



House of Commons  
Health Committee

---

# Value for money in the NHS

---

**Oral Evidence**

***25 March 2010***

*Reform, The King's Fund, and NHS Institute for  
Innovation and Improvement*

Ordered by The House of Commons  
to be printed 25 March 2010

**HC 517**  
Published on 21 July 2010  
by authority of the House of Commons  
London: The Stationery Office Limited  
£9.50

# List of witnesses

---

Thursday 25 March 2010

*Page*

**Mr Andrew Haldenby**, Director, Reform, **Professor John Appleby**, Chief Economist, The King's Fund, **Professor Bernard Crump**, Chief Executive Officer, NHS Institute for Innovation and Improvement

Ev 1

# Written evidence

---

## SAV

01 NESTA	Ev 22
02 PAGB	Ev 24
03 Reform	Ev 25
04 The King's Fund	Ev 27
05 NHS Institute	Ev 29
06 Professor Alan Maynard	Ev 32
07 Dr Jonathan Fielden	Ev 39
08 Royal College of Nursing	Ev 42

# Oral evidence

## Taken before the Health Committee on Thursday 25 March 2010

Members present

Mr Kevin Barron, in the Chair

Mr Peter Bone  
Sandra Gidley  
Stephen Hesford  
Dr Doug Naysmith

Mr Lee Scott  
Dr Howard Stoate  
Dr Richard Taylor

*Witnesses:* **Mr Andrew Haldenby**, Director, Reform, **Professor John Appleby**, Chief Economist, The King's Fund, and **Professor Bernard Crump**, Chief Executive Officer, NHS Institute for Innovation and Improvement, gave evidence.

**Q1 Chair:** Good morning, gentlemen. Could I welcome you to our one-off session in relation to value for money in the NHS? I wonder if I could ask you, for the record, to give us your name and the current position that you hold.

**Mr Haldenby:** Andrew Haldenby, Director of Reform.

**Professor Appleby:** John Appleby, Chief Economist of The King's Fund.

**Professor Crump:** I am Bernard Crump. I am Chief Executive of the NHS Institute for Innovation and Improvement.

**Q2 Chair:** Thank you and welcome. A general question, but I will direct it to you to start with, John. How tough do you expect the financial position in the NHS to be over the next Parliament, and (directly to you, John) can you tell us about your work with the Institute of Fiscal Studies on this issue?

**Professor Appleby:** Yes; thanks. I do not think it is a big secret now that the NHS is going to face essentially no real growth in its funding. At the end of this month we start the new financial year 2010–11. I think evidence from the Department to this Committee earlier this year showed that the real rise in total NHS budget in England is going to be about 1.6%, small relative to previous years' real rises. The indications from Alistair Darling in his Pre-Budget Report last year was that for 2011–12 and then 2012–13 (so beyond next year) essentially there would be a real freeze in funding for the NHS in England. That seems to be the situation: no real rise in NHS funding, a small rise this coming year and then two years of a real freeze—at least two years. This really is in line with work that The King's Fund did with the Institute of Fiscal Studies, which you referred to, which we produced last summer, where we looked at the future prospects for funding for the NHS and concluded that, given the macro-economic situation, given the state of public finances, the structural debt in the system, the prospects of giving the NHS anything more than a real freeze looked unlikely given the impact on other spending departments, given the potential impact on

taxes and so on. So our conclusion was what seems to have turned out to be the case, which is a real freeze in NHS resources.

**Q3 Chair:** David Nicholson said to us in January of this year that it was going to be £15–20 billion, which is the real freeze scenario. Do these sums add up and what would have been the e-factor we have in the National Health Service (the efficiency factor) that has been there since the National Health Service has been there? How would that add up to £15–20 billion? Would it equate? Does that go away? What happens?

**Professor Appleby:** This 15–20 billion, I think, needs some clarification. There has been, I think, some misunderstanding, not just outside the NHS but also within the Service actually, as to what we are talking about here and what the Department of Health really mean by this. It is not £15–20 billion worth of cuts. As I say, the budget looks like it will be frozen in real terms. The 15–20 billion is really an estimated difference between no real rise in funding for the NHS and what the NHS perhaps needs to meet various demand pressures and cost pressures. The Department's estimate is between £15–20 billion. That money is not going to be forthcoming, so the big thrust in policy from the Department is how can the NHS use its existing resources more efficiently to the value of something like £15–20 billion to meet various demands? That is the big policy push at the moment.

**Q4 Chair:** The efficiency factor has always been in NHS expenditure. Does that differ greatly from what has happened in the last decade to these expected three years' efficiency gains?

**Professor Appleby:** It is a huge step up.

**Q5 Chair:** It is more than what has normally happened in the system?

**Professor Appleby:** Massively so. That 15–20 billion is over three years, so roughly five billion plus a year value in productivity gains. The ONS produced some productivity figures yesterday showing that

productivity in the NHS in 2008–09 went down again; so over the last decade productivity has fallen in the NHS, crudely measured, I should say.

**Q6 Chair:** Would you both agree that this is a huge change, if it is 15–20 billion on efficiency, from what has happened in the last decade or more?

**Professor Crump:** Yes. None of us in our professional lifetime have seen a change like the change that is coming in terms of the greater emphasis on efficiency. John is quite right that some of this needs to be cash that is fully released to be reinvested in new products, new drugs, new approaches, some of it needs to make the resources stretch further, but historically lots of the efficiency gains that you have mentioned have been efficiency gains in which we have not had to release cash. We have done more for less than we would have done had we not operated at a certain greater level of efficiency. I have looked briefly at the ONS's publication from yesterday and, frankly, there is a fiendishly difficult challenge of putting a value on the outputs of health and healthcare. Certainly, as John says, using their current best practice, productivity is not moving in anything like the direction that would be needed by this.

**Q7 Chair:** Do you concur with that, Andrew?

**Mr Haldenby:** Yes, but, perhaps to be even more depressing than John, I am not sure that these numbers which we have currently got will be the last word on the subject. The question is: is the current projection of public finances within which the NHS budget sits going to hold water, or are we going to discover the public finance position is even worse than it looks now, which will lead to further pressure on all public sector budgets? I fear that that is what I would expect to happen, and the reason for that is that there are risks to the level of economic growth going forward. I do not think the financial services sector is settled, so there is the risk of another problem in that sector. In general, and perhaps a more arguable point, I think the proposals put forward in the Budget yesterday for improving the efficiency of the whole public sector are still looking at efficiencies on the border of public spending rather than actually dealing with the real problems that lead to inefficiency in the public sector. If you put those three things together, I think that there will be increased pressure on public spending budgets in the next Parliament, which perhaps will lead to an even tougher spending environment than John set out.

**Chair:** We are going to have a look at some of the areas of productivity to start with. Peter.

**Q8 Mr Bone:** I should say at the start, for the record, that I know Mr Haldenby personally, but I have not discussed this session with him. When I grew up the NHS was the best health service in Europe, but recently the Health Consumer Powerhouse showed the UK seventeenth out of 29 European countries, and the ones below it were the poorest in Europe. We have seen a doubling of the amount of money, in real terms, going into the NHS since the Government

came to power, but we have only seen a 23% increase in consultant-finished case episodes. You could argue: double the amount of money, double the cost to the taxpayer now each household pays more than £5,000 a year for the NHS, but you have seen a 23% increase in productivity. No other organisation in the world would have been allowed to get away with that. What I would like to know from our witnesses is in what three areas could productivity be massively improved in the Health Service and, in relation to that, would any of those measures be, in fact, a system that does not fund the NHS from direct taxation?

**Mr Haldenby:** Where does the NHS spend its money? It spends it predominantly on people. If, according to the best statistics we have got, 50% of the cost goes on the workforce—I must say that feels a bit low to me but let us say 50% goes on the workforce—that has to be the first priority. If the NHS is going to become more productive, it has to employ its people more productively and in different ways. Then one has to look at the capital infrastructure, and that is the other big thing that the NHS spends its money on. The Chancellor in his Budget yesterday was talking about the recent history of NHS spending, and he said that the NHS has delivered the largest hospital building programme in its history, with 118 new hospital schemes open and a further 18 under construction. The other major thing that the NHS does is build and run buildings. You suggested three things. I think those two are the two clearest examples to go after. As for the question of whether a more efficient service would be one that is not funded from general taxation, I think it is arguable. It is something that I happen to believe, because I think that an increased level of user charges for medical treatment will ameliorate the demand, it will make more efficient the demand for medical services, and, also, when one looks at countries like France and Germany, their systems have a greater level of competition between health providers, which you would normally expect to increase efficiency. I do not think a cast-iron piece of research has proved that fact, but it is something that I would put forward as a hypothesis.

**Q9 Mr Bone:** There is President Obama and his legacy in history and all the fanfares, and we were all in the House of Commons amazed by the ability of President Obama. If that is such a good system, why do we not switch to that?

**Professor Crump:** It is not a good system. You can look at different measures of the comparative performance of health systems. If you look at the analysis by the Commonwealth Fund, it showed that actually under that analysis the NHS was one of the strongest systems, in fact the strongest system in that particular analysis, with the US regularly at the bottom of the list, and we have a system which is envied around the world. We are visited in my Institute frequently by people from all parts of the world, and I do not think we should beat up our system too much; it has great strengths. Important aspects of the quality of care and the quality of outcomes have improved over the period you have

---

25 March 2010 Mr Andrew Haldenby, Professor John Appleby and Professor Bernard Crump

---

described. I would not regard it as the most important measure of the effectiveness of the system that we increase the number of finished consultant episodes—there is avoiding admissions to hospital—particularly when most people would argue that around 30% of the occupied bed days on any one day are not strictly necessary for the patients' health outcome. I do not think is a great measure of output. I think the issue about the different approaches to how you resource a public health service are more religious questions than they are questions of policy. I think really one's prejudices get into this. What I would say is that I have seen examples of dramatic and rapid improvements in health services in both publicly funded and privately funded systems. I think competition has a really important part to play because of the incredibly natural competitiveness of people who work in healthcare—I am a medic—particularly the medical profession, but that does not necessarily only have to happen through organisations which are competing. Competing against the standard, knowing where you sit compared to your colleagues, is a really potent way of improving.

**Q10 Mr Bone:** I am grateful to hear that our system is better than President Obama's proposal, which I think most people would, hopefully, accept, but there has been such a fanfare about it, so I am glad that the NHS have said that he has got it wrong. You said "finished consultant episodes" was not a measure that is really very good, but it is about one of the only ones we have got at the moment. How are we actually really going to measure productivity so we can see whether we are doing better or worse than other countries?

**Professor Crump:** It really is a challenge for health services to find the right way of valuing the outcomes from healthcare. We never from the outset, even in 1948, really sold the NHS to the population as being about improving their health status and health outcomes. We quite understandably at that point sold the NHS as providing them with a safety net, which would mean that they would not find themselves in a situation where if they suffered ill health they would become destitute or be unable to get access to services. The equity that we deliver, in contra-distinction to the US, for example, in our system is really valuable, but we have to find better ways of being able to put a value on the quality, the societal impact, the outcomes as well as the processes and day-to-day activities of the NHS. I do not think yet we have got a satisfactory measure of that. Indeed, what I can say is quite a lot of the changes one would want to happen will lead to deterioration in productivity by the measures that we currently use.

**Professor Appleby:** Perhaps I can add quickly to that that the NHS is absolutely not unique in having difficulty measuring what it produces. The financial services industry also has trouble over this. If you look at the ONS, their work on productivity is almost across the board, public and private, healthcare and non-health care. There are real difficulties in measuring what industries do and

produce and then measuring what the inputs are and the outputs and then getting a measure of productivity. I think the NHS has made some real strides over the last few years in trying to cover properly the activity that it does. There is a prospect soon, because the NHS is now collecting something called "patient-reported outcome measures" from patients, that this could act as a measure of changing quality which will improve our measures of productivity. We are not there yet, as Bernard says, but I think we are getting there.

**Q11 Mr Bone:** Would it be better to look at things like European outcomes of how long people survive from cancer and compare them to how long it is in this country? Is that a helpful measure, because you would think that the two are linked?

**Professor Appleby:** Yes, it is known as triangulation. The ONS have their measures and then they look at other indications of how the health system is performing, one of which is to do with survival, life expectancy, satisfaction that people have with their health system, and so on. There is a range of measures you can use, but no single measure really captures the whole thing perfectly, and I think that is the difficulty.

