

Empty Promises

The impact of outsourcing on the delivery of NHS services

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Executive summary

Advocates of outsourcing NHS services to the private sector often make sweeping claims about the benefits of privatisation on the care received by patients. UNISON wanted to move the debate on to a firmer factual basis by examining research and materials produced over the recent period (five to 10 years) to evaluate the impact of outsourcing on care. This project was commissioned by UNISON in September 2011 to examine the impact of outsourcing on the delivery of NHS services.

The process of contracting out of NHS services started in 1983 but was effectively limited to catering, cleaning and facilities management until the NHS Plan in 2000. The Private Finance Initiative (PFI) was introduced in 1992 as a way of providing new investment into public sector infrastructure, without apparently increasing public spending. Since 2000, when the NHS Plan was launched by the Labour government, contracting out of services has expanded to include clinical services and pathology services. Later white papers have introduced competition into primary care and community health services. The sequence of changes shows that the contracting out of catering, cleaning and facilities management services was an initial stage in a longer process of contracting out many more NHS services.

This report has interpreted delivery of patient services as covering quality of patient care, outcomes of patient care, innovation in patient care and organisational arrangements that impact on patient care. The studies that have been reviewed used a range of quantitative and qualitative research methodologies, which capture both process and outcomes of patient care.

Cleaning

Cleaning was one of the first services to be contracted out in the NHS in the 1980s. During the decade of the 1990s, there was an increased incidence of hospital acquired infections, such as meticillin-resistant *Staphylococcus aureus* (MRSA) and *C. difficile*. These had an impact on the quality of patient care and the costs of treatment in the acute sector. An international study, published in 2002, established links between cleaning and hospital acquired infections (Murphy, 2002). In the last decade there has been an increased awareness among government auditors about the problems of improving cleaning practices in the NHS when specifications of cleaning contracts are difficult to change.

A series of studies show that the impact of the contracting out of cleaning services in the NHS results from the way in which the process of contracting out fragments cleaning activities from the rest of the hospital. When a service is contracted out, each activity, which is included as part of the service, is itemised as a separate task. This move away from a holistic to a fragmented approach creates a lack of continuity between cleaners, clinical staff, managers, patients and visitors and there is no shared sense of responsibility for cleanliness across the hospital. The relationship between cleaning staff and clinical staff is crucial for maintaining high standards of cleanliness in a hospital. There are also problems in drawing up contracts, with not enough attention paid to regular reviews of contracts, whether for in-house or external contractors. This experience has now influenced the devolved regional governments of the UK to abandon the use of compulsory competitive tendering for cleaning services.

Facilities management

There has been limited research into the effect of outsourcing facilities management on patient care. Macdonald, Price and Askham (2009), in a study that examined a group of hospitals trusts that had achieved high scores in Patient Environment Audits, looked at whether the contracting out of facilities management contributed to these scores. They found that there was no apparent difference between in-house or external contractor

for facilities management. There are several limitations of this study. It did not look at why the majority of trusts had low Patient Environmental Audit scores, which might have highlighted external factors. There was no qualitative research with managers and clinical teams although this was a proposed second phase of the research. However, one conclusion is that there is a lack of evidence to show any positive effects of outsourcing facilities management.

GPs ‘out of hours’ services

The contracting out of GP ‘out of hours’ service is an example of the contracting out of clinical services. In 2004, as part of a new General Medical Services contract, GPs were allowed to transfer the responsibility for ‘out of hours’ services to primary care trusts (PCTs). For £6,000 per year, GPs could give overall responsibility to PCTs for seeing that providers complied with the Department of Health ‘National Quality Requirements’. 90% of GP practices gave up their responsibility for ‘out of hours’ services to the local PCT (Select Committee, 2010).

The National Audit Office (2006) found that the actual cost of the service was £9,500 and so the service had been under-costed. Several problems have been identified since 2004 that illustrate the problems of contracting out clinical services. The overall quality of services depends on the commissioning agency having strong monitoring processes and meeting regularly with providers. For providers, the provision of clinical staff has been one of the most problematic areas. For commercial providers, the processes of recruiting and selecting GPs have been inadequate in many cases. Information systems have often been unable to provide enough useful information about how ‘out of hours’ services are actually being delivered and do not allow access to services to be monitored effectively. There is little evidence that ‘out of hours’ services demonstrate equity of access. There is growing evidence to show that outsourcing of ‘out of hours’ services led to increased costs and poorer quality of care.

Independent Sector Treatment Centres (ISTCs)

The NHS Plan in 2000 increased investment in the NHS but part of the increased investment was to contract the private sector to provide clinical services. This included the creation of a network of treatment centres, described as a ‘network of fast-track surgery units’, which would reduce waiting lists. Some of the new treatment centres were to be run by the NHS and some by the private sector, which were called independent sector treatment centres (ISTCs). £700 million per year was to be invested into these new centres.

The results show that ISTCs did not have a significant impact on waiting lists. There is growing evidence to show that they do not provide value for money. Several ISTC contracts have been underused, with payments made to private providers for work which was not undertaken (Player & Leys, 2008). It is also questionable whether they have been the source of innovation because of problems with staffing and a lack of integration into the NHS. One of the most serious criticisms is the problem of collecting data for ISTC performance so that it can be compared to NHS performance (Healthcare Commission, 2007). From the experience of ISTCs, the outsourcing of clinical services has been shown to be ineffective. It has also highlighted some more fundamental problems about data collection by private providers. As Player and Leys (2008) argue, the real significance of the ISTCs lies in seeing it as ‘a crucial step in the replacement of the NHS as an integrated public service by a healthcare market, in which private providers will play an steadily increasing role’ (Player & Leys, 2008:71).

Clinical services

The introduction of ‘Payment by Results’ and ‘patient choice’ have contributed to the increased contracting out of NHS services. ‘Patient choice’ allows a patient to choose an

NHS or independent sector provider for elective surgery. The creation of a set of tariffs, 'Payment by Results', for different treatments, has contributed to an increased degree of competition in the NHS, with growing involvement of the private sector. There have been several studies which have examined the relationship between increased competition and patient outcomes.

There has been extensive criticism of many of these studies because of their small samples and partial analysis. Even when conclusions are unclear, more competition is recommended, rather than questioning whether competition is necessary. However, the influence of these studies on health policy development in the NHS has been extensive, showing that health policy on competition and outsourcing draws from a very limited evidence base. The recent research on equity and choice (Zigante, 2011) shows that 'choice' is not beneficial for people on low incomes with lower levels of education. This has important implications for equity in the NHS.

Shared services and IT

As well as outsourcing of catering, cleaning, facilities management and clinical services, there has been pressure to market test and outsource financial, administrative, human resources and IT services, called 'shared services'. In 2004, the Gershon Review identified the potential for shared services to generate savings across government and the public sector. In response to this recommendation, the NHS set up a formal joint venture with Xansa in 2005 (now called Steria), building on the experience of the pilot initiative in 2001. The main functions of NHS Shared Business Services under the original joint venture agreement included procurement, accounting and finance services. They have also recently been successful in obtaining contracts for other services, such as family health services.

A National Audit Office report (2007) found that the implementation had involved a large and complex system, extensive cultural changes and that customer expectations rose over time. Initially there was a slow rate of take-up by NHS organisations and a lack of acceptance by users. Gradually, as other benefits became clearer, customer expectations started to increase, although it remains more complex than outsourcing a single service. Additional benefits included better management information, paperless transaction processing, faster transaction processes and savings on procurement costs. However, there have been reports of recent problems for GPs in the use of shared services, leading to delayed payments, patients being taken off GPs lists and delays in transferring patient notes (McNicoll, 2011). This indicates that there are still problems facing the NHS Shared Business Services project.

IT

The most controversial failure of outsourcing technical expertise to the private sector was the introduction of a new IT system to the NHS. Started in 2002, the aim of the project 'Introduction of a new IT system to the NHS' was to set up the NHS Care Records Service so that health professionals could access relevant parts of patient records as well as X-rays, prescriptions and electronic booking (NAO, 2006). By 2006, several milestones had not been met and the cost of the project has also increased from an initial £12.5 billion to £20 billion (NAO, 2006). In 2008, the Public Accounts Committee found that the new system did not include any clinical functions so that the needs of clinical staff needs had not been met (PAC, 2009). More widely, there was a lack of commitment by NHS staff. In October 2011, the Department of Health abandoned the project (Wright, 2011). The consistent criticism of the project was the lack of consultation and involvement of NHS staff in the design of the systems. The project was very costly and overran its budget. The expertise, which IT providers were supposed to bring to the project, was not shared in an effective way with NHS staff.

