



National Audit Office

focus

Synopsis of National Audit Office findings on the Department of Health and NHS



Welcome...



Welcome to the autumn 2007 issue of Health Focus, setting out our health-related work from the past year, as well as some of our future projects. I hope you will find this both informative and relevant to your work. Of course audit is not only about holding to account, it is also about identifying and highlighting good practice. Our work looking across the whole of the NHS in England throws the spotlight on many examples of innovation and local initiative benefiting patients and improving performance from which others can learn.

Since the last edition of this briefing in the autumn of 2006, we have published five Value for Money (VFM) studies relating to the NHS, produced a range of other outputs and publications, and held a number of conferences. All of our reports have been examined by the Committee of Public Accounts, the senior Select Committee of the House of Commons. The Committee produces its own reports and recommendations to which the government must respond in the form of a Treasury Minute. Full copies of these reports and related materials are available from our website (www.nao.org.uk), together with a back catalogue of previous reports and health issues, and the website of the Committee of Public Accounts (www.parliament.uk/parliamentary_committees/committee_of_public_accounts.cfm).

The most recent of the above reports have been conducted against a significant background of change of approach and organisation of the NHS and, where appropriate, our reports reflect this. Likewise, the National Audit Office has recently seen some important changes in its health team. Most notably, I have taken over from Anna Simons as the Assistant Auditor General with responsibility for health. I look forward to the unique challenges this sector presents and hope to meet many of you over the coming months. We have also welcomed Mark Davies who will work alongside Karen Taylor as one of our two Directors of Health Value for Money audit, taking over the work of Chris Shapcott. Sid Sidhu and Claire Rollo maintain their responsibility for financial audit. Claire, who is now based in Newcastle, is focused on the Department of Health, the NHS Summarised Accounts and our report on Financial Management in the NHS, while Sid focuses on Arm's Length Bodies and Foundation Trusts.

Finally, as always, we welcome your input and ideas for areas that you think we should examine, and are keen to respond to your needs. If you feel an NAO examination could improve the delivery of a service, help identify and spread good practice or highlight areas of concern, we would like to hear from you. Please do not hesitate to contact me directly at michael.whitehouse@nao.gsi.gov.uk.

A handwritten signature in blue ink that reads "Michael Whitehouse". The signature is written in a cursive style and is positioned above a horizontal line.

Michael Whitehouse, Assistant Auditor General

Improving Quality and Safety – Progress in Implementing Clinical Governance in Primary Care: Lessons for the new Primary Care Trusts (January 2007)



The Health Acts of 1999 and 2003 set out a statutory 'duty of quality' for all providers of NHS services.

At the local NHS level, this duty of quality is discharged largely through implementing clinical governance. Since the first Primary Care Trusts (PCTs) came into being in 2001, they have had the dual role of providing primary care services and commissioning services on behalf of their local health economy with accountability for PCT performance vested in the PCT Chief Executive. Clinical governance, implemented effectively, can provide PCT Chief Executives with assurance that healthcare, whether provided directly or commissioned from other providers, is both safe and of good quality.

Our report found that the organisational structures and processes for clinical governance have largely been put in place at PCT level. But progress in implementing the different components of clinical governance varies both within and between PCTs. Whilst quality and safety are now more overtly monitored and managed with more explicit accountability of clinicians and managers for clinical performance, more needs to be done to strengthen the systems that provide

assurance about the performance of General Practitioners and which protect the safety of patients. We identified that the areas of greatest need for attention to ensure quality and safety in future PCTs were: leadership development; sustaining partnerships and joint working with social care; developing Practice-based Commissioning; and benchmarking of commissioning, specifically commissioning for quality.

Our recommendations include the following:

- In developing its guidance for PCT commissioning, the Department should ensure that quality is an explicit requirement and that there are clear measures in place by which Strategic Health Authorities and regulatory bodies can monitor that PCTs are including quality in their commissioning activities;
- Strategic Health Authorities should put in place effective oversight of accountability arrangements – as suggested by the Department's proposed Practice-based Commissioning governance and accountability framework – so that clear lines of accountability for clinical governance are in place throughout the system including handling of potential conflicts of interest; and

‘more needs to be done to strengthen the systems that provide assurance about the performance of General Practitioners and which protect the safety of patients’

- Primary Care Trusts, supported by their Strategic Health Authorities, should develop a strategy for engaging independent contractors in the clinical governance agenda.

In addition to the published report we provided guidance in the form of a set of Key Questions for PCT Boards to help boards maintain their commitment to evaluating progress and ensure an effective and safe transition to the new NHS. We also provided feedback reports to PCTs to enable them to benchmark their progress against other PCTs.



Dr Foster Intelligence: A Joint Venture between the Information Centre and Dr Foster LLP (February 2007)



In April 2005, the Department set up a new arm's length body, the Information Centre (for Health and Social Care), comprising the Department's Health Statistics Unit and the NHS Information Authority. The Department's goal was to improve the collection, analysis and use of information, but it considered that the Information Centre lacked certain skills and expertise and that the quickest way of acquiring these skills was a partnership with the private sector. It entered into exclusive discussions with Dr Foster Ltd, a private company with a high public profile in NHS data dissemination.

The Information Centre paid £12 million for a 50 per cent share in the joint venture, some 33 per cent more than their adviser's valuation, including a strategic premium of between £2.5 and £4 million. It also spent some £2.5 million on professional fees. The Department and the Information Centre did not open

‘there was a real risk that this joint venture may result in a less competitive health informatics market’

the opportunity to competition as they believed that Dr Foster was the right strategic choice, based on the market analysis and due diligence carried out during the negotiations.

