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Patient Choice at the Point of GP Referral

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DEPARTMENT OF HEALTH

Patient Choice at the Point of GP Referral

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This report has been prepared under Section 6 of the National Audit Act 1983 for presentation to the House of Commons in accordance with Section 9 of the Act.

John Bourn
Comptroller and Auditor General
National Audit Office

17 January 2005

The National Audit Office study team consisted of:

Ashley McDougall, Tom McDonald, Helen Koduah, Jeff Round, Frazer Clark and Matthew Wilkins under the direction of Chris Shapcott.

This report can be found on the National Audit Office web site at www.nao.org.uk

For further information about the National Audit Office please contact:

National Audit Office
Press Office
157-197 Buckingham Palace Road
Victoria
London
SW1W 9SP

Tel: 020 7798 7400

Email: enquiries@nao.gsi.gov.uk

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SUMMARY



1 The Department of Health has a Public Service Agreement target to ensure that by the end of 2005 every hospital appointment in the National Health Service in England (the NHS) will be booked for the convenience of the patient, making it easier for patients and their General Practitioners (GPs) to choose the hospital and consultant that best meets their need. The Department aims to provide patients with the opportunity to choose between four to five healthcare providers for elective hospital treatment by December 2005. In consultation with their GP, patients should be able to choose, from a menu of NHS and independent sector healthcare providers, their preferred location for treatment. Patients should also be able to book the time and date of their initial outpatient appointment within 24 hours of the decision to refer the patient for treatment. This target will apply to around 9.4 million patients referred for hospital treatment by their GP each year, around four per cent of the total estimated 241 million GP consultations.

2 Choice at referral can contribute to a more patient-focused health service, bringing benefits to both patients and the NHS. But providing such a choice will not happen by accident. There are a number of dependencies and interactions with other policies that need to be managed. Information Technology (IT) systems need to be developed and modified and significant cultural, organisational and behavioural changes will need to be made by patients, NHS organisations and staff.

3 This report examines whether the Department is on track to deliver choice at the point of referral successfully by the target date of December 2005. Our work has found that:

- a** Progress has been made towards delivering choice at referral through establishing the required organisational infrastructure, commissioning new IT systems and modifications to existing ones, and providing support for the NHS organisations that will deliver it.
- b** The engagement of GPs is currently low and is a key risk which the Department must address to deliver choice successfully. The Department plans to

address this risk through a campaign to inform and engage GPs during 2005 and it will need to monitor carefully the progress of this campaign.

- c** Choice at referral will be delivered most efficiently and effectively through electronic booking (e-booking, also known as Choose and Book), in which the Electronic Booking Service, commissioned by the Department's National Programme for IT (NPfIT), is linked to upgraded or new computer systems in hospitals and GPs' surgeries. However, e-booking will not be universally available by December 2005. Until e-booking is fully adopted choice will have to be provided in other, less efficient, ways.
 - d** Parts of the NHS still have much to do if they are to deliver choice. A significant minority of Primary Care Trusts do not yet have adequate plans in place to manage the introduction of choice and some may struggle to manage the required new commissioning arrangements.
- 4** Our more detailed findings are as follows.

Progress has been made towards delivering choice at referral

5 The Department believes that choice is affordable. Additional annual infrastructure and transaction costs are estimated to be £122 million – or 1.4 per cent of the current total expenditure on elective care. The main aim of introducing choice is to improve services for patients, but it should lead to increased efficiencies in primary and secondary care services worth an estimated £71 million, off-setting some of these costs.

6 It is essential that choice is supported by other elements of system reform including e-booking, payment by results, commissioning and appropriate capacity. Modelling exercises have shown that the system reforms should work in harmony with one another. Payment by results should enable the transfer of funding to follow the patient and there should be sufficient capacity across the system to enable choice to be effective.

7 Much of the organisational infrastructure that is required for choice is in place and there is clear accountability for the delivery of the programme. To strengthen detailed national programme management arrangements the Department created, on 22 December 2004, a new post of National Implementation Director for Choose and Book, with effect from 10 January 2005. The new Director will be responsible for overseeing the implementation of choice within the NHS whilst the National Programme for IT Group Programme Director for Choose and Book will continue to be responsible for Choose and Book technology development and deployment, patient access and Choose and Book contract management.

8 The Department has provided different types of support to the NHS – for example, ten pilot schemes have been run to test the policy in practice. It has set up a system for periodically measuring progress and used this to establish the position at the end of October 2004, creating a baseline against which to monitor future progress.

9 Research has identified what information patients will want to base their choices on, and the Department is seeking to provide this. While it is unlikely that full information will be available for December 2005, the majority of those aspects identified by patients as being the most important, such as waiting times and basic access information, will be in place. The Department plans to increase the information available over time.

The key risk to the delivery of choice is the engagement of GPs

10 Choice cannot be delivered without support from GPs but our survey of GPs found that around half of GPs know very little about it and 61 per cent feel either very negative or a little negative. GPs' concerns include practice capacity, workload, consultation length and fears that existing health inequalities will be exacerbated. The Department has deliberately held back its main effort to inform and engage GPs about choice until it has had a working e-booking system to show GPs, but it intends to mount a campaign to inform and engage GPs during 2005.

Until e-booking is fully adopted choice will be supported by other mechanisms

11 The Department has commissioned Atos Origin to develop a national system for e-booking, which will be linked to upgraded or new Patient Administration Systems

in hospitals and IT systems in GPs' surgeries to provide an overall service known as e-booking. The National Programme for IT has planned the roll out of e-booking on an incremental basis to minimise risk, and to link it by the end of 2005 to some 60 to 70 per cent of hospital systems and GP practices.

12 E-booking is the most effective and efficient way of delivering the Department's plans for choice, and alternative booking mechanisms offer poorer value for money. Atos Origin has delivered a functioning system and the first booking using e-booking was made in July 2004. However the roll-out of e-booking has been slower than planned and at the end of December 2004 only 63 bookings had been made. Problems have included the reluctance of users to work with an unreliable end-to-end system, limited progress in linking to GP and hospital systems, and the limited number of GPs willing to use the system.

13 The Department believes that new releases of software have addressed the reliability of the whole end-to-end system and that having a fully operational system will encourage GPs to engage with e-booking. The roll-out of changes to hospital systems to allow them to link to e-booking is gathering pace and four types of GP systems can now link to e-booking, although the largest supplier has not yet agreed an implementation plan. A combined team of Departmental and NHS personnel are working with the three main existing GP system suppliers to agree a national deployment schedule. This work should be completed by February 2005, along with a nationally negotiated commercial arrangement. The Department is also developing and trialling contingency plans against further delays, as well as alternatives to the fully integrated Choose and Book solution.

Parts of the NHS still have much to do

14 Programme management arrangements in the NHS are incomplete. While most Primary Care Trusts expect to be able to deliver the choice target, there is variability in their overall performance. As many as a quarter of Primary Care Trusts currently forecast that they will not deliver the choice targets. In addition, some Primary Care Trusts may struggle to manage the new commissioning arrangements and two-thirds have yet to commission the required number of providers. The department is developing a framework of support to assist trusts to overcome these obstacles.



RECOMMENDATIONS

15 The Department needs urgently to address the low level of GP support for their plans for implementing choice at referral, and should:

- I** Press on urgently with its plans for informing GPs about the implementation of choice at referral and its impact on GPs and patients.
- II** Monitor the views of GPs, for example by a regular survey, repeating key questions from our own survey, to assess the rate of progress being achieved towards the level of support needed to meet its target of full implementation by December 2005.
- III** Consider whether further action is needed to secure the required level of GP support, once GPs are fully informed on what choice at referral involves.

16 The Department should also:

- IV** Complete its planned benefits realisation plan for choice at referral by the summer of 2005, along with a monitoring mechanism and quantified targets.
- V** Keep under regular and close review the progress of its planned implementation of choice through implementing e-booking and consider the scope for accelerating the roll-out of e-booking to make it available everywhere by December 2005.
- VI** If it becomes clear that it is not possible to deliver e-booking everywhere by December 2005, the Department should:
 - a** monitor closely the development of the interim solutions to ensure that they meet their delivery dates; and
 - b** ensure that the implementation of interim solutions does not detract from the priority of bringing in fully integrated e-booking systems as soon as possible.
- VII** Establish an evaluation framework for Primary Care Trust commissioning to assist Strategic Health Authorities in assessing the capacity and skills of Primary Care Trusts in this area and securing improvements in capacity and skills where necessary.

PART ONE

Choice at referral needs to work in harmony with other reforms to deliver patient-focused elective care



1.1 This part of the report describes how choice at referral is intended to work and what the benefits should be for patients and for the National Health Service in England (the NHS). It also sets out the costs of the policy and describes how choice should be supported by other elements of the Department of Health's (the Department's) system reform agenda.

Choice is intended to deliver benefits for patients

Choice will be offered to up to 9.4 million patients each year

1.2 Each year there are an estimated 241 million General Practitioner (GP) consultations with patients. Of those, some 9.4 million result in referrals for hospital treatment, initially through attendance at an outpatient clinic.¹ These are known as elective referrals and are the subject of the policy of choice at the point of GP referral – 'choice'. This means that approximately one in every twenty-five consultations with a GP will result in an elective referral.

1.3 The policy of offering patients a choice of hospital or other provider at the point of referral is part of a wider drive to provide healthcare which is delivered at the convenience of the patient. It was encapsulated in a Public Service Agreement in 2002 and re-stated in 2004, which stated that the Department would:

*'Ensure that by the end of 2005 every hospital appointment will be booked for the convenience of the patient, making it easier for patients and their GPs to choose the hospital and consultant that best meets their needs.'*²

1.4 The Department's detailed plans for implementing the Public Service Agreement were set out as a policy framework in *Choose & Book – Patient's Choice of Hospital and Booked Appointment*³, published in 2004. This states that GPs offering choice at the point of referral should:

- offer patients the choice of four or five providers; and
- offer patients the opportunity to book a date and time of their first outpatient consultation within 24 hours of the decision to refer.

1.5 The booking element of the target relates to the patient's first consultant-led outpatient appointment, rather than any subsequent appointments. The limitation of choice to four or five providers will only last until 2008, at which point patients will be entitled to choose any provider in England, under so-called 'free choice'. The main differences between how referrals work now and how they will work in the future under choice supported by e-booking are set out at **Figure 1**.

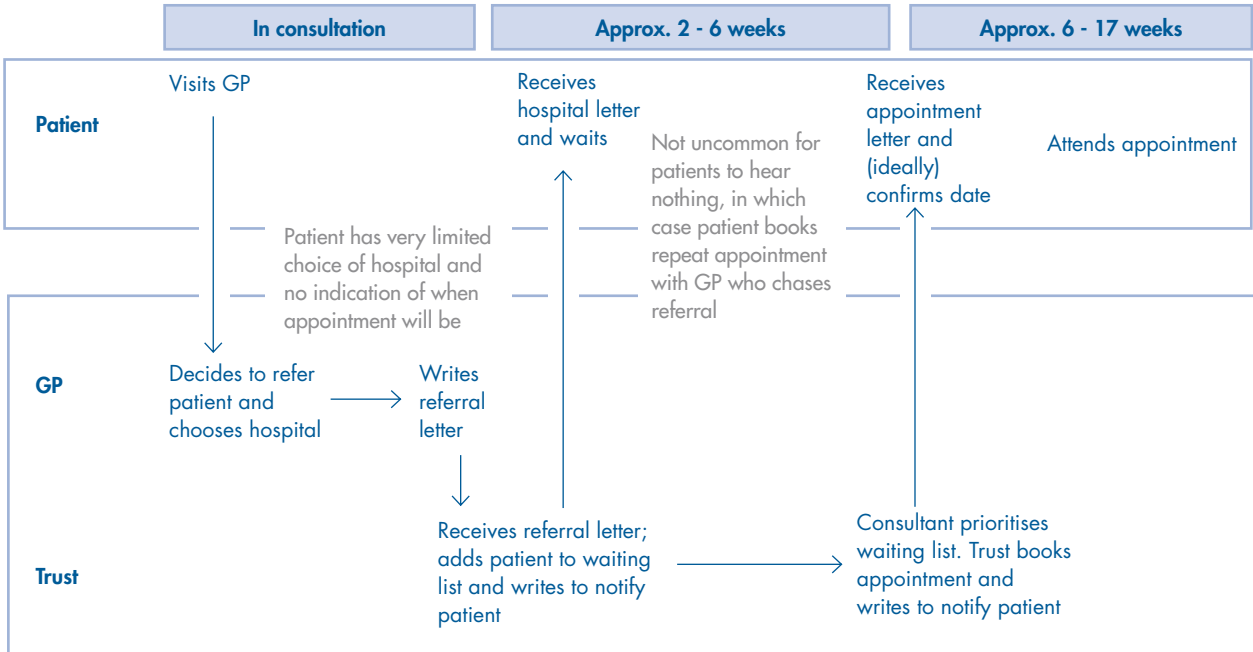
1 *General Household Survey* (2002).

2 *Spending Review 2002 Public Service Agreement*, Objective 1, No.4, Department of Health.