**Q12 Mr Bone:** Do you agree with the Powerhouse analysis, which tried to do all those things and ranked us at number 17?

**Professor Appleby:** I do not rate that survey as a very good survey actually, if you look at the detail of how they collect the information.

**Q13 Mr Bone:** But something like that would be a good idea.

**Professor Appleby:** It has been done. The World Health Organisation in 2000 produced a ranking of all health systems in the world. I think the UK came eighteenth overall, which may not sound good. That is out of 191 countries.

**Q14 Mr Bone:** We should be doing better than that, should we not? Eighteenth in the world is not very good for a country of our standing, the fifth or sixth biggest economy in the world.

**Professor Appleby:** You have to then look at things like how much money we were spending per head then on healthcare. We were way down the ranking. A lot of these differences you see internationally can be attributed simply to the fact that in France they spend nearly a third more per head on healthcare. It is not so much the design of the system, and so on. Quite often it simply comes down to the amount of resources going in.

**Q15 Dr Naysmith:** We are going to go on talking about the fact that there is quite a difference, quite a variation, in clinical practice in different parts of the country. Some people say that a lot of money could be saved if we got clinical practice more standardised and moved more into the efficient end. Do you think there are big savings to be made in standardising clinical practice around the best?

**Professor Crump:** I think there are big opportunities from trying to deal with unwarranted variation. I do regard some variation as a function of the fact that the population differs from place to place, sometimes quite substantially, so we have created a set of indicators called the Better Care, Better Value indicators, and if everybody moved to the best quartile of performance on those indicators, if that were appropriate, there would be a contribution of about £3 billion a year of released resources. An example is the proportion of patients who come into hospital for an elective operation who come in on the day of the operation, which generally patients prefer and which generally is associated with avoidance of risks associated with infection, et cetera. It varies enormously. Of course there are some clinical conditions where it is important the patient is in hospital the day before, and there are parts of the country where the rurality and the travelling times mean it would be unrealistic, so it is important not to use these indicators in a crude way, but they are a very important way of allowing organisations to shine a light on their performance and explain why they are so different.

**Q16 Dr Naysmith:** I seem to recall on this Committee, I cannot remember which inquiry it was, that there was wide variation between surgeons performing operations for cataract. Some surgeons could get through lots more in a day than other surgeons.

**Professor Crump:** Yes.

**Q17 Dr Naysmith:** Why is that allowed to continue?

**Professor Crump:** Firstly, it is true that there is wide variation in the number of cases done on a list. We have worked with the highest performing organisations and the poorer performing organisations, and we have pulled out the factors that determine high performance and we have made that information widely available, not just through managerial channels but also through professional channels, working with the Royal Colleges, the British Association of Day Care Surgery and others.

**Q18 Dr Naysmith:** Why is it taking so long to change?

**Professor Crump:** It is a good question, and I think it is true that in a period where we have had quite steep growth in resources the focus on those elements that are about productivity has probably taken something of a back seat to quality and safety issues of other sorts, and I think we need to be much better at making these materials and tools available and used. Frankly, what is coming is going to make it essential that they are used.

**Q19 Dr Naysmith:** How can the NHS actually do it? Let me give you another example. When I was a lad lots of people had tonsillectomies. Now it is a much rarer operation. That is partly, possibly, due to antibiotics being a bit better, but it is also fashionable, is it not?

**Professor Crump:** Yes.

**Q20 Dr Naysmith:** It has also been the fact that people have discovered that removing tonsils can actually be deleterious in terms of the removal of lymphoid tissue.

**Professor Crump:** Yes.

**Q21 Dr Naysmith:** All these things add up. Why cannot the NHS just insist on it? How about your organisation? Why cannot you kick backsides a bit more?

**Professor Crump:** I would say two things. There are fairly few things where it is universally the case that this particular procedure should never be used; it is never appropriate. What we do have are circumstances where currently things are used outside their most high impact indications. We have tried to shine a light on that by giving people comparative information, not just the organisation that does that operation, but the commissioning organisations, the primary care trusts. Both for emergency admissions and for exactly the things you describe—low back pain surgery, D&C surgery for women, et cetera, relatively low value, commonly used procedures—we have shown the PCTs what proportion of their resource they spend on this and we are working with them to turn that into changes in the care pathway that affect clinical practice. It is a slow process, but I agree that it is an essential process and we have not made enough progress.

**Q22 Dr Naysmith:** Are we making enough use of evidence-based clinical guidelines and insisting that places abide by the evidence and things like rigorous audit and improved incentives systems?

**Professor Crump:** These are all important. The quality of the development of the guidelines has improved a lot. It is still the case that we do not always have systems in place to remind practitioners, particularly practitioners who are not specialists in that particular area, of the current guidance at the point at which they need it because they are with a patient, where that guidance would be relevant. Improvements in IT will help that. We rely and we will always rely on professionalism. I do not think I can imagine a world in which external regulation will be able to become more significant than the professionalism of services. We are going to have to improve all of that, and the challenge of the productivity improvements that we are going to see, I think you will see these things move up the agenda extremely quickly, but I can understand the frustration about why it is slow to happen.

**Q23 Dr Naysmith:** John, you must have done a few studies in this area.

**Professor Appleby:** Going back to the first question, what are the three productivity areas? Variations, I think, is one that I would have said. Everywhere you look in the Health Service, whatever you look at—prescribing, admissions, techniques that are used, and so on, types of treatment given—there are huge variations and, again, not just in the NHS and not just in this country but in other countries as well. The US, for example, has been working on this through something called the Dartmouth Atlas for years and

they find big variations. You mentioned cataracts, nearly the most popular operation now on the NHS; we easily do enough cataracts overall. But when you look at the numbers of admissions at a PCT level, it varies three or fourfold across the country, and there is no real explanation as to why that is except, perhaps, the pattern of where ophthalmologists practise. There is an issue here. There is a sort of supply-induced demand type of thing going on—where you have got ophthalmologists, they will do cataracts, as it were. Just one example of where action has been taken. In a sense Bernard talks a bit top-down on the issued guidelines and so on. I think there is a big onus on PCTs to work on this and to actually work with their providers, and not just the provider hospitals but with the consultants in those hospitals, to do something about the thresholds that consultants operate in terms of admitting people from the list into the theatre. There are plenty of examples of that. The Suffolk PCTs some years ago worked on this in a very interesting way on hips, knees and cataracts. They got their consultants together that they were buying care from, they discovered that consultants even within the same hospital were using different criteria to admit people for a cataract and, through agreement, they got some sort of more consistent uniform threshold for admission of patients. It was not just an efficiency thing, it was also an equity thing. There were patients who could get into hospital quicker in certain areas than others simply because of the decisions of consultants. I think there are examples, but it is remarkably the system; variations just persist and persist and it does seem to take a long time to deal with them.

**Q24 Dr Naysmith:** Have the NICE guidelines made a difference?

**Professor Appleby:** Yes, there is evidence that NICE have made a difference. Perhaps not as big as one would wish, but it does go back to something that Bernard said, which is that quite often there is never a never situation with some of these things. There are clinical decisions to be made at the level of individuals, so even when NICE says, generally, “Do not do this thing”, whatever it is, there will often be a case where the clinical decision is that actually it could be appropriate here.

**Q25 Dr Stoate:** In fact, John, supply-induced demand is not a new concept; it has been around for probably 30 or 40 years. I remember seeing some very interesting papers from America that showed that emergency surgery was directly proportional to the number of surgeons in the local area. The number of appendectomies went up if you had more surgeons in an area compared with fewer, which is quite difficult to explain. You can explain elective surgery, but even emergency surgery varies. So it is an engrained subject which has been around for a long time. What the Government did four or five years ago was to introduce new contracts for GPs and consultants in order to try and address some of these issues. Is there any evidence that this has improved productivity at all?

**Professor Appleby:** No.

**Q26 Dr Stoate:** I thought you would say that!

**Professor Appleby:** The King’s Fund have produced some initial work on this a year and half or so ago, so we have done some work on this. It seems that the consultants’ contract, productivity per consultant, has been going down for a number of years, again, not just in this country, I should add. It is not just the NHS. There are interesting factors at work to explain that, but it appears not, no.

**Q27 Dr Stoate:** The interesting thing is the consultants’ contract was designed effectively to give hospitals a bit more flexibility and control over what surgeons in particular did and what consultants in general did, but Jonathan Fielden told us in his evidence that employers were simply under-using those contract flexibilities. Is that the problem?

**Professor Appleby:** I think that is largely the problem, yes. It is going to be down to individual human resource departments in trusts.

**Professor Crump:** And medical directors.

**Professor Appleby:** And medical directors as well.

**Q28 Dr Stoate:** So why are we not getting a handle on this? If we need to increase productivity (and, as you have already said, the need is going to get far more huge in the next few years), why are they not pulling these levers?

**Mr Haldenby:** Without wanting to lift it right up to the highest level, what are the factors within the Health Service that would lead managers to do those difficult things (and they would be difficult things) about changing?

**Q29 Dr Stoate:** The need is very obvious, because we are going to be in financial difficulties. The managers are now even more tightly controlled on their financial management than before. Here is a lever to pull and they are not pulling it.

**Mr Haldenby:** Looking back in time, why has this not happened? One of the common findings of Reform’s work across the public service is that actually the public sector is not this Stalinist monolith that some people describe it as. It is a very flexible and centralised thing. There is a lot of flexibility within contracts typically, whether teachers and so on. Police officers are the great exception, but otherwise public sector employment is quite flexible. It is just that managers do not use that.

**Q30 Dr Stoate:** We know they do not use it—we have heard that—but why do they not use it and what can be done to encourage them to use it?

**Professor Crump:** In the year that we are just coming to the end of now, I think the NHS is going to actually be in a surplus of about £1.4 billion. There are within that some organisations that are in financial difficulty now and will be using those sorts of measures, but it has not to date been the thing that has been their greatest priority. Their priorities have been things like maintaining the remarkable improvements there have been in waiting times in all

sorts of different ways. Engaging your consultants on that agenda has been a real priority and the productivity improvements have been a little way in the future. Most of us medics are very concerned that this golden opportunity to make changes now, to anticipate what is coming, may be being wasted, and we do need to raise the profile of productivity with people now, but the reality is that that is not what has been their priority this year.

**Q31 Dr Stoate:** John has already told us that productivity in the last ten years, if anything, has fallen. We have got new contracts in place in order to address that and nobody seems to have taken the slightest bit of notice. I still find it very difficult to understand.

**Professor Crump:** I do not think that those contracts principally were introduced to improve productivity and in the case of primary care, I would agree with John, there is no evidence that it has improved productivity. There is evidence, as I am sure you will be aware, of a significant attention to those aspects of anticipatory care, preventive care with a focus on the Quality and Outcomes Framework, and I think history will say that the implementation of the Quality and Outcomes Framework was one of the best international examples of a pay-for-performance system getting clinical attention to focus on important issues. At the same time, for reasons partly of the worries we had about recruiting and retaining a primary care workforce, we paid GPs a lot more when we were introducing the QOF. So productivity has not improved, but the focus on important aspects of the delivery of primary care has improved substantially by all measures. In fact, GPs moved extremely quickly, far more quickly than, as you will recall, the people who invented that contract thought would be the case, onto the focus that was set for them.

**Q32 Dr Stoate:** As a GP I could have told them that long ago.

**Professor Crump:** Yes, so could I.

**Professor Appleby:** This apparent paradox that there were these mechanisms in place but they have not been used in the past over the last five, ten years: I think part of the explanation is there was a lot of money in the system and the NHS did meet mostly all of its targets by spending that money—so employing more people to do more work, not necessarily to do more work per unit of hour or per pound, but they did do more work and the NHS met its targets. That was an easier route to doing the job than, as Andrew was saying, the difficult thing of starting to negotiate at a local level on contracts, starting to discover new ways of delivering care and so on. That is happening now, and you could argue it should have happened, but I am just saying there is a potential cause, or reason, why it did not happen in the last five or ten years.

**Q33 Dr Stoate:** Finally, I want to bring Andrew in. Assuming all these levers were pulled, what is the potential for savings in the NHS by making these contracts work to maximum efficiency?