Our report concluded that, by not going to tender or advertising the opportunity to the market, the Department and the Information Centre entered into a transaction that carried the risk of legal challenge. Also, without a competitive process the Information Centre had no fair comparisons or benchmarks to demonstrate that the joint venture with Dr Foster was the best structure to meet its needs, or that it represented good value for money. We also considered

that there was a real risk that this joint venture may result in a less competitive health informatics market.

Our recommendations include the following:

- The Department should require that all public-private partnerships are advertised within the European Union;
- The Department should maintain a competitive bidding process as far as possible or, in the absence of appropriate competitors, ensure adequate benchmarks exist to measure value for money; and
- The Information Centre should expedite the further deployment of policies to ensure that fair and equitable access to data can be demonstrated at all times.

Pay Modernisation: A New Contract for NHS Consultants in England (April 2007)



The new NHS consultants' contract, implemented in 2003, aimed to improve the working lives of consultants while giving the NHS more control over its medical professionals. It was the first major change to the contract for NHS consultants in over fifty years. The Department of Health expected that the new contract would improve the quality of, and ease of access to, care for patients by encouraging consultants to work differently.

The report found that, in negotiating the contract, the Department did not collect robust evidence on the actual numbers of hours worked by consultants in the NHS. As a result workloads were underestimated, undermining the Department's ability to cost the new contract accurately. In addition, most NHS trusts did not set cost boundaries when negotiating consultant job plans under the new contract and agreed more hours than they had budgeted for, leading to cost-overruns. By March 2006, three years after it had been implemented, the contract had cost the Department at least £150 million more than its initial estimate of £565 million.

The report highlighted the potential benefits that the contract was expected to deliver for the NHS but found that many benefits had yet to be realised. Whilst there is greater transparency about the hours that consultants work in the NHS and the duties they undertake, as yet, consultants are not working sufficiently differently. Consultants

also reported that they were providing less direct clinical care than before the new contract. And although the number of consultants working in the NHS increased by 13.2 per cent in the two years following contract agreement, the amount of consultant-led activity had increased by only nine per cent. Since few trusts had attempted to measure consultant productivity and ONS figures for 2005 and 2006 are yet to be published, it is too early to tell what impact the contract has had, if any, on consultant productivity.

Our recommendations include the following:

- The Department should ensure that it models all significant policy changes at key points to ensure that all different scenarios are better understood and fully costed;
- NHS trusts should work in partnership with consultants to improve the planning of their workloads, with further aligning of the work of consultants with the needs to patients;
- NHS trusts should consider using information technology solutions to help them administer, collate and regularly review job plans of consultants; and
- NHS trusts should strengthen clinical management to ensure all medical and clinical directors have the skills and time to implement job planning effectively.

‘workloads were underestimated, undermining the Department's ability to cost the new contract accurately’

Prescribing Costs in Primary Care (May 2007)



There were around 752 million prescriptions dispensed in primary care in England in 2006, at a cost of more than £8 billion.

By examining PCT prescribing patterns between August 2005 and July 2006, we concluded that the NHS could save at least £200 million a year, without affecting patient care, through more efficient prescribing. These savings could be achieved by prescribing a higher proportion of lower cost clinically effective medicines rather than more expensive branded equivalents. In our report we also highlighted the significant cost to the NHS – at least £100 million a year – arising from the wastage of prescribed drugs; and we conclude that both under and over prescribing, whenever they occur, represent poor value for money.

We explored which methods have proved effective in changing GPs' prescribing behaviour, and highlighted five areas which our research found to be particularly effective at driving efficient prescribing. These areas are:

- Communication from trusted sources and local opinion leaders



- Financial incentives
- Provision of tailored comparative (benchmarking) information to GP practices
- Provision of practical support such as pharmacist time to GP practices
- A coordinated approach to prescribing across the primary and secondary care sectors

Our recommendations include the following:

- The Department should build on the 'Better Care, Better Value' statin prescribing indicator to develop further metrics, across a larger proportion of the primary care drugs bill, that PCTs can use to quantify achievable improvements in areas of high prescribing volume and against which they can assess themselves;
- The Department should commission the NHS Business Services Authority and the Information Centre (Prescribing Support Unit) to collaborate in developing prescribing benchmarking tools for PCTs that improve on the currently available electronic prescribing analysis and cost data by incorporating local prevalence information;
- The Department should update the 1996 survey of residual medicines to come up with a more robust estimate of the scale of medicines wastage in England, and better information on why patients don't take their drugs; and

'we concluded that the NHS could save at least £200 million a year, without affecting patient care, through more efficient prescribing'

- Strategic Health Authorities should ensure that PCTs integrate approaches to prescribing across primary and secondary care, to ensure that patients discharged into primary care have their medicines reviewed regularly, that costly drugs are not continued for longer than necessary, and that there is consistency between GPs' and consultants' choices of drugs.

In addition to the published report we also produced a guide entitled *Influencing Prescribing Cost and Quality in Primary Care: A Suggested Communication Plan for Prescribing Advisers*. This was developed in conjunction with an expert adviser to the pharmaceutical industry on how to communicate with, and market products to, GPs and their practices. We also had extensive input from the National Prescribing Centre, the Medicines Management team at Keele University, and several practising prescribing advisers, to make the guide as informative as possible. The guide aims to help medicines management teams to design and execute communication strategies that are effective in driving change and ensuring PCTs' prescribing policies are implemented.

Improving Services and Support for People with Dementia (July 2007)



Dementia presents a significant and urgent challenge to health and social care in terms of both numbers of people affected and costs.