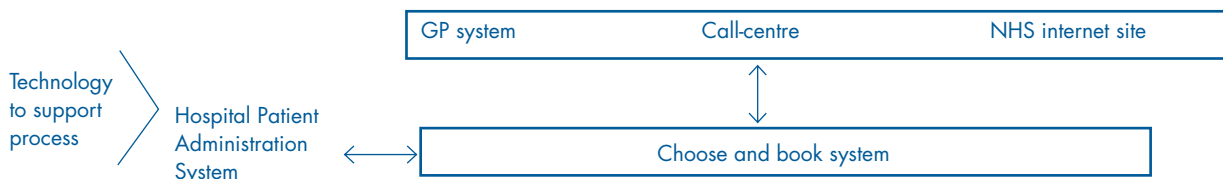
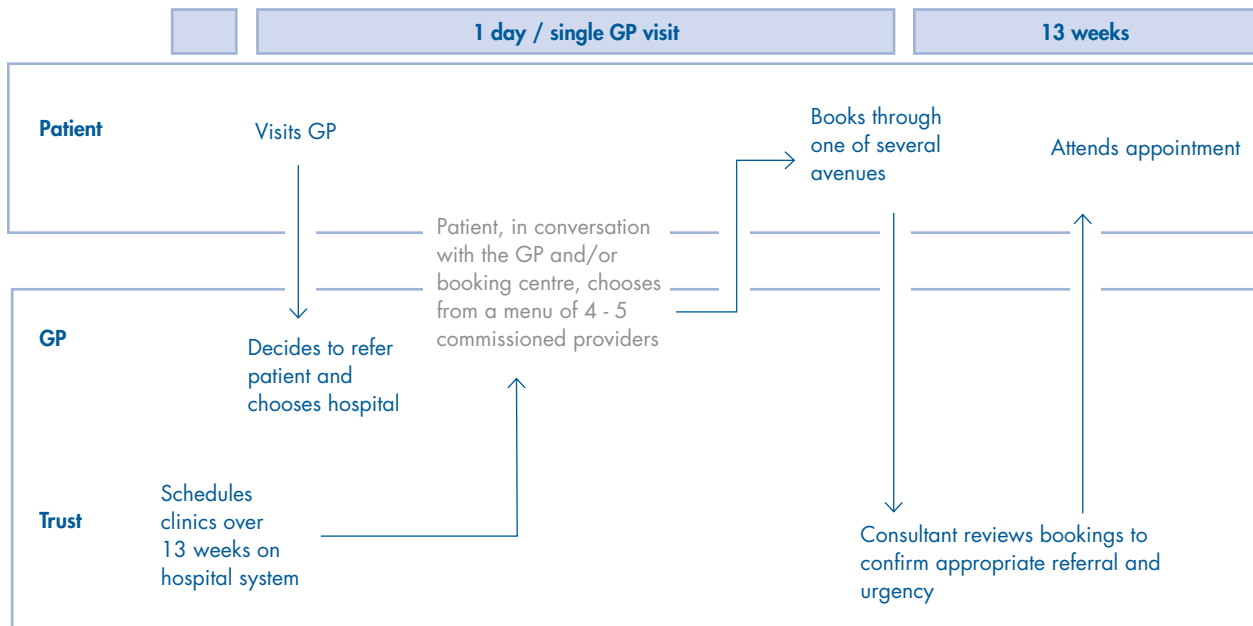
3 *'Choose & Book' – Patient's Choice of Hospital and Booked Appointment*, Department of Health, August 2004.

1 Choice will change the referrals process

How the referrals process works now



How the referrals process will work under choice



Source: Department of Health/National Audit Office

Patients will welcome the opportunity to choose

1.6 The Department has conducted research and made use of other studies on choice which has revealed what patients want. The various studies supporting the choice policy⁴ surveyed different clinical, patient and public groups and found the following:

- 71 per cent of the public thought it was important for them to be able to choose which hospital to go to;
- 76 per cent of the public and health professionals think that the main priority in health care is involving patients in decisions about their condition/illness or treatment; and
- 61 per cent of people think that choice over public services such as health would give them a lot or some more control over their life.

1.7 The Department's intention is that choice at referral will bring meaningful improvements to the way that patients experience the NHS and provide them with tangible benefits. These benefits should include:

- the opportunity to influence the way they are treated by the NHS through discussions with their GP or other professionals;
- the ability to discuss different treatment options; and
- greater convenience and certainty in arranging further treatment.

1.8 This study is confined to assessing preparations for the introduction of choice at referral at a key point, one year ahead of implementation. It does not examine the other types of choice available in the NHS, for example choice at six months.

The Department believes choice is affordable and should deliver benefits for the NHS

There are financial and non-financial benefits as well as costs in offering choice

1.9 The Department considers the likely additional annual infrastructure and transaction costs of £122 million for offering choice to be affordable. This figure is a best estimate which the Department will refine in the light of experience from the Early Adopters. The figure rests on a number of assumptions on take-up of choice, support to patients and transport costs. The total cost of providing elective care in 2003-04 was £8.7 billion.⁵ The costs of offering choice are broken down in **Figure 2**. The initial infrastructure costs also include the one-off costs of technology upgrades, which naturally decline over time (**Figure 3**).

1.10 The introduction of choice should result in increased efficiencies for primary care. GP practices and Primary Care Trusts should see swift benefits from routinely offering choice, including: reductions in patient enquiries regarding appointments; reductions in the amount of time spent on administration associated with the existing referral process; and increased patient satisfaction with the service.

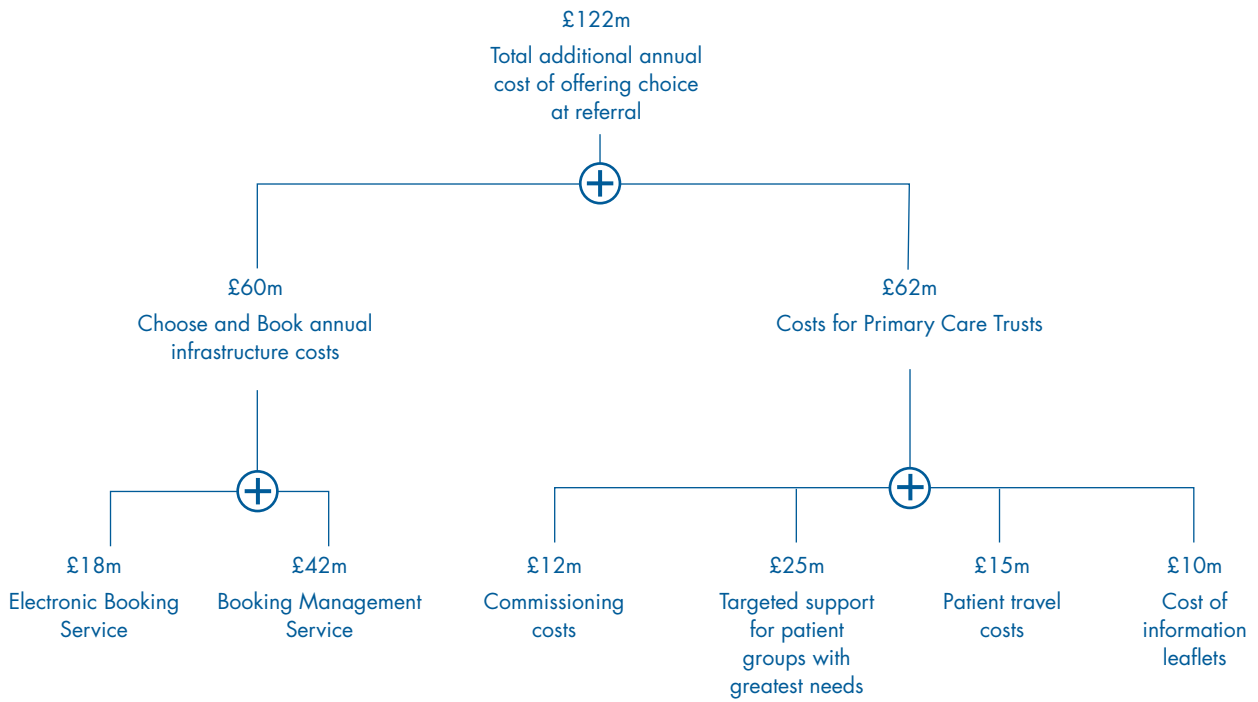
1.11 There should also be increased efficiencies for hospitals, including reductions in missed appointments (known as 'Did Not Attends') and cancellations, meaning clinics can be run more efficiently. The cost of these in 2003-04 was approximately £100 million for the 1.5 million missed first outpatient appointments that are most likely to be addressed by choice.⁶

⁴ Annex A, *Choose & Book' – Patient's Choice of Hospital and Booked Appointment*, Department of Health, August 2004.

⁵ Department of Health.

⁶ Department of Health.

2 Gross annual costs of choice at referral



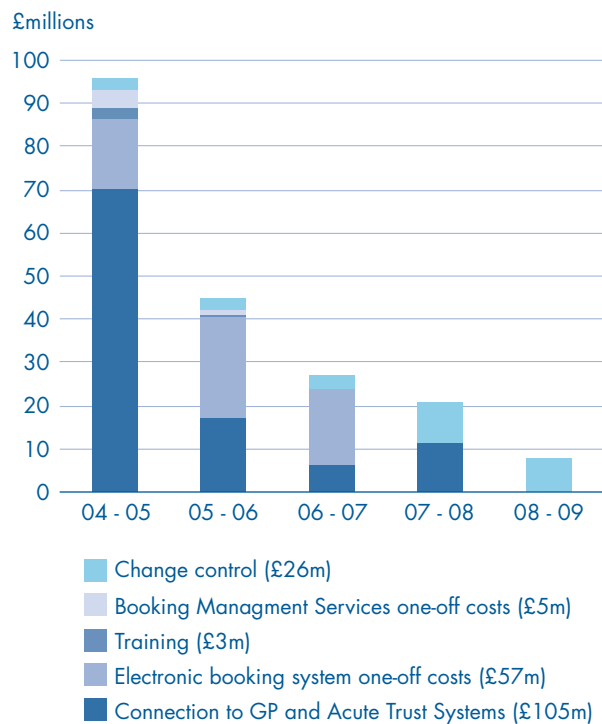
Source: Department of Health/National Audit Office

NOTE

Figures are based on estimated costs of offering choice in 2006/07, the first full year of choice at referral.

3 One-off costs associated with the technology to support Choose and Book

One-off costs of £196m for introducing Choose and Book are heavily weighted towards the beginning of the programme.



Source: Department of Health/National Audit Office

1.12 There are no plans to put a financial value on the offer of choice. However, as part of a wider benefits realisation work stream conducted by the Department's National Programme for IT, there are quantified forecasts of the benefits e-booking might deliver. Building up benefits over the first three years of operation, estimated benefits should eventually amount to £71 million per year, divided between primary and secondary care (£28 million and £43 million respectively). None of these benefits will necessarily enable cash to be released, but should result in a reduction of administrative duties which will give staff time to focus on those tasks which have a direct impact on the quality of patient care, service and communication.

Choice should be supported by other elements of the system reform agenda

Choice is a key part of the NHS system reform agenda

1.13 Bringing together all the elements needed for the introduction of choice is an extremely complex task. The Department has identified these elements – e-booking, payment by results, commissioning, capacity, changes in primary and secondary care, information provision and clinical engagement - and has sought to co-ordinate them.

1.14 Key elements of the reform agenda are set out in the Department's published documents: *The NHS Plan*⁷, *Building on the Best*⁸ and *The NHS Improvement Plan*.⁹ These provide a coherent picture of changes to the NHS which should result in the provision of more patient-focused care (Figure 4).

The system reform agenda supports choice

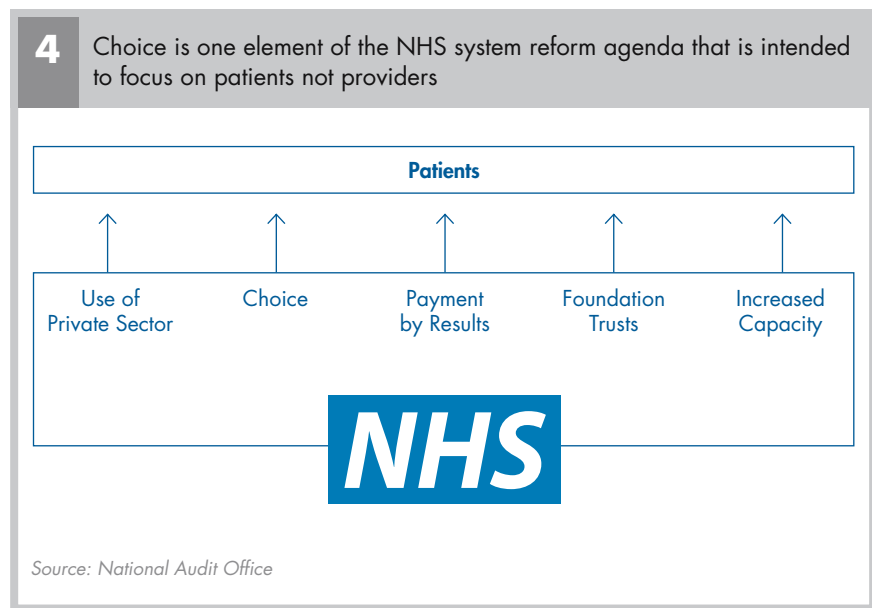
1.15 If patients are choosing to change provider at the point of referral, arrangements must be made for the chosen provider to be paid for that treatment. The Department has chosen payment by results as the mechanism for this process. Payment by results is a new financial system for the NHS and should enable the efficient transfer of tariff-based funding to follow patients receiving most types of elective treatment. It will operate from April 2005.

1.16 This report is only concerned with the introduction of payment by results as an effective mechanism for ensuring that money can follow patients exercising choice. It does not comment on the likely impact of payment by results on either the efficiency of the NHS or the financial standing of individual NHS organisations.

⁷ *The NHS Plan: a plan for investment, a plan for reform*, Department of Health, 2000 (CM 4818).

⁸ *Building on the best: Choice, responsiveness and equity in the NHS*, Department of Health, 2003 (CM 6079).

⁹ *The NHS Improvement Plan: Putting people at the heart of public services*, Department of Health, 2004 (CM 6079.)



1.17 The Department has commissioned and undertaken a number of quantitative and qualitative modelling exercises which provide assurance on the effects of implementing choice. This analysis shows that the gradual roll-out of choice, together with payment by results and other reforms, should result in manageable changes in the capacity that will be required.

