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- Head to head: Will 1 April mark the beginning of the end of England's NHS? Yes (*BMJ* 2013;346:f1951) No (*BMJ* 2013;346:f1975)
- Editor's choice: Sleepwalking into the market (*BMJ* 2013;346:f1850)
- Observations: The future of the NHS—irreversible privatisation? (*BMJ* 2013;346:f1848)

Is the great NHS sell-off under way?

One year on from the health reforms in England, **Peter Davies** asks whether there has been an increase in private provision of NHS services

Twelve months after a reorganisation widely perceived as a blueprint for increasing private sector participation in the health service, is the great NHS sell-off under way? Given steadfast public resistance to any suggestion of NHS privatisation, such a move would have to be subtle. But is it happening at all?

What do the figures reveal?

Official statistics from the Department of Health detailing NHS spending on independent sector providers in 2013-14 are not due to be published until July. But a study released this week (3 May) by the NHS Support Federation, which opposes a competitive market in the NHS, has tracked NHS commissioners' invitations to tender for clinical services and contracts awarded during the 12 months to April 2014. These appeared in the *Official Journal of the European Union* and on the Supply2health website.

Commissioners placed 390 contract notices during the year plus 22 "prior information" notices, while awarding 80 contracts. Among these, clinical commissioning groups (CCGs) were responsible for 274 advertisements, gave notice of 13 more coming up, and awarded 38 contracts. About 40% of CCG contract notices involved multiple partners.

Altogether this represented £13.5bn (€16.4bn; $22.7bn) of NHS funding, albeit spread over several years. The NHS Support Federation estimates this is more than three times the value of contract activity that it detected in the previous year. It found 77 types of clinical care and treatment covered compared with 44 in 2012-13. Diagnostics accounted for 19% of tenders, with mental health and pharmacy representing 7% each.

Of the 80 contracts awarded, 54 (worth a total of £475m) went to non-NHS providers, 25 (worth £88m) went to the NHS, and one was shared. The Department of Health maintains that NHS spending on independent providers remains modest at about 6% of total budget. But the federation's director, Paul Evans, says: "There is a clear trend emerging. More contracts are being placed into the market across a widening spectrum of care, and so far the majority are being won by the private sector."

Nevertheless, he acknowledges that private provision has not grown at the pace some feared when the Health and Social Care Act 2012 became law. Some private providers may be waiting to assess the direction of future health policy after the general election, he says.

How should the trends be interpreted?

The picture is "patchy," according to David Hunter, professor of health policy and management at Durham University. "Some people think we're on a journey with the direction of travel mapped out. But we're still in the foothills. It's hard to say whole swathes of the system have transferred to the private sector."

But this could be "the lull before the storm," he says. Last year witnessed "a sense of chaos and confusion" as newly formed CCGs struggled to interpret the procurement and competition rules governing the NHS market. Indeed, one survey covering 93 of the 211 CCGs found that more than a quarter had opened services to competition only because they otherwise feared falling foul of the rules.[1]

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Nigel Edwards, chief executive of the Nuffield Trust, a health think tank, says the picture is confounded because commissioning organisations have been "massively disrupted" by reorganisation. Contracts awarded in the first three to six months of 2013-14 were probably initiated before the reforms were fully implemented, he points out. Edwards argues that the "cost and onerousness" of the procurement process could work against privatisation. Writing a tender is difficult, expensive, and risky, especially where data are poor—such as for community health services, which are seen as a major growth area for private providers. In many instances commissioners may come to regard tendering as worth while only where failure to do so would provoke potential providers to challenge them under the procurement rules.

Some evidence suggests current fears about challenges may be exaggerated. Although the trust regulator Monitor has handled close to 200 inquiries in the past year, it has launched only three formal investigations, two involving challenges from private providers. One, from Spire Healthcare in Blackpool against two local CCGs, is ongoing. The other was settled when NHS England entered into a contract with the challenger, Thornbury Radiosurgery Centre.

What does the private sector say?

Virgin Care's head of service development and innovation, Neil Goulbourne, says many of its contracts currently in the pipeline pre-date the NHS reforms: "Much of the work we are currently doing has very little to do with the reforms. As the reforms have begun to take effect over the last 12 months, the number of services coming up for tender may have initially slowed slightly—mainly as the new commissioners began to get to grips with their new roles—but despite this our contractual pipeline has remained strong."

The NHS Partners Network, which represents independent sector providers of NHS clinical services, expects more opportunities for its members over the next three years. Its chief executive, David Hare, says CCGs have taken longer than hoped to settle into their roles, while the procurement rules have caused "much nervousness." That has meant the "overall trajectory" of private provision has been one of consistency rather than exponential growth over the past year.