**Mr Haldenby:** I am not sure about the contracts, but recently speaking to a chief executive of the PCT, recently speaking to a chief executive of the trust, recently speaking to a chief fire officer, all of them just said one should expect to be able to achieve a 20% actual reduction in spend—that is how they would express it—but a 20% efficiency gain. I am very struck by the fact (and I would take those as serious people with very strong professional judgment) that that was a figure that was repeated.

**Q34 Dr Stoate:** If you can save 20% just by tweaking these efficiencies, then we have got no problem, have we?

**Mr Haldenby:** When you say “tweaking efficiencies”, what are the reasons that managers have not taken the tough decisions that we are talking about? I think that it is actually about some of the structures of the service. The levels of competition within the service, the degree of central direction were the two obvious things, but those are major system reform changes which are not tweaked.

**Q35 Dr Stoate:** So you are advocating a more Stalinist approach then?

**Mr Haldenby:** No. Good managers are already doing this up and down the country, but I do think that the Health Service is politicised in the sense that I think that lots of health managers look up to the Department for a lead, and for most years now the lead has been, as the other witnesses are saying, to increase activity rather than to increase productivity. Even now there is a division, it seems to me that there is not a single voice. The Opposition party is saying that it will always guarantee health spending forever, which feels like a continuation of the fact there will always be money. The current Government is saying that it will, in NHS competition, prioritise the public sector against other kinds of providers. Even now, despite everything, I do not feel that there is a clear focus on productivity from the centre.

**Q36 Mr Scott:** Professor Crump, it was said that the Agenda for Change would bring improvements in productivity. Has it, or has it been a complete waste of money?

**Professor Crump:** I think Agenda for Change is not very dissimilar to the consultant and GP contract discussion. What Agenda for Change did, remarkably really, was move us from 30 or 40 different pay systems for different types of healthcare profession within the NHS to a single set of spines which make it much more straightforward to be able to work flexibly with staff—help staff, for example, to progress within their career without having to leave the institution in which they work. Having said that, again I do not think that the tools that have been given to people through Agenda for Change have been used for the purpose of improving productivity, and I do think that there is, not an inevitability, but there is a tendency within Agenda for Change for it to lead to an increase in pay on a natural progression basis unless managers manage the Agenda for Change agenda very actively. I think,

rather like the discussion about the other two contracts, there is more scope in many organisations to manage that programme more actively.

**Q37 Mr Scott:** John, would you agree with that?

**Professor Appleby:** Yes, I generally agree with what Bernard has said there. It was an amazing achievement, by the way, Agenda for Change, because I think it was one of the biggest renegotiations and re-designs of a pay system in the world in terms of the numbers of people it affected and so on, and it took years to get into place. It was not about productivity so much as simplifying the pay system and getting some consistency between different types of jobs, for example, and between men and women. There is a whole range of objectives within Agenda for Change that need to be recognised, perhaps not wholly solving, but dealing with.

**Q38 Mr Scott:** Perhaps I can start with you on this one, Andrew. What opportunities do you think there are for improvements in productivity through changes in the skills mix in both primary and acute care? Would there perhaps be any undermining of clinical standards because of that?

**Mr Haldenby:** I think that one of the most important things we should talk about is the idea of reducing levels of care in secondary care and increasing primary care services, which is something that we have written about. That would mean a transfer of workforce resources and skills from secondary care to primary care, and the doctors that we have spoken to whilst doing that research are very clear that advances in both clinical skill and technology allow transfers of care out of the secondary care. To take a few examples, it is now possible to have renal dialysis at home; it is now possible to have a gall bladder removed via a laparoscopy rather than through opening up a patient and in that case you can now have your gall bladder removed and spend one day in hospital, whereas previously it would have been seven days: in obstetrics, after a caesarean ten years ago you would have been in hospital for seven days; now it is two or three days. Very great opportunities have emerged to shift care from secondary care to primary care and the cost saving opportunity there is in the reduction of the hospital estate, which would be a major financial saving.

**Q39 Mr Scott:** It may be a financial saving, Andrew, but do you think it is to the benefit of the patients, which, after all, should be the primary concern?

**Mr Haldenby:** I think it would clearly be a benefit to a patient if they have to spend less time in hospital, if that is the care that they need. I am sure the Committee read the very good survey in the BMJ this week—the BMJ title was something like “How to save money in the NHS”, which is very timely to this discussion—where there were a number of doctors writing, saying that in some cases the delay of discharging patients from hospital was worsening their care. One (and I will try and find it) was pointing out—I think it was a psychiatric doctor—that often his patients had to wait for social workers

to assess them before they were able to move out of hospital into the home, and that would typically take two to four weeks. His simple suggestion was, why not have that assessment at home so the person can just go home? Clearly, you are then not going to catch hospital-acquired infections but also there are all the other psychological benefits of being at home. I would say the ability to shift care in hospitals is being driven by improvements in clinical skill and technology, and those are not bad things from a patient’s point of view.

**Professor Crump:** I would say there are many, many examples of adjustments in skill mix so that now things which, when I was in clinical practice 20 years ago, had to be done by a doctor or done by a nurse, things that had to be done by a nurse in general practice, are now being done by a specially trained receptionist. I think we really have a very positive record. In international comparison terms, if I visit Australia or the USA, I commonly will find that they are amazed at the extent to which we have matched the skills needed for the job to the delivery as opposed to keeping within professional silos. I think more could be done. I know of instances where physiotherapists do make quite significant surgery on carpal tunnel, for example, or where podiatrists have taken on roles that were commonly done by orthopaedic surgeons. I think we have got quite a good record in this respect.

**Q40 Dr Taylor:** Bernard, I am going to come to you and delve a bit more deeply into the Better Care, Better Value indicators. When they came out I think we were all struck with the tremendous potential, but I am not at all clear that they have actually reached their potential. You have already mentioned the variation in surgical thresholds with tonsils, D&Cs, hysterectomies, back surgery and grommets. Have you any measures of the lessening of these? Can you prove that in that particular instance there have been savings?

**Professor Crump:** The answer is, yes, but it is modest and less substantial than one would have hoped and anticipated.

**Q41 Dr Taylor:** I think you forecast something like a £2 billion saving of the first tranche, of the first ten?

**Professor Crump:** Across all of the indicators in the first tranche there was the potential to save around £2.1 billion. We have increased the number of indicators, and activity across the service has also increased substantially, so in some of the indicators there are far more cases. To move to best quartile performance paradoxically you can save even more, and we have not got most organisations to best quartile performance yet; they have not moved to best quartile performance yet.

**Q42 Dr Taylor:** Do you have any powers to make them move to this?

**Professor Crump:** No, we as an organisational do not.

**Q43 Dr Taylor:** So who should?

**Professor Crump:** The performance management route within the system is through strategic health authorities working with their primary care trusts as commissioners of the service. We believe that the Institute's role is best, not as a performance management organisation, as an organisation that the service sees is there to help them find the ideas that are the ones that they can use, but I agree that now, with the challenge that is coming, this is going to have to become much more of a performance management target for strategic health authorities. Indeed, what you can see is that in areas which had substantial in-year financial difficulty in the first years of the Better Care, Better Value indicators, those SHAs made real progress on them, but SHAs where there was not the pressure to balance the books tended to make less good progress. The one indicator that has improved most substantially is in relation to medications, as it happens—GP medications, the use of the NICE-preferred statins, the lower cost statins, for example.

**Q44 Dr Taylor:** I always remember when that indicator came out about generic statins, we looked at the constituencies of three of the Health Ministers at the time when there were about 300 PCTs, and three of the Health Ministers at the time were in the 290–303 sort of group.

**Professor Crump:** Yes.

**Q45 Dr Taylor:** Is there any place for MPs, when they discover that their particular trust is doing badly on one of these indicators, jumping up and down?

**Professor Crump:** Firstly, they are publicly available on a quarterly basis, so there is certainly no reason why they would not be available for that purpose. Secondly, they are indicators and it is important to think about circumstances where your particular population, or your particular setting, or indeed one of your particular institutions might have such a different case mix or such a different set of circumstances that they should not be used crudely. For example, we have removed from one of the indicators the hospitals that are the specialist cancer hospitals because they were appearing to be poor performers, but their specific case mix determined that actually, for example, their new to follow-up ratio in outpatients was bound to be different, but I would encourage them to be used, yes.

**Q46 Dr Taylor:** Three of the original ones were reducing staff turnover, reducing sickness absence and reducing agency costs. Have you made any progress on those?

**Professor Crump:** Those indicators are now not part of the dataset because the availability of reliable data was a real challenge for us in relation to those indicators. We are doing additional work with the Department and with its workforce directorate and we have not lost interest in those really important topics, but the availability of the data on a quarterly basis was not sufficiently strong for us to use them in the indicator package.

**Q47 Dr Taylor:** So what should we be recommending?

**Professor Crump:** I think these indicators are most helpful if there are not enormous numbers of them, if they do really provide a focus. I think the existing dataset is probably quite a reasonable dataset to use. Secondly, I think they should be taken seriously. I am perfectly comfortable about organisations that, having looked at their position on the indicator, reach a conclusion that they are satisfied with their particular position because they can explain why it is aberrant, but I would be very disappointed if organisations are not using them—chairs, boards, as well as the chief executives—and I think SHAs should be making sure, in their performance management of organisations, that they are taking these into account.

**Q48 Dr Taylor:** So we could remind SHAs of their duties in that respect?

**Professor Crump:** I think that would be helpful. Also commissioners, PCTs, should be looking at the indicator set (and they can do this) for the organisations that they commission from.

**Q49 Sandra Gidley:** Can I butt in a minute? You seem to be producing a vast amount of data. You cannot enforce it. You do not seem to have any idea who might or might not be using it. What is the point?

**Professor Crump:** The point is that prior to us making this data available in this way it was actually paradoxically harder than it was a decade before for an organisation to know where it stood compared to other organisations.

**Q50 Sandra Gidley:** But we have just learnt that some of them have no incentive to improve. Have you done any work to show who is using your data, if anybody?

**Professor Crump:** We have worked to show what happens to individual organisations through the data, and we know through our contacts with SHAs that some of them make them part of their performance management system, but, again, these indicators were the first attempt to try and help to give to managers some tools that got them to shine a light at some of the clinical processes in their areas.

**Q51 Sandra Gidley:** So would you say that the NHS Institution for Innovation and Improvement offers value for money?

**Professor Crump:** I would. This is one minor part of many things that we do that I would be very happy to talk to you about.

**Q52 Dr Taylor:** Moving on from Better Care, Better Value indicators, the Productive Ward initiative is one of yours, is it not?

**Professor Crump:** It is, yes.

**Q53 Dr Taylor:** We have seen it working in at least a couple of places. How widespread is this and is it really effective?

---

25 March 2010 Mr Andrew Haldenby, Professor John Appleby and Professor Bernard Crump

---

**Professor Crump:** There is independent work as well as our own work on this. Our estimate at the moment is that 30% of wards are using the Productive Ward in the NHS.

**Q54 Dr Taylor:** 30% of wards across the whole NHS?

**Professor Crump:** Yes.

**Q55 Dr Taylor:** In all specialities?

**Professor Crump:** Yes. There is still substantial potential for more wards to use it. Most organisations have at least one productive pilot ward. The university hospitals in Nottingham and in Manchester are doing whole-hospital implementations and are on a path to be able, for all of their 90 or 100 wards, to have used it over a two and a half year period.

**Q56 Dr Taylor:** Is it sufficiently popular so that, if one ward does it, it spreads to others in the hospital?

**Professor Crump:** That is the ideal, and it is what is happening in most places, but it needs leadership and it needs a purposeful process to ensure that it is used. It was designed 18 months ago, before the productivity focus was so great, specifically on releasing time for direct clinical care to improve quality and safety.

**Q57 Dr Taylor:** Can you give us one or two specific examples of what it has produced and how it has helped?

**Professor Crump:** Yes. Organisations, for example, in Sheffield, which have increased the proportion of the nurses' time during a shift that they spend in direct patient care from 25–28% at the baseline to 45–50% when they have implemented the changes.

**Q58 Dr Taylor:** What sort of changes have led to that increase?

**Professor Crump:** They focus typically on the common aspects of life on a ward that you will be very familiar with: handovers, ward rounds, drug rounds, meal times—these common processes. The nurses themselves use a series of tools but they themselves re-design the care in a way that suits their particular setting and their particular organisation but with the measurement of how that affects the time that they have for direct patient care.