1.18 One scenario planning exercise was designed to test the likely behaviours of NHS organisations in the first three years of full implementation. The model showed that:

- there were long lead times before the effects of patients' choices were felt as financial impacts by provider organisations, giving NHS organisations time to adapt to changing circumstances; and
- the NHS was remarkably stable, even with these new factors;

1.19 A complex modelling tool, commissioned by the Department from independent consultants, simulated the response of health systems to choice and payment by results.¹⁰ The key finding generated by the model is that waiting times seem to act as a 'makeweight'. If a popular provider becomes over-subscribed for its available capacity, its waiting times increase and those patients for whom waiting time is the key factor choose other providers. This will in turn reduce the strain on the original provider's capacity and bring down waiting times once more. As long as waiting times remain a key issue for patients, therefore, the system will stabilise itself and excess capacity will not be a problem.

¹⁰ The model used data from the North East Yorkshire and North Lincolnshire Strategic Health Authority to simulate a 'typical' health economy over a 10-year period and employs an algorithm to replicate likely patient behaviour on an individual basis. The patients' behaviour patterns in the model were based on a MORI survey of 2,000 members of the public from different geographic, socio-economic and age groups and the NHS data were taken from actual NHS organisations.

1.20 As well as acting as a central planning tool, the model is being used by a small number of Strategic Health Authorities, with technical support provided by the Department. Other Strategic Health Authorities have conducted their own modelling exercises as part of their capacity planning work.

1.21 The Department has also formulated a policy by which over-subscribed providers can cope with an inability to meet demand. In the short term, they can remove themselves from the menus of outlying Primary Care Trusts, thus reducing demand for their capacity instantly but preserving access for local populations. In the longer term, they may be able to create extra capacity using revenues derived from payment by results.

1.22 While the modelling suggests that current capacity will be sufficient for the NHS with choice fully operational, the Department has also procured extra capacity to meet access targets which could assist with the delivery of choice if required in the short term. For example, the Treatment Centre programme, which was launched in April 2002, has already treated over 120,000 patients. There are now over 30 treatment centres run by both the NHS and the independent sector and, by the end of 2005, it is planned that 80 will be open across England.

PART TWO

Progress has been made towards delivering choice at referral



2.1 This part of the report describes those elements of the infrastructure which are already in place to underpin choice and the support which the Department has given to the NHS to date in assisting their preparations for choice.

Much of the infrastructure required is in place

There is clear accountability for the delivery of choice

2.2 The policy was designed by the Choice Policy Team within the Department's Access Directorate. At the same time, the Department's National Programme for IT was procuring a national e-booking system. In April 2004, the Department decided that it would formally combine the two work streams and call the resulting project 'Choose and Book'.

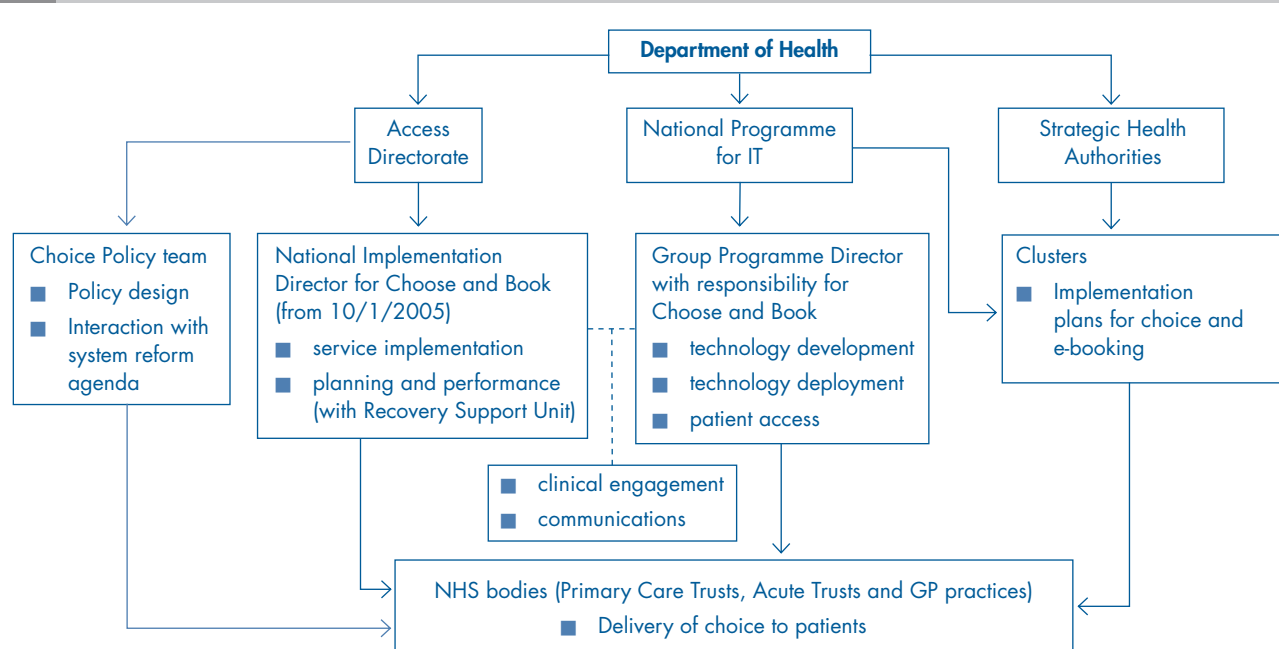
2.3 In order to deliver the joint choice and e-booking roll-out, the Department put together a combined implementation team, known as the Choose and Book team. Reflecting its twin purposes, the Choose and Book team reports to both the Access Directorate within the

Department (for the delivery of choice) and the National Programme for IT (for the delivery of e-booking). **Figure 5** sets out these relationships and the responsibilities of these teams for the delivery of choice.

2.4 The Department's Access Directorate has overall responsibility for co-ordinating action within the Department and the NHS. It is the responsibility of the Choose and Book team to equip the NHS with the services and tools required to offer choice. Primary Care Trusts and GPs will be responsible for offering choice to patients locally and hospitals for providing the actual care.

2.5 To strengthen programme management arrangements, on 22 December 2004 the Department created a new post of National Implementation Director for Choose and Book, with effect from 10 January 2005. This work had previously been the responsibility of the Group Programme Director for Choose and Book. The new Director will report solely to the Department's Access Directorate, rather than, as for the existing Group Programme Director, to both the Access Directorate and the National Programme for IT. The Group Programme Director will continue to be responsible for Choose and Book technology development and deployment, patient access and Choose and Book contract management.

5 Organisational Responsibilities for Choice



Source: National Audit Office

NOTE

A new position of National Implementation Director for Choose and Book was created with effect from 10 January 2005.

Careful programme management is required

2.6 The range of different organisations involved in delivering choice is considerable and includes: the various teams within the Department, Strategic Health Authorities, Primary Care Trusts, Acute Trusts, GP practices, Clusters and Local Service Providers. **Figure 6** below sets out their roles and responsibilities. Careful programme management arrangements are required for their activities to be successfully aligned.

2.7 The Choose and Book team have put in place detailed programme management arrangements which should enable successful delivery of the choice

target. In order to assist the NHS, they have identified a series of key milestones for the project, some of which are set out below:

- by March they should have commissioned four or five providers for all specialties;
- by June, they should be close to a recommended 75 per cent of fully booked first consultant outpatient appointments; and
- the period from October to December should reveal referral patterns which indicate that choice is already being offered in most areas before the target at the end of the year (**Figure 7**).

6 Principal organisations involved in delivering choice at referral

Organisation	Responsibility
Acute Trusts	Responsible for running hospitals and providing services commissioned by Primary Care Trusts.
Atos Origin	Responsible for the delivery of the Electronic Booking Service.
Choose and Book Team	A team within the National Programme for IT responsible for the implementation of choice and electronic booking. Accountable to both the National Programme for IT and the Department of Health.
Choice Policy Team	Part of the Department of Health. Responsible for devising the policy to meet the Public Service Agreement.
Clusters	Five virtual NHS organisations responsible for the local implementation of services provided by the coterminous five Local Service Providers. They represent the NHS organisations in that geographical area.
Department of Health	Accountable for delivering the choice at referral Public Service Agreement to offer patients the choice of four to five providers at the point of GP referral.
General Practitioners	Medical practitioners who are contracted by the local Primary Care Trust to take unsupervised responsibility for a specific list of patients. Responsible for the initial diagnosis and possible referral of patients to hospital outpatient clinics, at which point the choice policy is introduced.
Local Service Providers	Contracted by the National Programme for IT to deliver IT systems and services to be used locally, such as GP and hospital systems. Also make sure local applications can 'talk to' and share information with the national systems.
National Programme for Information Technology in the NHS	Responsible for the design, specification and procurement of all new major applications in the NHS, including the New National Network. Procured the Electronic Booking Service from Atos Origin. Contracted with Local Service Providers to implement.
Primary Care Trusts	The 302 Primary Care Trusts in England are responsible for commissioning the healthcare for their local population. They manage General Practitioners.
Regional Implementation Director	Part of the National Programme for IT team and reports to the National Programme for IT implementation director. Also responsible to the cluster board for delivery.
Strategic Health Authorities	28 Strategic Health Authorities are local headquarters of the NHS. They performance manage Acute Trusts and Primary Care Trusts.

Source: National Audit Office

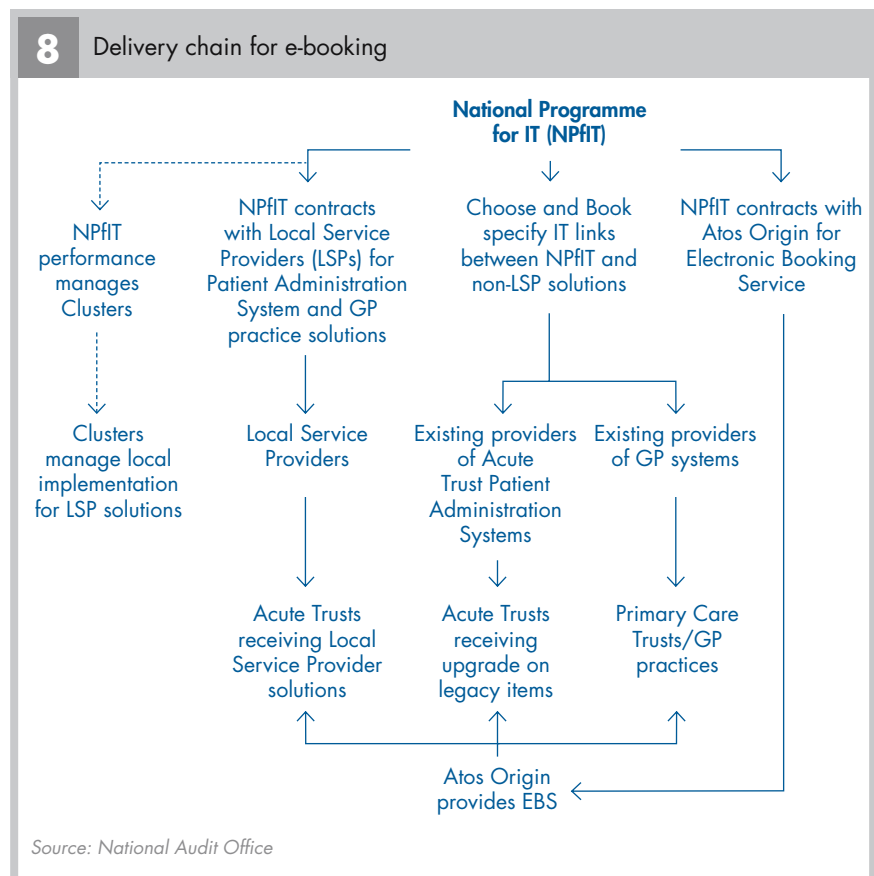
Choice is being implemented in the context of increased devolution of power within the NHS

2.9 The Department’s 2002 document *Shifting the Balance of Power*¹¹ set out a new relationship between the Department and the NHS, to be characterised by increased local decision-making and control of the resources necessary to enact those decisions. This means that the Department and the NHS share responsibility for the delivery of the choice target.

2.10 The Choose and Book team are working within the changed environment created by *Shifting the Balance of Power*. The local performance management of the implementation of Choose and Book is carried out by the 28 Strategic Health Authorities who are in turn accountable to the Department of Health. The Department carries overall responsibility for delivering the strategic objectives for Choose and Book.

Different strands of technology underpin the delivery of choice

2.11 E-booking is the technology that will be used to deliver choice. The organisations involved in its delivery are set out in **Figure 8**.



11 *Shifting the Balance of Power: The Next Steps*, Department of Health, 2002.

2.12 E-booking comprises three different elements: the Electronic Booking Service application itself, hospital Patient Administration Systems and GP practice systems. E-booking is itself supported by the Booking Management Service, which allows bookings to be amended over the telephone and the Care Records Service containing patients' details. The relationship and function of these systems is shown in **Figure 9**.

2.13 The Electronic Booking Service has been successfully procured by the Department in just nine months from publication of the competition notice in the Official Journal of the European Union to Project Agreement. The successful contractor was Atos Origin (formerly SchlumbergerSema). The contract value was £64.5 million, payable over five years. Part 3 of this report examines progress in delivering against the contract.

Booking Management Service

2.14 The main function of the Booking Management Service is to provide the patient, GP and hospital with the ability to make, change, track and cancel bookings through telephone based transactions. This service is only for referrals which have been made electronically through the e-booking system.

2.15 The Department's full business case for Choose and Book identifies an additional cost of £153 million over the first six years for the Booking Management Service function. For a full year of activity, based on assumptions in the business case and work by the Choose and Book team with NHS Direct, the Department estimates that the Booking Management Service could have to field around 18 million calls a year with an average length of 6 minutes at a rate of 42 pence per call minute. This equates to an annual cost of approximately £45 million.

