

Developments in the NHS

Increased funding and the NHS Plan 2000

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Reform of the National Health Service (NHS) was a major priority for the New Labour Government, when it came into power in the UK in May 1997. Modernising the NHS and raising NHS standards were seen as crucial to maintaining public confidence in public services.

Introduction

The Government set out its vision for the NHS in a White Paper published in December 1997, *The new NHS: Modern, Dependable*, amplified by the *Health Act 1999*, a 1998 public health White Paper, *Our Healthier Nation: Saving Lives* and many supporting documents. In 1998 sizeable increases in NHS expenditure were announced amid hot Ministerial debate and widespread allegations of misrepresentation. A key question at the time was whether the promised level of resources would be sufficient to deliver the Government's ambitious plans.

By the winter of 1999/2000, the answer seemed clear. Hospitals struggled in the face of a flu outbreak, leading to cancellations in elective treatment. The NHS came under sustained attack for its failure to cope with winter pressures, the scarcity of intensive care beds, sub-standard cardiac and cancer care, and its uncaring treatment of elderly people. Professional bodies demonstrated the scale of NHS financial deficits. The British Medical Association launched a review of health funding, including the possibility of NHS charges. The *Health Services Journal*, in its last editorial of the twentieth century, epitomised the NHS as 'underfunded, under pressure and under-appreciated'.

The Prime Minister himself, the Right Honourable Tony Blair, led the Government's reconsideration of its approach to the NHS. First, in March 2000, came a commitment to a substantial increase in funding for the NHS. Next came a period of work by specialist action teams and of consultation with NHS staff and the public to determine how to use this new

money to best effect. The product was *The NHS Plan: A plan for investment, a plan for reform* of July 2000.

This briefing note focuses on major points in the NHS Plan and its funding base. This note is therefore descriptive rather than evaluative. Following constitutional devolution, existing divergence between the NHS in England, Scotland, Wales and Northern Ireland has increased. The NHS Plan is primarily applicable to England. Details of earlier health policy documents can be found in the September 1999 HSRC briefing note, *Recent developments in the NHS: 1997–1999*.

NHS Public Service Agreement

Given a strong economy and healthy public finances, the UK Government in 2000 pledged that 'over time we aim to bring [NHS spending]

Key NHS financial features: 2000–2004

- Fixed 1999–2002 3-year settlement over-ridden by March 2000 Budget
- A commitment to an average annual NHS funding increase of 6.1 per cent UK in real terms over 4 years 2000–2004
- Total NHS expenditure in England to rise from £44.5 billion (2000/1) to £56.7 billion (2003/4)
- A step change in capital investment to tackle long-term neglect
- Flexibility to carry over any unspent planned funding to the next year
- Increased resources to be tied to reform and results.

NHS Public Service Agreement Targets

NHS

- Maximum wait of three months for outpatient appointments and six months for inpatient treatment by end 2005
- 2/3 of all outpatient appointments and inpatient elective admissions to be pre-booked by 2003/4, and 100 per cent by 2005
- Guaranteed access to a primary care professional within 24 hours, and to a primary care doctor within 48 hours, by 2004
- Year on year improvements in patient satisfaction
- To reduce substantially by 2010 the mortality rates from
 - heart disease (by at least 40 per cent in people under 75)
 - cancer (by at least 20 per cent in people under 75)
 - suicide and undetermined injury (by at least 20 per cent)
- To narrow the socio-economic and geographical health gap (specific targets to be developed in 2001)
- Trusts to meet value for money benchmarks for cost of care

NHS in partnership with social services

- High quality pre-admission and rehabilitation care for older people; year-on-year reductions in delay in moving people over 75 on from hospital
- Increase the participation of problem drug-users in drug treatment programmes by 55 per cent by 2004, and 100 per cent by 2008

up to the European Union average' – an acceptance that the NHS, however efficient, was slipping behind the standards of comparable countries and that funding was an issue. The World Health Organization's report in May 2000 ranked France 1st in the world for overall health system performance, and the UK 18th.

In 1998, the Health Public Service Agreement for the three years 1999/2000–2001/2002 had allocated the NHS an average annual increase of 4.7 per cent in real terms. The budget of March

2000 overrode that Agreement and promised substantially more: a commitment to an average 6.1 per cent per year in the UK (6.3 per cent in England) over four years from 2000–2004.