Voluntary/third sector contracting

The extent to which services have been contracted by the NHS to the voluntary/ third sector is limited. There is a shortage of studies to assess the impact on patients. Much research is concerned with the impact of contracting on the voluntary sector itself and whether the sector provides value for money. Allen et al (2011) found that the third sector did not necessarily provide more innovative or effective care than the NHS. In some cases this was due to lack of resources. Third sector organisations are often more effective at working with local communities and hard to reach groups, although ways of harnessing this expertise in partnership with the NHS are still being developed. The contracting of NHS services to voluntary/ third sector organisations is still limited and the implications for NHS staff are unclear. Some organisations have strengths in relation to working with local communities or hard to reach groups but not all services provided are more effective or innovative.

In the last two years, the transfer of funding and commissioning of social care for adults from the NHS to local authorities has led to the contracting out of mental health services and services for people with learning disabilities by local authorities to voluntary and for-profit providers. These services were originally part of the NHS and so NHS staff have moved from the NHS and are now employed by voluntary or for-profit providers on TUPE conditions. This is likely to expand as community health services and public health functions are also moved to local authorities.

Conclusion

This project has identified a range of studies that have examined some aspects of outsourcing in the NHS and the effect on patient care. It is noticeable that much of the evidence demonstrates either the negative aspects of introducing competition into the provision of health care services or inconclusive results (Appendix A). A lack of data makes it difficult to assess the impact of contracted out services on accessibility of services and health outcomes. Overall, there is a lack of evidence to show that outsourcing leads to improved quality of patient care. The experience of outsourcing cleaning services shows that there was a negative impact on patient care. Outsourcing of clinical services through ISTCs and GPs 'out of hours' services shows some negative effects on patient care, poor value for money as well as evidence of inadequate monitoring and evaluation of the services. Although there is some evidence of the benefits of shared services, the experience of the NHS IT project was a clear failure of outsourcing.

The introduction of outsourcing to the NHS has identified the need for data collected to measure the quality of patient care after the contracting process. At the moment, a combination of academic research, research from regulatory agencies and trade union research provide the most effective way of gathering evidence of the impact of outsourcing into the quality of patient care. Many of these studies do not show any demonstrable benefits from outsourcing. Other academic studies have assessed the impact of competition on the NHS in a limited way, either using one service, or one health outcome. The conclusions are then applied to the whole of the NHS, as a way of justifying more competition. This research needs to be challenged because it is being used to justify continued competition and marketisation policies in the NHS.

In the light of the 2011 Health and Social Care Bill, currently going through Parliament, the findings of this review are significant. Outsourcing often has a negative effect on the quality of patient care. It affects how NHS workers work together to deliver care. Effective commissioning, regular reviews of contract specifications and monitoring of contracts require skills and experience. The experience of how 'out of hours' services were contracted out and the effect on patient care illustrates the problems when commissioners and providers are unaware of how to fulfil their responsibilities. In a re-organised NHS, where much commissioning experience, developed in primary care trusts, will be lost, the likelihood of the new contracting systems affecting the quality of patient care will be even more likely.

The impact of outsourcing on the delivery of NHS services

Advocates of outsourcing NHS services to the private sector often make sweeping claims about the benefits of privatisation on the care received by patients. UNISON would like to move the debate on to a firmer factual basis by examining research and materials produced over the recent period (five-10 years) to evaluate the impact of outsourcing on care. This project was commissioned by UNISON in September 2011 to examine the impact of outsourcing on the delivery of NHS services.

The project brief was to:

- focus solely on gathering studies that have already been completed and summarising their results
- not conduct new research to assess the impact of privatisation
- focus principally on studies completed within the last five years, and not to include anything older than ten years
- provide a UK wide perspective, encompassing England, Scotland, Wales and Northern Ireland
- examine any variations in the impact of service delivery in terms of such factors as income groups, gender, ethnicity, regions or age should be drawn out.
- assess privatisations on the basis of their impact on patient care or service, including cleaning / catering services as well as commissioning treatment directly from private providers
- to provide a public sector comparison to the performance of private providers wherever possible
- only to include services funded by health bodies and not to include local authority privatisations of residential care homes
- to assess outsourcing to voluntary organisations as well as private companies, i.e. any non-NHS bodies.

1 Methodology

This project searched for academic, government, trade union and other research commissioned to look at the impact of outsourcing. The definition of outsourcing that was used to inform the project covers:

- contracting out - catering, cleaning, clinical services, high 'tech' diagnostic services (eg CT scans), kidney dialysis, mental health services, 'Out of Hours' GP services
- public-private partnerships - including PFIs, independent sector treatment centres

This broad definition of outsourcing has been translated into the following basic search terms, which have been adapted and expanded:

- contracting out cleaning/ catering/ facilities management/ clinical services NHS
- independent sector treatment centres
- GP 'out of hours' services
- PFI – impact patients
- public-private partnerships UK, England, Wales, Scotland, Northern Ireland.

2 Searches

Searches were conducted in the following databases:

- Swetswise, Sage, Wiley, Science Direct, Medline (academic databases);
- Government and regulatory sources have also been searched, including:
 - Department of Health, NHS Scotland, NHS Wales, Northern Ireland Department of Health, Social Services and Public Health;
 - Audit Commission, National Audit Office, Audit Scotland, Auditor General for Wales, Northern Ireland Audit Office;
 - Healthcare Commission, Care Quality Commission
- King's Fund, Nuffield Trust and other thinktanks/ charities
- Academic research centres specialising in some aspect of outsourcing, eg facilities management, health policy, marketisation, competition.

3 Policy context

As a background for the research that had been reviewed, this section provides a brief outline of how the processes of contracting out of catering, cleaning, facilities management, clinical services and the private finance initiative were introduced into the NHS.

Table 1: Key contracting legislation

Year	Legislation/ White Paper	Result
1983	Department of Health and Social Security Circular HC (83)18 - Health Services Management: Competitive Tendering in the Provision of Domestic, Catering and Laundry Services	Introduction of contracting out of catering, cleaning and facilities management in the NHS (and local authorities) – market testing of ancillary services – to test whether it was it cheaper to contract out services previously provided in-house
1991	NHS & Community Care Act 1990 'Working for Patients'	Introduction of internal market in NHS
1992	Introduction of Private Finance Initiative (PFI) – a private consortium (often facilities management....), raises loans and designs, builds, finances and operates new hospitals.	Private Finance Initiative introduced by Conservative government to keep expenditure off government accounts. Continued by Labour government 1997-2010. The NHS pays annual fees to cover the cost of borrowing and non-clinical services provided by the consortium over 30-60 years
2000	NHS Plan	Increased investment in NHS but proposals to use private sector to increase capacity. Clinical services start to be contracted out, through creation of independent sector treatment centres (ISTCs). Also preparation for contracting out of pathology and high technology diagnostic services.
2002	First independent sector treatment centre opened	
2005	'Commissioning a Patient led NHS'	Reduction in the role of PCTs as provider organisations. Encouraging practice based commissioning. PCTs have overall responsibilities for the health budget but PCT functions 'can be provided by external agencies, partners and consortia working on their behalf'.
2006	'Our Health, Our Care, Our Say' a new direction for community services	To improve community services through increased practice based commissioning, more joint commissioning with local authorities and competition for service providers for primary care.
2006	'Payment by Results'	National tariff to establish transparent system of pricing in the NHS

Table 1 continued

Year	Legislation/ White Paper	Result
2008	Introduction of 'Patient Choice'	Patients may choose any provider (NHS, private, not for profit) for elective care
2009	'Transforming Community Health Services: enabling new patterns of provision'	Guidance for all primary care trust (PCT) direct provider organisations to move to a contractual relationship with the PCT commissioning function. The range of organisational options includes community foundation trusts, social enterprises, merging with another NHS organisations or commissioning from a non-NHS organisation.