9 Technology elements of Choose and Book

Element	Function	Provider
Electronic Booking Service	Electronic Booking Service is the software application that will allow direct booking from compliant primary care systems to compliant hospital systems.	Atos Origin (formerly SchlumbergerSema).
Hospital Patient Administration Systems	Hospital systems record available and used clinic appointments. It is essential that any e-booking system can access information on these clinics directly to establish what choices are available to the patient and at what dates and times.	Existing suppliers for two thirds of hospitals. Local Service Provider for remainder.
GP Practice Systems	GP systems must allow the GP or practice staff to access hospital systems to offer available clinics to patients. GP practices operate a wide variety of IT systems.	Existing suppliers for circa 90 per cent of systems. Local Service Provider for remainder.
Booking Management Service	The main function of the Booking Management Service is to provide the patient, GP and hospital with the ability to make, change, track and cancel bookings through telephone based transactions. This service is only for referrals which have been made electronically through the e-booking system.	NHS Direct or as determined by local NHS.
Care Records Service	This will be an electronic store of over 50 million health and care records which can be accessed by health professionals wherever they are needed. It will also give patients secure Internet access to their own health record.	British Telecom.

Source: National Audit Office

2.16 Reflecting the investment in its infrastructure by the NHS and its call centre experience, NHS Direct has been identified as a default potential provider for the Booking Management Service, where local organisations do not provide the service themselves. NHS Direct at present only handles some 6 million calls annually and approximately the same number of web-based enquiries, as opposed to the anticipated annual volume of 18 million calls, although actual activity after December 2005 will depend on the pace of national roll-out and the degree to which bookings are managed in GP practices. This could require a significant increase in the human and physical capacity of NHS Direct, were it to face the full volume of calls, although NHS Direct anticipates that the hour by hour call profiles of its existing services should complement the anticipated profile of the Booking Management Services work.

The Department has provided different types of support for the NHS

Information is needed to support informed choice by patients

2.17 Information with which to make informed choices will be a crucial element of support for patients and GPs from December 2005. The Department's 2003 report, *Building on the Best*, set out clearly that effective choice requires better information for patients

*'We are committed to patients and doctors having access to the same high quality, evidence-based information, to support shared decision-making.'*¹²

2.18 People facing choice over their provider of treatment want clear and accessible information on a range of factors. Most important among these are:

- the ease with which they can access the service;
- the quality of care that they can expect to receive;
- the reputation of the provider of that care; and
- the length of time that they may have to wait to receive treatment.

2.19 Patients also want specific information on services, rather than the more generalised information available from the Department. This is supported by research carried out on behalf of the Department, by findings from a variety of pilot sites around the country and from the experience of other countries where choice of provider is available to patients. A study conducted by Dr Foster¹³ and the University of Nottingham to examine how choice was offered in 38 GP practices found that patients considered ease of access and quality of care as more important than waiting times in making their choice.¹⁴

2.20 The Department will be responsible for providing information on some items, such as waiting times, much of which will be available on the NHS website – www.nhs.uk. Primary Care Trusts will have an overall responsibility for providing information on local issues such as transport links, parking facilities and on-site facilities.

2.21 Patients are concerned about the cost of travel, particularly when alternative providers are some distance away. The Department has stated that those patients who are currently eligible for free transport will continue to be eligible to any of the available providers. The pilot studies have shown that choice of provider is influenced by cost of travel, and it is important that information regarding such costs and who will be responsible for meeting them is presented to patients before a choice is made.

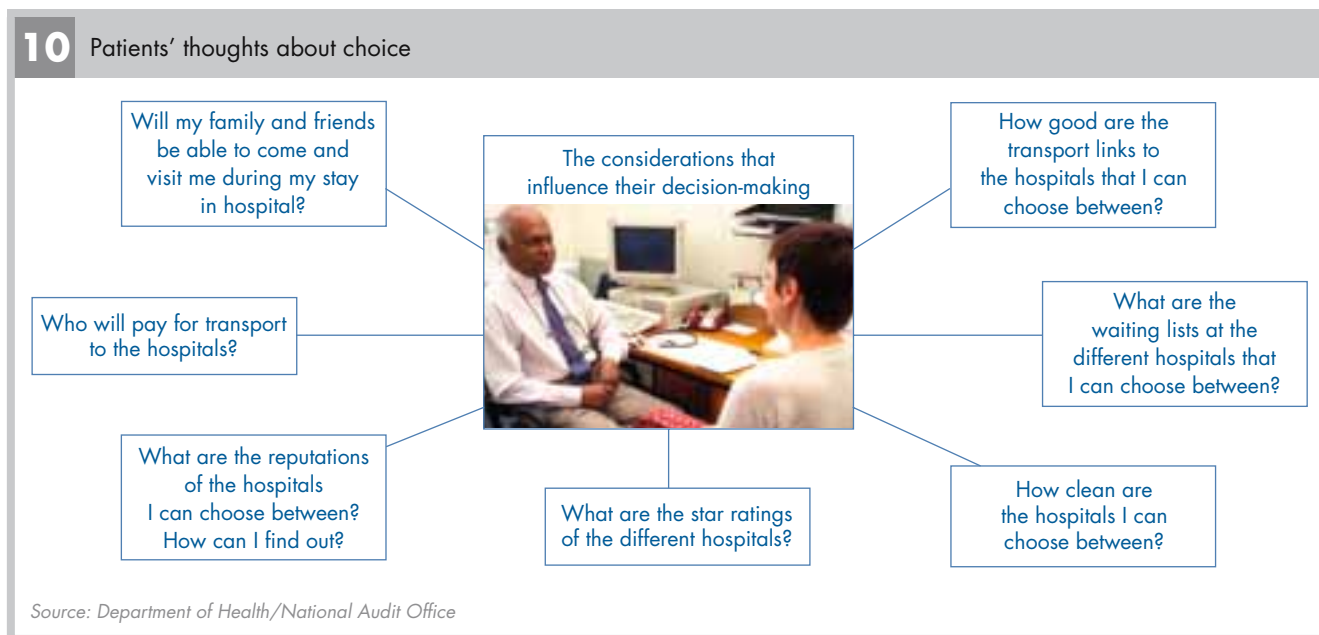
2.22 Progress has been made in some areas of information provision such as physical access to local services and outpatient waiting times. However, interdependencies with other areas of policy and a lack of baseline information have hindered efforts in others, such as the quality of services beyond a star-rating and the crucial question of health outcomes. Informed by the experience of choice pilots and *Dr Foster* research, the Department's view is that it would prefer to roll choice out with the existing limited set of information. While this is reasonable, it does fall some way short of patients' expressed preferences, as noted in *Building on the Best*¹⁵ for information on outcomes and quality to make choices (**Figure 10**).

¹² *Building on the best: Choice, responsiveness and equity in the NHS*, p. 48, Department of Health, 2003 (CM 6079).

¹³ *Dr Foster* is an independent organisation which collects and analyses information on the availability and quality of health services in the UK.

¹⁴ *Implications of offering Patient Choice for routine adult surgical referrals*, Dr Foster and the University of Nottingham, March 2004.

¹⁵ *Building on the best: Choice, responsiveness and equity in the NHS*, Department of Health, 2003 (CM 6079).



2.23 In addition to the data sets mentioned above, other areas need to be considered in greater detail. These include the information that will be available from non-NHS providers so as to make meaningful comparisons between them and their NHS counterparts and the total waiting times that patients will actually face from the beginning to the end of their treatment. The Department does not plan to have information available on total waiting times by December 2005, as the total waiting time target of 18 weeks does not come into force until 2008. It is, however, committed to the early piloting of the collection of such information.

Choice pilot schemes have been established

2.24 A series of pilot schemes to test choice have been run successfully (**Figure 11**). Pilot schemes were established in various Strategic Health Authorities across England at a cost of £53 million, although some of these were also testing other choice policies such as 'choice at 6 months'.

2.25 The pilot schemes have thrown up a range of useful findings, which will be of use to other parts of the NHS in preparing for choice. These include the following findings from a number of different Primary Care Trusts and Strategic Health Authorities involved in the pilot schemes:

- pilot scheme project managers underestimated the amount of time and effort required to introduce choice;

- once offered 'choice', patients begin to exercise choices in unexpected ways, such as wanting to split their treatment between two providers or wanting to choose providers not currently commissioned;
- patients need to have the whole treatment pathway explained at referral;
- most of the pilot schemes found it impossible to deliver choice without setting up some form of additional referral handling centre prior to the introduction of e-booking. GPs were keen on these centres because it relieved them and their practice staff of extra administration;
- new methods had to be established to cope with referrals from professionals other than GPs, such as optometrists;
- the decision as to whether or not patients qualify for transport to more distant providers was a crucial factor in rural areas.

2.26 The Department has used informal meetings to exchange best practice and lessons learned and staff involved in pilot schemes have made presentations at the Strategic Health Authority Choice Leads meetings. However, only two of the pilot schemes have been subject to formal external evaluation. The NHS could benefit from the work done by these schemes and those involved should consider commissioning external evaluations and distributing the results to other Primary Care Trusts and Strategic Health Authorities.

11 Choice at referral pilot schemes in England funded by the Department of Health

1 During 2005 Greater Manchester Strategic Health Authority will link choice to the development of new clinical services based on the extended roles of primary care health professionals who will support the clinical management of referrals and provide a greater range of assessments and treatments without the need to refer patients to traditional, hospital settings.

2 Thames Valley Strategic Health Authority started offering choice at referral for orthopaedics in September and ophthalmology in October in a small number of GP practices in West Berkshire. This will roll out to include general surgery in January and more practices throughout 2005.

3 Dorset & Somerset Strategic Health Authority – choice at referral is being offered in 4 Primary Care Trusts across a range of specialties including ophthalmology, ENT and orthopaedics.

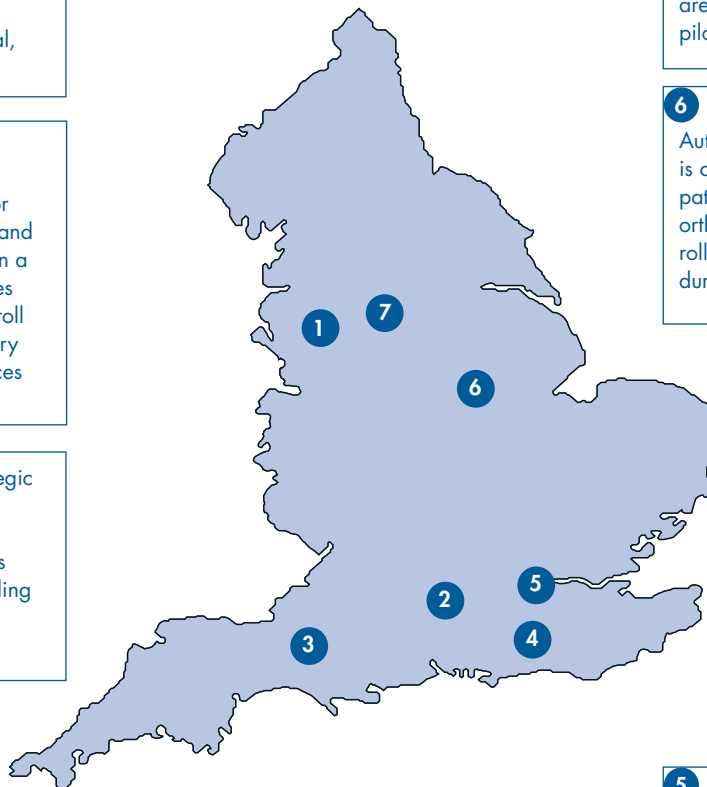
4 Surrey & Sussex Strategic Health Authority is currently developing a range of choice at referral pilot schemes. For example, in West Sussex, the primary care back pain service will offer a choice of hospitals from April 2005.

7 West Yorkshire Strategic Health Authority - Patients needing treatment for cataracts are being offered choice of hospital when they are referred by an optometrist. One of the choices is a Primary Care Trust-run treatment centre.

A study was conducted by Dr Foster and the University of Nottingham to examine the impact of offering choice on 38 GP practices across England.

South Cataract Project - 6 further Strategic Health Authorities in southern England are running choice at referral pilots for cataract patients.

6 Trent Strategic Health Authority - choice at referral is currently being offered to patients in ophthalmology and orthopaedics. Choice will be rolled out to all other specialties during 2005.



5 South West London Strategic Health Authority introduced choice at referral for cataract patients in September 2004.

5 North West London Strategic Health Authority offered choice at referral to patients with recurrent tonsillitis and osteoarthritis in 3 Primary Care Trusts from June 2003. This is being rolled out across the SHA and into more specialties.

Source: Department of Health/National Audit Office

PART THREE

The key challenge to the roll-out of choice at referral is clinical engagement



3.1 This part of the report describes the main challenges still facing the Department and the NHS before they can deliver choice. It sets out three challenges in particular which must be addressed:

- the need to increase levels of support among GPs for choice;
- the difficulty of delivering choice without e-booking; and
- the scale of the task that remains if the NHS is to be ready to deliver choice.

Choice will not be delivered without increased levels of GP support

3.2 The role of GPs is crucial in the delivery of choice. Although other clinicians and administrative staff will have roles to play, GPs will be the ones responsible for ensuring that patients whom they refer for elective care are given the choice of providers. We therefore examined the current levels of engagement among GPs and the Department's plans for securing their engagement with the implementation of choice.

GP engagement is currently low

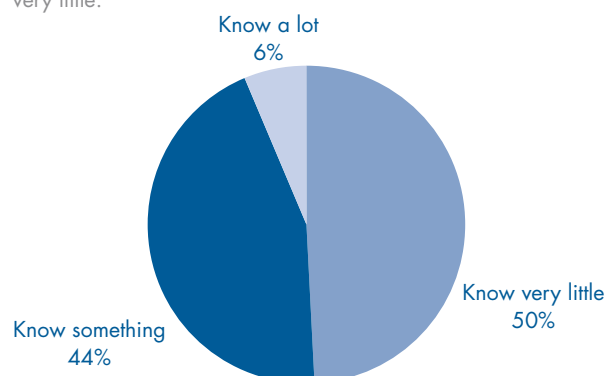
3.3 To discover what GPs thought about choice and the e-booking technology, we conducted an electronic survey of 1,500 GPs in October 2004, and examined the other evidence available on the extent of GP engagement. More information on our survey is provided in Appendix 2 and the survey report is posted in full on our website.¹⁶

GPs currently know little about how choice will be delivered

3.4 Our survey found that, with just over a year to go before they have to deliver choice at the point of referral, many of the GPs who responded knew little about how choice will be delivered. While 6 per cent of GPs responding claimed to know 'a lot' about choice, 45 per cent said that they knew 'a little' and 49 per cent said that they knew 'very little' about it. The survey showed little differentiation by region and a common degree of knowledge when analysed by date of registration as a GP (**Figure 12**).