The new money is generous: over five years it amounts to a real terms increase of one-third. But the Government is clear that it is to be tied to output and performance, accompanied by a range of incentives, penalties, inspections and information. The insistence on tying increased resources to reform and results is sensible, but it begs the question of what the Government will do if the NHS does not reform at the pace demanded. Removing the extra cash does not seem politically feasible.

The Department of Health's 2000 Public Service Agreement (PSA) with the Treasury defines a small but stretching core of targets for the NHS. It also tacitly marks the Government's belated acceptance that waiting times are a more appropriate measure of NHS performance than the numbers of patients on waiting lists. Perhaps the bravest – and most popular – of all the Plan's aims is a maximum three month wait for all stages of treatment by 2008.

The NHS Plan

Alongside the PSA, The NHS Plan sets out the totality of the NHS reform programme from which these targets were taken. In many ways, The NHS Plan is less a plan than a sequel to the 1997 NHS policy White Paper. It revisits the problems of the NHS, the options for funding healthcare and the Government's vision of a publicly funded health service designed around the patient.

It benefits from a more open process. While in 1997 policy was largely framed behind closed doors, in 2000 both staff and the public were consulted (albeit hurriedly). An alliance of many health professional bodies and interest groups explicitly signed up to the Plan and its implementation: *'While each of us may have different views on individual components of the Plan, we all support the process of modernisation and reform.'*

Payment and principles

The NHS Plan, like the 1997 White Paper, states bluntly that the public has to pay for healthcare by one means or another. It examines the options, including private insurance (where genetic testing raises new concerns about coverage and costs), NHS charges, social insurance, and a rationed NHS providing only a limited range of procedures. It concludes that the NHS remains a fair and efficient way of funding

healthcare. *'The principles on which the NHS was constructed remain fundamentally sound...Investment and reform are the twin solutions to the problems the NHS faces'*.

The Plan specifies ten core principles for the reformed NHS, some restating the founding values of the NHS, others reflecting issues important today.

10 NHS core principles

- A universal service for all based on clinical need, not ability to pay
- A comprehensive range of services
- Services shaped around the needs and preferences of individual patients, their families and carers
- Responsiveness to the different needs of different populations
- Continuous effort to improve quality services and minimise errors
- The NHS to support and value its staff
- Public funds for healthcare to be devoted solely to NHS patients
- Working with others to ensure a seamless service for patients
- Efforts to keep people healthy and reduce health inequalities
- Respect for patient confidentiality, while providing open access to information about services, treatment and performance

Current NHS problems

The NHS Plan sets out a frank analysis of the problems manifest in the NHS today.

- Underfunding and underinvestment in capital
- Too little action to prevent ill health
- Too little focus on the patient's needs and wants
- Too few doctors, nurses and other key staff
- No national standards, and unacceptable variations across the country
- Demarcations between staff, and barriers between services

- Few clear incentives and levers to improve performance
- Overcentralisation and disempowered patients

Against this background, the NHS Plan sets out what is to be done *'to prove...that a universal public service can deliver what the people expect in today's world'* (Tony Blair).

Action for change: NHS facilities

One thrust of the Plan is major investment in NHS facilities, from beds to equipment to clean wards and better food. This is no cosmetic exercise: for the rundown, overburdened NHS, such investment is fundamental to patient access, to good quality modern services, and to patient comfort and convenience.

The aim is that 40 per cent of the total value of the NHS estate will be less than 15 years old by 2010. The new buildings will be provided through a mixture of public capital and an extended role for the still contentious Private Finance Initiative (PFI). The latter will yield £7 billion of new capital investment by 2010.

A new private/public partnership – the NHS Local Improvement Finance Trust (LIFT) – will see up to 3,000 family doctors' premises substantially refurbished or replaced by 2004.

Investing for improvement

- Over 100 new hospitals between 2000 and 2010
- 7,000 extra beds in hospitals and intermediate care by 2004
- 1,700 extra non-residential intermediate care places
- 20 Diagnostic and Treatment Centres by 2004
- 500 new one-stop primary care centres, housing GPs, dentists, opticians, health visitors and social workers
- 250 new scanners, 45 new linear accelerators and other equipment
- Modern IT in NHS facilities, including patient access to electronic personal medical records and electronic prescribing by 2004
- Clean wards, better food, bedside televisions and telephones

One point to note is the contribution to the wider transformation of primary care to be made by IT solutions, the more holistic primary care centres, and the extension of intermediate care.