The process of contracting out of NHS services started in 1983 but was effectively limited to catering, cleaning and facilities management until the NHS Plan in 2000. The Private Finance Initiative (PFI) was introduced in 1992 as a way of providing new investment into public sector infrastructure, without apparently increasing public spending. Many new hospitals were built through this initiative. Several of the multinational companies with facilities management contracts became involved in PFI consortia. Since 2000, when the NHS Plan was launched by the Labour government, contracting out of services has expanded to include clinical services and pathology services. Later white papers have introduced fundamental changes for community health services, with the introduction of competition for primary care providers and the separation of PCT provider services from PCT commissioners. This sequence of changes shows that the contracting out of catering, cleaning and facilities management services was an initial stage in a longer process of contracting out many more NHS services.

Government auditors, for example, the National Audit Office, the Audit Commission, Audit Scotland, have provided some important studies that have looked at the effects of contracting out on services. Reports commissioned by the Health Select Committee have also provided information about the impact of contracting out of different services on patient care.

4 Assessing impact

The brief of the project was to assess the impact of contracting out and privatisation entirely on the basis of their impact on patient care or service. This needs to be discussed in relation to the different research methodologies, which are used in much academic research to measure the impact of health reforms on patient care.

The terms efficiency and effectiveness, both widely used as goals of health sector reform, are difficult to define and measure. Hussey et al (2009) in a systematic review of health care efficiency measures found that there had been few evaluations of the reliability and validity of widely used efficiency measures. A further finding was that quality of care was rarely considered by the 265 different measures of efficiency. It is this lack of consensus about how to measure quality of care that questions the many ways of measuring efficiency.

One of the issues arising is whether outputs are comparable, especially in relation to quality. There may be differences within a service or in a group of services. There may

be differences between patients. The review also found that most of the studies of efficiency of health care were focused on hospital care. Incorporating measures for quality in efficiency measures is a relatively undeveloped process and it is this lack of quality measures that undermine the validity of many current effectiveness measures. Quality of care was limited to clinical outcomes rather than focusing on quality of life. Relative few studies examine the 'voice' of patients or use creative ways of measuring patient experience and satisfaction.

This report has interpreted delivery of patient services as covering quality of patient care, outcomes of patient care, innovation in patient care and organisational arrangements that impact on patient care. The studies that have been reviewed have used a range of quantitative and qualitative research methodologies, which capture both process and outcomes of patient care.

5 Findings

The findings of this review will be discussed in the following sections:

1. Cleaning
2. Facilities management
3. GPs 'out of hours' services
4. Independent sector treatment centres
5. Clinical services
6. Shared services & IT
7. Voluntary/ not for profit sector

5.1 Cleaning

Cleaning was one of the first services to be contracted out in the NHS in the 1980s. During the decade of the 1990s, there was an increased incidence of hospital acquired infections, such as meticillin-resistant *Staphylococcus aureus* (MRSA) and *C difficile*. These had an impact on the quality of patient care and the costs of treatment in the acute sector. An international study, published in 2002, established links between cleaning and hospital acquired infections (Murphy, 2002). In the last decade there has been an increased awareness among government auditors about the problems of improving cleaning practices in the NHS when specifications of cleaning contracts are difficult to change.

In 2003, Audit Scotland inspected 20% of hospitals in Scotland as a follow up study to the Audit Scotland report, published in 2000, which reviewed domestic services in Scottish hospitals and was considered a base line review of cleaning services in Scottish hospitals. The 2003 study found that over half of hospitals did not have a high level of cleanliness in their wards. In 74 hospitals, local auditors and domestic services managers, who acted as peer reviewers, inspected four wards and public areas of each hospital. According to agreed criteria, each area was rated according to four categories: very good, acceptable, need for improvement or concern (Audit Scotland, 2003). A very good or acceptable level of cleanliness was found in 70% of wards and 80% of public areas. Hospitals were then grouped according to four categories. Table 2 shows the results for ward cleanliness.

Table 2 : ward cleanliness

Category	Results	Number of hospitals	In house provider	External contractor
Category 1	All wards and public areas rated good or acceptable	36 (49%)	31 (53%)	5 (31%)
Category 2	Wards mostly very good or acceptable with one need for improvement	17 (24%)	14 (24%)	4 (25%)
Category 3	Mix of very good, acceptable and more than one need for improvement	6 (8%)	5 (9%)	1 (6%)
Category 4	At least one ward or public area being of concern or all wards/ public areas show a need for improvement	14 (19%)	8 (14%)	6 (38%)

Source: Audit Scotland, 2003

Although the results showing ward cleanliness in relation to the type of provider show a higher proportion of external contract hospitals in Category four, with at least one ward or public areas being of concern, Audit Scotland pointed out that these results are not statistically significant. It is not possible to draw conclusions about the differences between in-house and external providers. However the results do show the overall effects of contracting on all hospitals. These are set out in the following paragraphs.

In 10% of hospitals no one had a designated responsibility for cleaning clinical equipment. Lack of staff time for cleaning was one factor that impacted on cleanliness. There was a lack of staff time for cleaning, supervising and monitoring, which resulted in cleaning done by untrained staff or in a short time. Supervising and monitoring were often left unfinished.

Staff turnover and sickness absence were problems for both in-house and external contractors. Low rates of pay made staff recruitment difficult. Half of trusts did not have targets or performance indicators for staffing indicators such as recruitment, sickness or turnover. This resulted in about 25% of wards having less staff time spent on cleaning than the hospital had planned and a 33% of wards having less staff to monitor cleaning than was planned. Over 40% of hospitals did not have adequate monitoring arrangements in place because of a lack of staff and pressures of workloads. One in six hospitals did not have a cleaning specification agreed with infection control teams.

One in five hospitals has cleaning contracted out to external contractors. Some hospitals reported that contracts with external contractors were often too general because outcomes were inadequately defined to meet acceptable levels of cleanliness. Many of the problems facing hospitals can be linked to the process of contracting out cleaning services, even if the in-house team was successful. The lack of detailed contract specifications and the problems of staff recruitment due to low levels of pay are both characteristic of contracted out services.

In a report by the Auditor General of Wales (2003), a link was made between contracting out of services and hospital infections. The findings of this study show how the contracting process needed more attention if standards of cleanliness were to improve. Cleaning services were usually considered the responsibility of the cleaning staff and not that of staff, patients and visitors. The report found that cleaning specifications had not kept up with changes in the hospital environment. The higher turnover of patients, new types of care and increased use of facilities all demand increased cleaning procedures. 25% of the

2,000 cleaning workers in Wales had only been in post for six months. Seven out of 17 acute hospitals in Wales had not re-written their cleaning contracts for 10 years, since the introduction of compulsory competitive tendering. Three out of the four hospitals with an external contractor had kept the same contractor.

The failure to review cleaning specifications led to a failure to draw up a realistic cleaning budget. This affected the purchase of new cleaning equipment. Cleaning contracts often did not take into account the expansion of ward areas, which increase the volume of cleaning required. Increasingly, cleaning staff were involved in serving food and working as health care assistants, which limited the time available for cleaning. Staff absences and high staff turnover also contributed to difficulties in working to existing cleaning contract specifications.

Liyanage and Egbu (2006) published two case studies of hospital cleanliness in two acute hospitals in Scotland, which covered an in-house contractor and a private finance initiative contractor. The in-house case study hospital had 615 beds and the PFI contractor hospital had 530 beds. 26 semi-structured interviews were conducted with domestic managers, infection control teams (ICTs), nurses, cleaners in the two hospitals. The results of these interviews informed the development of a postal questionnaire which was sent to domestic managers and infection control staff in hospitals across England and Scotland. 1,304 questionnaires were sent out and the response rate was 31% (412).

The results of the two case studies found that in the case of the PFI hospital there was a “clear rift between the ICT members and the domestic team in the PFI case” (Liyanage and Egbu, 2006: 249). The infection control team in the PFI hospitals felt that the PFI contractor did not seek their advice or recognise their role. All domestic supervisors and nursing teams felt that working as a team was important but domestic staff had a different perception. In both cases, domestic staff felt that they were separated from the health care team. However, in the ‘in-house’ hospital, the infection control teams felt that the domestic team generally took advice from the infection control team and nurses in the in-house case. Meetings, in the form of in-house working groups and domestic services liaison groups, were an important way for the teams to share information. The situation in the PFI hospital was different. Domestic teams and clinical teams did not meet regularly. The PFI domestic manager reported that contact was made only when necessary.

The questionnaire survey aimed to explore these findings in a larger number of hospitals. The results showed that there is a relatively higher level of integration between the domestic and ICTs in the in-house type of domestic service provision (Liyanage and Egbu, 2006). This supported the case study findings. The authors of this study recommended that clinical and domestic teams should be brought together, whether in-house or external contractor. They accepted that contracting was a permanent feature of the NHS and so made recommendations to improve the existing system rather than questioning the contracting out process itself.