"It hasn't generated the level of contracts going to the independent sector that was feared. It continues to be a steady evolution. But I'm optimistic for the long term—for our members and the NHS. I think we're moving steadily towards the point where plurality of provision is possible."

Have there been any landmark advances?

Three major contracts have attracted attention and controversy in the past year.

Cambridgeshire and Peterborough CCG invited bids to provide integrated services for

Going to market: Independent providers report a "steady evolution" in NHS business

older people, initially valuing the contract at £1bn over five years but later reducing it to £800m. Anti-privatisation campaigners accused it of breaching its duty of patient involvement by withholding tender documents shared with bidders on grounds of commercial confidentiality. Threatened with legal action, the CCG released the documents. The case highlights a conflict that many commissioners may face. Virgin Care, Optum, and Care UK remain in the bidding.

Bedfordshire CCG awarded a five year contract to Circle for musculoskeletal services worth £120m, 6% of the CCG's budget. Circle will be the prime contractor, assuming the risks and managing delivery of care, largely through an existing community provider. Bedfordshire general practitioner Andy Edwards says: "It is an ambitious project and as clinical commissioners we will be monitoring it carefully."

Four Staffordshire CCGs are seeking bids for a 10 year contract worth £1.2bn for cancer and end of life care. They have the backing of Macmillan Cancer Support, the county council, and Stoke city council. Their ambition is for "transformational and sustainable service change that recognises the primacy of the patient in the service model." The scale of this contract has shocked anti-privatisation campaigners. Clive Peedell, consultant oncologist and co-leader of the National Health Action Party, says: "This is a really important one for the future of the NHS. Frontline cancer services are not suitable for outsourcing. We want a network model. If we unbundle that it will create chaos. If they can do this the NHS has had it. You could argue the contract may go to the NHS—but if that's the case, why waste millions on this process?"

EU-US trade talks in the balance

Campaigners have succeeded in delaying progress on a free trade agreement between the European Union and the United States while public consultation takes place on a controversial measure that some fear could lock the NHS into a competitive market for good.[2]

The European Commission launched a three month consultation at the end of March on "investor protection" provisions in the Transatlantic Trade and Investment Partnership (TTIP), which it has been negotiating with the US since July 2013. These could enable companies to demand compensation from governments that act in a way that could curtail their profits. Some policy analysts predict that a future UK government might be reluctant to end outsourcing of NHS clinical services, whatever the evidence to support such a move, if it risked costly legal action. The campaigners have demanded that the NHS be specifically excluded from TTIP.[3]

Widespread public concern about investor protection since the TTIP talks started has forced the EU to act. Trade commissioner Karel De Gucht said: "I know some people in Europe have genuine concerns about this part of the EU-US deal. Now I want them to have their say."

He may have been more influenced by pressure from governments than from activists. France is concerned that investor protection could jeopardise its anti-fracking laws, while Germany is angry at finding itself subject to a claim from a Swedish company after deciding to close its nuclear power industry. Others on both sides of the Atlantic who support TTIP are alarmed that it could be derailed if investor protection is included, and have called for the measures to be dropped.

But the UK government remains sanguine. Despite entreaties, it has made no attempt to exclude health services from TTIP, and business minister Michael Fallon told parliament: "The TTIP will not affect the policy that it is for NHS commissioners to take decisions on the competitive tendering of services."

Kenneth Clarke, minister without portfolio, said: "The British have nothing to fear from such arrangements. They have already been put into all of our 94 investment treaties with other countries. So far, only two companies have tried to bring claims, and the government has won in both cases." He claimed "nothing in the agreement would open up access to the NHS beyond what is already permitted, and what was permitted under the previous government."

But Meri Koivusalo, senior researcher at the National Institute for Health and Welfare in Helsinki, warns that campaigners' fears are not groundless. "Health policies restrict many things and involve huge sums of money. Corporations will make claims when major interests are at stake."

Internationally investor protection claims have risen sharply in recent years, reaching a record 59 worldwide in 2012 and 57 in 2013, according to the United Nations Conference on Trade and Development.