At least 560,000 people in England have dementia and it is estimated to cost the economy £14.3 billion a year. This figure includes direct costs to the NHS and social care of £3.3 billion a year. The ageing population in England means that the number of cases of dementia is predicted to rise by over 30 per cent in the next 15 years.

Our report highlights that dementia has not received the priority status from the Department of Health, the NHS or social care that it deserves. It has suffered historically from poor awareness and understanding; and there is a widely held perception that little can be done and a lack of urgency attached to diagnosing and treating the condition. Failure to diagnose and treat patients with dementia can impair quality of life of people with dementia and their carers and can also lead to inefficiencies in the system. For example, people with dementia make up half of those whose discharge from hospital is delayed. In the case of older people admitted to hospital with hip fracture, we found that the effective identification of dementia and more proactive, coordinated management of their care and discharge could produce savings of between £64 million and £102 million nationally.

Our report found that much needs to be done to improve health and social care services for people with dementia. Too few people are being diagnosed early enough and early interventions that are known to be cost-effective, and which would improve quality of life, are not being made widely available. This results in spending at a later stage on necessarily more expensive services. Services in the community, care homes and at the end of life are not delivering consistently or cost-effectively against the objective of supporting people to live independently as long as possible in the place of their choosing. The Department needs to actively champion and co-ordinate improvements in dementia services and provide strong and transparent leadership for dementia management in order to improve diagnosis and early intervention, management of services and support in the community and gearing up the system as a whole to respond to the challenges of dementia in the future.

Our recommendations include the following:

- The Royal College of Psychiatrists and the Royal College of GPs should take the lead (working with others) in developing a multi-professional protocol for diagnosis and early intervention in suspected dementia;

- The Department should consider commissioning campaigns to raise awareness of dementia amongst frontline health and social care staff and the general public;

- The Department, Skills for Health and Skills for Care should work with the General Medical Council and the Royal Colleges to improve the coverage of dementia in undergraduate and postgraduate medical and nursing training, in view of the increasing number of patients a health professional is likely to come into contact with who have dementia. Similar consideration should be given to improving training for social care staff; and

- PCTs, working with GPs, should benchmark their performance in diagnosing dementia against expected prevalence and set local improvement targets.

We followed up publication of the report with a conference on *Improving services and support for people with dementia – Joining forces to improve dementia care*. We also gave away a copy of our *Journeys through Dementia* DVD, a moving film highlighting the experiences of people with dementia and their carers, to each of the 130 delegates who attended. Finally, we provided all Community Mental Health Trusts who responded to our survey with an individual feedback report to enable them to benchmark their performance in key areas.

PAC hearings and the Treasury's response

Once each of our reports has been examined by the Committee of Public Accounts, the Committee publishes its own report, to which the Government must respond, via a Treasury Minute. Here we focus on some of the Committee of Public Accounts' recommendations and the relevant Government responses.

Reducing Brain Damage: Faster Access to better stroke care

Recommendations by the Committee of Public Accounts include the following:

- **Stroke costs the economy £7 billion a year, including £2.8 billion in direct care costs to the NHS.** Stroke costs the NHS more than heart disease, and should receive the priority warranted by its impact and cost. To raise the profile of stroke with commissioners and clinicians, the Department of Health should work with the Healthcare Commission and the Royal College of Physicians to develop benchmarks for stroke care – for example the proportion of suspected stroke patients receiving a brain scan within three hours, or the proportion of stroke patients being treated on a stroke unit.

- **By increasing the proportion of stroke patients who spend the majority of their time in hospital on a stroke unit by 25%, around 550 deaths per year could be prevented.** Although most hospitals now have such a unit, only around two thirds of stroke patients spend time on one, and what constitutes a stroke unit varies considerably between hospitals. All stroke patients should be admitted to a specialist stroke unit as soon as possible following diagnoses of their stroke. The Department needs to communicate clear guidelines for an acceptable stroke unit and Primary Care Trusts should deliver acute stroke care through a stroke unit that meets these guidelines. The Department should set challenging targets to improve the proportion of patients treated on a stroke unit.

- **There are 640 patients per stroke consultant, compared with 360 patients per cardiac consultant.** The limited number of health professionals with training in stroke is a barrier to providing high quality acute care and rehabilitation. Future workforce planning targets should enable the NHS to move to a position where there are as many stroke consultants per patient as heart disease consultants per patient.

The Treasury Minute response to these recommendations included the following:

- Professor Roger Boyle has been appointed National Director for Stroke. Under his leadership the Department has established a dedicated stroke team and is developing a major new national stroke strategy to be published autumn 2007.
- Drawing on our economic modelling work, the Department has developed a stroke toolkit (the ASSET tool) that allows Trusts to benchmark their performance and quantify the benefits of key interventions. In December 2006, the Department published a commissioning guide for stroke services accompanied by a version of the ASSET tool specifically for commissioners.



- Professor Boyle published 'Mending hearts and brains' on 5 December 2006, setting out the clinical case for reconfiguration of stroke and heart disease services. This states that the stroke strategy will explore 'hub and spoke' models of provision, whereby patients could be taken to specialist centres for specialist care.

The Department no longer sets central workforce targets, but is working with the Workforce Review Team and the lead Post-Graduate Dean for Stroke to ensure limitations caused by the current level of stroke consultants are factored into their recommendations.

