BODY POLITIC **Nigel Hawkes**

Collision, collusion, and confusion

Can choice, localisation, and other NHS agendas all be followed successfully at the same time?

Choice is the mantra of the new NHS in England. Since the beginning of 2006 all patients across the country have theoretically been able to choose where and when they get hospital treatment—a great leap forward in empowerment of patients, if we are to believe ministerial statements on the subject. Hernias in Halifax, gall bladders in Gloucester: the world's your lobster, my son, as Arthur Daley used to remark in *Minder*.

But it is never long in the NHS before one policy begins to collide with another. No sooner was choice up and running than ministers discovered the joys of localisation. Services offered locally, conveniently, and more cheaply formed the basis of *Our Health, Our Care, Our Say*, the white paper that also emerged in 2006.

GPs and independent companies are now being encouraged to provide such services in competition with hospital trusts. Primary care trusts are uneasy about this—and with good reason. Rightly or wrongly they still feel a responsibility for the preservation of secondary care; and an uncontrolled "free for all" could seriously disrupt the local NHS economy.

The lack of clear market rules is a major problem. Combined with practice based commissioning, the choice and localisation agendas have created conflicts of interest that are screaming out to be resolved. Services that are based in primary care occupy a favoured position. Under practice based commissioning, GPs both provide and commission these services, abolishing the purchaser-provider split that is the basis of the market—and then are free to refer their patients to them. Primary care services that aim at keeping people out of hospitals are also allowed to undercut the tariff, giving them a competitive advantage. The result is potentially unfair to hospitals and to the private providers that the government has encouraged to enter the market.

The aim of practice based commissioning was to counter the tendency of secondary care to soak up all the available resources by giving GPs an interest in keeping patients out of hospital. But it cannot, surely, have been intended, in the words of Simon Stevens in a recent issue of *Health Service Journal*, to be "an opportunity for GPs to form local cartels capable of channelling taxpayers' cash to their own, for-profit, practices through the supply of substitute secondary care or diagnostic services, entirely immune from normal procurement rules or fair and transparent competition."

Mr Stevens, of course, has interests of his own. A former health adviser to the prime minister, he now chairs UnitedHealth Europe, which itself is bidding for contracts to supply such services. However, he is not exaggerating. The healthcare think tank the King's Fund made the same point in more moderate language in a recent report, calling for the Department of Health, "as a matter of some urgency," to provide a clear set of rules for competition in health care.

Take choice, for example. It applies only to treatments "on the tariff," the list of prices that hospitals are allowed to charge for each procedure. Hospitals are not allowed to charge less than the tariff, so giving a patient the choice between a range of hospitals is cost neutral for a primary care trust. But GPs' services are not on the tariff. They are allowed to charge less. And because they are not on the tariff they are not formally part of choice. Patients can be encouraged to use such services without being offered choice at all—and, because these services are provided by GPs whom they trust, are likely to do so.

True, the national guidance *Choice at Referral* says that although many patients will be content to choose from local services, "GPs will be expected to tell patients that the new national menu also exists and to discuss clinically appropriate options available." The General Medical Council says that there is a more general duty to inform patients if GPs have any financial interest in an organisation they plan to refer them to. What happens if they don't? They are hardly going to be named and shamed, I suspect, or struck off or even rapped on the knuckles. How will anybody ever know?

"The choice and localisation agendas have created conflicts of interest that are screaming out to be resolved"

The losers will be the acute trusts, who will find it increasingly hard to compete for patients against GPs with a special interest or GP funded diagnostic centres and the private companies hoping to get a foothold in the market. Few in the NHS would shed many tears for the private sector, but without its involvement the market simply won't fly. The benefits of marketisation will be lost, and another reform will bite the dust without having even dented the tough carapace of the NHS. This may be just what many doctors and primary care trusts hope for, but it is not the government's intention.

Quality is also an issue. GP provided services fall outside the remit of the Healthcare Commission, so nobody will know if they are as good as those delivered by acute trusts. The evidence so far is not especially encouraging.

Research carried out by Martin Roland and colleagues at the National Primary Care Research and Development Centre at Manchester University and commissioned by the health department found that GPs were good at delivering care for chronic conditions but less good at minor surgery, and that GPs with a special interest deliver more accessible care and shorter waiting times than hospital outpatient clinics (www.npcrdc.ac.uk/Publications/82-research-summarySDO.pdf). But the cost of services provided by GPs with a special interest is actually higher, and such services running without the support of local consultants may be unsafe. The research concludes that moving secondary services or specialists to primary care settings does not reduce referrals and loses the economies of scale that hospitals provide. How odd it is that the health department didn't issue a press release to alert us to this interesting study.