**Q59 Dr Taylor:** Is there an emphasis on communication between nurses and doctors, for example?

**Professor Crump:** There is. There is particularly an emphasis on reducing the time spent but improving the quality and effectiveness of handover between shifts. There is an emphasis on, for example, reducing interruptions through much better visual information about every patient on the ward to avoid the need for people being interrupted when they are doing something really important, like the drug round. The really important thing then is that the time that is released is spent on direct patient care and it is spent on the right clinical interventions. What we can now see, and we are collecting data on,

is the extent to which that has led to improvements in observations, detection of deteriorating patients, reductions in healthcare-associated infections, improved patient experience and patient satisfaction—all of those things.

**Q60 Dr Taylor:** Are you disappointed it has only spread to 30% of wards so far, or is that as fast as you would expect? Can you expect it to go right across the NHS?

**Professor Crump:** We do expect it to go right across the NHS, and I think things like the new national workstream that is being developed will give great stimulus to that, but we deliberately focused on disseminating this intervention through professional channels rather than through the managerial line. We worked a lot with nurses from wards in its development. It has two names, this piece of work. It is known as the Productive Ward, Releasing Time to Care. The nursing profession told us that they find that their members find the word “productivity” has negative connotations, that a focus on releasing time to care created far greater ambition to be involved, and so almost all of the dissemination happened nurse-to-nurse through professional channels and actually its reach across the service was faster than anything else that we have ever introduced. So I do think that there is merit in that kind of more professional dissemination rather than solely relying on the diktat from the Department of Health.

**Q61 Dr Taylor:** We should abolish the Productive Ward title and call it Releasing Time to Care?

**Professor Crump:** We use both titles. It is doubly named partly because the managerial community have come to know it as the Productive Ward, and it is one of a whole series. We have similar approaches now for community nursing, for operating theatres, for maternity wards, for mental health wards.

**Q62 Dr Taylor:** It really needs emphasising tremendously, because (and I am sure I am not alone) the complaints I get are about nurses not having time to care.

**Professor Crump:** Exactly.

**Dr Taylor:** Thank you.

**Q63 Stephen Hesford:** Patient safety. John and Bernard, has having better patient safety produced savings and efficiency and will it produce better savings?

**Professor Appleby:** To be perfectly honest, I do not know. The NHS has for many years put emphasis on patient safety. If you cannot keep patients safe at a minimum, then what on earth are you doing as a health system? Clearly that is an issue. We have recently had yet another inquiry in Mid Staffordshire. Clearly patient safety was completely compromised there, and that is an aspect of quality which is an aspect of productivity and so on, and so dealing with these things has to be a top priority. Patients have to be safe, at a minimum, when they are being cared for, but hospitals and healthcare do dangerous things to people and use dangerous chemicals and there are risks. I do not think the link

between patient safety and productivity has been made that strongly in the system. Patient safety is for patients' safety's sake, so the issue is whether the NHS is getting better at that. I am not aware of all the evidence around that. We know there are huge numbers of medical errors, we know there are problems, and we have examples like Mid-Staffordshire and other hospitals, and they will occur in the future, I am sure. It is more a case of doing the right thing for people and keeping them safe as a matter of course, I would have thought.

**Q64 Stephen Hesford:** Are we going to get any better at it though?

**Professor Crump:** I think there is some potential to contribute to the productivity challenge through the avoidance of some of the most egregious and difficult aspects of patient safety. For example, we have made a lot of progress on a range of healthcare-associated infections and some of them, like acquiring pneumonia when you are on a ventilator on ITU, are not just tragedies for the family and the person concerned, which result in very much worse outcomes, indeed often mortality, they also lead to far longer lengths of stay and therefore that ITU bed cannot be used for other patients. I think this might be the point to make the point that, in the end, where we have to release cash for other things, some of these improvements will only release the resource if we can capitalise on the improvements in utilisation of facilities and remove some of the facilities.

**Q65 Stephen Hesford:** We heard in our Patient Safety Inquiry that there is a kind of consumer resistance to this in the system, which from what John was saying is almost self-evidently daft. How can we break down that consumer resistance?

**Professor Crump:** I am sorry, which consumers?

**Q66 Stephen Hesford:** The people who are running the Health Service. They are not responding to this agenda, the new technologies. Bar coding of blood bags, for example, so you do not get the wrong blood. These things are just not being done.

**Professor Crump:** I would say there are two different things there. Are there managers in the Health Service, and indeed clinicians, who are resistant to the idea of trying to improve patient safety? I think it is true that many more of them are aware now than they were even five years ago of the significance of patient safety and the number of errors through the work of the Chief Medical Officer and others. However, are there systems to make sure that even apparently cost effective uses of, for example, new technology get introduced quickly? No, there are not, and there are three or four reasons for that in my view. We are not great at leading innovation. We do not choose our leaders and help them know how to lead for innovation. They tend to lead for compliance, for delivery of things they have been asked to do. Secondly, often, and the example you quote is a good example, there is a misalignment between the way the business processes of the way the NHS work with an objective like investing in a new technology to improve patient safety. It is very

difficult to get all of the necessary people together to agree on, for example, a capital investment or which particular model to use even where it looks as though the investment will be very cost effective. We have been very slow at overcoming some of those misalignments of business objectives.

**Q67 Stephen Hesford:** That is the description. What is the answer?

**Professor Crump:** The answer is that we have to identify how we introduce new innovative businesses processes. For example, how we can work with the suppliers to agree a process of perhaps a tapered tariff for a new system so that as the benefits arise to the NHS of the use of this new technology, those benefits are shared between the company that sold us the system and the NHS in a structured way, a bit like has been the case for some of the new drugs that are made available within the service. It is very hard to invest across some of our organisational boundaries at the moment and we have to break some of that down.

**Q68 Mr Bone:** In 1997 Tony Blair got it absolutely right when he said our Health Service was not good enough and we were falling way behind Europe. He also recognised that we were not spending much money on the Health Service in comparison to Europe and he thought the solution was to put lots of money into our Health Service and at least bring it up to the European average. My greatest criticism of this Government would be that they put the money in but they did not get anything in return for it, and I think if Tony Blair were here now he would at least go some of the way to saying that. Lord Warner, the former Health Minister, recently accused the NHS management of "monumental incompetence", "too much money given too quickly". Do you think that is right, Professor Appleby?

**Professor Appleby:** No, I do not think it is wholly right. I think when the decision was taken to put more money into the Health Service, as you said, compared with other European countries we were spending far less than our national wealth would suggest we could be doing, far less than I think the public wanted. There were lots of concerns about the NHS, particularly in terms of waiting times and so on. A decision was taken to put more money in. Sir Derek Wanless produced his seminal report on how much should be spent on the Health Service, and I think it was probably at the limits of what the NHS could sensibly absorb, but it is not true to say that the money went in and nothing happened; an awful lot happened. The issue we are facing at the moment is that the inputs went up and the outputs went up, but the outputs did not go up as fast as the inputs; that is one of the issues about productivity. Waiting times are now at a historic low. They are simply not an issue for members of the public by and large.

**Q69 Mr Bone:** In your own document, *Our Future Health Secured*, Sir Derek Wanless said that of the additional £43 billion spent on the NHS since 2002

44%, £18.9 billion, went on paying higher wages and inflation. That contradicts slightly what you are saying.

**Professor Appleby:** No, that was not too far out historically with where the money goes when you look at what is spent on the Health Service. It is, as Andrew was saying, a labour-intensive industry; it always will be. The NHS spends 60% of its funds on people. There are clearly issues about retaining staff and paying the wages that are needed to do that. In the period we looked at with Sir Derek Wanless for that review which you quoted that happened to be the figure, but that is not out of line with the previous decade and the decade before that, so, yes, the money does go on paying people more and on paying higher prices.

**Q70 Mr Bone:** Turning to Mr Haldenby, of the £50 billion or so extra each year that we are now getting in our NHS, Professor Appleby says not much of that has been wasted. Do you think any of that has been wasted and, if so, what proportion?

**Mr Haldenby:** I do not think it is possible to put a number on it at a national level for all the reasons that we have said, but I just repeat that the professional judgment of the people we speak to in the NHS, and it is similar in other public services, is that individual organisations can expect to save 20% without too much trouble.

**Q71 Mr Bone:** That is very good because I have also spoken to senior people managing the NHS who say, “You are going to cut 20%”, referring to my government if it comes into power, “and we can handle that”, so there is a sort of figure, a suggestion, that 20% has been wasted.

**Mr Haldenby:** It is just something that has been repeated to me independently by several people.

**Q72 Mr Bone:** Professor Crump, when those sorts of things are talked about in the future, that we are going to make these cuts, is not what the NHS is going to do is produce a series of completely unacceptable cuts, they are going to slash and burn rather than tackle the root problem? Is that not going to happen when whatever government is in power after the election?

**Professor Crump:** I hope not and I would not want at all to encourage a slash and burn approach. We are encouraging the exact opposite, which is an approach that takes, as its starting point, an identification of those areas where we can improve quality and safety in a way that reduces resource by, for example, tackling variation, tackling waste, like the productive series, and also by identifying the avoidance of unnecessary activity because there is by common consent unnecessary activity. I would be interested to talk to the colleagues that Andrew has talked to about how they would see this 20% reduction playing out because that would be bound to reduce activity, it would be bound to have an impact on public perception about the quality of the service.

**Q73 Dr Stoate:** As we have already heard, the Government has doubled the amount of money spent on the NHS. I suppose the simple question to Andrew is: is it possible to make these reasonable cuts without frightening the horses too much, or will it inevitably lead to public dissent?

**Mr Haldenby:** Given that we have just had at least ten years, and perhaps even 60 years, of debate around the Health Service, which has been based on the idea that spending more is good for the Health Service, and again it was written in the Budget yesterday—I will not make a long quote—since 1997 NHS spending in England has more than doubled in real terms . . .” (and various other public services as well), and that this “has enabled public services to deliver high quality and sustainable outcomes”, that has been the tone of the debate around public spending on the Health Service. There has also been a focus that increasing inputs is a good thing in itself, and I quoted the hospital numbers also from the Budget. I think it would be difficult for any politician, unfortunately, to stand up and say that savings will have to be made. That is a problem for politicians rather than for policy people, but in terms of the political challenge of frightening the horses it is obviously a very great one. However, the more positive side is that there are people within the Health Service who are already doing it, from changing the way facilities are used to changing the way that staff are employed, so any government will be able to work with those people and there are changes that can be made to the structure of the service which will help.

**Q74 Dr Stoate:** Recently there has been criticism about the A&E four-hour target and whether that has possibly been damaging patients in certain circumstances. Do you think that should be relaxed or should we be sticking to it?

**Mr Haldenby:** I think we need to follow the clinical evidence on it. Inevitably, these black and white targets will not be appropriate for some patients, but that is just a statement of the obvious. I would have thought that something like the waiting time targets are different from some of the other public services. Clearly, all other things being equal, it is better to treat people quicker because they do not deteriorate. Compare that with something like schools education, the main productivity measure in schools education at the moment is class size. I think in many cases a good teacher teaching a class of 40 kids is better than a bad teacher teaching a class of 20 kids. This is a controversial thing to say but, to compare those two services, I would have thought that the waiting time targets are more sensible in their approach than the one on class size.

**Q75 Dr Stoate:** You have just antagonised the entire teaching profession at a stroke! What about waiting times? Again, is it something the public would be prepared to accept, if waiting times were to creep up or do you think that is absolutely taboo?

**Mr Haldenby:** I am not sure any of us are arguing that waiting times should go up. One of the things that has been argued is that there is a re-orientation

of the service towards chronic disease so that that is much more heavily carried out in primary community care services. In our recent report on the hospital estate we discovered that the really heavy provision, the density of hospital beds, is in London, the North East and the North West, and Nick Bosanquet, one of the authors, was pointing out to me that each of those areas—London, Teesside and Manchester—have got incredibly high problems of chronic disease. It is in a way surprising that there would be lots of hospital beds in areas of lots of chronic disease, you would think that they would have much more primary community services. A service which organises demand better and is treating people more in primary community services is taking pressure off the hospital waiting lists.