NHS staff

Arguably the prime issue for the Government lies in the numbers and practice of NHS staff. The Plan itself acknowledges that the biggest constraint facing the NHS is the shortage of staff of all kinds, including doctors, nurses and therapists.

Investing in NHS Staff

- 7,500 more consultants and 2,000 more GPs by 2004
- 20,000 more nurses and over 6,500 more therapists by 2004
- Central funding for specialist registrar posts
- 1,000 more medical school places, in addition to 1,100 already announced, by 2005
- A new pay system for all NHS staff, and extra pay in shortage areas
- Childcare support, including 100 subsidised, on-site nurseries by 2004
- Improvements in occupational health and the working environment
- £140 million more for staff development, and a Leadership Centre

Expanding training provision is a crucial but medium-term measure, given the years it takes to train health professionals. Retention of staff is equally critical. Both pay and the working lives of NHS staff need to be improved, to make working in the NHS more attractive. Discussions on a new pay system are underway. A new Market Forces Supplement for shortage areas will be introduced quickly. By April 2003 NHS employers are expected to be accredited against an Improved Working Lives Standard, with targets. Hospital-based nurseries will be subsidised by £30 per place per week.

And in the short-term, the Government intends to recruit more staff from abroad, (e.g. 5,000 nurses from Spain). This has generated concern in some developing countries about loss of trained

staff despite the UK's commitment not to recruit actively in such countries.

But such investment is not without strings. The NHS Plan envisages radical changes in staff roles, appraisal and contractual arrangements, particularly for doctors.

Changes for NHS staff

- All NHS doctors to participate in annual appraisal and clinical audit; rapid mechanisms for handling under- and poor performance, including a new National Clinical Assessment Authority
- The majority of GPs to join the Personal Medical Services scheme by 2004; a revised, quality-based national contract for the remainder
- The option for GPs to work on a full-time or part-time salaried basis
- Hospital care possibly to be consultant-delivered, dependent on
 - a new consultant contract, with mandatory appraisal, effective job plans, 7 fixed sessions per week (pro rata), more and larger bonuses;
 - new consultants to work exclusively for the NHS for 'perhaps' their first 7 years, providing 8 fixed sessions and more out of hours service
- New skills and roles for nurses, midwives and therapists, including running clinics, ordering diagnostic tests, prescribing drugs etc
- 1,000 nurse consultants by 2004, and new consultant therapists
- 'Modern matrons' with clear authority on the wards
- Strengthened regulation of the clinical professions

All this represents a major challenge, both to secure the changes and to attract staff. The Plan makes clear that if agreement cannot be reached on a new consultant contract, it will review the option of creating more non-consultant career grade posts.

Simply announcing the new incentives is not immediately proving sufficient to resolve retention problems. In October 2000 the Royal College of Nursing warned that chronic nurse shortages (with 20,000 current vacancies), compounded by new evidence that nurses' posts were being downgraded to save money, could put the Government's plans to modernise the NHS in jeopardy.

NHS systems and structures

These changes for individuals will be reinforced by changed systems and structures.

In theory, the streamlined centre will focus on setting standards and targets, monitoring performance, providing backup to assist modernisation of the NHS and, where necessary, correcting failure. It is pledged to devolve responsibility to NHS organisations progressively as performance improves, on the principle of 'earned autonomy'. To old NHS hands this litany has a familiar ring. Time will tell whether those now at the top of the Department of Health (DoH) and NHS put it into practice more substantially than their predecessors.