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RICHARD GRANGER'S LEGACY

Computer says yes—and no

What is the future of the NHS IT programme now that its supremo has quit? **Michael Cross** reports

The NHS's IT programme —progress so far

- A central information "spine"—all NHS organisations are now connected to the spine, although its main function, to carry summary healthcare records, remains a "far-off dream"
- Electronic booking—the NHS has failed to meet targets for that proportion of bookings handled electronically, although the NHS's outgoing IT programme director, Richard Granger, claims that IT is not to blame
- QMAS (quality management and analysis system)—national installation of software to support new GP contracts and payment by results
- PACS (picture archiving, communications, and storage)—Connecting for Health says that 75% of trusts in England are now using the technology
- Electronic prescribing—slow to roll out. Connecting for Health says that the service is being used for 11% of daily prescription messages (although in tandem with paper prescriptions)
- Electronic records in secondary care—the IT programme's biggest failure. The original goal was NHS-wide availability by 2005. Of the two major suppliers, one has installed an "interim" system, while the other is only just rolling out systems

Five years ago, as the NHS considered the Wanless report's call for increases in national spending on health, nearly everyone involved in trying to computerise health care agreed on two things: firstly, that information technology (IT) needed new investment, ringfenced so it could not be diverted to more urgent needs; secondly, that IT needed strong central leadership to coordinate developments and to ensure that money was wisely spent.

Remarkably, the government granted both wishes. The 2002 public spending round included £2.3bn (€3.4bn; $4.6bn) earmarked for healthcare IT in England. In June 2002 a Department of Health strategy announced that a "new national IT programme director" would be appointed to "improve the leadership and direction" given to IT and ensure "ruthless standardisation." Five years on the 2002 consensus has evaporated. The constituency of individuals with opinions about IT in the NHS—vastly broader than in 2002—is divided over the technology, management, and ownership of electronic health information. The polarisation of debate, and the fact that it now involves clinicians, politicians, and civil liberties campaigners, as well as IT specialists, is a legacy of the man hired as IT programme director, Richard Granger.

Granger, who has announced that he plans to leave his post later this year (*BMJ* 2007;334:1290), was recruited in autumn 2002 after a career with management consultancies, where he specialised in installing IT for large companies and government departments. From the beginning he had a high personal profile, including the distinction of the highest salary on the civil service payroll. In 2004, when Tony Blair made a major speech on the future of the civil service, Granger was the only civil servant, apart from the cabinet secretary, mentioned by name. The announcement of his resignation—two weeks before Blair himself stepped down—made national newspaper headlines and was immediately portrayed by opposition politicians as an admission of failure.

Thanks to Granger the blocks of compatible technology are now becoming available to build the world's largest e-health service

The true verdict is more mixed. As director general of IT in the NHS in England, and later chief executive of the NHS agency Connecting for Health, Granger was tasked with turning into reality a 1998 strategy for nationally available electronic health records. The 2002 plan set out three separate strands of work: electronic booking of secondary care appointments, electronic transmission of prescriptions from doctor to pharmacy, and a lifelong electronic health record for each patient. The necessary systems would be deployed under national direction, rather than being left to the discretion of individual trusts and general practices, as had been the case previously.

Granger's true legacy must be judged by progress he made according to the 2002 plan. During the course of 2003 he put his stamp on the programme by negotiating a series of 10 year contracts to develop and install national systems, most importantly a central information "spine," and to replace organisations' IT in geographical areas. Apart from the scale and the unprecedented speed with which they were negotiated, the contracts were notable for insisting that contractors were paid only on delivery of working systems. In 2006 the National Audit Office commended this approach, although it has not been replicated elsewhere in the public sector.

Connecting for Health claims that substantial parts of the 2002 plan are now in place. All NHS organisations are now connected to the spine, which ensures that patients' demographic information (name, address, and NHS number) is correctly and consistently recorded. However, the main function of the spine, to carry a summary care record available everywhere and to transmit detailed health records between organisations, remains a far-off dream. One difficulty, which apparently came as a shock to Granger, is professional resistance to sharing information across a national system.

