National Audit Office

FOCUS

Spring2009**Health**

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

Welcome

Welcome to the Spring 2009 issue of Health Focus, setting out our health-related work from the past eighteen months, as well as some of our future projects. I hope you will find this both informative and relevant to your work.

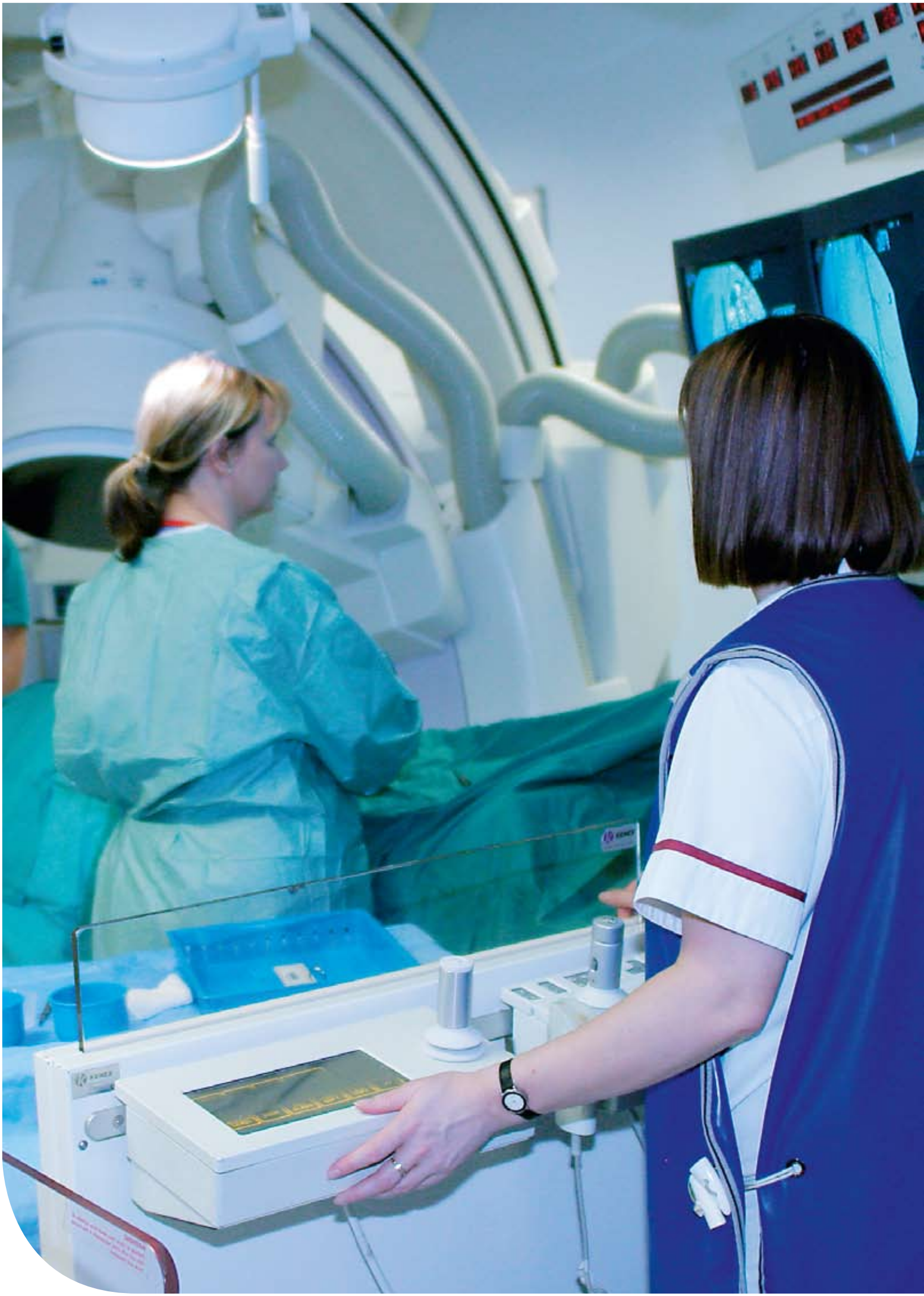
Since the last edition of this briefing in the autumn of 2007, we have published nine Value for Money (VFM) studies relating to the Department of Health, the NHS and social care. As well as serving as a mechanism for delivering accountability to the taxpayer, our VFM reports identify best practice and aim to make constructive and practical recommendations to improve services, whether directed at specific organisations or encouraging systemic change and reform. Most 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 on health issues, and the website of the Committee of Public Accounts *(www.parliament.uk/parliamentary_committees/committee_of_public_accounts.cfm)*. We have also produced a range of other outputs and publications, and held a number of conferences.

The National Audit Office (NAO) has seen some important changes over the past year. The position of Chairman has been created and Sir Andrew Likierman took up this post on 1 January 2009. Sir Andrew has a distinguished career in the accounting profession and academia, both in the public and private sectors. Further, Amyas Morse will take up post as Comptroller and Auditor General on 1 June 2009. Amyas joins the NAO from the Ministry of Defence, where he has served as Commercial Director since 2006. Before this, he was Global Managing Partner (Operations) at PricewaterhouseCoopers, having also held the role of Global Leader of Assurance practice (audit and related services) at the firm.

Over the last two years, I have remained as Assistant Auditor General with overall responsibility for the NAO's health work. Karen Taylor and Mark Davies have maintained their responsibility as Directors of Health Value for Money audit and we have welcomed Helen Feetenby and Dean Parker as our Directors of Health Financial audit, taking over the work of Claire Rollo and Sid Sidhu. Helen is focussed on the Department of Health, the NHS Summarised Accounts and our report on Financial Management in the NHS, while Dean 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**.

Michael Whitehouse, Assistant Auditor General



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NAO Report Findings

Helping people through mental health crisis: The role of Crisis Resolution and Home Treatment services (December 2007)

Crisis Resolution Home Treatment (CRHT) services have been developed to help people through acute mental health crises by providing intensive support in the least restrictive environment possible, ideally in their own homes. They are also intended to reduce inpatient admissions and bed occupancy, support earlier discharge from inpatient wards and reduce out-of-area treatments.

We examined the degree to which CRHT teams are fulfilling this intended role within the Department of Health's [the Department's] mental health service model. Our examination included a referral and admissions audit of CRHT teams and inpatient wards, a survey of referring clinicians, focus groups and feedback from service users and carers, economic modelling and data analysis covering team provision, activity, admissions and expenditure.