Changed systems for the NHS

- Streamlining at the top of the DoH, with a single, more autonomous Chief Executive responsible for public health functions, the NHS and social services and reporting to a new NHS Modernisation Board on delivery of the NHS Plan
- A leaner centre, with 'earned autonomy' for NHS organisations
- Core national standards and targets
- A Modernisation Agency to support best practice and improvement
- A mandatory reporting system for adverse healthcare events
- Independent inspection by the Commission for Health Improvement (CHI)
- Independent publication of performance information
- A £500 million Performance Fund to reward good performance, and intervention in the case of poor performance
- Local government to scrutinise the NHS locally

What is certainly new is the nexus of:

- *standards and targets*, as in National Service Frameworks for key conditions, and the Performance Assessment Framework as the basis for classifying NHS organisations as 'green', 'yellow' and 'red', and for publishing annual performance league tables

- *support and guidance* on best treatments from the National Institute for Clinical Excellence (NICE), and on service redesign from a new Modernisation Agency

- *inspection* of all NHS bodies every four years by the CHI

- *incentives and sanctions*, with the best (green) NHS organisations rewarded with greater autonomy and automatic access to money from the National Performance Fund, and the worst (red) legally required to produce a recovery plan, having their spending overseen by the Modernisation Agency, and being inspected by CHI every two years.

The aim is entirely laudable. The caveat is whether so many different bodies – NICE, CHI, the Audit Commission, the DoH's regional offices, the new Modernisation Agency and local Modernisation teams – can successfully coordinate a consistent, coherent, and encouraging message to beleaguered NHS organisations.

For many in the NHS, structural change remains the order of the day. By 2004 all Primary Care Groups are expected to become Primary Care Trusts.

And the NHS Plan offers a new option of integrated Care Trusts to commission and deliver social care as well as primary and community healthcare. This is an innovative and important experiment in overcoming the vexed division between health and social care.

Capacity will be a critical factor in meeting the Plan's targets. A long-needed concordat with the private sector will allow the NHS, as necessary, to harness the resources of private and voluntary providers to diagnose and treat more NHS patients, and to develop other forms of cooperation, for example in research and development and a new NHS occupational health agency, NHS Plus. The concordat also covers the involvement of private and voluntary sector organisations in local health planning and locally agreed protocols.

Health and inequality

One striking feature of the NHS Plan is the presentational predominance of service delivery, given the Government's earlier emphasis on broader health issues. Health and inequality are not tackled until Chapter 13 of the Plan, and even then the proposals are notably less developed. This doubtlessly reflects the political reality that the public is more concerned about

the state of health services than less tangible public health issues. Nonetheless, combating health inequality remains a prime concern.

There is a strong emphasis on targets to reinforce the cross-governmental focus on health and inequalities. And by 2003, following a review of the existing weighted capitation formula used to distribute NHS resources, increased resources will go to deprived areas.

Inequality targets

- ■ The PSA national health inequalities targets
- ■ By 2002 a new health poverty index to combine data about health status, access to health services, uptake of preventive services, and opportunities to maintain health
- ■ Reducing inequalities as a key criterion for NHS resource allocation by 2003
- ■ Action to reduce inequalities to be assessed through the NHS Performance Framework
- ■ New formulae and incentives to improve the distribution of primary care staff; Medical Practices Committee abolished
- ■ New screening programmes
- ■ Free fruit for young school children

Other measures include concerted action on child poverty; a new National School Fruits Scheme to give all nursery and 4–6 year old infant school children a free piece of fruit per day; expanded screening programmes; and action to combat smoking, and drugs and alcohol-related crime.

NHS patients

The NHS Plan is designed to ensure that the NHS meets patients' expectations of a modern health service. With quality of service as a constant backdrop, it focuses on four concerns: waiting, convenience, range of provision and patient empowerment.

Reduced waiting is ranked as the second priority (after more and better paid staff) in the public consultation. Hence the Public Service Agreement includes waiting targets for both hospitals and primary care – plus a further Plan target of a maximum four hour wait in Accident and Emergency departments. Waiting is the

proxy for the performance of the NHS as a whole.

Allied to this are wider issues of patient and user convenience.

The Plan reaffirms Government commitment to a comprehensive and adequate NHS. This entails easier access to routine screening, intermediate care, and by 2001 the offer to all of NHS dentistry, which had almost withered away in some parts of the country. Nationally only 44 per cent of adults are currently registered with an NHS dentist.

Improved services for heart disease, cancer and mental health will be priorities: expanded cancer screening and provision of cancer drugs, rapid access chest pain clinics by 2003, and 335 immediate response mental health teams.