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References are in the version on bmj.com.
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RESPIRATORY MEDICINE TEAM OF THE YEAR

Unsung successes in medicine

The Respiratory Medicine Team of the Year recognises a project or initiative that has measurably improved care in respiratory medicine. **Adrian O'Dowd** meets the candidates

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The BMJ Awards are sponsored by MDDUS. The awards ceremony will take place on 8 May at the Park Plaza Hotel, Westminster. To find out more go to http://thebmjawards.bmj.com.
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Community Pharmacy Future COPD case finding and support service, Alliance Boots

Making greater use of visits to the pharmacy by patients with respiratory problems to help boost their health and quality of life is central to the approach taken by four pharmacy companies. This service was launched in 2012 in the Wirral, Merseyside, after Boots UK, Lloydspharmacy, Rowlands Pharmacy, and the Co-operative Pharmacy, created the Community Pharmacy Future project team.

Manchester Adult Cystic Fibrosis Centre

Providing all the various forms of care needed for people with cystic fibrosis in one place is what makes the Manchester Adult Cystic Fibrosis Centre a standout success.

The centre was founded in 1982, but demand on the service kept growing as it dealt with ever increasing referrals from all paediatric units in the north west of England. The centre's team presented a business case for improved facilities and eventually convinced the local trust to agree to an £8m (€10m; $13m) investment.

The new centre opened in 2010, housing all the patients and multidisciplinary staff in one location. It has a 22 bed ward and nine bed outpatient service, a specialist kitchen for patients' nutritional needs, a pharmacy, clinicians, dietitians, physiotherapists, social workers,

Nottingham City integrated respiratory service

Integration is a buzzword for the NHS and sits at the heart of successful efforts to improve care by NHS Nottingham City Clinical Commissioning Group (CCG).

The CCG knew that Nottingham, the most deprived city in the East Midlands, had poor health, with one in three people recorded as having a long term health condition and more than 24 000 patients registered as having either asthma or COPD.

In November 2012, the CCG launched a new integrated respiratory service for patients with a suspected or confirmed diagnosis of respiratory disease to improve management of these patients in the community and reduce the need for them to present at hospital.

The service includes intensive assessment, monitoring, and proactive

Plymouth Asthma Team

The reason for Plymouth Asthma Team's success is that it has focused asthma care on the patients rather than on what the NHS wants.

Given that 75% of asthma admissions are estimated to be avoidable, and less than ideal discharge management and follow-up of patients with asthma increases risk of early readmission, in 2011 Plymouth Hospitals NHS Trust

Southend COPD psychology project

Healthcare professionals in the Southend COPD psychology project are doing crucial work in helping patients deal with more than just the physical problems of the disease. Mental health problems are around three times more prevalent among people with COPD than in the general population, and anxiety disorders are particularly common.

In 2011, Southend University Hospital NHS Foundation Trust set up a severe COPD multidisciplinary team at Southend Hospital, and during discussions it was noted that management of anxiety and depression was a major issue for over half of patients and frequently the cause of admissions.

In autumn 2012, the team successfully bid for funding to pilot a psychology project for people with COPD in partnership with South Essex Partnership University NHS Foundation Trust. Funding has now been renewed.

The service, run within 34 community pharmacies, helps patients when they are visiting to collect their prescriptions. It seeks to raise awareness of risk factors for chronic obstructive pulmonary disease (COPD), identify those potentially at risk, and make referrals to general practitioners for diagnosis.

Patients with known COPD are offered lifestyle advice, help with smoking cessation, and help to reduce exacerbations through improved medicines adherence as well as support to manage their condition better and improve their quality of life. This includes helping patients to recognise when their symptoms are worsening and enabling them to manage this.

Patients are also advised on their medicines, good inhaler technique, and problems such as breathing and sleeping and offered help to reduce risk factors.

Independent evaluation of the service six months after launch showed the various interventions led to improvements in patients' quality of life and adherence to medicines and reductions in the use of NHS resources.

Jonathan Buisson, healthcare policy manager for Alliance Boots, speaking on behalf of the project team, says: "As a service, it worked and did what we aimed to do. It's making every contact count so when people come in, these patients are getting a higher level of intervention, directed, tailored, and using validating tools such as quality of life scores and COPD assessments that are proved to work."

and administration staff as well as a car park. The dedicated specialist ward has increased the numbers of beds; the waiting times for inpatient admissions have fallen, and patients are no longer admitted for inpatient care on non-specialist outlying medical wards.

All patients have their medications dispensed direct to them in the outpatient room by a specialist pharmacist, reducing the time a patient has to spend in clinic, decreasing the risk of cross infection from mixing with patients at the main hospital pharmacy, and saving money.

Kevin Webb, clinical director of the centre, says: "Over the last 25 years cystic fibrosis has become one of the unsung successes in medicine. Survival has increased. We realised we needed an all singing, all dancing unit and that's what we did.