Tackling Child Obesity – First Steps

Recommendations by the Committee of Public Accounts include the following:

- Parents have not been engaged; the only initiative planned by the Departments (Health, Education and Skills and Culture, Media and Sport) that will directly target parents and children is a social marketing campaign, which will not be launched until 2007. The campaign should be started as soon as possible. It should present some simple but high profile messages and advice to parents, children and teachers, outlining the risks of obesity and show simple ways in which children can make a difference to their lifestyles.
- Despite embarking on a national programme to measure children in all primary schools in England, the Department of Health is still not clear about whether parents should be informed if their child is overweight or obese. The Departments decided originally that to protect children from stigmatisation and bullying, parents should not be informed. Reflecting the Committee's concerns, however,

the Department is now considering how and when parents could be informed. The Department should move quickly to disclose the information in ways that will help parents to address the dietary and exercise needs of their children.

The Treasury Minute response to these recommendations included the following:

- The Departments have made available an online calculator for parents to establish whether their child's weight is a problem, but it is not clear how this will be publicised and will be available to some parents only. In 2007-08, the Department of Health has added a section to the NHS Operating Framework prioritising the collection of data and is working with the Department for Education and Skills on producing updated guidance to schools. The Departments have commissioned research into parents' and children's attitudes towards weighing and measuring to inform their approach to feeding back the results to parents



Paddington Health Campus Scheme

Recommendations by the Committee of Public Accounts included the following:

- The Royal Brompton and Harefield NHS Trust and St Mary's NHS Trust had unreconciled organisational, clinical and financial interests and in the end the two Trusts took incompatible views of the way ahead. Capital schemes in the NHS should only proceed with more than one partner when there is a clearly identified single sponsor.
- Forecast cost increases over all current schemes exceed the 40% maximum addition to forecast capital costs which is allowed to correct for optimism bias. The allowance does not therefore adequately reflect Trusts' over-optimism on the costs of such schemes. To introduce a proper perspective on the likely affordability of schemes, the Department and the Treasury should agree on the

appropriate level of optimism bias for NHS capital schemes, based on experience to date.

- The Department was not adequately aware of the state of the Campus scheme because it viewed scheme development as a local issue. As a result it was slow to respond to the failure of the scheme to make progress. The Department should benchmark the capacity of its Private Finance Unit against similar Units in other Government Departments and against relevant Treasury guidance, to ensure that it has the capacity to provide sufficient support to procurement teams.

The Treasury Minute response to these recommendations included the following:

- Strategic Health Authorities (SHAs) will still have an important role in the approval of Business

Cases under the NHS principle of delegated authority, but at the most important stage – Outline Business Case (OBC) – the Department is also now responsible for approving OBCs with a capital value over £75 million.

- The Department will establish a performance management regime, also involving SHAs, to confirm that a scheme is remaining within its approval parameters.
- The Department has introduced Access Capacity Reviews for all major schemes at the OBC stage. These provide an objective, independent check on the activity and modelling assumptions to ascertain if these are realistic and properly suited to the needs of the local health economy. Reports on these reviews must be evidenced in the final OBC and are a condition of approval.

National Programme for IT in the NHS

Recommendations by the Committee of Public Accounts include the following:

- The Department has not sought to maintain a detailed record of overall expenditure on the Programme and estimates of its total cost have ranged from £6.2 billion up to £20 billion. Total expenditure on the Programme so far is over £2 billion. The Department should publish an annual statement outlining the costs and benefits of the Programme. The statement should include at both a national and local level original and current estimates of total costs and benefits, costs and benefits to date, including both cash savings and service improvements, and any advances made to suppliers.
- The Department's investment appraisal of the Programme did not seek to demonstrate that its

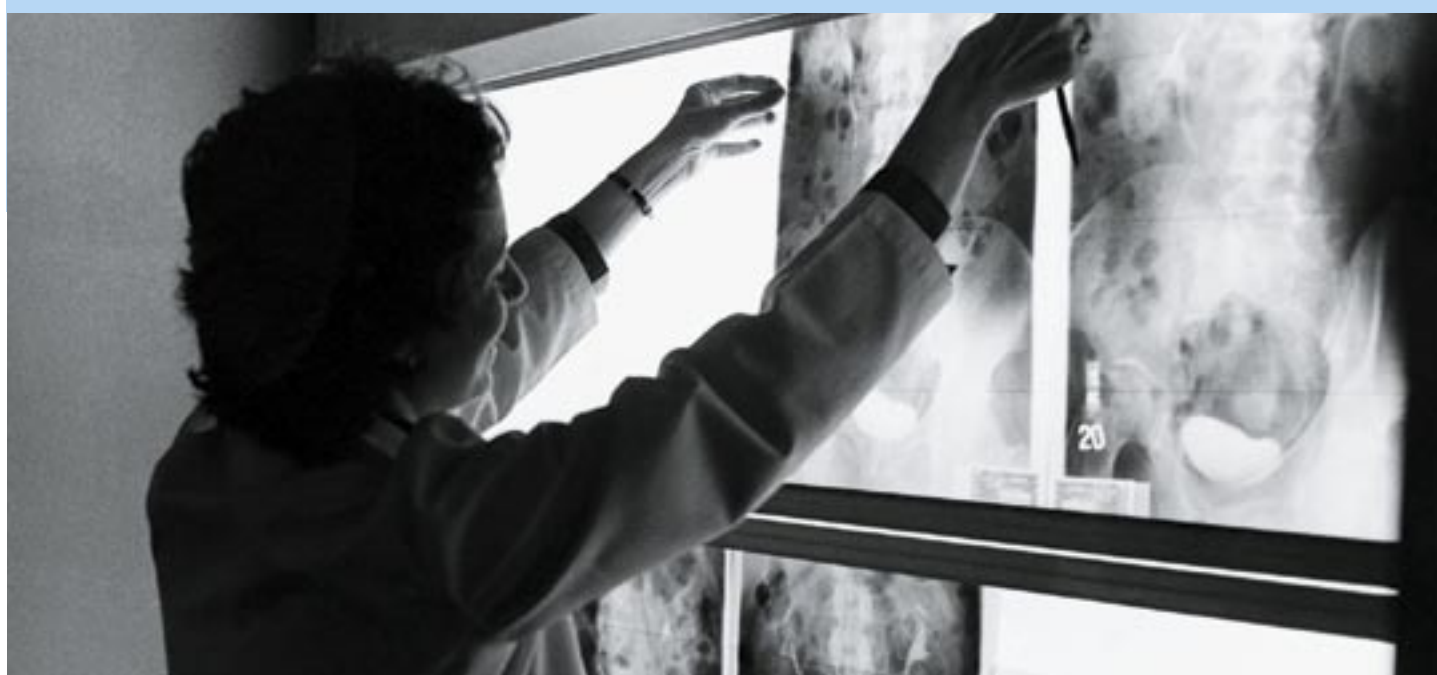
financial benefits outweighed its cost. The main justification for the Programme is to improve patient services, and the Department put a financial value on benefits where it could. The Department should also quantify non-financial benefits, even if they are not valued, to better inform decision making and to provide a baseline for work after implementation to ensure that the intended benefits are being fully realised. The Department should commission and publish an independent assessment of the business case for the Programme in the light of the progress and experience to date.

