitor would remain as a regulator of foundation trusts but nothing else. Anticompetitive behaviour would continue to be policed by the Cooperation and Competition Panel and the Office of Fair Trading.

Does the bill create other conditions that could lead to the greater privatisation?

Increased competition in the NHS is happening regardless of the bill. The "any qualified provider" policy has already been set out in published guidance and will be phased in from next year for selected clinical services. NHS organisations are already subject to competition law, payment by results, and, under the NHS constitution, a legal duty to offer patients a "free choice" of provider. Private sector providers are proliferating in the NHS. These include private sector management of NHS franchises—witness Hinchingbrooke Healthcare NHS Trust, Huntingdon, now run by Circle (a move made possible by legislation passed by the previous Labour government). There are already provider models that don't have to offer national NHS terms and conditions, such as foundation trusts and social enterprises. PCTs are already using private sector commissioning support. So what does the bill change? It consolidates and emphasises what is already happening. It provides a framework for the continued implementation of the government's policy to use market forces to drive improvement and efficiencies. The health secretary will issue a "choice mandate" to the NHS Commissioning Board, which will set out the limits of choice and competition in the NHS. And who's to say that the potential scope of choice won't grow ever wider in future years?

The bill does put a duty on the secretary of state, Monitor, and the NHS Commissioning Board "not to exercise their functions for the purpose of causing a variation in the proportion of services provided by any particular sector." But arguably this doesn't change much. The last Labour government had a "preferred provider policy" that favoured the NHS, but that has since been changed to "any willing provider." So the reality is that the procurement rules already force NHS commissioners to be neutral on provider ownership. You can't exclude a private sector provider because you are ideologically opposed to them.

Under the bill, the NHS Commissioning Board can make payments to CCGs in the form of a "quality premium." There are still concerns, despite amendments made after the Future Forum report, that the financial rewards associated with efficient commissioning will affect the doctor-patient relationship by creating an incentive to save money.

It allows foundation trusts to make almost half of their income from private patients

The bill controversially allows foundation trusts to increase their income from private patients up to 49% of their total income. Currently, the amount of income that foundation trusts get from private patients varies from almost nothing to 30%. Critics say the bill will create incentives for financially challenged trusts to place less of a priority on access to services for NHS patients.

But how far are foundation trusts going to make the most of this new ability? Nigel Edwards, senior fellow at the King's Fund, points out that the latest figures from analysts Laing and Buisson show that, for the fifth year running, NHS income from private patients is actually falling. "I'd say this is more a potential hazard than a real one. It will only become a real issue if a decision is made to exclude certain procedures [from NHS services] or if people are made to wait a long time—this will drive them back to private medicine." But it doesn't hold, he says, that a hospital with a successful private practice does so at the expense of its NHS patients. The Royal Marsden, for example, has a substantial private income with no noticable effect on its NHS care. For many trusts, private income is extremely low so the most that might happen is that a trust increases its private work from 1% to 2% of its total income, money that can be reinvested into NHS care.

The government policy of expecting all NHS trusts to become foundation trusts does not require legislation and is not in the bill. So if the bill was scrapped this policy could continue unimpeded. But the health secretary does need this legislation if he wants to outlaw all non-foundation trusts beyond a set deadline.

The bill will lead to the abolition of geographical boundaries

PCTs are currently responsible for all residents in a geographical area. But, under the bill, clinical commissioning groups will be responsible only for patients registered at general practices within their group. In the absence of PCTs, there will no longer be one body with a duty to get everybody on to general practice lists. And there will no longer be one organisation responsible for commissioning, providing, and monitoring care for an area based population. Critics say there will be no way of monitoring whether the NHS is providing a truly comprehensive service, monitoring inequalities, or finding out if vulnerable groups are being denied care. If your core source of information is general practice lists, you lose valuable geographical data on which to base resource allocation and monitor the health of populations and the uptake and outcome of services.

The bill changes the health secretary duties regarding providing comprehensive health services

Much has been made of this symbolic aspect of the bill. It is a flashpoint for those highly concerned about the bill's radical restructuring of NHS organisations, and the issue of fragmentation of services. If any part of this new devolved structure fails, is the health secretary responsible? As the *BMJ* went to press, the government was known to be working with peers to strengthen the wording of this part of the bill to make the health secretary's responsibility more explicit. The bill as it currently stands is open to interpretation. Some see it as allowing for only a slight loosening of the apron strings rather than a wholesale reneging on responsibilities. The health secretary would still be responsible for making sure that people are offered a free and comprehensive health service, but responsibility for providing it is devolved to the NHS Commissioning Board and CCGs. So if the health secretary is called to answer for the closing of a particular hospital on the *Today* programme he can rightly point the interviewer in the direction of local commissioners, who will become responsible for these difficult decisions. What the health secretary is responsible for is ensuring that the services of the closing hospital will be available locally under another provider, so that patients don't lose out. And for all this talk about government decentralisation, the secretary of state retains considerable powers over what local commissioners provide. A local CCG can't suddenly decide to stop doing hernia repairs, for example; it is not up to commissioning groups to determine the overall package of care. That is not legally possible. There are those that say politicians just won't be able to resist some meddling, witness David Cameron's latest pronouncement over nurses making hourly ward rounds.

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EDITORIALS, pp 7-8
FEATURES, p 24
OBSERVATIONS, p 36