We found that CRHT teams have been rapidly implemented across most areas of the country, are supporting early discharge and have been associated with reduced pressure on beds. We also found, however, that only half of service users in acute wards had been assessed by a CRHT team before being admitted, and conversely that CRHT teams were receiving inappropriate referrals who were not potential candidates for admission. This suggested that other health professionals needed better awareness and understanding the role of CRHT teams.

We found that, while CRHT staff head-count nationally was at around 90 per cent of the estimated requirement, there were wide regional variations in provision relative to local need. Many teams lacked dedicated input from key health and social care professionals, particularly consultant psychiatrists, restricting their ability to provide comprehensive care and be integrated and accepted within local services. We estimated that an additional £10 to £30 million would be needed each year to increase capacity and improve multi-disciplinary input, but that doing so would help to realise savings of at least £12 million a year through reduced inpatient costs.

Our recommendations included the following:

- NHS organisations should assess CRHT capacity in the context of local need, and invest sufficient resources to make fully staffed 24/7 CRHT teams an integral part of the mental health care pathway. This should include full clinical input and support from consultant psychiatrists, both to provide appropriate skills and to encourage acceptance and knowledge of CRHT teams' role within local services.
- Clinical directors and service managers should encourage regular dialogue between CRHT and inpatient teams regarding referrals, admissions and discharges, and consider the use of staff rotation and joint roles between inpatient and CRHT teams.
- Provider trusts should enforce written policies requiring every inpatient admission to be preceded by a CRHT gatekeeping assessment. NHS commissioners should work with local mental health providers, acute trusts, GP practices and Local Implementation Teams to develop comprehensive local protocols for mental health referrals.

We followed up our report by presenting our findings at five regional service development conferences in England and Wales, and produced an additional qualitative research study on service user and carer experiences of CRHT services.

Releasing resources to the frontline: the Department of Health's Review of its Arm's Length Bodies (January 2008)

In 2004 the Department initiated a review of its arm's length bodies, with the aim of reducing expenditure, cutting posts and substantially reducing the number of such bodies. We found that the Department is on track to meet most of the key targets identified prior to the review. By the end of 2007-08, expenditure reduced by £555 million, against the target of £500 million, and the number of posts in the sector decreased by 27 per cent, compared with the target of 25 per cent. Over the same period, the Department spent £61 million on implementing the review, including redundancy costs of £47 million.

The report found that, while the Department did collect performance information on its arm's length bodies prior to the review, this was put into a standard format only in 2006-07. In the wider context of developments in efficiency measurement since 2004, there remain some areas in which further evidence would be required to quantify the overall value for money achieved. There are lessons for departments generally in managing change programmes, including having clear baselines for performance measurement at the outset and assessing wider value for money.

Considerable savings had been achieved simply through the Department closing down organisations. The closure of the NHS Information Authority, for instance, contributed to the £66 million savings made by the Health and Social Care Information Centre. The report highlighted that five organisations were identified for closure within five years of their opening.

Our recommendations included the following:

- Departments undertaking major change programmes should establish baseline performance information in order to assess the 'before and after' effect.

- The Department of Health should ensure that ongoing efficiency requirements on arm's length bodies and the existing good practice governance arrangements are maintained after the conclusion of the arm's length bodies review in 2008-09.

- After the arm's length bodies review concludes in 2008-09, the Department of Health should ensure that the robust arrangements now in place for assessing the purpose and value for money of arms length bodies are applied whenever new bodies are proposed.

Reducing Alcohol Harm: health services in England for alcohol misuse (October 2008)

Alcohol misuse costs the NHS an estimated £2.7 billion per year. In 2006-07, there were 811,433 alcohol-related hospital admissions in England representing a 71 per cent increase in four years. At peak times, between 12 midnight and 5am on weekday nights, nearly three-quarters of all attendances at Accident and Emergency departments were alcohol-related.

There has been a national alcohol strategy since 2004, which was updated by the Department and the Home Office in 2007. Since April 2008, the Department has been a partner in delivering a new Public Service Agreement (PSA) on alcohol and drugs, which includes an indicator on the rate of increase of alcohol-related hospital admissions.

Our report evaluated how health care interventions are being used to address alcohol misuse, covering: local arrangements for planning and commissioning health services; measures to prevent alcohol misuse; and specialist services to treat alcohol misusers. Our report found that local strategies are lacking or inadequate in many areas and service delivery is fragmented, with resources allocated based on an incomplete picture of need. The report concluded that service provision has varied widely, both in type and degree of provision.

Our recommendations included the following:

- In 2009, at the end of the first year of the new PSA, Strategic Health Authorities should assess the progress made by Primary Care Trusts (PCTs) in each region towards the PSA alcohol indicator, taking local action if agreed progress has not been made;
- The Department should provide a framework to allow PCTs to assess alcohol misuse within a PCT area;
- The Department should set a review point to assess how effectively the new codes used in primary care for recording the provision of identification, screening and brief advice are operating.

Feeding back? Learning from complaints handling in health and social care (October 2008)

The NHS receives around 130,000 complaints each year and spends some £89 million in handling and reviewing complaints. For adult social care, local authorities receive around 17,000 complaints with an associated cost of some £13 million. In January 2006, the Department proposed a new 'comprehensive single complaints system across health and social care', which would be introduced in April 2009.

Our report examined the performance, capability, capacity and costs of the two separate systems for NHS and adult social care complaints, together with the issues to be addressed if the Department's ambition for a single comprehensive system is to be realised.

Our report found that the current systems did not meet the criteria for an effective complaints system of being accessible, responsive, and demonstrating lessons were learned. Where people were dissatisfied, there was a low tendency for them to go on to make a formal complaint. The main reason why people did not complain was that they did not feel anything would be done as a result. The culture and attitudes of organisations are often a barrier to responsive complaints handling. Pursuing a complaint beyond the initial local stage required considerable time, determination and resilience on the part of the complainant. There was a lack of formal mechanisms or methods for capturing lessons from complaints for cross-organisational learning.

Our recommendations included the following:

- The Department needs to effectively explain the new arrangements to the public, service users, carers and providers of health and social care services. It must also explain the transitional arrangements, so that the risk of confusion in moving to the new system is reduced.

- The Department should make it a requirement for registration with the new Care Quality Commission that health and adult social care providers can show evidence of consistently acting on complaints.