Ensuring patient convenience

- ■ NHS Direct as a one-stop gateway to out of hours healthcare by 2004
- ■ Better out of hours pharmacy services, more over the counter medicines, repeat prescriptions from the pharmacist, and delivery of medicines to the patient's door
- ■ More tests and treatment in primary care from hospital consultants and up to 1,000 new specialist GPs
- ■ On the spot booking systems for hospital appointments
- ■ NHS Direct nurses to check on older people living alone
- ■ Free translation and interpretation in all NHS premises via NHS Direct

Meeting the needs of older people

Following heavy criticism, special provision, including expenditure of an additional £1.4 billion on health and social services, is planned to secure the dignity, security and independence of people over 65, who account for two-thirds of hospital patients. Ageism is not to be tolerated.

These measures are not insignificant. But the Lancet editorial on the publication of the NHS Plan expressed concern that the changes would benefit only a tiny proportion of the UK's older population. There was wide disappointment that the Government had rejected the majority recommendation of the Royal Commission on

Serving older people

- A National Care Standards Commission in 2002 to drive up standards in domiciliary and residential care
- A National Service Framework on services for older people
- Resuscitation policies in all NHS organisations
- A pilot in 2001 of a free NHS retirement health check
- Breast screening for women aged 65–70
- Personal care plans
- A new Care Direct service, more home care and support, as well as more intermediate care
- Subject to Parliament, free nursing care in nursing homes
- But not free personal care

Patient Information and Empowerment

- A Patient Advocacy and Liaison Service (PALS) in every Trust by 2002
- Reform of procedures for complaints and 'informed consent'
- A new NHS Charter by 2001
- The abolition of Community Health Councils in favour of a Patients' Forum in every Trust and a local advisory forum in every HA
- Patient and/or citizen representation on the NHS Modernisation Board, each Trust Board, CHI teams and a new Independent Reconfiguration Panel to advise on contested major service changes
- A new Citizens' Council to advise NICE on clinical assessment

Long Term Care for all personal care in nursing and residential care homes to be free.

Patient involvement

Finally, several new or refashioned mechanisms are intended to support and inform patients, and enhance their influence within the NHS. NHS Direct – online, by telephone, by digital TV – will provide information to guide self-care. Information on GP practices will promote real choice of doctors. Patients will be copied letters between clinicians about their care, as well as having access to their own records – preferably in future via smart cards, subject to feasibility studies. Patients are to have a voice through new representation mechanisms.

Conclusion

On the plus side, the Plan provides a heartening vision of what the long-valued NHS could be like. The Plan is brave, bold and optimistic, offering an appealing marriage of modern practices and technology (NHS Direct, electronic patient records) and traditional values and common

sense (reaffirmation of NHS principles, modern matrons). It genuinely seeks to shape services around patients' needs and wants. And it is supported by real extra cash, including a welcome investment in facilities after years of denial.

But there are points to watch. Most crucial will be the NHS' ability to attract and retain the requisite numbers of staff – and that still looks problematic. Next, can the NHS cope with so much, so fast – especially the very ambitious (though very popular) waiting targets? Can the NHS assimilate so much guidance and inspection without the disaffection provoked in the education sector? Organisationally, are roles and responsibilities clear? Can the many different bodies – NICE, CHI, the new Modernisation Agency and local Modernisation Boards, the DoH's regional offices, the Audit Commission, specialty Czars, PALS – coordinate a consistent, coherent and encouraging message to beleaguered NHS staff? Will the fusion of health and social care prove manageable? Time will tell.

Key Documents

The NHS Plan: A plan for investment, a plan for reform. Cm 4818-I London 2000

Prudent for a Purpose: Building Opportunity and Security for All

2000 Spending Review: New Public Spending Plans 2001–2004. Cm 4807 London 2000

The World Health Report 2000. Health Systems: Improving Performance. World Health Organization 2000

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

Saving Lives: Our Healthier Nation. Cm 4386 London 1999

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"With Respect to Old Age: Long Term Care – Rights and Responsibilities". Cm 4192-I London 1999

Independent Inquiry into Inequalities in Health Report. Stationery Office 1998

Smoking Kills. Cm 4177 London 1998

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

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

Websites

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

Information on how the NHS works can be found at www.nhs.uk

The NHS Plan is at www.nhs.uk/nhsplan

Quality health information and advice can be found at www.nhsdirect.nhs.uk

Details of the Spending Review 2000 are at www.hm-treasury.gov.uk/sr2000/index.html



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