In two reports in 2005 and 2007, Davies drew together research on hospital acquired infections with contracting out of services. He argued that high quality cleaning has an important role to play in reducing hospital infections. The contracting process contributes to problems in drawing up contracts that are flexible enough to meet changed circumstances. External contractors are often unwilling to share poor financial and management information because it is considered commercially sensitive. This also results in problems of imposing sanctions. The separation of the cleaning team from other infection control teams in hospitals makes the process of improving cleanliness in a hospital more difficult and less coordinated. Davies also highlighted two dimensions to contracting out of services. First, the effect of the tendering process on the service delivery, whether or not the in-house bid is accepted and second, the results of an external contractor delivering the services (Davies, 2005: 19). Cleaning is a labour intensive process so that any attempt to cut costs will be made at the expense of workers.

The impact of the contracting out of cleaning services in the NHS results from the way in which the process of contracting out fragments cleaning activities from the rest of the hospital. When a service is contracted out, each activity, which is included as part of the service, is itemised as a separate task. This works against the development of team work in the hospital. This move away from a holistic to a fragmented approach creates a lack of continuity between cleaners, clinical staff, managers, patients and visitors and there is no shared sense of responsibility for cleanliness across the hospital. The relationship between cleaning staff and clinical staff is crucial for maintaining high standards of cleanliness in a hospital. There are also problems in drawing up contracts, with not enough attention paid to regular reviews of contracts, whether for in-house or external contractors.

These changes contribute to a growing public perception that cleanliness in hospitals has declined and the inflexibility of cleaning contracts has contributed to this decline. This has resulted in differences in policy between England and the three devolved governments of Scotland, Wales and Northern Ireland. The problems of contracting cleaning services influenced decisions by both NHS Scotland and NHS Wales to abandon compulsory competitive tendering of cleaning services (Tweddell, 2008; NHS Wales, 2009). In Scotland, catering and facilities management will also not be subject to outsourcing (Tweddell, 2008). In Northern Ireland, outsourcing of cleaning services was not used extensively and now all cleaning is done in-house.

Key points

- Contracting out of cleaning services affects the way that cleaners work with other groups in hospitals, reducing teamwork, which impacts on patient care.
- In-house cleaning contractors are more likely to be integrated with infection control teams than external contractors.
- In many hospitals, contract cleaning specifications, whether for in-house or external contractor, have not been reviewed regularly and have not kept up with changes in the hospital environment.
- Contracting out of cleaning services has led to problems of recruitment and retention due to low wages, for both in-house or external contractors, because of pressure to reduce costs.
- The experience of contracting of cleaning services has led devolved governments in Scotland, Wales and Northern Ireland to abandon contracting-out of cleaning services.

5.2 Facilities management

Research into facilities management is a growing academic field. Existing research shows how facilities management is seen as part of the management function. Studies have examined facilities management outsourcing but have also explored the relationships between high performing hospitals, as defined through government inspections and types of relationship with external providers.

Macdonald, Price and Askham (2009) in a study that examined a group of hospitals trusts that had achieved high scores in Patient Environment Audits, looked at whether contracting out of facilities management contributed to these scores. The Patient Environment Action Team (PEAT) initiative was introduced in 2000, with each hospital required to develop action plans which would improve the patient environment. This was usually seen as the responsibility of the facilities management team. Patient Environment Action Teams consisted of nurses and other clinical staff, FM managers, trust directors, estates managers and patients, patient representatives and members of the public. Until 2004, hospitals were given a red (poor), amber (acceptable) and green (good) scores. After 2004, hospitals were rated as excellent, good, acceptable, poor or unacceptable.

This study started by identifying hospitals which had been given high scores in the period 2000 -2004 and analysed the characteristics of these hospitals. The analysis considered a range of criteria, including type of trust, size, number of hospitals in trust, age of trust, characteristics of local population, including population size and density, age profile, income and health profile and economic activity. Two additional criteria were the organisational arrangements for FM (integrated FM services, contract/in-house services); and geographical spread. The study did not find that any external factors contributed significantly to explaining why some trusts had scores for Patient Environmental Audits. This included no apparent difference between in-house or external contractor for facilities management. There are several limitations of this study. It did not look at why the majority of trusts had low Patient Environmental Audit scores, which might have highlighted external factors. There was no qualitative research with managers and clinical teams although this was a proposed second phase of the research.

Overall, there is a lack of evidence to show the positive effects of outsourcing of facilities management services. Even analysis of large scale NHS surveys does not highlight any obvious improvements that can be attributed to outsourcing.

Key points

- There is a lack of relevant research on outsourcing of facilities management services.
- Evidence drawn from a large scale surveys, as part of NHS initiatives to grade hospitals, did not provide any positive evidence to support the outsourcing of facilities management.
- Exploration of different types of contracting requires a more complex research process with key stakeholders.

5.3 GPs 'out of hours' services

The contracting out of GP 'out of hours' service is an example of the contracting out of clinical services. There are several reports and studies which provide some evidence about the impact on patient care, published since 2004. They are presented in chronological order of publication to show how the process of contracting out a clinical service resulted in poor patient care, over a relatively short period. It also shows how the recommendations of government auditors are not always implemented.

Since the mid-1990s, GPs 'out of hours' services had effectively been run by a mix of cooperative and private sector providers. In 2000, the Carson Review made recommendations for how these services should be run, in the context of the NHS Plan. In 2004, as part of a new General Medical Services contract, GPs were allowed to transfer the responsibility for 'out of hours' services to primary care trusts (PCTs). For £6,000 per year, GPs could give overall responsibility to PCTs for seeing that providers complied with the Department of Health 'National Quality Requirements'. 90% of GP practices gave up their responsibility for 'out of hours' services to the local primary care trust (PCT) (Select Committee, 2010).

A National Audit Office (NAO) report (2006) found that the initial implementation of this change in responsibility was difficult because PCTs lacked experience of commissioning this type of service. Many providers operated without formal contracts after 2004. 39% of PCTs had operated a tendering process but the NAO found that the services which had been subject to tendering process were no better or cheaper than those which had not been tendered. The cost of the contracted service was also higher than expected, with costs of about £9,500 per GP, rather than the £6,000 which each GP was contributing. This questions the assumption that contracting out is cheaper than providing a service within the NHS.

There was confusion among PCTs about whether providers of 'out of hours' services should be adhering to 100% of the 'Quality Requirements', set by the Department

of Health. The different approaches taken by PCTs resulted in the provision of lower standards of care. There was also an inadequate monitoring and evaluation of the 'Quality Standards' by many PCTs. The targets, set out in the Quality Requirements, for telephone and face to face access were least successfully met. Just under 10% of PCT respondents fully met targets for telephone clinical assessment. Just over 20% of respondents met targets for face- to- face clinical assessment. The NAO also found that the PCTs often lacked basic data on the operation of these services, especially when two or more providers were involved.

A NAO survey (2006) of patients found that a fifth of respondents were dissatisfied with the service, although there were some qualifications about patients' understanding of 'out of hours' care. This survey was commissioned by MORI. In contrast, the data collected by PCTs and providers presented a much higher rate of satisfaction. The NAO concluded that the providers were currently unable to 'capture negative feedback' perhaps because they were recording patient satisfaction rather than patient experience.

The NAO (2006) recommended that the Department of Health should ensure that the 'Quality Requirements' were better understood and that providers were trained to improve management information systems. It recommended that PCTs should try and better understand local demand for out-of-hours services and providers should improve their collection of patient experience data. These recommendations are significant because four years later evidence emerged that showed that they had not been implemented.

In 2010, the Health Select Committee published a report on 'The use of overseas doctors in the provision of 'Out of hours' care'. This was the outcome of an inquiry that the Select Committee had conducted, following the death of a patient as a result of being treated by an overseas doctor who had inadequate language skills and was not clinically competent. This inquiry focused on the use of doctors from the European Union by commercial providers of 'out of hours' services.

The Health Select Committee found that, as with the (2006) NAO report, the quality of 'out of hours' services around England was uneven. The focus of the inquiry was on the use of doctors from the European Union and the extent to which primary care trusts and providers of services actually undertook the checks that they were responsible for. Each PCT has to maintain a medical performers list, which involves assessing a doctor's language and clinical skills. The findings of the Health Select Committee showed that PCTs were unclear about their responsibilities with varying levels of compliance. Strategic health authorities were also found to have failed to monitor PCTs.