- To support the ongoing development of learning between complaints managers locally, regionally and nationally, the Department should reinvigorate the existing Voices for Improvement Action Network of complaints managers to underpin the new system.

- The Department should develop a mechanism for capturing and disseminating lessons as a result of complaints locally, and for identifying general patterns across all complaints.

In addition to the report, we produced individual feedback reports for each NHS trust and local authority showing their individual data against the population of other trusts and local authorities and against comparator groups. These reports included questions for trusts and local authorities to ask themselves, in order to promote benchmarking as a means of providing assurance on their complaints handling performance. We also published a report on the complaints systems in other countries, which was prepared on our behalf by Evidence Consulting, and is available at **www.nao.org.uk**.

End of Life Care (November 2008)

In England, approximately half a million people die each year, almost two-thirds of whom are aged over 75 years. People approaching the end of their life often require a complex mix of health and social care services provided in hospitals, care homes, hospices and their own home. Most people would prefer to be cared for and die in their home but the number of people who are able to do so varies with age, geographical area and, most significantly, by condition.

We found that NHS and social care services are not meeting the basic needs of many people approaching the end of their life. Coordination between health and social care services is generally poor. There are wide variations in Primary Care Trusts' [PCTs'] expenditure on specialist palliative care services (from £154 to £1,684 per death) and in the availability of palliative care beds which fail to reflect local need. Seventy per cent of hospices have only one year contracts with PCTs and 90 per cent consider that they are not funded for the NHS services they provide.

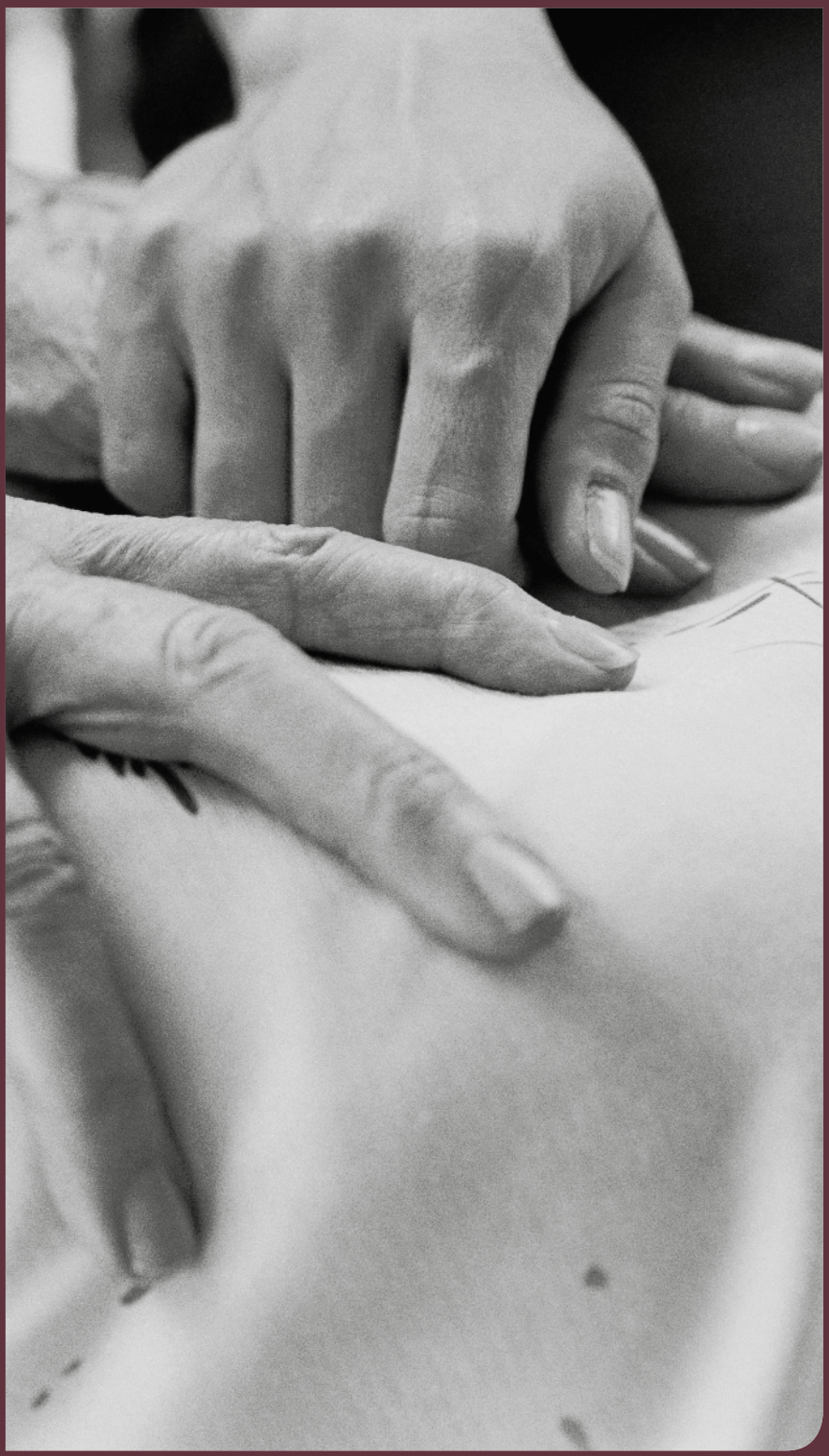
A lack of prompt access to 24/7 services and support in the community leads to people approaching the end of their life being unnecessarily admitted to hospital. There are significant gaps in end of life care education and training for most health and social care professionals and many care home staff have insufficient training in end of life care. Our detailed examination of patient records in one PCT found that 40 per cent of patients who died in hospital did not have a medical need to be there. Our modelling work showed that reducing emergency admissions of cancer patients by 10 per cent and their length of hospital stay by 3 days would enable £104 million to be redistributed for providing services that would better meet people's preferences over place of care.

Our recommendations included the following:

- The Department should provide more information and, as appropriate, guidance to assist PCTs to meet end of life care needs and allocate resources more efficiently and effectively by building on the evidence from our work;
- When working with local authorities in carrying out Joint Strategic Needs Assessments and developing priorities for Local Area Agreements, directors of public health should monitor whether the current provision of end of life care services and the needs of the local population are fully assessed and gaps addressed. PCTs should use our feedback reports on the results of our PCT census to evaluate the extent of their services;
- PCTs should work with independent hospices to develop three year contracts, based on commissioned services and levels of activity, to enable hospices to better plan the use of resources and develop services; and
- PCTs should explore the possibility of commissioning more services from hospices to support patients with conditions other than cancer. Such services could include the coordination of care in the locality, providing training to generalist staff working in other settings, and working in partnership with care homes to enhance the care that they provide.