**Professor Appleby:** On waiting times, they are now very low indeed; the majority of patients get treated well within 18 weeks, by the way, and that is the maximum. Public surveys show that it is simply not an issue with most people any more. In a sense the NHS has done the work. It has got over that hump; it does not need to work even harder to reduce waiting times, so I think it is sort of there. One of the things I suggested in our written evidence to the Committee was that Wanless, for example, was recommending a maximum wait of two weeks from GP referral to a bed in hospital if you needed it. I suspect now that most people are generally content with that. I am not saying it is going to stay like that but at the moment it seems to be the case. Just on beds, the UK is not exactly over-endowed with beds, if you look at other OECD countries we are near the bottom of the league table for the numbers of beds per thousand of population. As a country the UK has also reduced its bed stock the fastest of any other OECD country. This issue about getting rid of beds and so on is a little bit moot. It needs to be examined a bit more.

**Q76 Stephen Hesford:** Labour costs—pensions, wages—you mentioned, Andrew, 50%, it is more than that, of the total NHS bill. It is one of the things that you were asked about before, whether there were areas where you could save money.

**Mr Haldenby:** Yes.

**Q77 Stephen Hesford:** Has there been any work done on how much could be saved and what are the realistic ways of saving money in this area, labour costs and pension costs?

**Mr Haldenby:** In terms of better use of people, and the Treasury highlighted it yesterday, there is a huge amount to be saved in sickness absence. The Treasury pledged yesterday £555 million to the service.

**Q78 Stephen Hesford:** We will come to sickness absence. That is an area that I was not particularly focusing on. I was thinking more of pensions and pay. Have you done any work on that?

**Mr Haldenby:** The question would be: have pay increases in the NHS been out of line with those in other public services? The last time I looked at the pay review bodies I think they found that for

doctors—so there is evidence here—the increases had been much greater than in other public services and for nurses the increases had been in line with other public services, so there would be an opportunity to look at doctors' pay levels and perhaps bring those back. My personal contact with doctors would indicate that they do feel overpaid because they got too generous a deal in the last contracts. On pensions, as we know, the provision of final salary linked pensions in the public sector in general is now out of line with the rest of the economy and there is focus in all parties on how to move away from the final salary system in the public sector, and that would bring down costs.

**Q79 Stephen Hesford:** When we report would you be urging on us to say something like there should be real effort to bear down on pension costs as a legitimate and doable way, instead of having some kind of massive row and getting nowhere?

**Mr Haldenby:** It is clearly not accepted as a given that all public sector pensions are going to move into line with private sector pensions, and that is an argument that has to be had, but what has happened is that the private sector has discovered that it cannot afford pensions at that level, it has tried it and it has not worked, and now the public sector is going through that process and so is lagging behind.

**Q80 Stephen Hesford:** John or Bernard, if we did freeze pay and we did look at pensions, how would that affect recruitment and retention and would it be adverse and would it be worth the candle if we got that wrong and we stopped getting doctors and nurses?

**Professor Appleby:** I think the policy is a pay freeze in the NHS. GPs, as I understand it, have essentially had a pay freeze for two years now. In the Pre-Budget Report Alistair Darling essentially produced a 1% cash pay cap for the whole of the public sector and a pay freeze in cash terms for senior people within the NHS, including senior medics. Pay for doctors, and I should say nurses as well, is not unreasonable by international standards.

**Q81 Stephen Hesford:** Is there any evidence that it affects recruitment and retention, the fact that we are going into this area?

**Professor Appleby:** Recruitment and retention are good and have been for a number of years now and I think that is what the Pay Review Board reports show as well. A pay freeze—this is my opinion—I do not think it will have much impact on recruitment and retention.

**Q82 Stephen Hesford:** Bernard, should the NHS introduce pay differentials, from your experience within the service, so within one area a nurse would get paid X, in another area Y, and I suppose different payments for different clinical specialties in different areas to encourage GPs and consultants into understaffed area? What can we do with that?

**Professor Crump:** This is not an area we have looked into in any detail. Very briefly, I would say that historically whether the output of your medical

---

25 March 2010 Mr Andrew Haldenby, Professor John Appleby and Professor Bernard Crump

---

school favours going into a primary care part of the NHS or into hospital practice has been affected by comparisons of pay between the two sectors. There is some sensitivity in those sorts of choices. We have had a long system of not paying differentially for different specialties. There is a great deal of benefit in that in my own personal view. I do think the use of tariff and what we pay an organisation for delivering different sorts of care is a potent way of changing practice which we have only just begun to use and there is lots of potential to use that to help with productivity in my view.

**Q83 Stephen Hesford:** You would prefer the payment by results route rather than pay differentials?

**Professor Crump:** Yes. Personally, I am not in favour of substantial amounts of pay for performance at the individual level. I do not think the international evidence is very strong on that. On tariff, if you are going to have payment by results at all then we should use it more intelligently than we have been using it in the past.

**Q84 Sandra Gidley:** I am not quite sure who to aim this one at. Nursing is going to become a graduate profession. What is the implication of this for staffing costs?

**Professor Appleby:** At a guess, an increase, I would have thought. It is tricky to speculate on this. One of the things you learn as an economist is that if you change something in the system something else will react against it, so if you try to predict the behaviour of the system, as it were, it may start to bear down on the total numbers of nurses employed, for example, if they are more costly per nurse. It may stimulate a harder look, going back to the skill mix issue, at what is the most appropriate training, let us say, for doing this particular set of activities and these sorts of things. It is hard to predict what the impact would be on the total costs.

**Q85 Sandra Gidley:** Andrew was nodding as you said "an increase", but we had, Philip Nicholson in front of us; if not him it was some Department of Health bean counter, who said that there would be no extra cost.

**Mr Haldenby:** Well, he would say that, would he not?

**Q86 Sandra Gidley:** That was my view.

**Professor Appleby:** I think he was coming at it from the total budget end as well, that the budget would simply stay the same anyway. I was trying to moderate my initial reaction to your question in the sense that I think it is quite hard to know what would happen given the reactions by managers and the hospital and so on to a potential change in cost for those nurses.

**Q87 Sandra Gidley:** Would a fair summary be that if they are all graduate nurses that would mean higher pay but there may be an attempt to rebalance the work with the skill mix to keep the overall costs similar?

**Professor Appleby:** Certainly a pressure for higher pay, whether that is met is another matter as well.

**Q88 Dr Naysmith:** John, York University researchers claimed that management and admin costs amount to 25% of all NHS staff costs. Does that figure look about right to you?

**Professor Appleby:** It sounds initially a bit high, but when you look at the staffing figures produced by the Department of Health they do various categories. They have one for senior managers and they have support to clinical staff and NHS infrastructure support. Those groups include admin people, secretaries, a whole range of different jobs, not just senior managers. When you multiply up the numbers by the average pay on that, I have got a figure which is over £11 billion.

**Q89 Dr Naysmith:** It is not far out then?

**Professor Appleby:** That is matching how much we spend on doctors in the NHS, but that is all managers, all admin, all secretarial support in the entire NHS.

**Q90 Dr Naysmith:** So it is about a quarter of the money that is spent on pay?

**Professor Appleby:** It is not far off that figure.

**Q91 Dr Naysmith:** We have to make 30% reductions in managerial costs in primary care trusts and SHAs; the Department is requiring this amount. Which areas should we start focusing on to get this large sum down a bit?

**Professor Appleby:** PCTs are going to be under pressure. I do not know whether you have visited a PCT and seen exactly how many people work in some of these organisations. It is not as many as you might think perhaps. At SHA level these are organisations which have transformed over decades and the numbers of people in these organisations are not that great. The bulk of the staffing is in hospitals. PCTs will be under pressure on this with their reduction in management costs and I think there is an argument to say that that is the wrong place to start cutting management costs. We are probably underskilled and there are simply not enough people with the right skills in PCTs to do the job that the system is asking of these organisations. I guess the focus perhaps should be more on secondary care.

**Q92 Dr Naysmith:** It has been suggested that strategic health authorities lack a clearly defined role. Do you think that is true? If there were cuts on them would it make much difference?

**Professor Appleby:** I think traditionally they have been the buffer organisation between the secretary of state and the rest of the system in part, have they not, so they do have a role to play. I think they are here to stay but I agree with you: I think they need more clarity, certainly in the public side and people outside the system, as to what role they do fulfil. As I understand it, they are working down the PCT commissioner route to manage that part of the organisation, but I think if you looked in detail at

how SHAs carry out their work and their functions you would find they vary quite a bit from region to region.

**Q93 Dr Naysmith:** If we are not going to have an influence on PCTs and strategic health authorities where will this 30% cut in managerial jobs come from?

**Professor Appleby:** I think it is focused on PCTs and SHAs. That is the message from the Department. All I am saying is that I think there is a strong argument to say do not cut PCTs' management in terms of numbers. In fact, there is an argument for boosting numbers there.

**Q94 Dr Naysmith:** If the Department goes ahead with these reductions and insists on them, what will be the effect on the NHS?

**Professor Appleby:** I do not think it is going to have a positive effect on the ability of PCTs to do what is a very difficult job. They handle about 80% of the NHS budget, so £80 billion-plus. They are there to make decisions on our behalf, their residents' behalf, the population's behalf, about what care gets paid for and provided and so on. These are big and difficult functions that we ask these groups to carry out on our behalf with public money and I think bearing down on the management costs, yes, there may be some case for that in some areas, but a general blanket 30% target I personally think that is inappropriate.

**Q95 Dr Naysmith:** I know this could be opening up a wide area and I do not want to do that at this stage in the morning, but most of this money is paying for maintaining the purchaser/provider split. We know that in Scotland and Wales they are in the process of getting rid of that. Is that where the management costs should really be?

**Professor Appleby:** It is not going on maintaining or running this quasi-market system that we have. That is not where the money goes. Roughly these sorts of proportions of spend on admin, on managers and so on, that has been the case for decades in the NHS.

**Q96 Dr Naysmith:** Has anybody got anything to add?

**Professor Crump:** Two things briefly. Our experience of working with PCTs on areas like shifting care from secondary to primary care is that a crucial determinant of whether that is successful is their execution skills, their capacity, their capability to manage that process. The second thing to say is that it is quite likely there will be a pressure, I guess, for amalgamations with PCTs. In some areas there are rather small PCTs, rather large numbers of them, and I guess that pressure is going to continue. The third thing is this process we are all waiting to hear the results of, which is the decision about their provider functions. What we do know from our work is that there is very substantial potential for improving the effectiveness and the productivity of community-based services and they are somewhat

under-managed in our experience, so the quality of the management effort brought to deploy those services really needs improving.

**Q97 Dr Stoate:** That neatly brings me on to evidence because you have just mentioned the idea of shifting work from secondary to primary care back into the community and improving community services and so on, all of which is exactly the flavour of the month in terms of where we are going, but is there any hard evidence that that works in terms of saving money?

**Professor Crump:** There is hard evidence that it works in terms of achieving the objective. As to whether that objective saves money, the evidence is less good.

**Q98 Dr Stoate:** What objective?

**Professor Crump:** For example, we worked with 15 projects that sought to care for patients in community settings or in their home where they had previously been admitted to hospital and we were able to support those organisations—this was independently reviewed by the Health Service management centre in Birmingham—and in all but two of those instances they achieved the shift of care.

**Q99 Dr Stoate:** I am not saying you cannot shift the care; what I am saying is, is there any evidence that doing so achieves anything apart from shifting care?

**Professor Crump:** For that particular work at that particular time the financial objective was not the objective that we were looking for. There are pieces of work that suggest that caring for patients in community settings, who would otherwise be in hospital, on a day-by-day basis is about as costly in a community setting as it is in hospital but the length of time that you have to deliver that care is significantly shorter in community settings, so the spell, the episode of care, costs less in a community setting than in hospital. The watchword about early discharge from hospitals is that you should try and avoid people ever getting in in the first place if you can because once you are in hospital discharge is very difficult to achieve, so, yes, there is some evidence.

**Q100 Dr Stoate:** Let me turn to Andrew. Let us assume that in the brave new world we are preventing people from going into hospital and we have therefore presumably saved that episode of cost. How quickly can we execute changes in configuration? I know your organisation Reform has done some work recently on this. Assuming, if Bernard's figures are right, that we do not need so many hospitals or beds, and that is what you have been saying with Reform, how quickly and relatively easily can you reduce capacity in the acute sector to make the savings needed?