The Treasury Minute response to these recommendations included the following:

- A commitment to publish the first annual statement of the costs and benefits later in 2007/08. This will set out the process that the

Department is implementing, in partnership with the Strategic Health Authorities, to obtain evidence of the costs and benefits, which are expected to be derived from a mixture of actual and representative data. The statement will report on those first phases of live deployments where post implementation reviews have been completed. The data will also support the more extensive performance management framework, implemented in April 2007, to support the local NHS in its responsibilities to account for ensuring implementation of the Programme and the realisation of the benefits.

- A commitment to include details of both the financial and non-financial benefits within the annual statement of benefits realised.





Improving the use of temporary nursing staff in the NHS acute and foundation trusts

Recommendations by the Committee of Public Accounts include the following:

- Trusts have not taken a strategic and managed approach to controlling the demand for temporary nursing. Each trust should develop a local strategy to improve its understanding and management of demand for temporary nurses. The strategy should be underpinned by a clear understanding of the requisite establishment levels needed to provide safe and effective care, which IT-based workforce management and rostering systems could help to determine. Trusts should use a standard system for recording the reasons why booking temporary cover was deemed necessary. Directors of Nursing should compare booking information with information on staffing needs to determine compliance with the trust strategy on controlling demand.
- When booking temporary cover, ward staff do not have sufficient

information to determine the most cost-effective procurement route. Trusts should have arrangements in place to obtain temporary staff at best value, underpinned by performance measures to assess all suppliers (both in-house and external). Trusts should provide guidance to wards on the preferred route for booking temporary cover based on an objective and evidence-based assessment of the cost and quality of the different options including: using nurses from its own bank; whether NHS Professionals might provide a more cost-effective option; and the cost and quality of staff from the different nursing agencies.

The Treasury Minute response to these recommendations included the following:

- NHS Employers has been working on the development of a code of practice to address the employment and deployment of temporary staff. Contributions to this work have been made by the service managers and stakeholder organisations.

- The *Better Care Better Value Indicators (BCBVIs)*, including one on 'agency costs', were launched by the NHS Institute for Innovation and Improvement, supported by the Department, to assist trusts in benchmarking their performance against other trusts.
- NHS Employers will be highlighting mandatory training in their new edition of the Healthy Workplace Handbook, due to be published in October 2007.
- PASA has included annual mandatory training as a requirement of all its Agency Framework Agreements for temporary staffing.

As part of this study, we worked with the Department of Health and NHS Employers to develop a good practice guide on managing the use of temporary staff. This is available at: http://www.nao.org.uk/publications/nao_reports/05-06/05061176_Good_Practice.pdf.

We are planning to publish the following studies in the coming months:

Crisis Resolution Home Treatment (CRHT) Services

Crisis Resolution Home Treatment (CRHT) teams deliver acute treatment and observation at home to mental health patients suffering a temporary crisis in their condition. They are intended to provide an alternative to inpatient admission, allowing patients to be treated in the least restrictive environment with the minimum of disruption to their lives. Independent clinical evaluation of the working of CRHT shows that this model of services is preferable to inpatient treatment in appropriate cases, resulting in higher patient satisfaction and equal or better patient outcomes. However, these benefits can only be fully realised through effective implementation and integration of CRHT within the acute mental health care pathway.

The key questions for our study are:

- Are CRHT services seeing the patients they are supposed to see?
- Is England served by the correct number and distribution of CRHT teams to achieve the Department of Health's desired impacts?
- Do CRHT services remain economical and appreciated by service users?

We are working in conjunction with the Mental Health Advisory Group and the Healthcare Concordat (comprising other regulators and researchers in the field) and with the Acute Care Steering Group and CSIP CRHT regional leads who are acting as expert advisers.

To be published December 2007

Caring for Vulnerable Babies: The Re-organisation of Neonatal Services in England

Each year around ten per cent of all babies need some kind of special care at birth and demand for neonatal services is increasing due to a range of factors. In 2003 the Department of Health recommended the organisation of neonatal units into regional networks with the aim that the full range of care for mothers and babies should be provided within each network. This study aims to gather national data on how well neonatal networks are working and our main study question is: Are neonatal services delivering value for money?