In addition to our report we published other outputs. We provided PCTs and hospices with individual feedback reports and published summary reports on both. We also produced separate publications on the results of: our surveys of care homes, doctors and nurses; our focus groups of patients and carers; our economic modelling work; our survey of deceased patient records in Sheffield; and our reviews of end of life care services in City and Hackney, Herefordshire and Sheffield PCTs.

The Committee of Public Accounts held its hearing on 17th December 2008 and its report will be published shortly.



Pay Modernisation in England: Agenda for Change (January 2009)

The Agenda for Change programme, implemented between December 2004 and December 2006, aimed to reform and standardise the pay and conditions of around 1.1 million staff in the NHS in England (all those except doctors, dentists and senior managers). With the Knowledge and Skills Framework, which provides a way of defining the skills needed in a job as well as a process for reviewing an individual's knowledge and skills against that outline, it also aimed to give a structure for a career in the NHS.

We found that the Department and NHS, in partnership with the trade unions, successfully transferred some 1.1 million employees to the new pay system, but that most staff are not working sufficiently differently from when they were on their old pay contracts. The Department had placed no requirement on trusts to achieve efficiency or productivity improvements locally as part of implementing Agenda for Change, despite specifying in its business case an expected year-on-year rise in productivity of 1.1 – 1.5 per cent. Our modelling showed that Agenda for Change did not have a significant impact on the annual pay bill.

The Knowledge and Skills Framework, key to realising the wider benefits of Agenda for Change, has not been implemented by all trusts and for all staff. At the time of our fieldwork in August and September 2008, 54 per cent of staff had received a knowledge and skills review.

Our recommendations included the following:

- Trusts should have a champion at board level to make sure that: all staff have annual reviews; managers have the training to use the Knowledge and Skills Framework effectively; and staff have the time to participate fully in reviews. The champion should work with

operational colleagues to exploit opportunities where effective use of the tools within Agenda for Change and the Framework can contribute to wider organisational and service improvements through better, more productive ways of working.

- Directors of Human Resources in trusts should check that the job evaluation process is applied rigorously to all new and modified roles. Strategic Health Authorities and trusts should regularly compare and benchmark a sample of posts with other trusts.

- To motivate trusts to get more out of Agenda for Change the Department should recommend that trusts specify, within business cases for changes to the way services are delivered, how the planned improvements to patient care and/or productivity will be augmented by use of Agenda for Change, for example through the creation of new roles or a change in the grade mix of staff around a given patient pathway.

- The Department should collate information from individual trusts which shows how working differently under Agenda for Change has contributed to changes in productivity and patient care, so that there is a picture nationally of how Agenda for Change is delivering improvement.

PAC hearings and the Treasury's response

The following NAO reports have had a hearing of the Committee of Public Accounts (PAC) in the last eighteen months. In this section, we summarise the main recommendations of the PAC's reports and, where available, the responses from the Treasury Minute.

Prescribing costs in Primary Care

The NHS spends some £8 billion a year on prescription drugs in primary care in England. The continued development of new drugs for use in the NHS, the identification of new applications for existing drugs, and England's ageing population, mean that the cost to the NHS of prescription drugs in primary care is likely to grow. The NAO report examined the ways in which the Department could support doctors and other prescribers in their prescribing decisions, in order to achieve better value for money.

Recommendations in the Committee of Public Accounts' report (January 2008) included the following:

- The NHS could save more than £200 million a year, without affecting patient care, by GPs prescribing lower cost but equally effective medicines. Many drugs are available in both branded and generic versions, and the latter is usually much cheaper than the brand name drug, for which the manufacturers have to recover research and development costs.
- The proportion of lower cost prescriptions for some common conditions varies greatly between Primary Care Trusts (PCTs), for example between 28 per cent and 86 per cent for statins. Strategic Health Authorities should work with the National Prescribing Centre to spread best practice in prescribing and help those PCTs that have difficulty implementing switching programmes to learn from PCTs that have successfully done so.
- Comparing GP practices and PCTs on indicators of efficient prescribing is an effective way of influencing prescribing behaviour. The Department, in conjunction with the NHS Institution for Innovation and Improvement, should develop more prescribing indicators to measure the proportion of generics dispensed and the level of potential savings where more cost effective prescribing would generate significant savings.

The Treasury Minute Response to these recommendations included the following:

- The Department accepts the Committee's conclusion that the NHS could save around £200 million a year, without affecting patient care, by GPs prescribing lower cost but equally effective medicines. Substantial progress has already been made towards achieving these savings.
- The Department agrees that Strategic Health Authorities should work with the National Prescribing Centre to spread best practice in prescribing. Electronic systems maintained by the Prescription Pricing Division of the NHS Business Services Authority contain a range of indicators and comparators, which are useful to PCT prescribing advisers.
- As the Committee recommend, the Department is currently working in conjunction with the NHS Institute for Innovation and Improvement and the Information Centre for Health and Social Care to consider the feasibility of extending the range of indicators to other categories of medicine and therapeutic areas.

Pay Modernisation: a new contract for NHS Consultants in England

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. By March 2006, the contract had cost the Department at least £150 million more than its initial estimate of £565 million. Whilst 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. The NAO 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.

Recommendations in the Committee of Public Accounts' report (November 2007) included the following:

- Consultants' pay has, on average, risen by 27 per cent in the first three years of the contract compared to the Department's prediction of a 15 per cent increase. Higher pay has helped improve recruitment and retention and has halted a rising trend in the amount of private practice carried out by NHS consultants. The increased pay will only be justified, however, if the expected improvements to productivity are achieved. In return for their increased pay, consultants should increase their support for service redesign with the aim that productivity gains will be achieved by working differently.

- In the first two years of the contract, job planning for consultants tended to follow historical patterns of service provision, with insufficient links to organisational objectives and little consideration of redesigning services, such as introducing evening clinics, to meet patient needs. NHS trusts should agree job plans, in partnership with consultants or teams of consultants, which are consistent with organisational objectives and reflect feedback from patients. Whilst job plans should be renegotiated annually, managers and consultants should assess individual job plans more frequently and agree to modifications, where appropriate, if they fail to meet patient needs.