"What we have assured is continuing clinical, holistic, medical care for people with cystic fibrosis in the north west. Everything they need is in one place."

management of a patient's condition to prevent further deterioration and exacerbation and also offers care planning, diagnostic spirometry testing, and direct access to pulmonary rehabilitation.

In the 12 months to October 2013, hospital admissions for respiratory patients (COPD, asthma, and bronchiectasis) fell by 10% compared with the same period the previous year. In August 2013, admissions figures for the three respiratory conditions were down to their lowest point for two years, and the service has had patient surveys reporting service satisfaction scores as high as 100%.

The service costs £800 000 per year and achieved Quality, Innovation, Productivity and Prevention (QIPP) savings for the service of £146 000 from April to September 2013.

Maria Principe, director of service integration at the CCG, says: "This innovative new service has united colleagues from across primary and secondary care, has led to improved services through reduced hospital admissions and appropriate support in the community, and has led to significant cash savings."

decided to tackle the problem by setting up an asthma in-reach team to focus on improving inpatient care.

In October 2012, this service was expanded further to actively identify all patients who had attended the emergency department in the previous 24 hours and arrange follow-up in an asthma nurse specialist clinic.

The multidisciplinary team, based in the chest clinic at Derriford Hospital, provide specialist asthma assessment and support for all adults with asthma admitted to the hospital with an acute attack.

At the clinic, asthma nurse specialists check that patients understand their condition, assess their inhaler technique and compliance with medications, support smoking cessation, and use written asthma management plans. All patients are discussed in a weekly asthma multidisciplinary meeting.

Since the introduction of the team, the trust has seen a 6% reduction in hospital admissions for asthma and 27% drop in 30 day readmissions (from September 2011 to September 2013), while emergency department visits have fallen by 10% and there have been significant improvements in standards of asthma care.

Matthew Masoli, consultant in respiratory medicine at the trust, says: "It's in everyone's interests to make sure that these patients have as good asthma control as possible because then they will have a better quality of life, they will cost less, and they will be less likely to come into hospital, so everyone wins."

A clinical psychologist has trained team members who had no previous background in psychology to become "psychology champions" and gain skills in cognitive behavioural therapy approaches to panic, mood, and anxiety.

Everybody who comes into contact with the COPD team is screened for psychological distress and there is a tiered response to problems, from self help manuals, to cognitive behavioural therapy, through to referral for formal psychiatric assessment.

The project has achieved its aims to improve quality of life, confidence, and wellbeing in patients with psychological distress and COPD as well as reducing admissions.

In the 12 months before the intervention, COPD patients accounted for 337 hospital admissions compared with 201 in the 12 months after it was introduced. The project has also led to savings over a year of £273 000.

Duncan Powrie, consultant respiratory physician at the trust and project leader, says: "We identified a problem that is common but frequently unrecognised and undertreated— depression and anxiety in COPD patients."

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UK RESEARCH PAPER OF THE YEAR

Evidence that matters

The UK Research Paper of the Year category recognises outstanding research by one or more UK authors that has potential to considerably improve health and healthcare. **Trish Groves** describes the shortlisted papers.

The shortlist for the Research Paper of the Year award comprises five quite different studies, none with the same design. Four studies were conducted in the UK; one in Africa. Four looked at the effectiveness and safety of medicines, and one at a high tech diagnostic tool. Which paper will the judges deem to have the greatest potential to help doctors make better decisions about practice, public health, or research methodology and to improve health outcomes for patients or populations? Which is truly outstanding?

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Competing interests: I have read and understood BMJ policy on declaration of interests and have no relevant interests to declare.

The Research Paper of the Year Award is sponsored by *The BMJ*. The BMJ Awards are sponsored by MDDUS. The awards ceremony will take place on 8 May at the Park Plaza Hotel, Westminster. To find out more go to http://thebmjawards.bmj.com.

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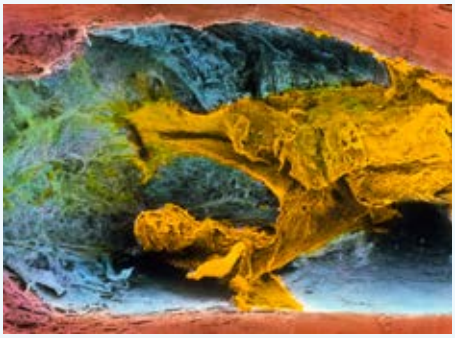
Probiotics in antibiotic associated diarrhoea