12 GP knowledge of Choose and Book

A very small proportion of GPs feel that they know a lot about Choose and Book, while just under half feel that they know very little.



Source: National Audit Office Survey of 1,500 GPs

3.5 The survey also revealed discontent at the way in which the Department had communicated with them. Ninety-two per cent of GPs said that they have not had the opportunity to feed in to the consultation process for Choose and Book and 97 per cent said that the Department had not communicated adequately on the timetable for the introduction of choice and e-booking.

Most GPs feel negative about choice

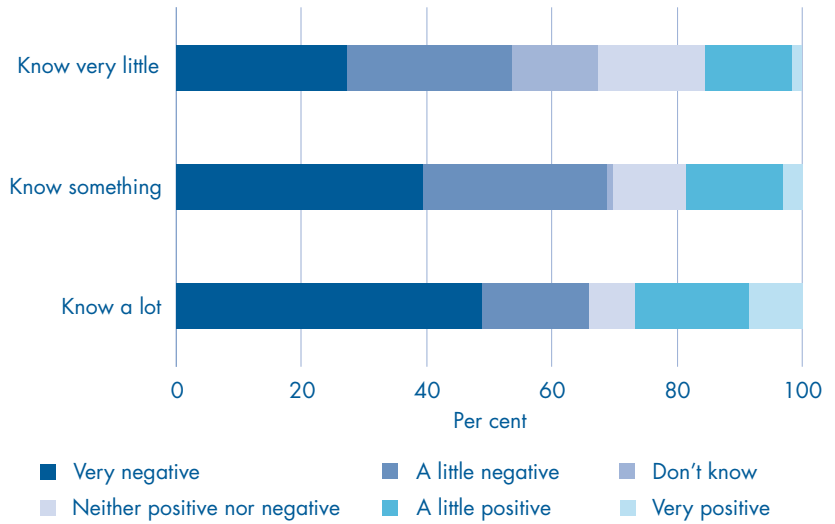
3.6 The survey found that only 3 per cent of GPs responding said they were 'very positive' and 15 per cent 'a little positive', whereas 61 per cent said they were either 'very negative' or 'a little negative'. Those GPs who felt they knew more about the proposals were clearer in their views about it - more were positive, although nearly two thirds remained negative (**Figure 13**).

3.7 A key area of concern for GPs relates to the impact of offering choice on their current working practices. For example, 84 per cent of those responding said they believed that they will have to work differently as a result of choice and 90 per cent of them believed that their overall workload will increase. In addition, 91 per cent of them believed that their consultations will be longer. Awareness of the training required to deliver choice is very low. Nearly three quarters of GPs responding were not aware of what training they might need and, of the quarter who were aware of the training requirements, 90 per cent of these were not aware of how the training will be organised and paid for (**Figure 14**).

16 <http://www.nao.org.uk>

13 How GPs felt about the prospect of Choose and Book

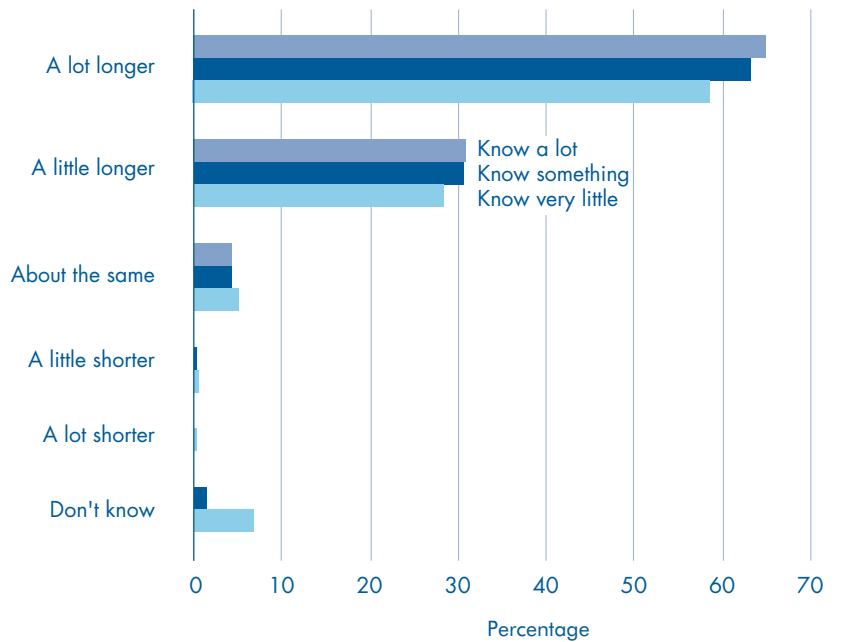
GPs generally felt negative about Choose and Book; the more they know, the more likely they are to have strong feelings about it, whether positive or negative.



Source: National Audit Office Survey of 1,500 GPs

14 GP views on consultation length when offering choice

Regardless of level of knowledge of Choose and Book, a large majority of GPs expect that consultations with patients will take longer.



Source: National Audit Office Survey of 1,500 GPs

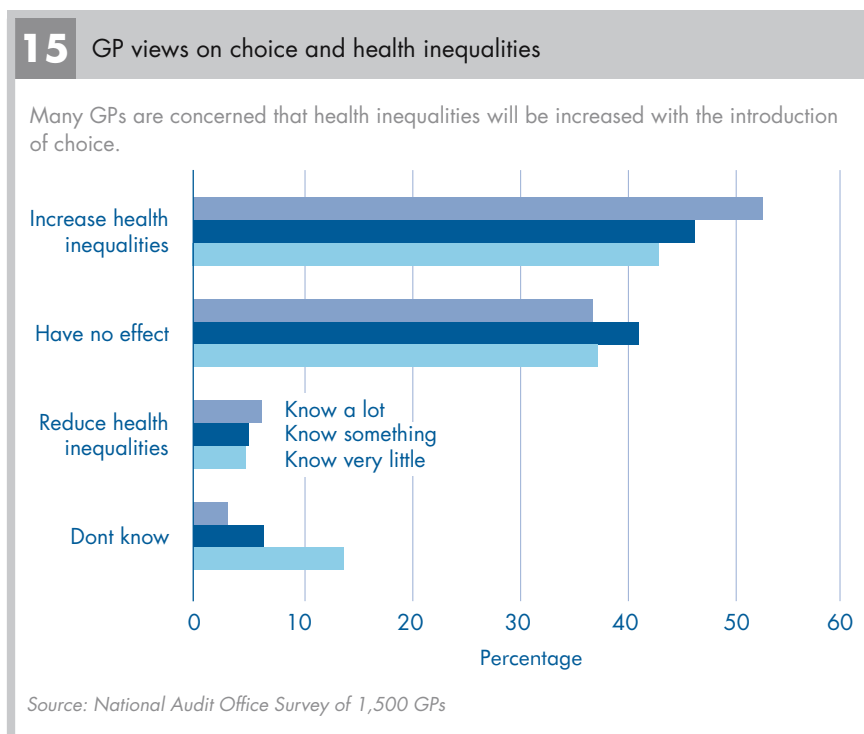
3.8 GPs responding had a range of views on the impact of choice on their patients. Most of them thought it will have a neutral or slightly positive impact on patients' experience of healthcare. However, 45 per cent told us that they thought choice will increase health inequalities for disadvantaged sections of their practice population and only 5 per cent believed it will reduce them (Figure 15).

Other evidence corroborates the findings of our survey

3.9 During our fieldwork, we met various members of the two most relevant representative bodies: the British Medical Association and the Royal College of GPs. They confirmed that clinicians in both primary and secondary care remain supportive of the principle and benefits of offering choice but are sceptical about its implementation and dissatisfied about the level of

consultation and clinical engagement from the Department. They also confirmed that GPs were concerned that consultations in which referrals were made would be much longer than in the past.

3.10 Research for the Department, carried out during May and June 2004, further corroborates the findings of our survey. Interviews with 100 GPs found that, despite a rise in awareness since 2003, 71 per cent of GPs felt ill informed about how choice would actually work in practice. Most respondents agreed that there were benefits, such as patient convenience and a streamlining of the booking process, but a majority of clinicians felt that choice would not improve their job satisfaction or make their jobs easier. Overall, however, there was substantial endorsement for offering patients the choice of both a time and date (91 per cent) and a hospital (82 per cent).



3.11 Other work has revealed similar findings. A survey of 500 primary and secondary care clinicians conducted by Medix for the BBC in October 2004 found that only 27 per cent of GPs surveyed said that they would be either 'likely' or 'very likely' to use choose and book when it was introduced. Thirty-two per cent said they were 'unlikely' or 'very unlikely' to use it and a further 27 per cent said that they either knew nothing about it or had insufficient information to comment (**Figure 16**).

The Department has plans to engage and inform GPs

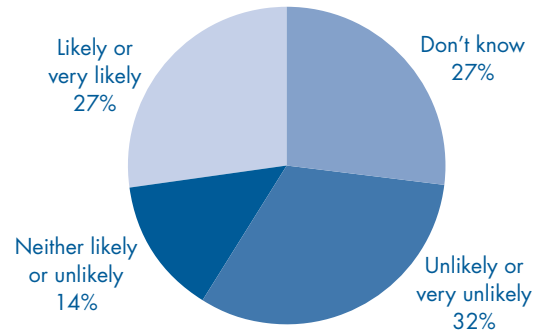
3.12 The Department recognises the importance of engaging and informing GPs and has a range of plans in place to mitigate the risk of GPs being unwilling to deliver choice. These include technology demonstrations, local events run by clinical and executive leads, the development of the Choose and Book website and the possible use of incentives for primary care. These strands are set out in **Figure 17**.

A 'back-loaded' communications strategy has been planned

3.13 The Department has always planned only to fully engage and inform GPs towards the latter stages of preparations for choice. As the GPs' representative bodies

16 GP views on whether they will use Choose and Book

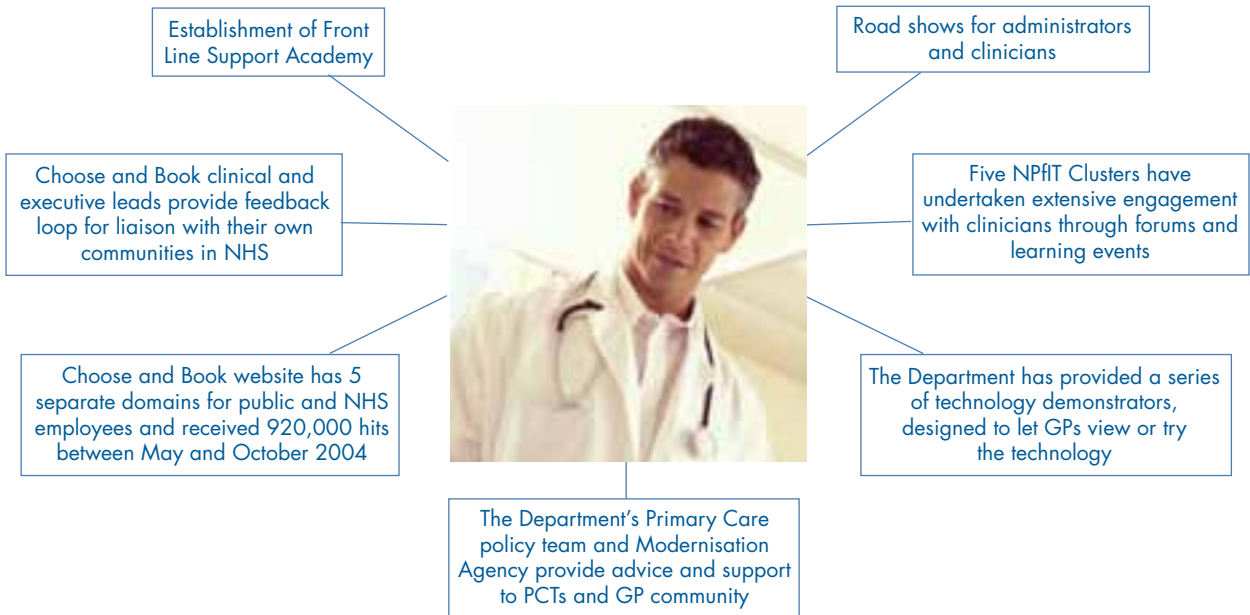
A large number of GPs still feel that they are unlikely to use Choose and Book when it is introduced.



Source: Medix/BBC

told us, this strategy has a risk that the information void will be filled by adverse opinion and rumour, potentially making it harder to engage GPs in due course. However, the Department has taken the view that it will be easier to engage GPs when the Department has real confidence that the system is fully operational and can show 'live' technology to the future user community.

17 The Department's strategy for communicating with GPs has multiple strands



Source: National Audit Office

3.14 These activities have not always been fully co-ordinated thus far, but representatives from these teams are now meeting on a regular basis and the Department is working hard to ensure that this is improved during the next year.

3.15 It will be crucial for the Department to monitor changes in the level of GP engagement as the target approaches. At present the Department has no plans to do this.

A planned demonstrator version of the IT system should help

3.16 The ability of the Choose and Book clinical leads to communicate effectively about choice is increasing, thanks to some recent developments. During 2004, the clinical lead stakeholder group identified a need for a 'hands-on' demonstration environment that could be used to explore the functionality of the Choose and Book application - allowing clinicians to 'test-drive' the technology.