The evidence gathered by the Select Committee found, albeit anecdotal, evidence that the quality of for-profit providers was likely to be compromised by the need to cut costs (Select Committee, 2010: 10). PCTs had also not been rigorous enough in their monitoring of contracts with providers.

The Department of Health was pressured to commission research into 'out of hours' services as a result of this Health Select Committee inquiry. The research for this report (Colm-Thome and Field, 2010) included visits to five sites in England to assess the commissioning and provision of out-of-hours services. Providers from the NHS Alliance of Out of Hours Providers Leadership Group were surveyed about their use of locum GPs. Colm-Thome & Field (2010) found that the best providers of 'out of hours' services were not-for-profit GP cooperatives because they were more likely to have good links with local GPs. They found that PCT monitoring was variable in quality, with often the most rigorous being with social enterprises and the least rigorous with the PCT's own provider arm. As with the 2006 National Audit Office report, they found that PCT monitoring of 'Quality Requirements' was uneven. Few PCTs were aware of the procedures that providers followed for assessing clinical staff or induction of new staff. 'Out of hours' services were rarely considered a priority for PCTs when compared with other priorities such as accident and emergency or ambulance services.

Colm-Thome & Field (2010) found that many providers of 'out of hours' services did not assess the clinical skills of GPs and only relied on checking qualifications. Induction processes for new staff were also variable in length and content. The results of the questionnaire survey of providers found that there was variation in the process of vetting of locums. Six providers used 15 locum agencies. Some providers did not check references. The quality of care being delivered to patients was variable. There were also varied approaches to managing the skill mix of 'out of hours' services, with the use of GPs, nurses and advanced practitioners for home visits.

A further research report which examined the monitoring and surveillance of access to out-of-hours health care in Scotland found that arrangements for the collection of routine data on 'out of hours' services were fragmented. Surveillance systems were unable to cope with the increasing complexity of how services are delivered. More information needs to be shared across agencies if equity access to services is to be measured (Godden et al, 2010).

The research into GP 'out of hours' services conducted since 2004 has found some striking problems in the provision of services by providers as well as the monitoring of services by primary care trusts. It illustrates some of the problems of contracting out a clinical service. The overall quality depends on the commissioning agency having strong monitoring processes and taking an active role in meeting regularly with providers. For providers, the provision of clinical staff had been one of the most problematic areas. For commercial providers, the processes of recruiting and selecting GPs have been inadequate in many cases. Information systems have often been unable to provide enough useful information about how 'out of hours' services are actually being delivered and do not allow access to services to be monitored effectively. There is little evidence that 'out of hours' services demonstrate equity of access. Outsourcing of this service led to increased costs and in many cases, poorer quality of care.

Key points

- From 2004, the year that 'out of hours' services were outsourced, there was under-costing of 'out of hours' services because GPs were contributing £6,000 per year and the cost was £9,500 per year.
- As commissioners of 'out of hours' services, primary care trusts were unaware of their responsibilities, did not commission effectively and did not fulfil tasks of monitoring and regulation.
- Research showed that commercial providers often used inadequate vetting procedures for vetting and for inducting new GPs, leading to criticisms of the standards of services.
- Providers of 'out of hours' services often fail to collect adequate information collected to properly measure access to 'out of hours' services, which is crucial for assessing patient care.
- Outsourcing of 'out of hours' services led to cost-cutting and an uneven quality of service across England.

5.4 Independent Sector Treatment Centres (ISTCs)

The NHS Plan in 2000 increased investment in the NHS but part of the increased investment was to be used to contract the private sector to provide clinical services. Delivering the NHS Plan: next steps on investment, next steps on reform, the Department of Health set out plans for the use of the extra investment. This included the creation of a network of Treatment Centres, described as a "network of fast-track surgery units", which would reduce waiting lists. Some of the new treatment centres were to be run by the NHS and some by the private sector. £700 million per year was to be invested into these new centres. The aim of a treatment centre was to streamline the process of consultation, diagnostic tests and surgery for common conditions, such as hip replacement and cataract surgery. Some NHS treatment centres had already been developed as a way of improving

the coordination of treatment and care. The significance of the independent treatment centres was that it was the first time that the private sector has been commissioned to provide clinical services for the NHS on such a large scale. 27 centres were planned initially, with 11 new buildings. By 2008, local health commissioners were expected to contract out 15% of clinical services to the private sector (Department of Health, 2008).

There have been several studies which explore the implementation of the Independent Sector Treatment Centres, many trying to assess the value for money of the schemes. One recent study has looked at patient satisfaction data and tried to assess whether there was any significant difference between Independent Sector Treatment Centres and NHS hospitals. Drawing on patient experience is an important way of assessing the quality of care but does have to be set against health outcomes.

The Healthcare Commission undertook a review of Independent Sector Treatment Centres in 2007. The main findings were that data collected by the ISTCs is often incomparable to NHS data. The Healthcare Commission found that it was unable to evaluate the ISTCs because there was a lack of data available to compare them to NHS services. There were fewer patients treated by the ISTCs than had been expected but the centres were still being paid for operations even when not performed. The director of the Healthcare Commission commented that the emphasis on speed for setting up the new centres meant that systems for collecting data had not been set up. The Department of Health had asked companies to collect data, as part of their contract, but this was not data at patient level and so could not be compared to the NHS. The first wave of ISTCs was asked to report “key performance indicators” as well as routine NHS statistics. However, much of this routine data has not been collected. The following year, 2008, the Healthcare Commission found that although there had been some improvement in data collected by ISTCs, there were still limitations in the quality of data collected. ISTCs were particularly weak at recording the ethnicity of patients being treated.

There is some evidence of poor quality health care provided by ISTCs. The Healthcare Commission (2007) observed that the emergency readmission rates for hip replacements was similar to NHS rates but said “This is perhaps unexpected, given the mix of patients treated at ISTCs, which excluded those with the most complex needs” (Public Finance, 2007) . This suggests a slightly higher emergency admission rate.

White et al (2009) published a study of total hip replacements (THRs) performed on patients, referred from the Cardiff and Vale NHS Trust waiting list to Weston-Super-Mare ISTC. The need for revision surgery was identified in 20 (18%) out of 113 total hip replacement at a mean of 23 months’ follow-up. This revision rate is much higher than the 0.5% five-year failure rate reported in the Swedish Registry for the components used. The need for extra surgery was caused by poor technique. This had an impact on the work load of the NHS hospital department, which had to deal with these extra cases.

In one of the few studies which looked at health outcomes and patient views, Browne et al (2008) studied 769 patients treated in six ISTCS and 1,895 patients treated in 20 NHS providers (both NHS trusts and NHS treatment centres). Patients had three day surgery procedures, which included hernia repair, varicose vein surgery and cataract extraction) and hip and knee replacement. Health outcomes measures were adjusted for patient characteristics. The study found that the post-operative response rate varied by procedure and were similar for patients treated in ISTCs and NHS hospitals. When data was adjusted for pre-operative characteristics, patients who had cataract surgery or hip replacement surgery in ISTCs achieved a slight greater improvement than in the NHS. For patients having hernia repair, the NHS patients achieved a greater improvement than those in ISTCs. For the other two procedures, varicose vein survey and knee replacement surgery, there was no difference between ISTC and NHS patients. Most patients reported the result of their operation as excellent, very good or good, whether they were treated in the NHS or ISTCs. Browne et al (2008) urge caution in interpreting these results because

the case-mix of patients using ISTCs was different to patients in the NHS and very few ISTCs took part in the research.

Perotin et al (2011) used NHS trust in-patient surveys from 2007 and ISTC in-patient and day case surveys from 2007 and 2008 to see whether hospital ownership affected the level of non-clinical quality reported by patients. The study found that the experience of patients in public and private hospitals was different because different aspects of non-clinical quality are delivered in different ways in the two sectors. ISTCs were felt to provide more all round quality, fewer discharge delays and more comfort than NHS hospitals. NHS hospitals were felt to be better at giving information to patients. However ownership effects were not found to be statistically significant and so ownership does not affect the quality of the patient experience. Patient characteristics and how patients are allocated to public and private hospitals are more significant.