The Treasury Minute Response to these recommendations included the following:

- Consultant pay has increased broadly in line with the Government's intention which was to deliver, over time, a 15 per cent real terms increase in career earnings and a 24 per cent increase in the maximum basic salary. These increases were accompanied by a multi-year pay deal providing headline awards of 10 per cent over three years. The Department agrees with the recommendation that the contract was a "something for something deal" with investment in return for reform. The Department remains committed to ensuring continuous improvement in realising the benefits of this important change.

- The Department of Health commissioned NHS Employers to deliver a Large Scale Workforce Change Programme over ten months from October 2007. This was a fast-paced programme based around the consultant contract, and focused on sharing good practice to deliver benefits to patients, staff and employers. The specific aim was to help trusts and consultants to identify, articulate and share benefits and learning that have been secured through effective implementation of the contract.


Purell

Improving services and support for people with dementia

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 within the next 15 years.

Recommendations in the Committee of Public Accounts' report (January 2008) included the following:

- The Department should appoint a Senior Responsible Officer to drive through the dementia strategy, learning from the model used for cancer services.

- Diagnosis should always be made, regardless of whether interventions are available. The rate of diagnosis could be significantly improved by GP practices receiving greater support.

- People with dementia and their carers should be given a single health or social care professional contact point to improve the co-ordination of care between the various services and professionals. This contact point could be a social worker or a community psychiatric nurse.

- Local health organisations and their social care partners need to develop an action plan which gives priority to assessing and meeting the needs of carers.

The Treasury Minute response to these recommendations included the following:

- The final dementia strategy and implementation plan will be published in October 2008. [Note that the plan was actually published in February 2009] and sets out 17 objectives grouped under: raising awareness and understanding; early diagnosis and support; living well with dementia.]

- The government will consider whether there is a compelling case for a national clinical director.

- The Department agrees on the need for the diagnosis of dementia to be made in all cases and the importance of it being made as early as possible.

- Staff in care homes should be appropriately trained to care for residents with dementia. There will be a need to improve the general skills of hospital staff and availability of specialist input into general hospitals.

Caring for Vulnerable Babies: The reorganisation of neonatal services in England

Every year around ten per cent of babies are born prematurely or suffer from an illness or condition which requires care ranging in complexity. In 2006-07 some £420 million was spent on running neonatal units. Between 2003-04 and 2005-06, the Department invested £72 million to help implement networked models of intensive neonatal care, as evidence from other countries showed that this model of care produced the best outcome for babies.

Recommendations in the Committee of Public Accounts' report (June 2008) included the following:

- The Department should set the Neonatal Task Force clear objectives and associated milestones for improving services, and monitor achievements against these milestones to ensure delivery of the objectives by the end of 2008–09;

- Strategic Health Authorities working with networks need to develop local partnering arrangements so that all neonatal units have 24 hour access to appropriately staffed transport services; and

- In setting tariffs for neonatal care, the Department should ensure that the full costs, including the costs of meeting professional staffing standards and providing transport services, are taken into account.

The Treasury Minute response to these recommendations included the following:

- The Department accepts the Committee's recommendation, and will set the Task Force clear objectives and milestones. The intention is that the Taskforce will complete its work programme by November 2009, having set out its proposals for improving services and proposals for monitoring achievements to ensure delivery of the objectives;

- The Department accepts the Committee's conclusion that only half of the networks provide specialist neonatal transport 24 hours per day, seven days a week. All networks have access to some form of transport for transfer of neonates but the taskforce's working group on transport will consider all of the options for providing access to 24 hour transport services. These will be outlined in some quality standards for transfer available by Autumn 2009; and

- The Department accepts the Committee's conclusion that there are wide variations in costs and charges between the different units and believes that understanding of costs is inconsistent across the service. The Department will be using reference costs to get the information it needs and will be issuing costing methodology guidance this year to aid the NHS in producing their 2008-09 reference costs, for return to the Department in Summer 2009. This collection will be used to inform the national tariff development.

NHS Pay Modernisation: New contracts for General Practice services in England

In 2006-07 there were around 290 million primary care patient consultations at a cost to the NHS of £7.7 billion. In 2004, the Department 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.

Recommendations in the Committee of Public Accounts' report (October 2008) included the following:

- The Minimum Practice Income Guarantee (MPIG) has stood in the way of the needs-based funding formula reducing historic inequality of service provision. The Department should consider replacing MPIG with a redesigned global sum allocation in order to move more money into areas of greatest need.

- The Quality and Outcomes Framework (QOF) links GPs' pay to the quality of patient care they deliver but requires further enhancement, with less emphasis on indicators that are easy to measure and more on improvements in population health. The Department should:

  - develop QOF so that it is better aligned to national health priorities;

  - give more weight to achieving health outcomes, rather than clinical practices which are easy to measure; and

  - allow Primary Care Trusts some discretion to agree the content of the Framework to reflect local priorities.

The Treasury Minute Response to these recommendations included the following:

- The Department agrees that MPIG, which was introduced as part of the new contract to protect GP practices' historic income for essential core services, has outlived its purpose and should be phased out. Through NHS Employers, the Department has been discussing this with the BMA and on 14 October 2008 announced changes to the contract for 2009-10, which will, depending on the Doctors' and Dentists' Pay Review Body recommendation for GPs for 2009-10 and the Government's response, take the first step towards abolishing MPIG.

- The final report of Lord Darzi's NHS Next Stage Review acknowledged that the number of organisational or process indicators in the QOF should be reduced and resources focussed instead on new or enhanced indicators to promote health and greater clinical quality. The report also gave a commitment to introduce a new, independent process to provide advice on QOF indicators. The Department published a consultation document on 30 October 2008 on how the new independent process led by the National Institute for Health and Clinical Excellence (NICE) should work and will consult widely with patient and professional groups and other stakeholders. The consultation document also seeks views on the proposal to allow more flexibility to PCTs to allow them to determine local indicators based on local health needs. Any decision to reserve a proportion of a nationally agreed investment in QOF for locally selected indicators would be a matter for future consultation with the General Practice Coucil. PCTs would be free to invest their own additional resources into local voluntary incentive schemes based on indicators chosen from a NICE approved menu.

The National Programme for IT in the NHS: Progress since 2006

Launched in 2002, the National Programme for IT in the NHS is designed to reform the way the NHS in England uses information, and hence to improve services and the quality of patient care. It will involve substantial organisational and cultural change to be successful, and is dependent upon the deployment of systems in a highly devolved NHS. Further, there have been new requirements arising from policy and operational changes in the NHS.