3.17 The Department addressed this need in three ways. First, it provided an electronic presentation with screen shots of what the final technology might look like. While useful, this highlighted the fact that GPs wanted to explore the real system. Second, the Department negotiated with the supplier of its e-booking system, Atos Origin, to provide an e-booking demonstrator which could be displayed on a stand-alone basis at a cost of approximately £1.6 million. Delays in this procurement process meant that the demonstrator would not be available until January 2005. As a result, the Department took a further measure. On 1st November 2004, a small number of clinical leads were given the training required to grant them live access to the e-booking system. As a result they can now conduct real-time demonstrations showing how to book test patients into test appointments. Those involved told us that these two tools should make their presentations much more convincing for their audiences.

The Department is considering incentives for primary care

3.18 Beyond the strategies described above, the Department is also considering whether to offer incentives for primary care. No final decision has yet been taken in this regard.

Choice is best delivered through e-booking, but e-booking will not be universally available by December 2005 so other mechanisms will initially also have to be used to deliver choice alongside e-booking

3.19 The Department's chosen vehicle for delivery of choice at the point of referral is e-booking (also known as Choose and Book). It allows the patient to book a clinic at a date and time of his or her convenience from the GP's surgery immediately the referral is made. It delivers certainty of booking, thereby improving the patient experience, and efficiency for the NHS by reducing bureaucracy and lowering the numbers of patients failing to attend outpatient clinics.

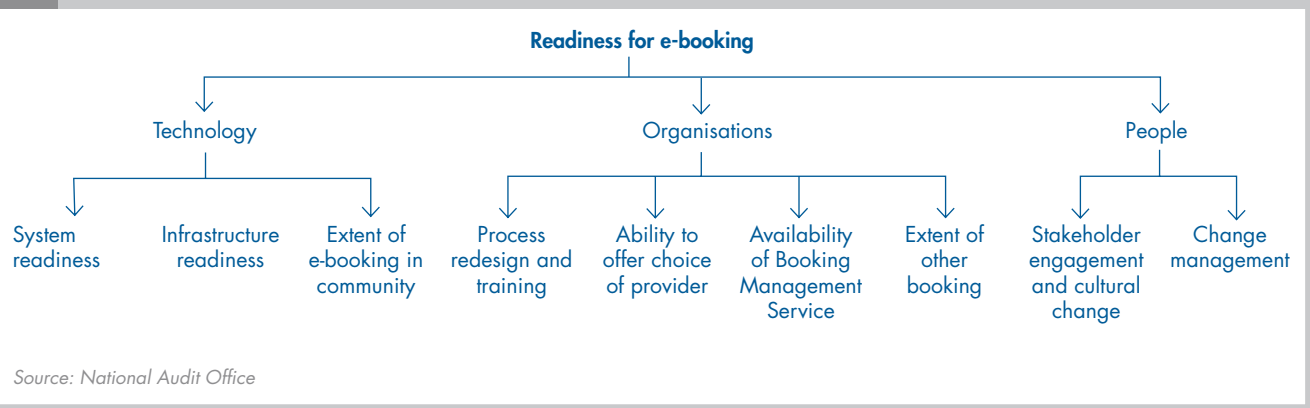
3.20 As described above, the Department took the decision to link choice with e-booking, as it felt that the latter was the best way of delivering choice. Since that point many NHS organisations have been planning to deliver the two in an integrated fashion.

Change management

3.21 The Department has recognised that the delivery of choice at the point of referral requires significant technological, behavioural and organisational change. In identifying e-booking as the delivery vehicle for choice, the Department has highlighted the changes required to support e-booking and therefore choice. These are set out in **Figure 18**.

3.22 The change management required to deliver choice has been therefore linked to the e-booking timetable. Any delays in e-booking may affect the delivery of choice as the local health community may not have adopted the changes in practice required to deliver choice. To deliver choice without the cultural and organisational changes required risks undermining the quality of choice that can be delivered.

18 Conditions for deploying e-booking



Implementation of e-booking

3.23 The June 2004 *NHS Improvement Plan*¹⁷ stated that there would be 100 per cent e-booking by December 2005. The Department’s contract with Atos Origin provided for the delivery of the system in June 2004. Planning the deployment of the system was a matter for Clusters, in conjunction with NPfIT.

3.24 In May 2004 the Department concluded that, to minimise implementation risk, it would deploy e-booking only in a tightly controlled and sustainable environment and that a phased implementation approach was more prudent than the Key Milestones for implementation already in the contract with Atos Origin. It therefore replaced the original Key Milestone 6 (Figure 19) with a series of more incremental implementation targets (Figure 20), which have subsequently been revised a second time.

3.25 However, even against the revised milestones, the roll-out of e-booking has been slower than anticipated. Milestone 6.0 was achieved on 2 July but the subsequent Milestones have not yet been achieved and the Department is in the process of setting new Key Milestone dates. While departmental projections in July 2004 estimated that by the end of December 2004 there could have been a total of over 205,000 bookings through the new system, in the event there have been 63 so far. While the Department regarded activity as adequately demonstrating the technical feasibility of the new system, which in testing had been proven successfully with volumes of work equal to those expected in the second year of operation, it recognised that this had yet to be implemented by the NHS on a national scale.

3.26 The principal causes of delay in meeting even the revised implementation schedule are at Figure 21.

3.27 A key factor affecting the pace of the roll-out of e-booking has been links with hospitals’ Patient Administration Systems. On current plans, only 60 to 70 per cent of hospital systems will be compliant by October 2005, the effective readiness date to go fully live across all specialties by December 2005. Figure 22 on page 30 shows that the Department is only planning to deliver just under 70 per cent compliance across all Clusters. In fact, even against the agreed implementation timetable there has been some slippage. The Department had planned on upgrading 22 Patient Administration Systems by December 2004, but only 7 were actually completed by this point.

19 Original implementation Key Milestones for e-booking

Key Milestone	Target date
6 Completion of 10 new bookings and referrals across a group of 10 GPs via the system over a period of 24 hours as part of their ordinary working practices in the London and North East clusters.	30 June 2004
8 Completion of 10 new bookings and referrals across a group of 10 GPs via the system over a period of 24 hours as part of their ordinary working practices in the Southern, Northwest and Midlands and Eastern clusters.	30 September 2004

Source: Electronic Booking Service contract with Atos Origin

17 The NHS Improvement Plan: Putting people at the heart of public services, Department of Health, 2004 (CM 6079).

20 Changes in delivery milestones for implementation of e-booking

Difficulties in implementing electronic booking at Early Adopter sites have led to the timetable being revised but the revised milestones have again been missed.

Key Milestone	New Milestone date (June 2004)	Revised milestone date (October 2004)
6.0 Completion of one new booking and referral in one GP practice via the system as part of its ordinary working practices in the London cluster	30 June 2004	2 July 2004 (Achieved)
6.1 Completion of five new bookings and referrals across a group of five GPs via the system over a period of 24 hours as part of their ordinary working practices in the London cluster	23 August 2004	29 November 2004
6.2 Completion of 10 new bookings and referrals across a group of 10 GPs via the system over a period of 24 hours as part of their ordinary working practices in the London cluster	7 September 2004	16 December 2004
6.3 Completion of 10 new bookings and referrals across a group of 10 GPs via the system over a period of 24 hours as part of their ordinary working practices in the North East cluster	14 September 2004	29 November 2004
8 Completion of 10 new bookings and referrals across a group of 10 GPs via the system over a period of 24 hours as part of their ordinary working practices in the Southern, North West & Midlands and Eastern clusters	30 September 2004	4 February 2005

Source: Department of Health/National Audit Office

3.28 Links with GP systems have also been an important issue. The Department does not expect the suppliers to upgrade all minor systems but will wait for users voluntarily to adopt the Local Service Provider solution. For this reason, GP system compliance is not expected to rise above 90 per cent. In any event, the GP system rollout will necessarily only match the hospital system rollout timetable as both elements are necessary to make e-booking work.

3.29 The lack of an agreed roll-out schedule with EMIS – the main supplier of GP systems – puts the implementation of e-booking through primary care systems at risk. Despite negotiations in the Autumn of 2004 and the existence of a technically compliant solution, EMIS and the Department have not yet been able to agree a roll-out plan. A combined team of National Programme for IT personnel and Primary Care Trust executives are working with the three main existing GP system suppliers to obtain agreement on a deployment schedule, which should be completed by February 2005.

3.30 The Department told us that it is taking action urgently to address the issues identified in Figure 21. By the start of December 2004 there were four compliant GP systems, although the dominant supplier has not agreed an implementation plan, and the roll-out of upgrades to

hospital systems was gathering pace. Both should make it easier to co-ordinate new bookings. The Department told us that it strongly believed that having a fully operational demonstrable system will encourage GPs to engage with the new system. The Department also believed that new releases have addressed the main problems affecting the end-to-end system reliability issue and that this was no longer an issue.

21 Causes of the delay in meeting e-booking roll-out targets

The principal causes for delay are:

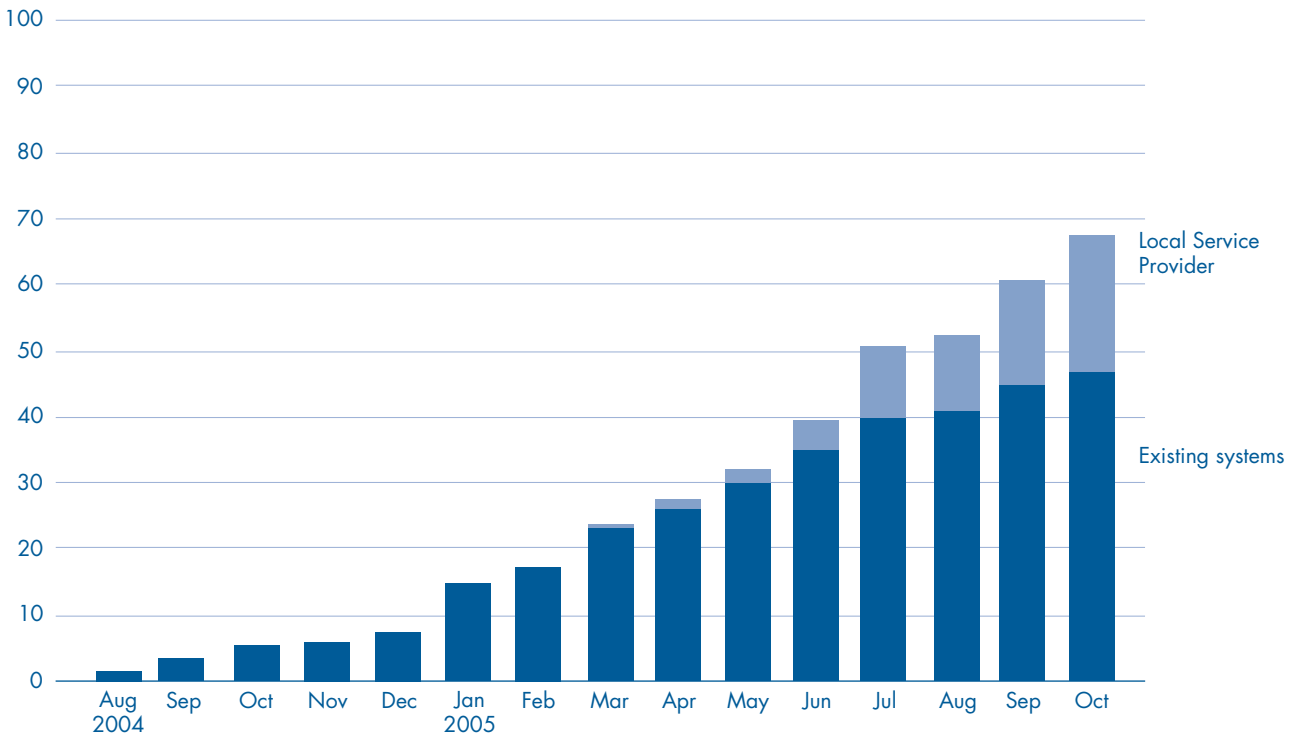
- an intermittent fault with authentication has prevented access to the e-booking and other IT systems;
- the reluctance of new users to engage with an unproven end-to-end system;
- the limited number of compliant GP systems;
- the limited number of specialties that had been configured on hospital systems to receive e-bookings; and
- the limited number of GPs who were willing to use the system in the first place.

Source: National Audit Office

22 Patient Administration System national roll-out timetable

The planned timetable for compliance of patient administration services across England indicates that compliance will not reach 100 per cent by December 2005. Systems must be compliant by October 2005 to allow a minimum of two months for full adoption.

Percentage of hospital systems



Source: National Audit Office analysis of Department of Health data

NOTE

The delivery of Local Service Provider systems shown above incorporates a two month slippage as a contingency factor.

3.31 The Department and Atos Origin agreed a contract variation for the delayed implementation of actual booking volumes as the implementation milestones against which Atos Origin would be paid largely reflect work in proving the technology and demonstrating its feasibility at early adopters. Although Atos Origin met the new Key Milestone 6.0 (completing one e-booking) two days after it was due, Atos Origin agreed with the Department that it would not receive the full Fixed Monthly Charge of £694,000 but would receive only 50 per cent for July and August and 75 per cent in September. The full Charge was paid from 1 October 2004. This reflected the Department’s desire not to pay for a service that the NHS was not using but also recognised that the delay was not down to Atos Origin. The Department also extended the full term of the

contract by a further three months, so that Atos Origin would be in the same position financially over the length of the contract.

3.32 The Department also initially withheld some £3.75 million of the full capital development payment of £10.6 million due to Atos Origin on achievement of Key Milestones 1 to 6. This was subject to achievement of Key Milestones 6.1 to 6.3 (Figure 20 above). However, this retention was paid to Atos Origin on 15 December 2004, less approximately £0.25 million for one, minor, outstanding item, even though these Key Milestones had not been achieved, because the Department recognised that the causes for delay did not reflect Atos Origin’s performance.