**Mr Haldenby:** I think it will vary but the major reductions in the hospital estate are clearly not going to happen in 12 months. It is going to be more like the life of a parliament and that is because of the necessary consultations that will need to be undertaken, and I think we are starting from a low

base on this, so one would expect a major programme of changing the estate to take a number of years.

**Q101 Dr Stoaite:** Yes, but your organisation has just come out with some fairly hard-hitting figures that we have got something like 30% too many beds in the NHS. I have forgotten what the figures were, but it is all very well saying that; what are you going to do about it?

**Mr Haldenby:** What we need to do is help the NHS focus much more aggressively on value for money. As I said earlier, good people are doing this in the NHS. We spoke to people in the Birmingham PCT who have been closing hospitals and opening new local facilities, and this process is going on around the country. The question is what pressure can we put upon managers in order to see—

**Q102 Dr Stoaite:** It is not so much pressure on managers; it is how you achieve your objectives. If your objective is that we need 30% fewer beds, for the sake of argument, unless you can come up with a way of achieving that it is rather pointless.

**Mr Haldenby:** The beds figure that we put out was a comparison of bed density in the South Central SHA with the most heavily dense areas, so we are just pointing out that there is a regional difference in this country which would indicate that some areas could make progress. I think the real job is a structural one: how do you make chief executives of PCTs think that their job is to think in a whole new way free of historical constraint about the design of services in their areas? I come back to something like giving citizens a choice of PCT so that suddenly we increase the accountability of chief executives of PCTs.

**Q103 Dr Stoaite:** It all sounds a bit woolly. John, have you got any views on how we go about this? It is easy to say there are too many beds but no-one is suggesting what we should do about it.

**Professor Appleby:** Part of the reason why we have variation in bed numbers, by the way, is that there is a variation in need for healthcare across the country. That accounts for some of the difference there. As I pointed out earlier, we are not exactly over-endowed with beds in the UK and never have been and yet we have reduced the numbers mainly in line with reductions in length of stay which are driven by medical changes, not so much by managers sitting round saying, “We don’t need so many beds now” or, “We are under financial pressure”. It is much more driven by changes in medical technology, techniques and so on, so people simply do not have to stay in hospital so long, you do not need so many beds, and that is what has really historically driven changes in beds. In terms of now, certainly as long as I have been working in the Health Service and outside it and as an economist, there has been a feeling that it is dominated by secondary care. You could do more in the community, you could do more in patients’ homes and push everything down the line, as it were, but it has been very hard to achieve. The plan is now to do that. London, for example, is a good example and the way they are doing it is it is being driven by

the strategic health authority. There were initial reports, as you know, by Lord Darzi about healthcare for London and what the broad look of the system could be. Those are now being worked up by individual PCTs along with trusts so there is quite a co-operative thing going on. In terms of the public, as they hear about these plans they are starting to get worried about this. In my local neck of the woods the local A&E department may be downgraded to a minor injuries unit but A&E re-provided in a bigger way, and hopefully a better way than another hospital. These things are going to come out into the public arena and there are going to be issues there about how they are dealt with, and, I have to say, particularly by local MPs as well. It is happening now. In terms of timescale, yes, it will be two, three, four, five years, depending on what the change is.

**Q104 Stephen Hesford:** Care for the elderly and patients with chronic conditions—what are the issues about changing, saving money, better value for money, in those areas?

**Professor Crump:** Lots of the approaches to improving the time that nurses have available for clinical care are focused on elderly patients. The vast majority of patients in hospital care are elderly. Improving the ways in which we give responsibility to nurses to use, for example, criteria-based discharge, is an important way of helping people get home quickly. A big focus, however, for me would be on trying to identify, condition by condition or presenting complaint by presenting complaint, those areas where we have historically admitted more people to hospital than is clinically necessary. Finding ways and incentivising people to deliver different appropriate care in community settings is really important. The decision in the last operating framework that if a hospital has emergency admissions above its 2008 level then in future, instead of getting a full tariff payment for those admissions, they will only get 30% of a tariff payment comes in next week. That decision has already had a big impact on getting hospitals much more actively involved in discussing with their local PCTs what alternatives there are for hospital admissions.

**Q105 Stephen Hesford:** Did you want to come in on this, Andrew?

**Mr Haldenby:** I found a quote in the BMJ this week from Professor Adam Timmis, Consultant Interventional Cardiologist at Barts, who said that cardiology patients tend to be elderly and for patients who were coping well at home before admission “every day spent in hospital is a disaster as patients lose their independence and are at risk of hospital acquired infections”. He is saying there has to be strong self-management by patients and also strong community services to manage care and as far as possible keep cardiology patients out of hospital.

**Professor Appleby:** There is an issue here around the role of health and social care in chronic conditions as well. I do not think it is simply a case of having to save money. It is a case of improving quality within the budget, and that will be an improvement in

---

25 March 2010 Mr Andrew Haldenby, Professor John Appleby and Professor Bernard Crump

---

productivity. There are good examples in the NHS. Torbay Care Trust, for example, has been doing good stuff, because people's health needs are quite often health and social care-type needs and these things can be substitutes, they can be complementary, depending on what the issue is. There are examples within the NHS of providing better care within the budget and a better quality of care, so more productivity.

**Q106 Mr Scott:** Private finance initiatives have left the NHS with very huge bills. Do you think firstly they should not be used in the future for improvements to the NHS estate?

**Professor Crump:** I would not pretend to be an expert on PFI, but it is true that there is a legacy. This legacy is not very evenly distributed across the country. There are places where the historical legacy to use a certain amount of estate because of the nature of the private finance initiative is going to be a big problem to overcome. However, in places I have worked, I have seen hospitals that for decades have needed to have much needed improvements which had not happened under previous capital regimes but certainly the legacy of a 40-year commitment in some parts of the country to a very large annual spend will tend to mean that estate will be the estate that people will want to continue to use, and that is going to be quite a challenge, particularly because it is so unevenly distributed.

**Q107 Mr Scott:** John, you referred to "in your neck of the woods". I am not quite sure where that is.

**Professor Appleby:** North London.

**Q108 Mr Scott:** In north-east London, my own constituency area, there were proposals put forward which fortunately the minister came and put a halt to yesterday; I cannot think why! Nonetheless, the cost of the PFI has obviously affected or could affect the services at other facilities in the area. If there was not a PFI what other suggestions would you have for funding it?

**Professor Appleby:** PFI and nearly all capital spending has ground to a halt now in the NHS and I do not think we see much prospect of that over the next few years and across the public sector. In terms of the legacy, and as Bernard said it is very uneven, there are some hospitals with huge amounts of PFI and it is then a commitment from their revenue budget. They have to earn the money to pay that off over years. I have not done any detailed work on this but I do wonder whether there is potentially a case for the liabilities being bought out on PFI in certain cases, simply that it would make more economic sense—

**Q109 Mr Scott:** —to get rid of it now?

**Professor Appleby:** Yes, to pay off the debt now, for the State to do that. When you look at the sorts of commitments into the future, even allowing for inflation and so on, and that is in the future, I wonder whether there is a case in certain instances for just, "We will deal with that capital payment and we will pay it now".

**Q110 Sandra Gidley:** Moving on to GPs, the PAGB have argued that we could save £2 billion a year if patients with minor ailments were educated not to "bother" their GPs. Would any of you agree or disagree with this?

**Professor Appleby:** I always thought it was one of the main skills of a GP, something they learned for those patients in those areas to be able to usher them out of the door quite quickly; that is a key skill that GPs have to acquire quite quickly.

**Dr Stoate:** I could not possibly comment!

**Q111 Sandra Gidley:** It would be much more of a skill if they could stop them going there altogether if it was a trivial complaint.

**Professor Appleby:** I suspect there is some saving that you could make here but I really do not think it is substantial. I do not know what Howard would say in his role as a GP but there will be patients who turn up and say they feel they have something wrong with them and it turns out it is nothing or it is very minor or it is self-limiting but they do not know that. I think the proportion of people deliberately bothering their GP is pretty small.

**Q112 Sandra Gidley:** The IMS survey indicated that a fifth of GPs' workload was things like backache, coughs and colds, headaches, which you do not need to see a GP for.

**Professor Appleby:** Yes, I could have bothered my GP with a cough and maybe I would not be coughing now during this session.

**Professor Crump:** I would say three things. We are aware of innovations in many different ways in respect of trying to tackle this problem but it is not an easy problem to tackle. There are practices that have developed minor illness policies and booklets and education programmes and have worked with their population, particularly where they have a more stable population, with apparently positive effects, places that have introduced completely different approaches to making an appointment. We have promulgated a programme that was developed in Christchurch in Dorset where every call that comes in is taken directly by a doctor immediately and a very substantial proportion of those calls are handled without the patient coming to the surgery. There are lots of examples of nurses who are first responders to these kinds of complaints, which works particularly well in bigger practices which have the ability to sustain a regular, high quality, first nursing response service. Whether that number that they quoted, 54 million visits, is accurate and whether you could reduce the resources by the amount they say I would not know. I guess pharmacy is another important arena. There are lots of different places where there has been a much more active role played by pharmacy in the management of—

**Q113 Sandra Gidley:** In Scotland they have a minor ailments scheme. Has your organisation done any work to compare whether that is more cost effective?

**Professor Crump:** We have not looked at that scheme. I will find out about that.

**Q114 Dr Taylor:** You have been fairly dismissive of self-care for minor ailments. Are you aware of the work of the National Endowment for Science, Technology and the Arts, NESTA, which predicts that self-care for long-term conditions could save even more, £6.9 billion? Is that fantasy?

**Professor Crump:** I do not know about the financial value that they have come up with. I am sorry if I have come over as dismissive of the importance of patients in self-care. There is no doubt at all that the role of things like the Expert Patient programme, where it has been successful, peer/peer support from patients to other patients, has had a big impact on quality of life. I am seeing NESTA this afternoon so I will talk to them about that particular study because that seems like a very high financial value to be placed on that initiative.

**Q115 Dr Taylor:** Moving on to user charges, particularly for GP services, is this something the Government should be promoting?

**Mr Haldenby:** It seems to be thinking about it for the reason that we have heard, that other countries, France being an obvious example, do see a very small level of charge, usually then remitted afterwards, as a means of increasing responsibility amongst patients for GP visits.

**Professor Appleby:** I think it is a blunt instrument for your objective. If the objective is to get rid of so-called frivolous visits to GPs, there are many other more cost effective ways of doing it which do not have the downside, that you may dissuade even a small number of people, which would not be acceptable, who should be going to their GP because there is something seriously wrong with them. In terms of raising money, we have a much more efficient system of doing that, that is called taxation. User charges, governments have thought about it and I think they have thought about it and then dismissed it.

**Q116 Dr Taylor:** You are tackling the very people who cannot afford them in any case.

**Professor Crump:** I agree more with John on this, though I would say that I have always thought that it would be incredibly positive if when patients have interacted with the NHS, they saw what it had cost for them to receive the treatment even if they had to make no direct contribution to it at all. I would have wanted on every prescription, when I pick up my prescription for my blood pressure, to see the real costs. There is an issue here that I know that occasionally I will be getting a medication that I will be paying more for from my pocket than would be the cost, and I appreciate that that has to be handled. When I am discharged from hospital I can see no objection to being able to make the patient aware of what has been the cost of the care they have received, not that they should pay it but I think it would be helpful to give them some sense, even if it is within a band, of what they have been the beneficiary of.

**Q117 Dr Taylor:** Yes, I understand that. You are trying to make them realise what it costs but you are not actually putting a charge on them for it?

**Professor Crump:** No. I do think we have had a culture which has meant that some people have regarded the Health Service as free and they would be very surprised, I think, in some cases, at the scale of the cost of the service they have received.

**Q118 Dr Naysmith:** We have spent quite a lot of time talking about PCTs driving up productivity and moving care out of acute settings, but PCTs are price and quality takers rather than price and quality makers. Some people have said that the relationship between the commissioners and the providers is a bit unequal. How can the relationship be made more equal and what cost savings or productivity gains might this yield?

**Professor Appleby:** You say they are price and quality takers, they are to an extent, quite a large extent, at the moment. There are certainly very strong indications that in the next few years the fixed price tariff set by the Department of Health could be relaxed so that you do not have a fixed price but you have some negotiation going on between commissioners.