Recommendations in the Committee of Public Accounts' report (January 2009) included the following:

- The Programme is not providing value for money at present because there have been few successful deployments of the Millennium system and none of Lorenzo in any Acute Trust. Trusts cannot be expected to take on the burden of deploying care records systems that do not work effectively. Unless the position on care records system deployments improves appreciably in the very near future (i.e. within the next six months), the Department should assess the financial case for allowing Trusts to put forward applications for central funding for alternative systems compatible with the objectives of the Programme.

- Recent progress in deploying the new care records systems has been very disappointing, with just six deployments in total during the first five months of 2008-09. The completion date of 2014-15, four years later than originally planned, was forecast before the termination of Fujitsu's contract and must now be in doubt. The arrangements for the South have still not been resolved. The Department and the NHS are working with suppliers and should update the deployment timetables. Given the level of interest in the Programme, the Department should publish an annual report of progress against the timetables and revised forecasts. The report should include updates on actions to resolve the major technical problems with care records systems that are causing serious operational difficulties for Trusts.

- The Department hopes that the Programme will deliver benefits in the form of both financial savings and improvements in patient care and safety. In March 2008, the Department published the first benefits statement for the Programme, for 2006-07, predicting total benefits over 10 years of over £1 billion. There is, however, a lot of work to do within the NHS to realise and measure the benefits. Convincing NHS staff of the benefits will be key to securing their support for the Programme, and the credibility of the figures in the benefits statement would be considerably enhanced if they were audited. Future benefits statements should be subject to audit by the Comptroller and Auditor General. The Department should also review achievements under the Programme so that lessons can be identified and shared where products and services are working well.

The Committee of Public Accounts published its report in January 2009 and the Treasury Minute response is therefore expected in March 2009.

Coming up

Supporting People with Autism through Adulthood

There are around half a million people with autism in England. Autism is a lifelong developmental disability that affects the way a person communicates and relates to people around them. While some people with autism can live relatively independently, others require a lifetime of specialist care. The cost of autism to the UK economy is estimated to be around £28.2 billion per year. This study considers the extent to which existing services meet the needs of adults with autism, focusing particularly on the transition from adolescence and the subsequent provision of health, social care, education, benefits, and employment support to adults across the whole autistic spectrum. It focuses on adults, as evidence indicates that autism services for this group are less well developed than those for children.

Our report also explores the scope for improvements in planning, commissioning and delivering services to adults across the autistic spectrum. We examine the extent to which government departments responsible for care services, employment and benefits are working together with Local Authorities and NHS organisations to provide appropriate interventions for adults with autism. The report will highlight how the delivery of services for people with autism could be improved, including ways to address the risk of individuals not accessing the services they require. It will identify the potential quality-of-life improvements and savings to the public purse of providing appropriate health, social care and employment services to adults with autism.

Publication Schedule

We will publish our report in Spring 2009.

Tackling Healthcare Associated Infections in Hospitals

Tackling healthcare associated infections in hospitals is a key priority for the NHS. Around eight per cent of patients have such an infection, the majority caused by bacteria or viruses which affect the urinary tract, surgical wounds, the lower respiratory tract, the skin and the bloodstream. In 2007-08 there were over 4,500 cases of MRSA and 45,000 cases of Clostridium difficile.

The NAO has published two reports on the subject. *The Management and Control of Hospital Acquired Infection in Acute NHS Trusts in England* (February 2000) had a significant impact in raising the profile of this important issue and highlighted the need to improve prevention, management and control. *Improving patient care by reducing the risk of hospital acquired infection* (July 2004) reviewed progress against the NAO's and the Committee of Public Account's recommendations and noted that improvements were at best patchy and that serious challenges remained. Healthcare associated infections continue to be an issue within many hospitals.

This study reviews progress made since the last NAO report. It looks at how well the Department's strategy has been developed and implemented and focuses on the successes at trust and ward level and the impact on staff, patients and the public. It also examines the roles, responsibilities and relationships of the Department, the many arm's length bodies that

have a specific role in managing healthcare associated infection and the individuals at trust level who have specific responsibility for infection prevention and control. The report identifies the effectiveness of various intervention strategies and the extent to which previously identified barriers and constraints have been overcome.

Publication Schedule

We will publish our report in Spring 2009.

Rheumatoid Arthritis

Rheumatoid arthritis is a condition relating to inflammation of joints, and is usually progressive and chronic. Around 400,000 people in the UK have rheumatoid arthritis, with around 12,000 new cases diagnosed each year. Many people are first diagnosed with rheumatoid arthritis when still of working age.

Our report will focus on the potential for improving service delivery to people with rheumatoid arthritis. We will examine whether cases of rheumatoid arthritis are identified and diagnosed accurately and on a timely basis; whether people with rheumatoid arthritis are receiving timely and appropriate intervention; and whether people with rheumatoid arthritis have access to effective long term care, including help to remain in work or return to work. The study has a working age focus and will examine the personal, social and economic benefits of getting management of the disease right in England.

Publication Schedule

We intend to publish our report in Summer 2009.

The National Chlamydia Screening Programme

The NAO is undertaking a value for money study of the National Chlamydia Screening Programme (NCSP) in England. Chlamydia is the most common sexually transmitted infection diagnosed in genito-urinary medicine (GUM) clinics in England and around 10 per cent of sexually active young people are likely to be infected, according to Department of Health estimates. People infected with chlamydia often do not have any symptoms, but if left untreated, it can cause serious conditions including pelvic inflammatory disease (PID) and damage to the Fallopian tubes in women, resulting in infertility.

The National Chlamydia Screening Programme has extended chlamydia screening beyond GUM clinics in hospitals, to a wide range of medical and non-medical settings, such as pharmacies, universities, GP surgeries, community contraceptive services (formerly known as family planning clinics), youth centres and military sites.

Our study will consider the rationale for introducing such a programme and evaluate the effectiveness of its roll-out and implementation to date. The study will also evaluate the arrangements in place to monitor programme performance and to provide treatment to people who test positive for chlamydia and notify their partners.

Publication Schedule

We intend to publish our report in Winter 2009.

Urgent Care: Treating severe injury

Severe injuries, for example from road traffic accidents, falls from height and violent attacks, are the leading cause of death for those under 40. There is a significant economic impact from such incidents and from the ongoing care for those who are left with long-term disability. The Darzi review of the NHS highlighted care for those who have been severely injured as an issue that needs to be considered by Strategic Health Authorities. Studies published over the last few decades have been consistently critical of the standard of care given to those with severe injuries.