Planning to deliver choice without e-booking will lead to inefficiencies

The Department needs to ensure that alternative delivery mechanisms are in place for choice until full adoption of e-booking

3.33 The Department's target is to deliver choice everywhere by December 2005. However, a fully integrated e-booking system will not be available throughout the NHS by then. The Department needs to make sure, therefore, that the NHS can deliver choice without e-booking where necessary.

3.34 The Department has looked into alternative electronic solutions and in December 2004 instructed the NHS to plan the local roll-out of Choose and Book using interim solutions as necessary. There are two main alternatives to the integrated Choose and Book solution. These are:

- a interim solutions for primary care:** where GP systems are not compliant, the Choose and Book software can be accessed directly via a web based solution. This enables patients to be offered the full Choose and Book service (choice of 4/5 providers, electronic booking of appointments etc.). However, existing mechanisms for sending referral letters may have to be maintained unless the referral attachment facility in Choose and Book is utilised.
- b interim solutions for secondary care:** the Choose and Book software has been enhanced so that, where hospital PAS systems are not fully compliant, hospital clinics can still be displayed on the GP's Choice menu (although without actual appointment dates and times). Where a patient chooses one of these services, appointments cannot be booked direct onto the PAS system. However, the Choose and Book system will be electronically available to the hospital, which will then contact the patient to agree a time and date. Services booked in this way are known as Indirectly Bookable Services (IBS).

3.35 The web-based Choose and Book service is available now, with improvements to the referral letter to be ready by February 2005 and the Indirectly Bookable Services solution is planned to be ready for use by the end of May 2005.

3.36 These interim arrangements provide some but not all of the benefits of the fully integrated Choose and Book system. They should both enable GPs to offer choice to patients and patients to book appointments more efficiently than at present. However, the web-based application does not offer the same integrated system to the GP and cannot transmit the clinical details as the full e-booking system would. The Indirectly Bookable Service does not allow patients to compare the times of potential appointments at clinics and may not allow patients the opportunity to book an appointment within 24 hours of the referral decision.

3.37 A further complication of any interim solution is the risk that its introduction could detract from the considerable efforts required to introduce choice through e-booking, confuse communications activities and set back clinical engagement.

3.38 There is, as yet, no proven alternative system for delivering choice together with the opportunity to book a specific appointment at an outpatient clinic within 24 hours of the decision to refer, which was the policy aim. Pilot schemes and other organisations in the NHS have formulated a range of innovative ways of offering choice, but none of them can do so at the same time as providing the up-to-date information required for patients to benefit from the convenience and certainty which the policy is meant to provide. It is therefore unlikely that the patient experience will be of the same quality under the interim systems.

Alternatives to e-booking are less efficient than e-booking

3.39 As the roll-out of e-booking will not be complete by December 2005, some Primary Care Trusts and Strategic Health Authorities have been developing interim manual solutions to handle referrals. These comprise a wide range of processes and structures which have come to be known as referral management centres.¹⁸ These centres are being used in different ways and some are already providing extremely valuable services, such as the improved management of GP referrals, better use of local primary and secondary care resources and better information gathering about referral patterns.

¹⁸ This term covers a range of facilities, but referral management centres tend to provide a central administrative point for referrals. They should not be confused with clinical assessment services, which are staffed by clinical personnel with specific skills who are able to provide a clinical input to the referral process, typically to refine a provisional diagnosis.

3.40 However, if referral management centres have been set up simply to support choice, they are likely to be poor value for money. Using the cost of one such centre set up as part of a pilot scheme as a guide, we estimate that money spent on these solutions could cost around £60 million, if replicated across the entire NHS.

3.41 The Department is quite clear that NHS organisations should not set up referral management centres just to deliver choice. The Department therefore wrote to the NHS in December 2004 to outline technology alternatives to the fully integrated e-booking solution and to instruct NHS organisations to plan using those interim solutions where necessary (see paragraphs 3.34 to 3.36 above).

3.42 In addition, where NHS organisations persist in setting up referral management centres specifically to support choice, but are unable to meet the standards set by the Choose and Book team for Booking Management Services, they will not be funded centrally and NHS organisations will have to find the money from their own budgets. This is likely to be particularly poor use of public money overall, since they may only be operational for a few months until e-booking is delivered to individual areas.

Parts of the NHS still have a lot to do if they are to be ready to deliver choice

3.43 This part of the report looks at the remaining challenges facing Primary Care Trusts and other NHS organisations in preparing to deliver choice. It explains that some Primary Care Trusts are not well placed to manage their new responsibilities under choice, that programme management arrangements in some parts of the NHS are incomplete and that there are a number of more detailed issues which require resolution before choice can be fully implemented.

Programme management arrangements in the NHS are incomplete

Readiness returns provide a baseline for monitoring performance

3.44 In order to develop a picture of progress towards implementation and establish a baseline for measuring activity throughout 2005, the Department asked all Primary Care Trusts to fill in a 'readiness return' by 30 October 2004.

3.45 The readiness returns contain a series of questions designed to identify the NHS' state of readiness to deliver Choose and Book. They originally contained 180 questions, but this number was reduced to only 43 mandatory questions once the document had passed through the Department's Gateway process, giving the Choose and Book team less of an idea of overall readiness. The returns cover seven work streams: programme management, commissioning and contracting, supporting primary care, developing new ways of working, delivering full booking and choice, migration to e-booking with choice and information and support to patients.

3.46 The first readiness returns reported the position at the end of October 2004 and provide a baseline against which progress can be tracked throughout 2005, as the Department plans to ask Primary Care Trusts the same set of questions on a quarterly basis until December 2005. The picture thrown up by this process should allow trend analysis and the identification of any remaining problem areas. The next return is due at the end of January 2005.

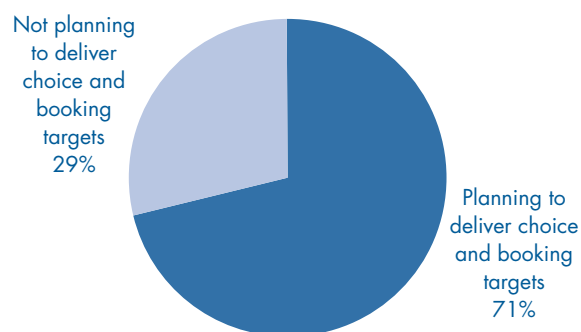
3.47 There are some important caveats to be made about the scope and utility of this work. First, the Department had no best practice template or ideal position against which to judge the returns. This makes it difficult to say whether or not Primary Care Trusts are on track in each of the seven areas. The Department did, however, indicate that they had expected levels of preparation to be further advanced in three particular areas: programme management, commissioning and supporting primary care. Second, answers could only be given as a 'yes' or a 'no'. In some cases, the real answer lay in between the two and Primary Care Trusts took different decisions as to how to respond in those circumstances. Despite these factors, the return was completed by all Primary Care Trusts and remains the only available baseline of achievements to date and indicator of future progress.

Not all Primary Care Trusts have agreed plans in place to deliver choice

3.48 The first set of returns show that most Primary Care Trusts are planning to deliver Choice and Booking targets, although 29 per cent are not. The Department is assessing those Primary Care Trusts who responded in the latter category to check whether there has been any confusion or misinterpretation. However, if those figures were to stand, they would show that over a quarter of the NHS was not on track to deliver choice through e-booking (**Figure 23**).

23 Primary Care Trusts planning to deliver choice and booking

More than a quarter of Primary Care Trusts reported that they did not plan to deliver choice and booking by December 2005.



Source: National Audit Office analysis of State of Readiness returns

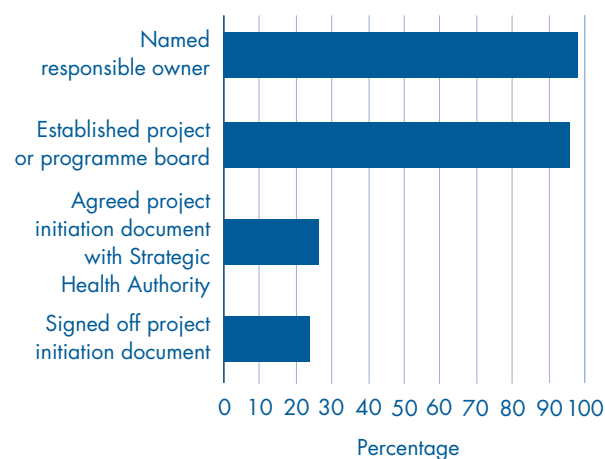
3.49 Some Primary Care Trusts did not (as of 30 October 2004) yet have adequate plans in place to deliver choice. Although 98 per cent and 96 per cent of them had a named responsible owner and an established project or programme board respectively, only 24 per cent had signed off their project initiation document and only 26 per cent had agreed it with their Strategic Health Authority. These figures suggest that while Primary Care Trusts have begun the process of planning for choice, most of them still need to sign off their key planning document (**Figure 24**).

3.50 On commissioning, 32 per cent of Primary Care Trusts said that they had commissioned 4 or 5 providers for all specialties covered by choice at referral. This means that 68 per cent have still to commission these services in the months remaining before the April deadline for completing this. A sign of better preparation was that 54 per cent of Primary Care Trusts did have a strategy in place for monitoring demand for services against available capacity (**Figure 25**).

3.51 There was not much evidence of real progress in supporting primary care. While around half of all Primary Care Trusts had involved clinical leads in their preparations, 32 per cent had implemented a strategy for engaging clinicians and only 12 per cent had put in place training and change management arrangements to help staff adapt to their new roles (**Figure 26 overleaf**).

24 Progress in Primary Care Trusts' programme management

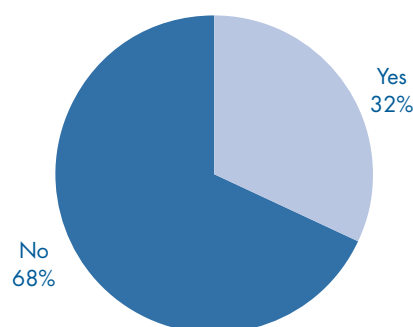
While most Primary Care Trusts have appropriate governance arrangements, few have agreed actual plans for implementing Choose and Book.



Source: National Audit Office analysis of State of Readiness returns

25 Primary Care Trusts' commissioning arrangements

Just 32 per cent of Primary Care Trusts have commissioned the four or five required providers in preparation for choice.

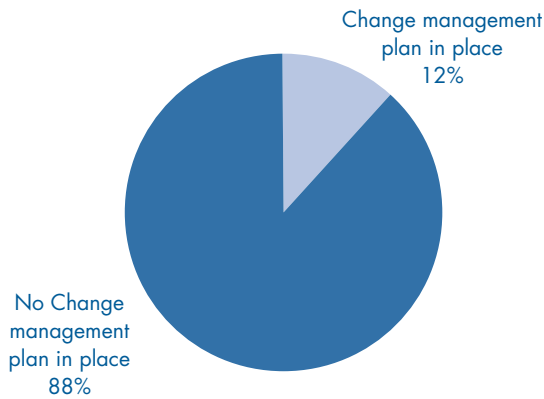


Source: National Audit Office analysis of State of Readiness Returns

3.52 There was a surprising lack of agreement on plans to deliver e-booking and choice. Only 17 per cent of Primary Care Trusts had agreed a timetable for the deployment of the choose and book application. A slightly higher number of Primary Care Trusts (28 per cent) had agreed the processes and timetables for ensuring IT readiness.

26 Primary Care Trusts with a change management plan in place

Almost 90 per cent of Primary Care Trusts have yet to introduce a change management plan.



Source: National Audit Office analysis of State of Readiness returns

Some Primary Care Trusts may struggle to manage new commissioning arrangements

The quality of Primary Care Trust commissioning is variable

3.53 A range of evidence shows variability in Primary Care Trusts' overall performance which may hinder their ability to manage new responsibilities such as preparation for and delivery of choice. The evidence described below sets out a number of weaknesses in this area.

3.54 Primary Care Trusts were first established as independent NHS bodies in 1999, and have been given a growing set of responsibilities since then. The Department's 2002 publication *Shifting the Balance of Power*¹⁹ devolved a large percentage of the direct NHS budget and many decision-making powers to Primary Care Trusts on the basis that, as local organisations, they were best placed to commission and deliver healthcare which was most appropriate to the needs of local populations.

3.55 The Commission for Healthcare Improvement issued a sector report on Primary Care Trusts in 2004²⁰, based on 48 clinical governance reviews carried out in 2002 and 2003, patient and staff surveys, national performance indicators and other published research. The report found that Primary Care Trusts were doing some things well and

that they were viewed as good employers by their own staff. However, it also found that the leadership capacity of many Primary Care Trusts was stretched, that most Primary Care Trusts were not yet effectively collecting or using information about services or the needs of the local population to inform commissioning decisions and that a number of Primary Care Trusts were struggling to mature as organisations by learning from experience or actively monitoring progress.

3.56 The Audit Commission's 2004 report *Achieving first-class financial management in the NHS*²¹ noted a particular lack of financial management capacity at the level of Primary Care Trusts. Auditors expressed concern about inadequate staffing and management capacity in relation to finance at 34 per cent of Primary Care Trusts, as opposed to 21 per cent of Strategic Health Authorities and at 14 per cent of Acute Trusts.

3.57 The report also noted that one consequence of the establishment of an increased number of smaller commissioners (Primary Care Trusts) is that they are not individually big enough to manage the significant financial issues that are likely to arise.

3.58 Question marks remain over Primary Care Trusts' capacity to commission in a dynamic environment. Although this is not crucial for the introduction of choice by December 2005, it will rapidly become important after that point as providers are moved on and off the menu of choices and Primary Care Trusts have to respond to patients' choices with a changing set of contracts in an environment in which, under payment by results, money must follow patients. Those contracts signed with Foundation Trusts or private sector providers will be legally binding and Primary Care Trusts will have to learn how to balance rigorous legal agreements with the flexibility required to be able to respond to patients' wishes.