Indicators of improved patient care may include higher rates of innovation in health care practice. Turner et al (2011) looked at the influence of external providers on innovation in the NHS. This is a different approach to assessing the impact of contracting out of clinical services. Part of the rationale for introducing for-profit providers in the provision of clinical services in the NHS was that they would introduce new ways of delivering services as part of the competition process. Secondly, existing NHS providers would be pushed to introduce innovative approaches to improve performance (Turner et al, 2011). The study looked at the impact of one Independent Sector Treatment Centre on orthopaedic surgery provision in one local health economy in England. Two NHS trusts and an ISTC, owned by a for-profit company, agreed to take part in the study.

The study found that professional communities played different roles in the NHS trust compared to the ISTCs. Consultants felt that sharing clinical practice with colleagues was an important part of their professional life. NHS clinicians were also involved in trauma work, which was not undertaken by ISTCs. NHS clinicians from both trusts also knew each other and sometimes worked together. NHS chief executives had used the threat of competition to introduce changes. This raises questions about the relationship between professional communities and organisational change.

The ISTC programme aimed to introduce innovation into the NHS. One of the main innovations of Independent Sector Treatment Centres was that the centres were designed around patient pathways. Innovations appear to be in the clinical management techniques and management processes rather than in surgical innovations. ISTCs are also limited to standard procedures and do not deal with complex procedures or trauma. Clinicians were recruited from outside the NHS. There was a strong performance management system.

One of the immediate effects of the ISTC in the study of the health economy was to stimulate innovation in the NHS trusts. One NHS trust has introduced a patient pathway approach. Perhaps the most significant differences concerned governance and training. With a local ISTC, much routine surgery was taken away from the NHS. Some NHS clinicians felt that the ISTC appeared to have responsibility towards the continuing care of the patient. Turner et al (2011) found that the NHS trusts still provided a 'stronger learning environment in which medical innovations were more likely to occur' (Turner et al, 2011:528).

Only eight out of 28 performance indicators against which ISTCs are monitored are clinical. The lack of comparable data for ISTCs and NHS trusts makes it difficult to draw conclusions about the health care provided by different providers. The research into the performance of Independent Sector Treatment Centres (ISTCs) illustrates some of the problems. Studies have looked at a single ISTC or ISTCs covering one health care intervention (Browne et al, 2008). It is not easy to compare these studies although there is some evidence to show that the recruitment of staff to ISTCs is sometimes problematic and that the ISTCs are not integrated into the professionalism of the local NHS trusts.

New commercial contractors are less likely to have strong working relationships with local clinicians and practitioners.

ISTCs were introduced to increase capacity and reduce waiting lists in the NHS. The results show they have not had a significant impact on waiting lists. There is growing evidence to show that they do not provide value for money. Several ISTCs contracts have been underused, with payments made to private providers for work which was not undertaken (Player & Leys, 2008). It is also questionable whether they have been the source of innovation because of problems with staffing and a lack of integration into the NHS. One of the most serious criticisms is the problem of collecting data for ISTC performance so that it can be compared to NHS performance (Healthcare Commission, 2007). From the experience of ISTCs, the outsourcing of clinical services has been shown to be ineffective. It has also highlighted some more fundamental problems about data collection by private providers. As Player and Leys (2008) argue, the real significance of the ISTCs lies in seeing it as 'a crucial step in the replacement of the NHS as an integrated public service by a healthcare market, in which private providers will play an steadily increasing role' (Player & Leys, 2008:71).

Key points

- Independent Sector Treatment Centres (ISTCs) were introduced, as part of the NHS Plan, to help to reduce waiting lists.
- ISTCs were set up quickly, with favourable terms for private companies, which has meant that companies were paid for operations even when there were not enough patients.
- Initially ISTCs were not allowed to use NHS staff and so used overseas staff, who were not again an issue and their separation from the local health community
- Some studies have shown that the need for re-admission follow ISTC operations is higher than expected.
- National Audit Office investigations found that ISTCs failed to collect adequate information, which has made it difficult to assess the quality of patient care.
- The impact of ISTCs on local health innovation has been limited.
- Research into the effectiveness of ISTCs is often restricted to one centre or type of intervention, which is not enough to evaluate the whole scheme.
- Existing evidence shows that ISTCs did not reduce waiting lists significantly.
- ISTCs have contributed to the creation of a health care market, using private providers, in the NHS.

5.5 Clinical services

The introduction of 'Payment by Results' and 'Patient choice' have contributed to the increased contracting out of NHS services. 'Patient choice' allows a patient to choose an NHS or independent sector provider for elective surgery. The creation of a set of tariffs, 'Payment by Results', for different treatments, has contributed to an increased degree of competition in the NHS, with growing involvement of the private sector. There have been several studies which have examined the relationship between increased competition and patient outcomes. These will be discussed in the context of the suitability of research techniques used.

Gaynor, Moreno-Serra & Propper (2010/1) analysed the impact of the new pricing system, 'Payment by Results', which was introduced in 2006 by comparing data from 2003/4 to 2007/8 and comparing it to hospital mortality. 'Payment by Results' was a fixed price prospective reimbursement system. Private providers were introduced into the NHS, through a series of contracts that gave favourable terms to private companies (Player &

Leys, 2008). A third change was that patients were given the opportunity to choose which hospital to go for in-patient care, through an initiative called 'Patient Choice'.

Gaynor et al (2010/1) used the Herfindahl-Hirschman Index (HHI) to calculate the degree of competition by measuring the patient flows to a hospital as an indicator of market share. It was assumed that the greater the number of patients attending the hospital, the higher the degree of market concentration, with fewer competitors, and so a lower rate of competition. The study found that market concentration had a statistically significant positive effect on mortality, so that higher market concentration (a larger HHI) led to lower quality. A 10% increase in the HHI led to an increase of 2.91% in the acute myocardial infarction (AMI) death rate. A 10% fall in the HHI was associated with a fall in the 30 day death rate following acute myocardial infarction admissions, by 2.91%. Reductions in market concentration were found to result in a reduced length of stay. There were no increases in operating costs or expenditure per admission so that markets that became less concentrated did not appear to increase costs. The study concluded that the 2006 reforms in pricing led to improved health outcomes as measured by reductions in mortality and shorter length of stay in hospital, resulting in either no increased expenditure or in some cases reduced expenditure.

This study of the NHS internal market uses a methodology (HHI) that attempts to assess the degree of competition among NHS providers. The assumption that patient flows to a hospital can be considered as an indicator of competitiveness can be questioned because competitiveness concentrations, are most often measured by share of sales, which are different to health care interventions. The use of this methodology, which is drawn from a manufacturing or industrial context, is not necessarily appropriate for health care in the NHS. This study only looked at one cause of mortality, which makes comparisons difficult. Making policy recommendations on the basis of one healthcare condition shows the limited evidence base that is used to inform the continued development of the health care market in the NHS. More innovative methodologies are required if the actual impact of different forms of competition are to be assessed in terms of patient care.

Studies that look at a specific intervention in a specific region or geographical area need to be interpreted with care. Another study, Cooper et al (2010), which has been influential in health policy debates about competition, looked at the effect of competition on efficiency in England after the introduction of 'Payment by Results' in 2006. Efficiency was measured using hospitals' average length of stay (LOS) for patients undergoing elective hip replacement. Length of stay was broken down into two key components: the time from a patient's admission until their surgery (pre-surgery LOS) and the time from their surgery until their discharge (post-surgery LOS). Data from the period 2002 to 2008 was analysed, so covering the period before the introduction of 'Payment by Results'.

This study found that hospitals cut down on the pre-surgery length of stay but not on post-surgery length of stay, which led to an overall reduced length of stay. This was interpreted as being more efficient. The study concludes that the measures to stimulate competition after 2006, including payment by results, private sector competition and patient choice, resulted in improvements in hospital efficiency. This study is of one single intervention, hip replacements, and uses length of stay as its indicator of efficiency. Length of stay cannot always be considered an indicator of improved patient care.

Using the results of a single intervention to generalise about competition in the NHS is not a basis for drawing conclusions about the effectiveness of patient care. Also, the impact of increased competition from the private sector is not technically accurate as the independent treatment centres were given highly favourable conditions for entering the NHS market (Leys & Player, 2008). Attempts to measure the effects of competition on patient care as seen through mortality or length of stay, draws on research methods developed for use in the manufacturing sector. Health care does not operate as a type of manufacturing and imposing assumptions from a different sector do not provide a credible evidence for the beneficial effects of competition.