Salty medicines and cardiovascular risk

Accelerating care for African children with HIV

Identifying atherosclerotic coronary plaques



β- blockers after myocardial infarction in COPD

A few years ago *Clostridium difficile* and other causes of antibiotic associated diarrhoea were causing as much concern to patients and staff in UK hospitals as meticillin resistant *Staphylococcus aureus* (MRSA) infection. Trials and systematic reviews had suggested that probiotics could prevent such diarrhoea, but none was sufficiently rigorous, clinically relevant, or generalisable to guide policy and practice. So Stephen Allen and colleagues did a double blind, placebo controlled randomised controlled trial with nearly 3000 older inpatients and found—perhaps unexpectedly—no evidence that a multistrain preparation of lactobacilli and bifidobacteria worked.[1] This pragmatic, negative trial should make policy makers and clinicians think twice, and it will help other trialists to ask more focused questions.

This pragmatic, negative trial should make policy makers and clinicians think twice

1 Allen S, Wareham K, Wang D, Bradely C, Hutchings H, Harris W, et al. Lactobacilli and bifidobacteria in the prevention of antibiotic associated diarrhoea and Clostridium difficile diarrhoea in older patients (PLACIDE): a randomised, double blind, placebo controlled multi-centre trial. *Lancet* 2013;382:1249-57.

It's a cautionary tale with potential implications for millions of patients and prescribers

Many effervescent, dispersible, and soluble drugs contain high levels of sodium. For instance, an adult taking eight dispersible or effervescent paracetamol tablets can exceed the recommended daily sodium intake (2.4 g or 104 mmol sodium), and that's without eating anything. Jacob George and colleagues wondered whether patients prescribed such sodium containing drug formulations might have higher cardiovascular mortality than patients taking the same drugs in standard or capsular form. And that's just what their nested case-control study in UK primary care found.[1] It's a cautionary tale with potential implications for millions of patients and prescribers.

1 George J, Majeed W, Mackenzie I, MacDonald T, Wei L. Association between cardiovascular events and sodium-containing effervescent, dispersible and soluble drugs: nested case-control study. *BMJ* 2013;347:f6954.

Diana Gibb and colleagues' ARROW (Anti-Retroviral Research for Watoto) study was a factorial randomised controlled trial in untreated African children with fairly advanced HIV infection.[1] It showed that modern regimens of three or four antiretroviral drugs can be delivered safely without the need for laboratory testing to check drug toxicity. This was the first such trial in children, and its results provide strong support for accelerating the much needed roll-out of antiretroviral treatment to children in sub-Saharan Africa.

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1 ARROW Trial Team. Routine versus clinically driven laboratory monitoring and first-line antiretroviral therapy strategies in African children with HIV (ARROW): a 5-year open-label randomised factorial trial. *Lancet* 2013;381:1391-403.

Could functional molecular imaging identify ruptured plaques and necrotic plaques that might burst soon?

Rupture of an atherosclerotic plaque in a coronary artery is the main precipitant of a myocardial infarction and, sometimes, of sudden cardiac death. These plaques can lie hidden for a long time, causing no obstruction and remaining invisible on angiography. Could functional molecular imaging identify ruptured plaques and necrotic plaques that might burst soon? Nikil Joshi and colleagues' highly innovative prospective trial found 18F-fluoride positron emission tomography to be a promising non-invasive test in patients with myocardial infarction and stable angina.[1] Now its predictive performance needs assessing in larger studies.

1 Joshi NV, Vesey AT, Williams MC, Shah AS, Calvert PA, Craighead FH, et al. 18F-fluoride positron emission tomography for identification of ruptured and high-risk coronary atherosclerotic plaques: a prospective clinical trial. *Lancet* 2014;383:705-13.

Jennifer Quint and colleagues confirmed that patients with COPD who took a β blocker after a first myocardial infarction had significantly lower mortality than those who did not.

Patients with chronic obstructive pulmonary disease (COPD) can take β blockers safely these days, and if they have myocardial infarctions these drugs may reduce their mortality. Yet β blockers remain underused in such patients. Jennifer Quint and colleagues' study using data from UK hospitals and general practices confirmed that patients with COPD who took a β blocker after a first myocardial infarction had significantly lower mortality than those who did not.[1]

Underprescribing was still prevalent, however, with six out of 10 potentially eligible patients not getting the drugs. It's time to look more closely at the reasons for this.

1 Quint JK, Herrett E, Bhaskaran K, Timmis A, Hemingway H, Wedzicha JA, et al. Effect of β blockers on mortality after myocardial infarction in adults with COPD: population based cohort study of UK electronic healthcare records. *BMJ* 2013;347:f6650.