Another pillar that is substantially in place is electronic booking, the scope of which was extended to allow patients a choice of hospital under the government's Choose and Book programme. Although the NHS has failed to meet government targets for the proportion of bookings handled electronically, Granger says with some justification that the IT is not to blame.

Other projects now claimed as successes bear little relation to the 2002 plan. One is the national installation of software known as

QMAS (the quality management and analysis system), hurriedly deployed in 2004 to support a new contract for GPs that involved payment by results. Another is picture archiving, communications, and storage (PACS) technology for handling digital x ray pictures and other diagnostic images. Although a proved technology, PACS was at the bottom of priorities in the 1998 vision of electronic health records, largely because of cost. A national procurement in 2004 moved PACS up the agenda, and Connecting for Health says that three quarters of hospital trusts in England are now using the technology.

By contrast, electronic prescribing, seen in the 2002 plan as a "quick win," has been slow to roll out, partly because of the difficulty of dealing with community pharmacies. Connecting for Health says its electronic prescribing service is now being used for 11% of daily prescription messages, but in almost all cases these run alongside paper prescriptions.

The programme's biggest failure is over the installation of electronic patient records in secondary care. The 1998 strategy envisaged these being available across the NHS by 2005, procured trust by trust from at least a dozen suppliers. The national programme's "ruthless standardisation" replaced this market with two key software firms, the UK firm iSoft and the US's IDX, later replaced by Cerner. Both encountered problems developing systems to the specification required by the NHS; iSoft has relied on installing an "interim" system, while the roll-out of Cerner's systems began late and is only now getting under way.

The second flaw was a failure to engage properly with clinicians at the outset of the design of the electronic health record

In retrospect, the national IT programme as executed by Granger contained two big mistakes. One was in the contract structure, which did not reflect NHS loyalties on the ground and alienated the existing IT community. The second flaw—which Granger vehemently denies—was a failure to engage properly with clinicians at the outset of the design of the electronic health record. Granger's departure, and Gordon Brown's arrival as prime minister, create the conditions for face saving changes of policy. Despite the kneejerk political and media verdicts of failure, thanks to Granger the blocks of compatible technology are now becoming available to build the world's largest and most integrated e-health service—if the will to do so is there.

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WHATS ON BMJ.COM

Protecting vulnerable populations

A recent *BMJ* article on the treatment of mentally disordered offenders triggered a range of responses, writes **Birte Twisselmann**

Becky Sales and Nigel MacKenzie propose that the new Mental Health Bill be amended and a time limit imposed for transfer of mentally ill offenders from prison to hospital to guarantee equivalence of care and basic human rights (*BMJ* 2007;334:1222). They also propose that the bill should contain statutory obligations to ensure that patients who are judged as needing hospital treatment while in police custody or in the court system cannot be sent to prison. Prison capacity is not great enough, and, at the same time, more prisoners are awaiting hospital beds.

Andrew Fraser, director of health and care in the Scottish Prison Service, and his colleagues point out that all mentally ill offenders in Scotland have to be transferred to hospital because of a lack of inpatient prison facilities. However, the prison population is bigger in England and the number of psychiatric beds is greater in Scotland, while the configuration of mental health services is different in the two countries. They add that adequate services, clear purpose, and good understanding between prisons and secure hospitals are needed.

Peter O'Loughlin, a drug and alcohol recovery specialist in Kent, agrees that mentally disordered offenders do not belong in prison. He reminds us, however, that they are in prison for the crimes they have committed. Should those crimes be ignored, or the offenders be found not guilty, for the sake of treating their disorder?

Ciaran Regan, psychiatric specialist registrar in Pentonville Prison in London, is concerned that the fact that mentally disordered prisoners are detained—but cannot be treated adequately in prison facilities—reinforces society's view that detention is all that is needed for people with mental health disorders, thus emphasising the disparity between physical and mental health care. Labelling personality disorders as untreatable is questionable, adds Martin Zinkler, consultant psychiatrist in London, and can increase stigma and the feeling of hopelessness that surrounds many such patients.

Nisha Shah, locum consultant psychiatrist in London, suspects that imprisonment also reinforces negative attitudes towards offenders. Crucially, she blames political expediency for the lack of willingness to change legislation—because such a change may well not win votes.

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The full text of these reponses is available at www.bmj.com/cgi/eletters/334/7605/1222