Study methods include a census of all 180 neonatal units in England, structured interviews with staff at all 24 neonatal networks, telephone interviews with Strategic Health Authorities, analysis of existing research data on outcomes, international comparisons and consultation with parents and neonatal staff.

To be published December 2007



Arm's Length Body Review

In October 2003 the Department of Health announced a four year review and reconfiguration of its Arm's Length Bodies, aimed at improving efficiency across the sector and rationalising the number of bodies. The review aims to cut operating costs by £250m, achieve £250m of savings through improved procurement, cut the number of Arm's Length Bodies from 38 to 20 and reduce the number of whole time equivalent posts in the sector by 25 per cent. We are undertaking a study of the review. It will address the following issues:

- Have the outputs claimed by the Department been achieved?
- What have the Department done to ensure that the Review has not had a detrimental effect on the operations of the bodies involved?
- How has the way the Department managed the programme contributed to the outcomes achieved?

We hope to make recommendations applicable to the Department of Health and to other Departments with arm's length bodies.

To be published early 2008

Pay Modernisation: New contracts for General Practice Services in England

We are planning to undertake a study on the new contracts for general practice. This study is the second in a series of studies on Pay Modernisation in the NHS.

In 2004, the Department of Health introduced a new contract for general practices, with the intention of improving pay and conditions for GPs and improving patient care by allowing practices more flexibility in the services they provide. The contract also introduced a new incentive system, the Quality Outcomes Framework (QOF), which links pay and quality of services. This new General Medical Services contract (nGMS) is in addition to the existing Personal Medical Services contract (PMS), which covers around one third of practices. Primary care services can also be contracted using either the APMS

contract, for commissioning services from alternative providers, or the PCTMS contract, for directly employing primary care workers.

The study will address the question: Are the contracts for general practice providing the benefits expected of them? It will be evaluating the effectiveness of the development, communication, implementation and use of these contracts in delivering the expected benefits. In assessing the extent to which the aims have been achieved, the study will, where appropriate, make recommendations and spread good practice on how the contracts are used.

The study's methodologies include a survey of GPs; primary care trust census; case study visits to GP practices and NHS organisations; interviews with key stakeholders; data analysis and a review of existing research.

To be published early in 2008

Complaints handling in Health and Social Care

The Department of Health has announced plans in Our Health, Our Care, Our Say to develop a comprehensive single complaints system across health and social care by 2009. Our report will examine the current arrangements across both health and social care for handling complaints and highlight the strengths and weaknesses of the complaints handling systems so that conclusions and lessons can be drawn about how the systems have functioned, to inform the new arrangements. The study will assess the capacity, capability and effectiveness of the current systems and the risks that will need to be managed if the proposal for a single comprehensive system is to be implemented effectively.

To be published in Summer 2008.

Further details of our forthcoming studies can be found on our website at <http://www.nao.org.uk/publications/workinprogress/wipindex.asp>. All our reports will be made available online once they have been published.

Financial audit

The majority of our work on financial management and governance looks at the Department of Health and its arm's length bodies.

For 2006-07, all 24 of the Department's Arm's Length Bodies laid their accounts before Parliament before the summer break, with an average two day advance in the date of laying thanks to timely production of draft accounts. The Department's accounts will be laid at the beginning of October, some four weeks earlier than last year and the NHS Summarised accounts are due to be laid before Christmas alongside our report on financial management in the NHS.

The Department of Health, along with other central government departments, has been subject to a capability review over the summer. The action plan was published on 12 September to address the identified areas of weakness, and we will provide support wherever possible as the Department implements the action plan. More information on capability reviews can be found on the Cabinet Office website: <http://www.cabinetoffice.gov.uk/>.

Our last report on financial management in the NHS, (2005-06 HC 1092-I) was published in June 2006, and was considered at a PAC hearing in January 2007. Key recommendations included:

- That NHS bodies should take a whole organisation approach to managing risk, as those bodies who react best to financial pressures do so most effectively because they have the support and commitment from all parts of the organisation;
- That the management of change, including new policy initiatives and organisational restructuring, is made an early, Board-level priority to ensure that financial risks can be managed;
- That further progress is made on increasing the transparency of funding and reporting arrangements, to increase the clarity and comparability of the performance of NHS bodies; and

- That advances are made in the accounts preparation timetable, to secure the faster production of the national NHS accounts.

Our report for 2006-07 will cover the financial standing of the NHS for 2005-06 and 2006-07, how financial balance has been restored following a period of overall deficits, and the financial pressures which the NHS faces looking forward. We expect the report to be available at the end of 2007.

2007-08 will see the first application of International Financial Reporting Standards in producing opening balances for 2008-09 accounts. We are working with Treasury, the Audit Commission and the Department to identify potential issues and areas where further guidance will be needed for the health sector. The iFReM – financial reporting manual for central government – will be published shortly, and NHS Manuals for Accounts will follow.

Outside of our statutory audit responsibilities we have continued to provide focused reviews of aspects of financial management for our audit clients, and will provide a digest of good practice for the arm's length body sector in November. We have developed a number of tool kits, for example the efficiency and procurement toolkits, which are available on our website. We have also provided organisational health checks to several arm's length bodies on the overall ability of the body to achieve its aims.

We have recently helped the Appointments Commission to deliver training for NHS non-executives, focusing on the work of the Audit Committee in the NHS. We facilitated a day long workshop for the South West region with colleagues from the Audit Commission and local internal audit consortia, giving non-executives the opportunity to reflect on their own committee's effectiveness and bench mark against others while networking. We will be facilitating another workshop for the North East, Yorkshire and Humber regions after Christmas. More details are available from the Appointments Commission website: <http://www.appointments.org.uk/>.