The Department plans to support new commissioning arrangements

3.59 Two thirds of Primary Care Trusts have not yet commissioned the required providers which places some pressure on them to do so before the end of the current financial year. As noted above, 32 per cent of Primary Care Trusts said that they had commissioned four or five providers for all specialties covered by choice at referral. If Primary Care Trusts fail to do this, they will be unable to offer choice across all specialties as required.

¹⁹ *Shifting the Balance of Power: The Next Steps*, Department of Health, 2002.

²⁰ *What CHI has found in: primary care trusts*, Sector report, Commission for Health Improvement, 2004.

²¹ *Achieving first-class financial management in the NHS*, Audit Commission, 2004.

3.60 The Department is aware of the challenges facing Primary Care Trusts generally, as well as the particular hurdles they face in preparing to offer choice. However, it has not compiled any qualitative or quantitative assessments of the relative merits of Primary Care Trusts as a group or of their ability to commission in the new dynamic environment. Assistance tends to be given therefore on the basis of star ratings, auditors' and inspectors' reports or anecdotal evidence. Primary Care Trusts' record in meeting recent targets for patient access and out-of-hours care could also provide some guide to likely performance in preparing for choice.

3.61 In order to assist Primary Care Trusts, the Department has put or is putting in place various work streams:

- the Department's Recovery Support Unit works with Primary Care Trusts which have low star-ratings in order to improve their performance;
- the Department's Primary Care team originally planned to roll out a framework to assess all Primary Care Trusts' ability to commission for choice. A decision was subsequently taken to drop this in favour of a 'toolkit' which should be less bureaucratic and more helpful, although the latter has not yet been issued; and
- the National Primary and Care Trust Development Programme (NATPACT) has produced a Competency Framework and a Commissioning Friend which contain explanations of policy and guidance on best practice. It has also organised events for Primary Care Trust staff to familiarise themselves with the kinds of skills they will need under choice and runs chat rooms on its website in which staff can swap experiences.

3.62 New commissioning arrangements are being promoted to maximise the use of limited skills. Recognising the variability of Primary Care Trust commissioning, the Department is looking to develop a 'mixed economy' of commissioning, in which large-scale activity might be taken on by Strategic Health Authorities or the Department itself, while Primary Care Trusts could commission on a pooling or lead basis, enabling the scarcer skills and expertise to be spread around the system. The Department has also proposed that some Primary Care Trusts could even be 'kite-marked' as having the required skills and competencies to deal with complex commissioning arrangements. Recent moves to increase the volume of practice-led commissioning may have implications for choice which the Department and the NHS will have to manage carefully.

There are a number of more detailed issues in the NHS requiring resolution

The Department has taken action to support equity of access to choice

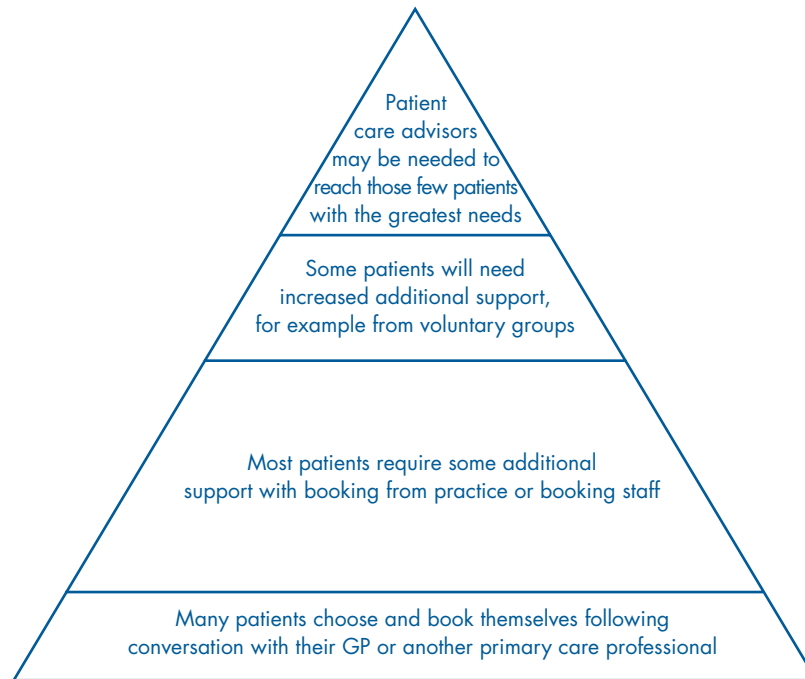
3.63 The Department has plans to ensure equity of access to choice and is keen to ensure that all users of the NHS are helped and supported appropriately in articulating their preferences and needs. The concept behind these plans is shown in **Figure 27 overleaf**. A key concern in delivering choice is that the ability to choose does not exclude any 'hard-to reach' groups, such as patients with special needs, patients for whom English is not their first language, or who are illiterate, and patients who do not have access to the Internet or other information sources.

3.64 The Department has the following strategies in place to help ensure equity of access to choice:

- for those few patients with greatest needs, the choice policy proposes the use of Patient Care Advisers, who can guide patients through the system and be a continuous point of reference throughout their care pathway. The role of a Patient Care Adviser could be played by GP practice staff, staff from the Patient Advice and Liaison Service or by dedicated staff working from a call centre;
- Trent Strategic Health Authority is currently hosting a pilot scheme designed to examine the effects of offering choice in two disadvantaged communities. The pilot scheme has not produced any findings yet, but the Department is keen to learn from it in due course and will disseminate any lessons learned to the wider NHS; and
- the Department is keen to work in partnership with established voluntary sector organisations to provide advocacy and support for patients. In conjunction with the Council of Ethnic Minority Voluntary Organisations and other groups, the Department produced draft guidance in October 2004 on how the NHS might work with voluntary sector organisations to deliver choice.

27 Patient support needs

A small number of patients will require significant levels of support to exercise their choice.



Source: Department of Health/National Audit Office

Choice will require hospitals to change existing practices

3.65 Hospitals and other providers will have to make changes if they are to contribute effectively to choice. Whichever mechanisms are used to offer choice to patients, hospitals will have to make available timely information about the services that they can offer. They will need to re-organise and register their Directory of Services to make them available electronically and, in order for clinics to be available in a universal format to all referring GPs, services will have to be described using common terms.

3.66 Feedback from NHS organisations has highlighted that, in some cases, it may be difficult to book consultant clinics beyond 6 weeks. Currently, consultants have the right to book leave at a minimum of 6 weeks' notice, but under choice, patients will be able to book appointments up to thirteen weeks' ahead. This means that some

hospitals may run the risk of having to cancel a booked appointment, undermining the certainty of booking. However, the Department's view is that, in many cases, providers will have to show the same flexibility they are required to currently when a consultant falls ill or cannot do their work at short notice for some other reason.

Choice will mean changes for NHS staff

3.67 It is likely that choice will mean changes for various elements of the non-clinical NHS workforce, especially administrative, clerical and secretarial staff. Some job descriptions in these areas may change considerably and these changes will need to be carefully managed so that valuable staff are not lost, but are re-trained or equipped to do new roles. In order to assist NHS organisations with this work, the West Yorkshire Workforce Development Confederation has produced a document²² which sets out how to model, support and develop workforces in preparing for choice.

22 *Human Resource Management Framework: Supporting the Implementation of Choose and Book Version 2*, West Yorkshire Workforce Development Confederation in association with the NHS Modernisation Agency Changing Workforce Programme, 2004.

The Department is taking action to address key issues highlighted in this report

3.68 As noted throughout this report, the Department is taking action to address the challenges it and the NHS face in implementing choice. **Figure 28** summarises the Department's view of the most important actions taken, or in hand, in this regard.

28 Actions taken by the Department of Health

The Department of Health:

- has ensured that the availability of the core Electronic Booking Service has exceeded the contracted level of 99.5 per cent since the system went live in summer 2004, although a fault with the user authentication system has intermittently prevented access to the system;
- has developed interim IT systems for use where it will not be possible to link the core Electronic Booking Service to local systems by December 2005;
- has appointed a new National Implementation Director for Choose and Book and is applying to the implementation of Choose and Book the central performance management techniques it has used to deliver key patient access targets;
- is developing robust performance management arrangements for Choose and Book, working with Strategic Health Authorities and their Directors of Performance;
- against this background, is reviewing the milestones to ensure choice at referral is delivered on schedule;
- is developing a framework of incentives to deliver Choose and Book;
- is developing mechanisms for effective GP engagement through early adopters supported by national clinical leaders.

APPENDIX 1

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APPENDIX 2

Methodology

1 We have used a number of approaches to gather the information that has been used in this report. These included visits to pilot project sites and training events, interviews with Department of Health staff, consultations with numerous stakeholders, a survey of GPs, analysis of Department of Health data and documents and audit interviews and document reviews at the Department of Health and the National Programme for IT.

Interviews, consultations and visits

2 Interviews were conducted with a number of Department of Health staff, including the representatives of teams involved in planning choice, capacity, financial reforms and primary and secondary care. We also interviewed representatives from the Department of Health's Strategy Unit and a number of staff from the National Programme for IT.

3 A series of semi-structured interviews were carried out with staff from the following strategic health authorities that have been involved in pilot projects of the Choice initiative: Thames Valley, Trent, Dorset and Somerset and North West London. We also visited the London Patient Choice Project, a pan-London project that has run a number of pilot studies throughout London. We have also attended choice learning events, pilot study forums and NHS primary care training events for those organisations currently preparing to offer choice.

4 We also met with a wide range of stakeholder organisations, including the British Medical Association, the Royal College of General Practitioners, their Joint Information Technology Committee, *Dr Foster*, and Atos Origin.

Survey of General Practitioners

5 We commissioned a survey of GPs from Doctors.Net, a research agency specialising in online surveys of medical professionals. The work was carried out between the 13 and 29 of October, 2004, following an endorsement of the survey by the Royal College of General Practitioners, which encouraged all its members

in its monthly bulletin to complete the survey at Doctors.Net. Of the approximately 25,000 General Practitioners registered with Doctors.Net at that time, all 11,500 members who had used the site in the previous 90 days (some 33 per cent of all GPs), were invited by e-mail to complete our questionnaire which was made available to them electronically from the Doctors.Net web-site. Doctors.Net accepted, on our instructions, the first 1,500 responses.

6 Analysis of the sample respondents by location and year of qualification of the respondent indicates that the sample is broadly representative of the age of the GP population as all regions have a similar 'age' profile. The two exceptions are a slightly higher proportion of doctors who qualified in the 1990s in Greater London and a significantly higher proportion of doctors who qualified in the 1980s in Trent.

7 The survey, in accepting the first 1,500 self-selecting respondents, carries an unknown sample bias. However, the results are supported by corroborating evidence from other surveys, the Department's own research and the views of the British Medical Association and the Royal College of General Practitioners.

8 The questionnaire addressed a number of areas, including GP awareness about Choose and Book including the expected benefits, what information they felt patients would want in order to make choices and attitudes to date towards the implementation of Choose and Book. A copy of the survey questionnaire and the results can be accessed at <http://www.nao.org.uk>.

File and document review

9 We reviewed records and management information held by the Department on capacity planning for choice, change management, electronic booking, provision of information, international comparisons and Primary Care Trust readiness returns. We also made use of Department of Health data and policy documentation to assess progress against the Choose and Book targets and milestones.

APPENDIX 3

Glossary of Terms

Acute Trust	Responsible for running hospitals and providing services commissioned by Primary Care Trusts.
Booking Management Service (BMS)	A call centre or similar that any relevant party can contact to perform an initial booking, change, cancel or query an Electronic Booking or Electronic Referral. Such a service will have access to relevant scheduling, PAS and other systems.
Cluster	Five virtual NHS organisations responsible for the local implementation of services provided by the coterminous five local service providers. They represent the NHS organisations in that area.
Choice at the Point of Referral	As of December 2005, patients will be able to choose a convenient place, date and time for their initial hospital appointment. They will also be able to choose from one of four or five hospitals (or other healthcare provider facilities) commissioned by their PCT. Also referred to as Choose and Book or simply Choice.
Early Adopters	A group of GPs from a PCT booking appointments online via a compliant GP system over the internet with the patient present in each case, and using the EBS for a limited number of secondary care services, in advance of full roll-out.
EBS	Electronic Booking Service (e-booking). An on-line booking service which provides some direct booking management functions.
Electronic Booking	In this document we use Electronic Booking to mean a system when the patient can be Electronically Booked direct into clinic via a PAS, but can alternatively be routed via a call-centre/BMS type operation. We do not mean where patients can only be booked via a call-centre.
GP	Medical practitioners who are contracted by the local Primary Care Trust to take unsupervised responsibility for a specific list of patients. Responsible for the initial diagnosis and possible referral of patients to hospital outpatient clinics, at which point the choice policy is introduced.
GP System	A computer system used in a GP practice, for example, for recording demographic and contact information about the GP's patients.

In-patient	A patient who is admitted to hospital.
Local Service Provider (LSP)	Contracted by NPfIT to deliver IT systems and services to be used locally, such as GP and hospital systems. Also make sure local applications can 'talk to' and share information with the national systems.
National Programme for Information Technology (NPfIT)	Responsible for the design, specification and procurement of all new major applications in the NHS, including the New National Network. Procured the Electronic Booking Service from Atos Origin and contracted with LSPs to implement it.
Outpatient	A patient requiring a part day visit to a hospital.
PAS	Patient Administration System - a computerised administrative solution that assists with planning, tracking and recording the patient's attendance throughout their visit to the Trust.
Payment by results	The framework for ensuring that NHS finances are deployed directly in line with patient treatment.
Primary Care Trust (PCT)	The 302 Primary Care Trusts in England are responsible for commissioning healthcare for their local population. They manage GPs.
Specialty	A way of categorising services into related conditions or procedures.
Strategic Health Authority (SHA)	The 28 Strategic Health Authorities are local headquarters of the NHS. They performance manage Acute Trusts and Primary Care Trusts.

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