A recent study of choice in the NHS has shown that there are significant equity issues to be addressed. Using data from the British Social Attitudes survey (2007) and the British Household Panel Survey (2007), Zigante (2011) found that a higher level of perceived choice was associated with a higher level of satisfaction with the NHS. However, the significant finding was that the effect of competition on life satisfaction was only positive for people with good income and high levels of education. For those on lower incomes, with lower levels of education, there was not a positive relationship. This is an important study because it questions some of the assumptions made about the value of choice in the NHS. From this study, choice and competition benefitted higher income groups.

There have been extensive criticisms of many of these studies because of their small samples and partial analysis. Even when conclusions on unclear, more competition is recommended, rather than questioning whether competition is necessary. However, the influence of these studies on health policy development in the NHS has been extensive, showing that health policy on competition and outsourcing draws from a very limited evidence base. The recent research on equity and choice (Zigante, 2011) shows that 'choice' is not beneficial for people on low incomes with lower levels of education. This has important implications for equity in the NHS.

Key points

- The research methodologies that have been used to assess the impact of competition in the NHS are drawn from the manufacturing sector and are inappropriate because they fail to measure quality of care or patients.
- Evidence of the value of competition is still drawn from a limited number of studies in the NHS and even if the conclusions about the value of competition are unclear, they have been given an over-rated influence in health policy.
- Recent research has shown that 'choice' does not benefit low income and less well educated groups, showing that 'choice' and competition have an impact on accessibility to health care.

5.6 Shared Services and IT

As well as outsourcing of catering, cleaning, facilities management and clinical services, there has been pressure to market test and outsource financial, administrative, human resources and IT services. These are often called 'shared services'. A series of case studies of shared services in local NHS organisations, which covered finance, payroll, HR, estate maintenance and management, informatics (IM&T), governance, PR/communications and fleet management, identified a set of critical success factors (Fairhurst & Reilly, 2010). The study, published by the Institute of Employment Studies, highlighted the importance of considering how an external provider will adapt to changes or, drive them, because the service that they offer will change over the lifetime of the project.

The critical success factors identified by this project show several issues which could be applied to outsourcing of a range of services. Having the right staff in place to both implement and then manage the service(s) is important. The report recommends that partnership, outsource and in-house arrangements should all be considered. Another critical factor is that the commissioning organisation must understand what the shared service is delivering and be able to challenge this, if problems arise, not just abdicating responsibility to the provider. A high degree of standardisation and automation is needed. Although an initial aim will be to achieve savings, it is also essential to improve service quality and consistency. Effective management of staff during the change process is another important success factor, along with leadership from the top. Good governance arrangements, which allow all players to have an influence and to manage performance, was also highlighted (Fairhurst & Reilly, 2010). The experience of creating shared service arrangements has generated some useful learning about using external providers.

In 2001, the NHS piloted 'NHS Shared Business Services' as a joint venture with Xansa, now called Steria, a specialist private sector shared services company. In 2004, the Gershon Review identified the potential for shared services to generate savings across government and the public sector. In response to this recommendation, the NHS set up a formal joint venture with Steria in 2005, building on the experience of the pilot initiative in 2001. The process of introducing shared services to the NHS by region, has not necessarily followed all the critical success factors outlined above. For example, the options of partnership, outsourcing or in-house arrangements are not always fully explored.

The NHS Shared Business Services joint venture initially included functions such as procurement, accounting and finance. In recent years, it has widened its scope to include family services. The National Audit Office report (2007) found that the implementation had involved a large and complex system, cultural changes were needed and that customer expectations rose over time. Initially there was a slow rate of take-up by NHS organisations and a lack of acceptance by users. Gradually, as other benefits became clearer, customer expectations started to increase. Additional benefits included better management information, paperless transaction processing, faster transaction processes and savings on procurement costs. The NAO report acknowledged that the initial stages of establishing shared services are often difficult for users of the services because shared services are more complex than outsourcing a single service. As an indication that the process of establishing shared services can still be difficult, the GP magazine, Pulse, in 2011, reported problems with the introduction of shared services for GPs in the South West of England. These included delayed payments, patients being taken off GP lists by mistake and delays in the transfer of patient notes (McNicoll, 2011).

IT

The most controversial failure of outsourcing technical expertise to the private sector was the introduction of a new IT system to the NHS. Started in 2002, the aim of the project 'Introduction of a new IT system to the NHS' was to set up the NHS Care Records Service so that health professionals could access relevant parts of patient records as well as X-rays, prescriptions and electronic booking (NAO, 2006). The Department of Health set up a unit to procure and deliver IT systems, called 'Connecting for Health'. The aim of the unit was to centralise and coordinate IT procurement for the whole of the NHS, which was expected to save money. Although leadership of the unit remained stable from 2002-2006, the engagement with the NHS was more erratic and engagement only really started after procurement had taken place. By 2006, several milestones had not been met, including the setting up of the National Data Spine and the NHS Care Records Services. The cost of the project has also increased from an initial £12.5 billion to £20 billion (NAO, 2006).

In 2008, the Public Accounts Committee found that the Lorenzo Care Records software was not being used by any NHS trust. Accenture, ComMedica and IDX, three local private providers, had dropped out, leaving only two local private providers, with limited capacity. The lack of clinical functions of the new system meant that the needs of clinical staff needs had not been met (PAC, 2009). More widely, there was a lack of commitment by NHS staff. The problems of NHS staff commitment to the project were a central concern throughout the project. In October 2011, the Department of Health abandoned the project (Wright, 2011). The consistent criticism of the project was the lack of consultation and involvement of NHS staff in the design of the systems. It was also very costly and overran its budget. The expertise, which IT providers were supposed to bring to the project, was not shared in an effective way with NHS staff.

Key points

- The NHS set up a formal joint venture with Xansa (now Steria) in 2005, to create NHS Shared Services, building on the experience of the pilot initiative in 2001. It covers three functions: procurement; accounting and finance.
- Customer expectations have increased over time and have been accompanied by a range of benefits, e.g. paperless transactions, reduced procurement costs.
- Many of the critical success factors including, exploring partnership, outsourcing or in-house arrangements, retaining responsibility and understanding of the service being outsourced, or maintaining services quality and consistency as well as reducing costs are not always followed.
- The NHS IT project illustrates many of the problems when the external contractor is the sole source of expertise and NHS staff were not properly involved in the project design.

5.7 Voluntary sector/ third sector

The extent to which services have been contracted by the NHS to the voluntary/ third sector is limited. There is a shortage of studies to assess the impact on patients. Much research is concerned with the impact of contracting on the voluntary sector itself and whether the sector provides value for money. Macmillan (2010) in a review of the evidence of the third sector providing services found that research had focused on the views of staff in third sector organisations rather than on the views of stakeholders, particularly service users. There is almost an underlying assumption that the quality of patient services would be acceptable. Mental health services have a longer experience of contracting out and the search for some form of evaluation is continuing.

Allen et al (2011) in a study of how the diversity of providers in the NHS had changed during New Labour governments, found that there was limited use of either private or third sector. However, there were differences in approach by the private sector and the third / voluntary sector. The private sector was more concerned with improving patient pathways and patient experience but the third sector took a more holistic approach, with more community involvement. The most significant finding was that as competition increases, information sharing decreases.

This study found that the third sector did not necessarily provide more innovative or effective care than the NHS. In some cases this was due to lack of resources. Third sector organisations are often more effective at working with local communities and hard to reach groups, although ways of harnessing this expertise in partnership with the NHS are still being developed. Some third sector organisations are led by the values of their staff. In one case study, a mutual organisation had been set up, which brought together primary care staff and local GPs and was governed by a council, with both primary care staff and local members of the community. In another example, patients became stakeholders and led a project which used volunteers to provide services to other local people. The contracting of NHS services to voluntary/ third sector organisations is still evolving, with the implications for NHS staff are unclear. Some organisations have strengths in relation to working with local communities or hard to reach groups but not all services provided are more effective or innovative.

In the last two years, the transfer of funding and commissioning of social care for adults from the NHS to local authorities has led to the contracting out of mental health services and services for people with learning disabilities by local authorities to voluntary and for-profit providers. These services were originally part of the NHS and staff have moved from the NHS and are now employed by voluntary or for-profit providers on TUPE conditions. This is likely to expand as community health services and public health functions are also moved to local authorities.