Other output

Other products and guidance published in the last year that may be of interest to health managers and professionals

We have recently set up a number of Practice Areas, establishing formal networks of staff with common interests and experience in a particular subject. Externally, the Practice Areas aim to promote their capabilities and expertise to ensure we add value in these key areas of public sector management.

THE EFFICIENCY PRACTICE AREA

Acting as a centre of excellence for efficient working within the public sector, the Efficiency Practice aims to:

- **Generate efficiency** – we help public sector bodies improve their efficiency through Value for Money studies and good practice toolkits
- **Test efficiency** – we review reported efficiency gains to provide assurance on progress towards efficiency targets
- **Promote efficiency** – we promote the concept of efficiency to help improve public services by championing successful efficiency initiatives.

The Practice has developed two web-based toolkits:

- **The Efficiency Toolkit** – this is designed to provide practical guidance on assessing an organisation's current approach to achieving efficiency. It can be used to identify and explore areas for future efficiency savings.
- **The Consultancy Assessment Toolkit** – this provides a framework for reviewing the extent to which an organisation is achieving value for money from its use of consultants.

In February 2007 the Practice published its latest report on the progress of the Government's Efficiency Programme.

This is all available from the Practice's website:
<http://www.nao.org.uk/efficiency/>

THE PRIVATE FINANCE PRACTICE AREA

The Private Finance Practice covers a number of areas of public/private interaction; principally the Private Finance Initiative itself, Public Private Partnerships, privatisations, acquisitions and disposals. It brings together skills relating to markets, contracts and commercial financing that are now used extensively in the delivery of public sector projects and services.

The area has published the following reports in the past year:

- **Benchmarking and market testing the ongoing services component of PFI projects:** the report examined early examples of the public sector using contractual processes to benchmark and market test the value of these services. It found that value for money had been achieved through the value testing process in about half of the cases. In other cases, including some where the private sector negotiated price increases during these processes, the information available suggested it was uncertain whether value for money was likely to have been achieved through the value-testing process.

The report details lessons that have been learned in these early examples where services such as catering and cleaning were value-tested, and states that there is now new detailed Treasury guidance which public officials can call on when using these processes. Facilities services account for a substantial part of a PFI contract and, with increasing numbers of projects about to use value-testing, typically after five years of a PFI contract being in operation, the NAO has highlighted issues which officials need to keep in mind when using these processes.

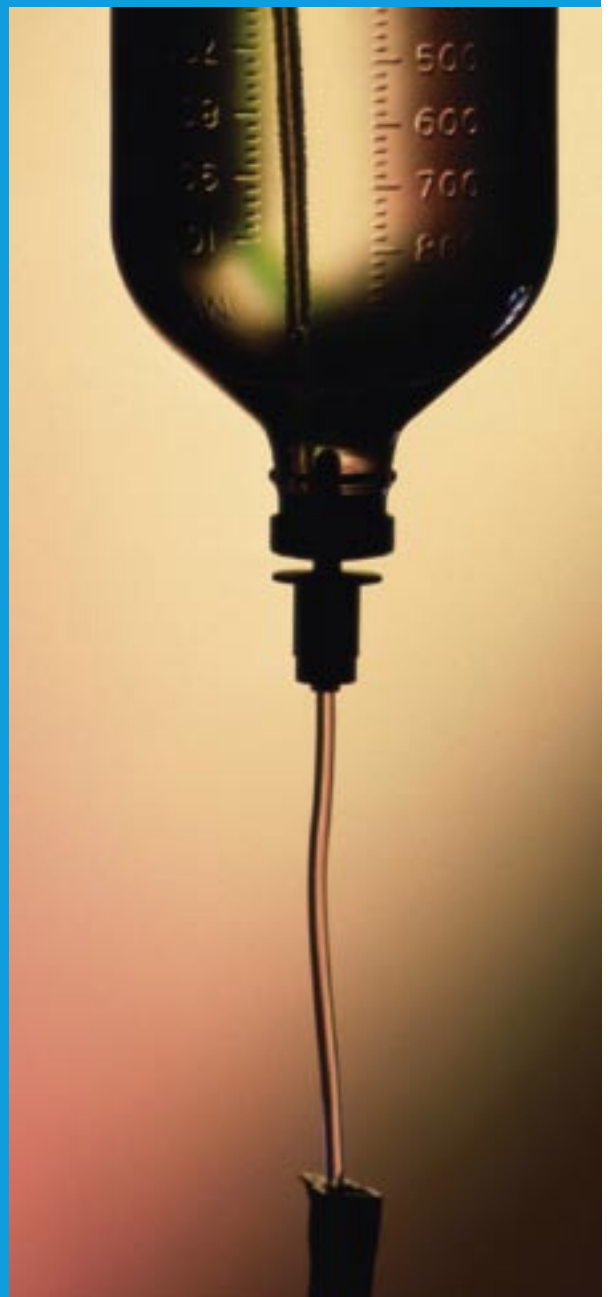
- **Improving the PFI tendering process:**

Our report examined the tendering process for all central Government Department PFI projects in England that closed between April 2004 and June 2006, including PFI schools and hospital projects. Tendering periods overall lasted a period of 34 months (38 for PFI hospitals) – no better than the average for projects that closed between 2000 and 2003. Value for money is most at risk in the final stage of negotiations with a single remaining preferred bidder. This final stage lasted 15 months on average. One in three projects examined made significant scope and specification changes to the project during this period amounting to 17 per cent of the total project value.