Our report will focus on whether the pathway of care for the severely injured is effectively coordinated; whether the outcomes from similar severe injuries vary; and whether the costs of treating similar severe injuries vary. We will examine whether the key decisions along the pathway are being made by the right people in a timely manner and whether the system for trauma care is one in which patients can be moved to the right place for the right care at the right time. Our study will consider the pathway from the dispatch of emergency services to respond to an incident up to the time when access to rehabilitative care is sought.

Publication Schedule

We intend to publish our report in Winter 2009.

Heath Inequalities

Nationally, life expectancy has improved year-on-year over the past decade. However, the health of the most disadvantaged has not improved as quickly as that of the better off. Inequalities in health persist and gaps in health outcomes between affluent and deprived areas continue to increase in many places. In the most deprived wards, men and women are likely to die 20 and 23 years earlier respectively than their peers in the most affluent wards. Government action has been focused in spearhead areas, a fixed list consisting of the local authority areas in the bottom fifth nationally for three or more of five health outcome or deprivation indicators. The spearhead list is made up of 70 local authorities and the 62 primary care trusts which map to them and contains 28 per cent of the population of England.

Our report will focus on the approach taken by the Department of Health to reduce inequalities, action being taken by local health communities in spearhead and non-spearhead areas to address inequalities, and the results achieved so far (including progress against Government targets).

Publication schedule

We intend to publish our report in Winter 2009.

Stroke Care: a progress report

A stroke is the brain equivalent of a heart attack and is one of the top three causes of death in England. Approximately 110,000 strokes and a further 20,000 transient ischaemic attacks (TIAs or 'mini strokes') occur in England every year. Stroke costs the economy about £7 billion a year, including £2.8 billion in direct care costs to the NHS.

Our 2005 report, *Reducing brain damage: faster access to better stroke care*, identified how making improvements to stroke care services could lead to benefits for the NHS, including 550 deaths avoided and over 1,700 people fully recovering from their strokes each year who would not otherwise have done so. Reconfiguring services could also potentially save some £20 million annually.

Our follow-up study will examine the extent to which the recommendations made in our previous report, and subsequent Committee of Public Accounts report, have been implemented. The study will also evaluate whether current services offer value for money by assessing stroke care against the quality markers set out in the National Stroke Strategy (2007). The study will use a range of methods, including: patient and carer focus groups, a survey of hospitals, a needs assessment on post-stroke care; interviews with key stakeholders; and dynamic modelling.

Publication Schedule

We intend to publish our report in Winter 2009.

Financial Audit

Our financial audits cover the Department of Health, the NHS Summarised Accounts, the Consolidated Account of NHS Foundation Trusts, the Department of Health's 23 Arm's Length Bodies and NHS Direct NHS Trust.

The Department's 2007-08 accounts were signed by the Accounting Officer on 25 September 2008, an advance on the previous year, and presented to Parliament in early October 2008. The three sets of NHS Summarised Accounts, covering Strategic Health Authorities, Primary Care Trusts and NHS Trusts, were all presented to Parliament before Christmas 2008 alongside our report on financial management in the NHS. The consolidated account of NHS Foundation Trusts was presented to Parliament in October 2008.

All of the Department's Arm's Length Bodies prepared 2007-08 accounts before the Parliamentary summer recess, and on average nine days earlier than the previous year. The quality and timeliness of the draft accounts continues to improve, as does the quality of the final Annual Report. Our audit teams also observed improvements in the standard of financial management within Arm's Length Bodies, and similarly improvements in the effectiveness of internal control systems.

Financial Management in the NHS

The NAO has also published two reports on NHS Financial Management since the last edition of Health Focus. The C&AG's *Report on the NHS Summarised Accounts 2006-07: Achieving Financial Balance* (HC 129-I, 2007-2008) was published in December 2007 and considered by the Committee of Public Accounts at a hearing in January 2008.

The C&AG's report *Financial Management in the NHS: Report on the NHS Summarised Accounts 2007-08* (HC 63-I, 2008-2009) was published in December 2008 and considered by the Committee of Public Accounts at a hearing in February 2009.

Report on the NHS Summarised Accounts 2006-07: Achieving Financial Balance

The NHS improved its financial standing by over a billion pounds in 2006-07, turning a £547 million deficit into a £515 million surplus.

80 per cent of deficits existed in 10 per cent of NHS organisations in 2006-07. The Committee of Public Accounts recommended that: Strategic Health Authorities should better support deficit organisations in achieving financial balance; boards of NHS organisations should ensure that their financial systems are fit for purposes; and that Strategic Health Authorities should identify poor forecasters and help them to improve through training and sharing of best practice.

The Department accepted that there was room for improvement, and it pledged to work with Strategic Health Authorities to improve the financial performance of organisations which were facing significant challenges to achieve financial balance.

Financial Management in the NHS: Report on the NHS Summarised Accounts 2007-08

The NHS improved its financial standing by a further billion pounds in 2007-08, recording a total surplus of £1.67 billion

In addition to a planned contingency surplus, NHS organisations delivered more than expected savings from cost improvement plans which contributed to the large surplus. Financial management in the NHS showed significant improvements in 2007-08.

The Committee of Public Accounts is expected to publish its report, including its recommendations for the Department of Health and the NHS, in spring 2009.

Challenges Ahead

We are working with our clients to address the two main financial reporting challenges:

- All public sector organisations are required to introduce International Financial Reporting Standards from 1 April 2009 and we have been involved in the implementation of this major change with the Department, the NHS and the Arm's Length Bodies. As part of the preparation of full IFRS-compliant accounts for 2009-10, organisations are required to restate opening balance sheets as at 1 April 2008 and prepare dry run accounts for 2008-09 so that prior year information can be shown in 2009-10 accounts.

- There is a drive towards the earlier completion of the accounts of the Department and NHS bodies. We have been working with the Department and NHS to implement this change so that all of these organisations are expected to publish their accounts before the Parliamentary summer recess in July 2009.

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Good Governance

The NAO aims to promote the highest standards in financial management and reporting in the public sector. To achieve this, we work with the organisations that we audit through a programme of work that we term good governance. This is designed to provide targeted services to our audited bodies to address areas for improvement. Examples of good governance work completed since the last edition of Health Focus include:

- Several organisational health checks on the Department's Arm's Length Bodies. These checks are holistic assessments of organisational effectiveness. They are particularly useful in times of change, as they focus on both transactional and transformational factors.