**Q119 Dr Naysmith:** Would it be a good thing if they could compete on price?

**Professor Appleby:** Potentially, but what I am saying is that in terms of that taking of the price, there is going to be a certain amount of making of that or negotiation around that. In terms of the quality and to an extent the price that PCTs pay, there is a system called CQUIN—it completely escapes me as to what it stands for, but quality and innovation—which is a way of giving an added incentive on providers to provide a certain level of quality, and if they do not, they do not have so much money given to them; they do not get a proportion of the contract price. At the moment it is only standing at about 0.5% of the contract price. I do not quite understand why it is not 100%, to be honest, or a much bigger proportion of the contract. I think there is scope there for some of these levers, so the price lever to be changed, and also, frankly, for PCTs just to start using the powers they have had since 1991, when all this was introduced, to influence the quality of care that providers provide.

**Q120 Dr Naysmith:** There is this feeling of inequality. You get a big teaching hospital, a university teaching hospital and, as you pointed out, a little PCT in a corner somewhere trying to negotiate. Do you think they have got the levers to do things now, to negotiate?

**Professor Appleby:** In theory they have. I suspect, and it goes back partly to that question about cutting back on management costs for PCTs, I do not think they have had a whole range of things, the skills, in a sense almost the political clout with a small “p” with where the action is in the Health Service, which is operating on people, it is providing care, it is prescribing, it is all that stuff. There is probably an argument for having fewer and bigger PCTs. There may be an argument, for example, for exploiting what the NHS has developed through things like cancer networks. There may be an option

simply to give the cancer budget to cancer networks and for them to focus solely on commissioning cancer services, so they specialise in certain areas. That may be a way forward as well, so that we have a mixture if you want to retain a split between groups who have the money and no services and organisations which have services but no money and we want some transaction to go on. I think there is a variety of options ahead that could be looked at.

**Professor Crump:** I guess we should also mention practice-based commissioning and the role of GPs as commissioners, which I do not think has fulfilled its potential, and we can talk about why that might be but I know that there are plans for it to improve. I think that particularly the involvement on both sides of the discussion of the clinical teams as well as the finance teams is an essential part of the process which has not always been given enough prominence. The best practice tariff which is being introduced, but only for a small number of conditions, is something we have been advocating for a very long time. We looked at common things that are done in hospital. We found high performers and poor performers and we have been able to codify that into a way that would allow the tariff to be based on how high performers work and that should produce substantial reductions in tariff, and it certainly gives an incentive for organisations to look hard at exactly how they are delivering certain types of care. We have evidence that where they do that you can produce very substantial changes in clinical care over short periods of time, nine months or so for dramatic improvements in caesarean section rates, for example, in hospitals.

**Q121 Dr Naysmith:** Have you anything to add, Andrew?

**Mr Haldenby:** We have spoken to PCT chief executives who feel the system militates against them exercising their powers, particularly on the financial side, if they achieve a surplus. There have been examples where that surplus is then, they feel, taken from them and used to “bail out” another organisation which made a deficit. In the current operating framework I think there is a commitment to allow PCTs to keep some of the savings they are making, at least in the current financial year, but clearly if there is uncertainty about that, and if PCTs are able to keep their surpluses and reinvest them themselves that gives them a strong incentive to do it.

**Q122 Dr Stoaite:** Just to boast a bit about the tariff, John, what we want to know is whether the tariff can be used as a lever to control demand rather than simply price.

**Professor Appleby:** I think Bernard gave an example of that. It is the action on the supply side but by implication potentially on demand as well, so hospitals admitting more than, I think, 2008 levels of emergency admissions will not get paid the full tariff; they will get 30%. I have a suspicion that even at that price it may be worth doing for many hospitals, to be honest. Maybe the price should be set at zero if you

want to really have an impact, so I wonder how much you have to waggle that price lever to get an effect.

**Q123 Dr Stoaite:** That is what I am really coming to, that things like payment by results and a tariff obviously have severely skewed the way hospitals operate. Do you think there is any scope there for saving money?

**Professor Appleby:** I am not sure it has necessarily skewed the way they operate. There is a growing focus on those elements of a hospital’s activity which are paid for via the fixed price tariff.

**Q124 Dr Stoaite:** In terms of payment by results, for example, the more they do they more they get paid for regardless of any other consideration, so the incentive is to do as much as you possibly can.

**Professor Appleby:** Not necessarily. If I were a trust and my costs were higher than the tariff then I am not sure I would want to do more and more and make bigger and bigger losses, so I think there is an issue about the cost relative to tariff. You are right though: it was implemented largely to try and stimulate activity to deal with waiting times issues.

**Q125 Dr Stoaite:** That is what I am saying. Is now the time to revisit that?

**Professor Appleby:** I think hospitals now are more canny about their production costs. They are into things called service line reporting and lower levels of budgets within hospitals. They are much more aware now of what it is they want to do. Most hospitals in a sense cross-subsidise from one specialty to another, so they may have high cost relative to tariff, low cost relative to tariff, making a surplus, but in the end it is the bottom line that really counts. I think there is much more focus now within trusts on which lines, as it were, are making money and what do we want to do about those areas where our costs are higher than the tariff, especially as the tariff has now been frozen in cash terms, let alone in real terms, over the next few years. At the margins hospitals are going to have to make some tricky decisions: “Do we carry on supplying ophthalmology”, or whatever it may be, “or do we really try and reduce our costs here?”, and so on. It has taken time for it to have an impact and it is because without the in-depth knowledge of the business, as it were, the production costs and how things fit together, it is an incentive which is not pushing against anything. People see it as an incentive in theory, but in reality, unless you have some knowledge about then how to play the game correctly to react to the incentive, it does not have any effect. I think that is changing.

**Q126 Stephen Hesford:** My question is a massive area, it is the drugs bill. We could have a whole session on that and given time constraints we cannot. Basically what can we do to drive down the drugs bill? A supplementary is the power relationship between the NHS and drugs companies in terms of purchasing, so what are the issues around that?

---

25 March 2010 Mr Andrew Haldenby, Professor John Appleby and Professor Bernard Crump

---

**Mr Haldenby:** We have not done a huge amount of work on productivity within the drugs budget, but I think I would say that this question is usually framed, just as you ended there, about the power relationship between the Department and the companies and this idea that somehow the Department has to screw a better national deal out of the companies, and there has been year by year a renegotiation of the PPRS to that effect. My submission is that it needs to be more of a local decision, so it is about individual NHS organisations commissioning drugs on behalf of their patients and I suspect it does then bring you back into this wider discussion.

**Q127 Stephen Hesford:** You mean they are not using enough generic drugs or something like that?

**Mr Haldenby:** Yes, and also there is lots of evidence that when drugs are prescribed they are not very well used. People do not stay with their programmes of treatment and so on, so there is an enormous amount of waste. Those would all be things where better services at the local level could make better use of the bill.

**Q128 Stephen Hesford:** And that is a PCT management issue?

**Mr Haldenby:** GPs as well.

**Professor Appleby:** On the generic issue, the NHS has done pretty well over the last couple of decades. I cannot remember the figures exactly but we must be approaching three-quarters generic.

**Q129 Dr Stoaite:** It is between 70% and 75%.

**Professor Crump:** Certainly in dispensing areas.

**Professor Appleby:** That is a tremendous rise. It could go further, what, another 10%?

**Q130 Dr Stoaite:** Probably.

**Professor Appleby:** Probably, so it could go further on that. Clearly, the NHS is almost a single buyer, a monopsonist of a lot of pharmaceutical products, and for it not to use the power that that gives it over price would be silly, it seems to me. Clearly, there have been problems with competing objectives at a broader government level so the NHS would like to use its power to extract the cheapest price for the drugs it prescribes and gives. On the other hand the pharmaceutical industry is quite a big industry and a big earner for the country nationally, so there has been a competing theme between health and wealth, if you like, and that has been tricky to square within the Department and the PPRS and so on, but certainly I think there is scope for looking at more innovative ways of paying for drugs but also negotiating prices as well, and, of course, through NICE. What is the point of the NHS prescribing drugs of very little value, so do not waste the drugs bill on things which are not clinically effective and do not do patients good. That is NICE's role.

**Q131 Stephen Hesford:** So, in a sentence, on that particular aspect, NICE is a force for good?

**Professor Appleby:** Completely, yes.

**Professor Crump:** I would agree with all of that. I would just reiterate the point that Andrew made. People not using the drugs that they have been prescribed is one of the greatest wastes of all and very common. The numbers are staggering in terms of the potential for being able to address that either by not making the prescription or by helping people to get the value out of the drugs that have been prescribed.

**Q132 Dr Taylor:** We gather that PCTs are now going to be able to withhold payment for Never Events. Is that going to save much money?

**Professor Crump:** I do not think it will save an enormous amount of money. I think it is quite important symbolically. What has happened in the US has been that the debate has moved on so that hospitals now say, "Not only will we expect that you will not pay the bill; we will not bill for a Never Event. We will recognise that it is not appropriate if we have led to harm". Never Events for people who are not aware are rare but I am talking about things like leaving in a swab, operating on the wrong kidney. There is a change. In the US the list of Never Events has grown towards areas where there is a risk that, as they become more common or potentially more common (since in the end the clinicians and the hospital who cared for the patient have to 'fess up by admitting that they have had such an event because only they are in a position to do that), people may become less open and honest and fully code their episodes if they become such a huge financial incentive.

**Q133 Dr Taylor:** Should we be pushing for an extension of the list because the list is very short?

**Professor Crump:** It is short. I would say it is more symbolically important to give people a focus on safety than it will be a major contributor to the £15 billion to £20 billion.

**Q134 Dr Taylor:** What sorts of things should we be putting on the list? Errors in prescribing?

**Professor Crump:** The difficulties are those which are definitely attributable to the organisation concerned. For example, one of the biggest areas would be patients who fall in hospital and have a prolonged stay as a consequence of having had a fall when they are in the care of the hospital. They are very common. It would be very difficult to attribute that to, for example, deficient care. Another big area is the care of patients who have pressure-related ulcers which develop when they are in hospital but, as you will be aware, clinically there is often a debate as to whether that process had begun before the patient was admitted. If you stick to "Don't operate on the wrong side", "Don't leave inside instruments or swabs", the most egregious events, the numbers are, thankfully, fairly small.

**Q135 Dr Taylor:** Is there any compulsion on hospitals to have policies to avoid falls? We visited some where they do have initiatives on this.

**Professor Crump:** We are a co-sponsor of the National Patient Safety Campaign, Safety First, and that has been a very major part of that campaign. That campaign has not run on the basis of compulsion. We have tried to make it compelling rather than compulsory, but those policies have been so successful and the dramatic reduction in the number of falls in hospitals in places that really take those policies seriously is very impressive that you could make the case for regulators introducing a requirement that that is an expectation, for example. That may well make sense.

**Q136 Dr Taylor:** You would be a bit careful about increasing the list of Never Events?

**Professor Crump:** I would be anxious that it did not then spawn an industry of how one checked. I think there is a case for considering whether there might be a way of patients, who should know and many often will know whether they or their family member have been the subject of a Never Event, being part of the process of policing it, but I am worried if we get a very long list.

**Q137 Dr Taylor:** So we come on to the complaints process, really?

**Professor Crump:** Yes.

**Professor Appleby:** Just on that, I think these Never Events, not paying for something that should never happen, is down at the extreme end in the CQUINs; that is what it is about. Can I just again emphasise that the extent to which not paying for a Never Event contributes to the £15 billion to £20 billion is not about saving money; it is about preventing a Never Event, an incentive. The value of that in itself contributes to the £15 billion to £20 billion.

**Q138 Dr Naysmith:** You will all be glad to hear we have reached the last question of this session. The National Audit Office have highlighted in reports on subjects such as autism and dementia, and we have touched on it in a number of areas already this morning, that the interface between health and social care is too often a problem and a barrier. Why can we not seem to do anything about that? Perhaps, Professor Crump, you can begin and tell us what, if anything, your organisation is doing about it.