We describe the measures taken by the Government to improve the PFI tendering process: including the development and enforcement of standardised contractual guidance. Recommendations in our report add to these, calling for the introduction of testing target times backed up by improvements in project management and better use of existing expertise across government.

These reports, and those from previous years, are available from the Practice's website, along with a database of all recommendations from NAO and/ or PAC reports on the subject: http://www.nao.org.uk/practice_areas/private_finance/index.htm

‘It brings together skills relating to markets, contracts and commercial financing’



Other reports involving the Department of Health or health bodies

Evaluation of Regulatory Impact Assessments 2006-07

In our fourth evaluation of Regulatory Impact Assessments (RIAs), used to assess the need for, and potential impact of, new regulations, RIAs were sampled from the Department of Health and the Department for Communities and Local Government. While the majority of RIAs in the sample were competent, with fewer cases of poor quality analysis, there were continued weaknesses in the quality of cost-benefit analysis and insufficient consideration of the impact of the proposed regulatory changes.

Government on the Internet: progress in delivering information and services online

This report looked at the progress made by government in delivering services and information online since we last reported in 2002. Government has made progress in making a wide range of information available to the public through the internet. However, although internet users rate government websites reasonably well, the quality of those websites has improved only slightly since 2002. The report highlights the potential for better web-based information: for example to inform choice such as finding schools for children or choosing NHS hospitals for operations.

‘there were continued weaknesses in the quality of cost-benefit analysis and insufficient consideration of the impact of the proposed regulatory changes’



Sure Start Children's Centres

Sure Start is the Government programme to help give the best start in life for every child by bringing together early education, childcare, health and family support for pre-school children and families. The Government is delivering services for families, particularly disadvantaged families, through multi-purpose children's centres, with 1,000 established by September 2006 and plans for 3,500 centres in total by 2010.

We focused on the ability of the responsible local authorities to deliver value for money through sound financial management; reaching the most disadvantaged families; and monitoring their performance effectively. Our findings include:

- Health services, employment advice and childcare provision all require improved partnership arrangements, which may need to involve more formal local agreements about the services to be delivered through children's centres. Although



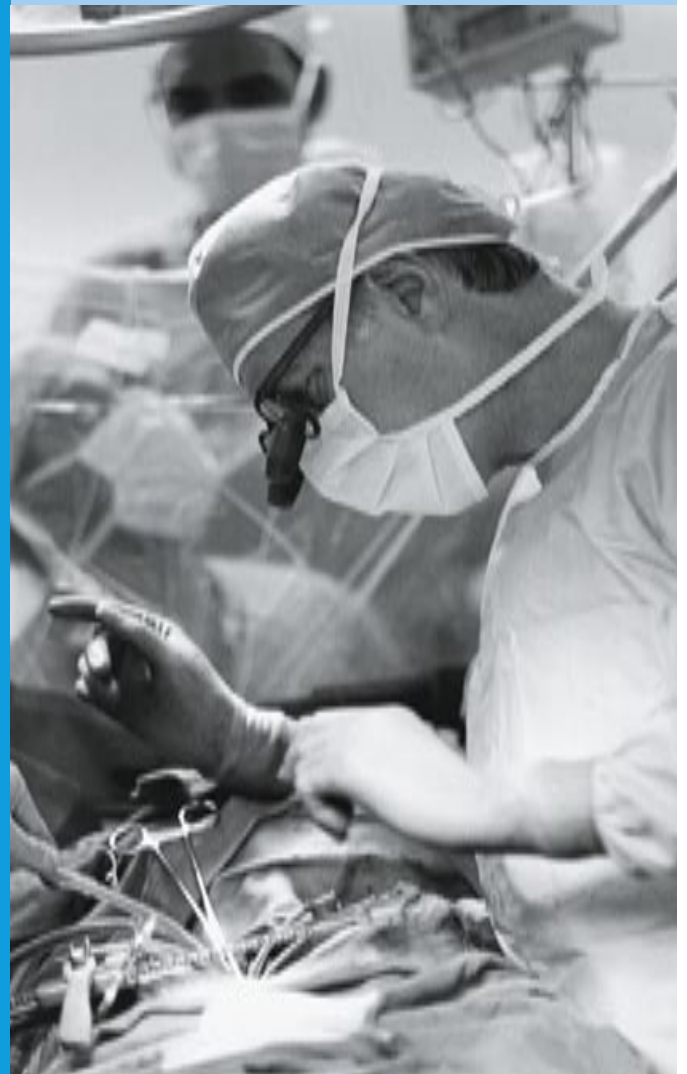
Our work and the Healthcare Concordat

The Healthcare Concordat is a voluntary agreement between organisations that regulate, audit, inspect or review elements of health and healthcare in England. It was launched in June 2004, led by the Healthcare Commission. There are now 20 signatories, including the NAO, working together to coordinate activities such as audits, reviews and inspections in order to reduce the duplication and overlap of work. Further information on the Healthcare Concordat can be found at www.concordat.org.uk

centre staff might be well trained in a particular field, working together needed additional skills and centre managers had an important role to play to equip their staff for new roles.

- The most disadvantaged families and children have the greatest need for the integrated services provided by children's centres. Most centres needed to do more to identify families with the highest needs, make them aware of the services on offer and help them to access these services.
- The costs and uptake of centres' various activities were not well understood, making it difficult for centres and local authorities to take informed decisions to move resources on the basis of priority and cost-effectiveness.

Full details of these reports and others can be found at: <http://www.nao.org.uk>



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