- Several facilitated workshops with Audit Committees. These focus on a self assessment of the current effectiveness of the Audit Committee and the creation of a bespoke action plan for the Committee going forward.

- Reviews of specific functions within our audited bodies, for example a review of current procurement practice leading to a targeted action plan, and several IT reviews at the Department of Health to ensure that systems are fit for purpose and sufficient to meet future needs.

Good practice guidance

The National Audit Office has developed a number of good practice guides and toolkits which can be applied to any public sector organisation. These are outlined below. Many can be completed by self-assessment and are available via our website at **www.nao.org.uk**. We would be happy to discuss the use of any of these good practice guides with interested organisations; please contact the NAO health financial audit directors Dean Parker (**dean.parker@nao.gsi.gov.uk**) or Helen Feetenby (**helen.feetenby@nao.gsi.gov.uk**).

Other Work Coming Up

We are reviewing the systems in place for the collection of data for, and reporting on, the indicators which underpin the Departmental Strategic Objectives, which include Public Service Agreement targets, of the Department of Health. We expect our report to be produced later in 2009.

Good practice guide	Description
Efficiency toolkit	This toolkit provides practical guidance on assessing an organisation's current approach to achieving efficiency. The model uses a broad interpretation of "efficiency" and also looks at some aspects of effectiveness – i.e. what resources are used for. It is focused on the drivers and indicators of efficiency – inputs, outputs and outcomes.
Procurement toolkit	This toolkit provides both a high level and detailed assessment of an organisation's procurement practices and identifies areas where savings and efficiencies can be made.
Consultancy assessment toolkit	This toolkit provides a framework for reviewing the extent to which an organisation is achieving value for money from its use of consultants.
Sickness absence toolkit	The NAO has produced a number of value for money reports on sickness absence across the public sector to reflect ongoing efforts to reduce the impact of absence across government. This toolkit has been developed to help departments and other organisations address this issue.
Change management toolkit	Managing change is fundamental to success in the public sector and this toolkit is based around the six key principles of successful change management identified as recurrent themes in NAO and PAC reports and existing literature.
Value for Money public services toolkit	The Committee of Public Accounts has identified that public projects are not always as well planned as they could be taking account of lessons learned elsewhere. This toolkit sets out the seven aspects of service delivery identified by the Committee against which organisations need to target to achieve better value for money, and against which the Committee will assess delivery.
Support for Audit Committees	Audit Committees help organisations function according to good governance and accounting and auditing standards, and adopt appropriate risk management arrangements. We have developed a range of guidance and tools to assist public sector Audit Committees. We have prepared an Audit Committee toolkit since 2004; this has recently been revised to reflect the Treasury's new Audit Committee Handbook.
Support for Boards	Board members receive financial information on a regular basis through internal financial management reporting processes and, if timely and accurate, this information helps them to make informed decisions and assists with the successful running of the business. Boards can assess the standard of the financial information reported to them by using the NAO checklist Reporting Financial Information to the Board.
Risk management support	This is a simple checklist intended to help organisations assess whether their risk management is fit for purpose to deliver the benefits identified in the NAO report "Managing Risks to Improve Public Services" (2004-05 HC 1078).

Other reports involving the Department of Health or health bodies

Improving the efficiency of central government's office property

This report examined whether departments are effectively managing and achieving value for money from their own office space. The NAO recommended that departments should improve their understanding of the factors that feature in improving building efficiency. Departments need an accurate and up-to-date understanding of the number of people, the occupation level, the number of work stations, accommodation costs and the environmental performance of the building. The NAO estimated that gross annual expenditure on offices could be reduced by around £330 million.

Improving the corporate functions using shared services

Shared services are where corporate service activities across different parts of an organisation, or across different organisations, are combined in order to bring efficiency savings and an improved services. The NAO found that the NHS Shared Business Service was on course to deliver savings, although the level of efficiency in best practice private sector organisations was not being achieved. The report concluded that there needed to be an improvement in the overall management of corporate services and an increased momentum across central government to develop shared services so that the potential savings could be realised.

Making changes in operational PFI projects

There are some 500 operational PFI projects in the United Kingdom, many of which have a contract life of 20 to 30 years. Therefore it is inevitable that during the life of these contracts changes will be necessary. The NAO found that larger changes to contracts were not always competitively tendered and that the cost of making smaller changes was relatively high. The NAO recommended that authorities should utilise the full range of guidance published by the Treasury and the help provided through its Operational Taskforce.

Managing financial resources to deliver better public services

This report looked at how capable departments were at managing their financial resources in comparison with the findings of a previous NAO report in 2003. It found that departments were producing better information about their financial resources and that there had been an increase in the number of professionally qualified staff. Some departments still did not have a professionally qualified Finance Director at board level and there had not been any improvements in the accuracy of forecasting expenditure requirements.

Central government's management of service contracts

This report examined the way that central government manages contracts for services such as IT, security, catering and cleaning. It found some cases of good practice with senior level engagement with suppliers, the use of benchmarking and joint working between government organisations. There were weaknesses in key performance indicators and a limited use of financial incentives to improve supplier performance. The NAO, working with the Office of Government Commerce, produced a good practice framework for contract management alongside its report.

Assessment of the Capability Review Programme

The Cabinet Office's Capability Review programme aims to assess and improve government departments' ability to deliver their objectives. The NAO report showed that the programme has led to evidence of greater capability in departments, but that departments could not show that the programme had had an impact on outcomes in delivering public services. There was some uncertainty in departments about whether, or how, the programme would continue, which risked a loss of momentum.

Helping government learn

To obtain value for money from public spending, departments need to learn from both success and failure. This report highlighted that the main barriers to learning within departments are ineffective tools to capture and share learning, keeping insights and information within the team rather than sharing them across the organisation, high turnover within the workforce leading to a loss of knowledge, and a lack of time given to capturing lessons from experience. The report concluded that departments should give higher priority to learning within their organisations.

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 21 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**.

Conferences

On 17 June 2009 we will be holding a conference to platform the key findings, methodologies and good practice identified in our report on End of Life Care. The conference will also be an opportunity to highlight the conclusions and recommendations in the PAC report and for the Department and other NHS, social care and voluntary organisations to explain how they have responded to the Department's strategy and what they are doing to improve partnership working.

We are also planning to hold conferences on autism and rheumatoid arthritis in Autumn 2009.


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