Key points

- At the moment, there is limited contracting to the voluntary / third sector by the NHS.
- Research had focused on views of staff in relation to contracting rather than views of service users
- There are some examples of the voluntary/ third sector working with the NHS and the different types of partnerships are evolving, with the implications for staff unclear.
- The transfer of adult social care to local authorities is resulting in NHS staff being transferred to voluntary/ third sector providers

6 Conclusion

This project has identified a range of studies that have examined some aspects of outsourcing in the NHS and the effect on patient care. It is noticeable that much of the evidence demonstrates either the negative aspects of introducing competition into the provision of health care services or inconclusive results (Appendix A). A lack of data makes it difficult to assess the impact of contracted out services on accessibility of services and health outcomes. Overall, there is a lack of evidence to show that outsourcing leads to improved quality of patient care. The experience of outsourcing cleaning services shows that there was a negative impact on patient care. Outsourcing of clinical services, for example ISTCs and GPs 'out of hours' services, shows negative effects on patient care, poor value for money as well as evidence of inadequate monitoring and evaluation of the services. Although there is some evidence of the benefits of shared services, the experience of the NHS IT project was a clear failure of outsourcing.

What is emerging from research into the impact of privatisation and contracting out is that the initial impact can often be strongest on how people are organised in internal hospital systems, which in turn impacts on the ways in which health workers and health professionals work together. This is a complex relationship but appears to be a significant one if the impact of contracting out is to be assessed in terms of patient care.

The tendering process has an impact on how services are organised, the flexibility for responding to change and the pressure to reduce staff costs. A lack of comparable data has been identified as a problem for both ISTCs and GP 'out of hours' care. With increased competition, information is less widely shared and often considered commercially sensitive for private sector providers

The introduction of outsourcing to the NHS has identified the need for data collected to measure the quality of patient care after the contracting process. At the moment, a combination of academic research, research from regulatory agencies and trade union research provide the most effective way of gathering evidence of the impact of outsourcing into the quality of patient care. Many of these studies do not show any demonstrable benefits from outsourcing. Other academic studies have assessed the impact of competition on the NHS in a limited way, either using one service, or one health outcome. The conclusions are then applied to the whole of the NHS, as a way of justifying more competition. This research needs to be challenged because it is being used to justify continued competition and marketisation policies in the NHS.

In the light of the 2011 Health and Social Care Bill, currently going through Parliament, the findings of this review are significant. Outsourcing often has a negative effect on the quality of patient care. It affects how NHS workers work together to deliver care. Effective commissioning, regular reviews of contract specifications and monitoring of

contracts require skills and experience. The experience of how ‘out of hours’ services were contracted out and the effect on patient care illustrates the problems when commissioners and providers are unaware of how to fulfil their responsibilities. In a re-organised NHS, where much commissioning experience, developed in primary care trusts, will be lost, the likelihood of the new contracting systems affecting the quality of patient care will be even more likely.

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8 Appendix A

List of studies assessing positive, negative or inconclusive impact of sourcing

Study	Positive impact of outsourcing	Negative impact of outsourcing	Inconclusive
Cleaning			
Audit Scotland (2003) Hospital cleaning A report presented to the Scottish Parliament	NO	YES	
Auditor General for Wales (2003) The Management and Delivery of Hospital Cleaning Services in Wales – presented to the National Assembly for Wales 23 May 2003	NO	YES	
Comptroller & Auditor General (2004) Improving patient care by reducing the risk of hospital acquired infection: A progress report HC 876 Session 2003-2004: 14 July 2004	NO	YES	
Liyanage C. & Egbu C. (2006) The integration of key players in the control of healthcare associated infections in different types of domestic services Journal of Facilities Management 4(4): 245-261	NO	YES	
Davies S. (2005) Hospital contract cleaning and infection control UNISON	NO	YES	
Davies S. (2005) Making the connections Contract cleaning and infection control UNISON	NO	YES	
Facilities Management			
Macdonald R. Price I. and Askham P. (2009) Excellent patient environments within acute NHS trusts External influences and trust characteristics Journal of Facilities Management 7(1): 7-23	NO	NO	YES
GP 'Out of hours' services			
National Audit Office (NAO) (2006) The Provision of Out-of-Hours Care in England, HC 1041 Session 2005–2006	NO	YES	
House of Commons Health Committee (2010) The Use of overseas doctors in providing out of hours services Fifth report of session 2009-2010	NO	YES	

Study	Positive impact of outsourcing	Negative impact of outsourcing	Inconclusive
Colin-Thome D.& Field S. (2010) General Practice Out-of-Hours Services Project to consider and assess current arrangements London: Department of Health		YES	YES
Godden S. Hilton S. Pollock A. (2010) Monitoring and surveillance of access to out-of-hours health care in Scotland Centre for International Public Health Policy University of Edinburgh	NO	YES	
ISTCs			
Healthcare Commission (2007) Care provided by independent sector treatment centres	NO	YES	YES
Healthcare Commission (2008) Independent sector treatment centres: the evidence so far Inspecting Informing Improving July 2008	NO	YES	
House of Commons Health Committee (2006) Independent sector treatment centres. Fourth report of the session 2005-6 London: Stationery Office		YES	
White S.P. John A.W. & Jones S.A.(2009)Short-term results of total hip replacements performed by visiting surgeons at an NHS treatment centre Journal of Bone & Joint Surgery (British edition)91(9):1154-7	NO	YES	
Browne, J. Jamieson L. Lewsey J. van der Meulen, J. Copley L. and Black N. (2008) Comparison of case-mix and patients' reports of outcome in Independent Sector Treatment Centres and NHS providers: prospective cohort study BMC Health Services Research 8. p. 78. ISSN 1472-6963	NO		YES
Perotin V. Zamora B. Reeves R. Bartlett W. & Allen P. (2011) Does hospital ownership affect patient experience? An investigation into public-private sector differences in England http://campus.usal.es/~ehe/Papers/BernardaZamora2011.pdf			YES
Player S. & Leys C. (2008) Confuse and Conceal: The NHS and Independent Treatment Centres London: Merlin Press	NO	YES	

Study	Positive impact of outsourcing	Negative impact of outsourcing	Inconclusive
Turner S. Allen P. Bartlett W. Perotin V. (2011) Innovation and the English National Health Services: A qualitative study of the independent sector treatment centre programme Social Science and Medicine 73: 522-529	NO	YES	YES
Clinical Services			
Cooper Z. Gibbons S. Jones S. and McGuire A. (2010) Does Hospital Competition Improve Efficiency? An Analysis of the Recent Market-Based Reforms to the English NHS LSE Centre for Economic Performance (CEP) Discussion Paper No 988 June 2010	YES	NO	
Gaynor M. Moreno-Serra R. and Propper C. (2010/11) Death by Market Power Reform, Competition and Patient Outcomes in the National Health Service Working Paper No. 10/242 Centre for Market and Public Organisation	YES	NO	
Zigante V. (2011) Assessing welfare effects of the European Choice Agenda: the case of health care in the United Kingdom LSE 'Europe in Question' Discussion Paper Series No 35/2011		YES	
Shared Services & IT			
National Audit Office (NAO) (2007) Improving corporate functions using shared services HC 9 Session 2007-2008 27 November 2007	YES	NO	
Fairhurst P. & Reilly P. (2010) Back Office Efficiency: Shared Services Case Studies London: Institute for Employment Studies	YES	NO	
National Audit Office (NAO) (2006) The National Programme for IT in the NHS HC 1173 Session 2006-2007 16 June 2006			YES
Public Accounts Committee (2009) The National Programme for IT in the NHS: Progress since 2006 14 January 2009	NO	YES	
Voluntary/ Third Sector			
Allen P. Bartlett W. Matchaya G. Perotin V. Turner S. Zamorra B. (2011) Provider diversity in the NHS: a study of recent developments in four health economies Paper presented in the 9th Annual ESPAnet Conference Sustainability and transformation in European Social Policy Valencia, 8-10 September 2011			YES

Study	Positive impact of outsourcing	Negative impact of outsourcing	Inconclusive
Allen P. & Jones L. (2011) Diversity of health care providers in Mays N. Dixon A. Jones L. (eds.) Understanding New Labour's Market reforms of the NHS King's Fund			YES
Macmillan R. (2010) The third sector delivering public services: an evidence review Third Sector Working Paper 20			YES
Total	4	18	11

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