**Professor Crump:** We are supporting a group of PCTs who are working with their local authority partners on a range of different interface issues, including interface with social care but also interface around health inequalities. I think there is progress that can be made but within the limits of systems which have different accountabilities and often different priorities. I do not think the Berlin Wall, as it used to be described, is evident in the places that we are working with but there is a substantial challenge to being able to get really effective partnership working. The key to it in the work we have done so far is in the buy-in from both chairs and boards and their local council partners, often in the context of this series of pilots that have been called Total Place where in many places the

Health Service is playing a pretty active role. I am quite optimistic that these arrangements will become more successful and more of a focus over the next year or two. I think we know how to do it but it is certainly not happening everywhere yet.

**Q139 Dr Naysmith:** Could there be a case for spending more on social care in order to save money in the Health Service?

**Professor Crump:** Yes, and I believe there are examples of that. Indeed, less commonly, there are some examples where people have also spent Health Service money on housing provision, for example, targeted around specific housing requirements of people which affect their health.

**Mr Haldenby:** There is different policy and particularly funding frameworks in health and social care, one is not means-tested and one is funded by national taxation and one is funded by both national and partly local taxation. It would seem to me if it is accepted that there can be greater flexibility about the NHS budget that, for example, in some cases there could be some means-testing or variation in funding, that would make it easier to combine services.

**Q140 Dr Naysmith:** John, you get the last word. There must be a number of studies in the King's Fund that have looked at the interface between social care and health care.

**Professor Appleby:** As Bernard said, there are examples where much closer working, not complete and total integration, between health services and social care services produces good things for people. The NHS has a history of trying to do that through, for example, setting up budgets which are shared between services. Some work I did some time ago in Northern Ireland where they have, at least formally, an integrated health and social care system showed that the social care people were not that keen on it, in part because they felt that when push came to shove with budgets it was the health care side of things which took the money and the social care was seen as a bit of a poor relation. One of the points they made was simply to put these services together, put them in the same building, give them the same budget, give them a joint manager, whatever you do to bring them together, was not enough and the good work happened at a professional level between people who worked in social care and individuals who worked in the NHS. That does not necessarily imply that you have to put the two systems together to get those things.

**Q141 Dr Naysmith:** What happened to joint commissioning? There used to be a big thing about that.

**Professor Appleby:** There still is, and maybe it should be bigger. The point I would make is there is an integration at a professional level and that is where you may get much more the benefits which are better quality and maybe some cost savings, but if you get better quality that is good enough.

---

25 March 2010 Mr Andrew Haldenby, Professor John Appleby and Professor Bernard Crump

---

**Chair:** Could I thank all three of you very much indeed for coming along and helping us with today's evidence session. We will not be putting any commentary alongside this evidence session because of the imminence of a General Election, but it will be on our website in a few days anyway. Thank you very much indeed.

---

# Written evidence

---

## Memorandum by NESTA (SAV 01)

### THE HUMAN FACTOR—HOW TRANSFORMING HEALTHCARE TO INVOLVE THE PUBLIC CAN SAVE MONEY AND SAVE LIVES

#### INTRODUCTION

1. This note outlines key findings from the Human Factor research report, published by NESTA in November 2009. This information been provided at the request of Dr Richard Taylor MP to support the work of the Committee.

2. UK public services face an immense challenge: they will have less money but also face a range of seemingly-intractable issues such as an ageing population. As a result, David Nicholson, Chief Executive of the NHS, has said that the NHS needs to save £15 to £20 billion over the next few years.

3. The Government is reportedly planning for £10 billion in efficiency savings in the NHS, but this will only generate part of the savings required.<sup>1</sup> To meet the scale of the challenge, traditional centrally-led efficiency drives need to be complemented by more patient-focused services and more effective preventative health approaches.

4. However, it is often difficult to develop and implement new approaches within the existing health service. Despite the efforts of the NHS Institute for Innovation and Improvement and initiatives such as Health Innovation and Education Clusters, the organisational structure and culture of many NHS organisations stands in the way. NESTA's own practical work and investments in healthcare have provided copious evidence that many innovations struggle for support or fail to get adopted across the system.

5. NESTA's recent report, *The Human Factor*, examines a range of innovative approaches in healthcare, and indicates that these approaches can generate savings of between 5% and 20%, particularly in the costs of long-term health conditions (the largest cost to the NHS)—this would amount to savings of £6.9 billion a year, that is £20.7 billion, by 2014.

6. NESTA is the UK's leading independent expert on how innovation can solve some of the country's biggest economic and social challenges. It combines early-stage investment with research and practical programmes, including the Public Services Innovation Lab to develop new approaches to the design and delivery of more effective public services.

#### THE CHALLENGE OF LONG-TERM ILLNESS AND PREVENTABLE DISEASE IS THE REAL COST PRESSURE FACING THE NHS

7. The biggest challenge facing the NHS is no longer acute illness, but long-term conditions. There are 15 million people in the UK living with a long-term health condition, costing the NHS £69 billion per year in care. Only by addressing this cost can the NHS deliver more significant and sustainable savings as well as better outcomes for the public.

8. *The Human Factor* shows the biggest opportunities to save money come from redesigning care pathways and services that draw on the needs and innovative potential of patients, frontline workers and communities. It describes how these approaches have the potential to significantly reduce the costs of long-term conditions if they are adopted more widely across the health service.

#### HEALTHCARE PROFESSIONALS REDESIGNING SERVICES WITH PATIENTS TO ENSURE MORE RESPONSIVE PATIENT-CENTRED CARE

##### *Birmingham OwnHealth: telephone-based self-care for those with long-term conditions*

9. In 2007 Birmingham East and North (BEN) PCT collaborated with Pfizer Health Solutions and NHS Direct to trial Birmingham OwnHealth, a telephone-based self-care management service for patients with a range of chronic diseases. Around 100,000 live with a long-term illness in this catchment area. Having achieved improvement in clinical indicators, use of resources and patient satisfaction levels, BEN PCT intends to extend the programme to reach 27,000 patients by 2013.

10. The small initial investment is already seeing a considerable return—at least ten times in savings across the PCT. Within the current client group of 2,000 patients with established disease, Birmingham OwnHealth has reduced demand for hospital services by half.

---

<sup>1</sup> Guardian (4 March 2010), "Treasury plans to set out £11 billion government spending cuts". Accessed 5 March 2010, available at: <http://www.guardian.co.uk/uk/2010/mar/03/treasury-spending-cuts-budget>

*NeuroResponse: home based treatment for those living with Multiple Sclerosis*

11. 85,000 people in the UK are living with Multiple Sclerosis (MS), costing the NHS £400 million and £1.4 billion for the economy as a whole. Part of this cost is the high demand for hospital-based clinical appointments and inpatient stays.

12. NeuroResponse is a new model of care for people with MS pioneered by Bernadette Porter, a Neurological Nurse Consultant at the National Hospital for Neurology and Neurosurgery. It enables patients to receive treatment at home rather than having to travel to a clinic or hospital, comprising a direct telephone/triage advice line, an email advice service, and teleconferencing.

13. The potential impact of approaches such as NeuroResponse is significant; the Department of Health has suggested that self-care support technologies could assist 70–80% of long-term conditions, and a systematic review of self-care systems available has demonstrated anything from 10–15% improvements in productivity of services. Some interventions reduced spending on hospital admission by as much as 80%.

## COMMUNITY-LED BEHAVIOUR CHANGE TO ENSURE MORE EFFECTIVE PREVENTION INITIATIVES

14. If the NHS is to encourage the preventative health agenda new ways of working with communities, which go beyond traditional public behaviour campaigns, must be stimulated. This means new ways of inviting and supporting innovative approaches to health challenges from different types of actors.

*Knowsley at Heart: reducing cardiovascular diseases across Merseyside*

15. Given that in 2007 cardiovascular disease cost the NHS £3.9 billion (projected to rise to £4.7 billion by 2015 and £6.1 billion by 2050), this is an area for significant savings.

16. Mortality rates for cardiovascular disease in Knowsley, Merseyside are significantly higher than the UK average. Knowsley Council and PCT formed a partnership, including a cardiovascular programme “Knowsley at Heart” to reduce rates of heart disease and stroke.

17. Knowsley at Heart represents a model for how to engage the community in preventative health. The partnership offers clinical check-ups in non-medical locations such as shopping centres and pubs, championed by local people. Lung cancer morbidity rates have reduced by 28% as well as a 32% increase in people quitting smoking.

*Action Diabetes: early detection of diabetes in Slough*

18. The NHS spends more money treating diabetes than any other disease—10% of the total health service budget (or £1 million an hour). In 2004 Slough PCT commissioned Dr Foster to develop a community-focused approach to tackle diabetes amongst the local population; 4% had been diagnosed with diabetes and a further 3% were thought to have the disease but remained unaware.

19. Dr Foster developed an “Action Diabetes” campaign tailored to Slough. Critical to its success was the involvement of local diabetes patients who volunteered as health councillors and visited residents. A mobile testing bus was also used. The first three months saw a 164% increase in early detection.

## CONCLUSION AND RECOMMENDATIONS

20. NESTA analysis of these and other innovations in services and preventative health suggests a range of impacts from 5% to 20% reductions in cost. If these approaches were more widespread across the NHS, even a 10% reduction in the cost of long-term conditions could save the NHS £6.9 billion per year, that is, £20.7 billion by 2014.

21. The Human Factor report includes policy recommendations that, if enacted, could help to ensure the development and adoption of many more of these types of innovative approaches:

- Protect and extend the projects that are implementing innovative new approaches and proving their effectiveness.
- Reform projects that are focusing on the right issues but using the “wrong” means, for example, refashioning Change4Life into a community-led programme.
- Establish locally-based, staged “incubation” processes for social innovations, so that radical new approaches that show how to involve the public can grow and be adopted more widely within the NHS.
- Advance the agendas of community ownership of services exemplified in the Foundation Trust policy, giving more communities and patient groups a real stake in their services, and of clinical leadership, wherever possible giving clinicians control over budgets and management decisions.
- Encourage wide spread high quality responses to social challenges through much more open and flexible grant funding processes.

## Memorandum by PAGB (SAV 02)

### SAVING MONEY IN/GETTING BETTER VALUE FOR MONEY FROM THE NHS

#### ABOUT PAGB

PAGB (Proprietary Association of Great Britain) is the national trade body which represents the manufacturers of non prescription medicines and food supplements. PAGB was founded in 1919 to regulate the advertising of member companies' products through pre-publication scrutiny. This process led to the development of the PAGB Code of Standards of Advertising Practice. This system of self regulation continues of all products in membership. From 1987, PAGB has commissioned baseline surveys into self care and self medication of minor ailments.

#### 1. *Summary*

- Patients seeking the advice of a healthcare professional for minor ailments is a grossly inefficient use of NHS resources.
- This issue alone results in £2 billion a year of unnecessary NHS spending.
- However, research conducted over 22 years demonstrate that people have not changed their behaviour in either the extent to which they self care for their minor ailments nor in the quantities of visits to GPs for such ailments, which now take up almost a fifth of GP workload.
- This behaviour is based on:
  - Continued dependence on the GP.
  - People electing to use the NHS to satisfy a demand for care, rather than clinical need—these two positions are significantly different.
- The founding principle of the NHS is that care is provided free at the point of use, and based on clinical need not the ability to pay. But during its 62 year history, the common understanding of “clinical need” has moved towards “demand for care”—this must be redressed.
- A demand-led culture cannot be sustained by a service with finite resources—the NHS is already in deficit, and will be facing greater demands in the future to care for a population now living longer with long term conditions and co-morbidities.
- Changes in patient behaviour and culture are needed now, both in schools and medical training to address the issue.
- Furthermore, minor ailments are generally dealt with most effectively by people opting to self care; consequently the practice of self care is a “win-win” for both the general population and the NHS.

#### 2. *What are minor ailments?*

Minor ailments are part of every day life for us all—the most common are:

- Backache.
- Coughs and colds.
- Headaches and migraine.

In most cases people manage these minor ailments through self care using an Over the Counter (OTC) product, but PAGB's research indicates there is often a significant level of dependency on the doctor.

The research shows that people often abandon self care in favour of a trip to the doctor. Typically, this switch is made within a period of four to seven days. According to GPs, this is earlier than needed, generating unnecessary consultations.

#### 3. *The scale of the problem*

The first major study into NHS resources used for treating minor ailments was commissioned by PAGB, and undertaken by IMS in 2007. The study was tasked with quantifying GP workload for minor ailments and the associated costs.

Research showed high volumes of GP consultations for minor ailments:

- 57 million consultations per year (51.4 million of which involve a minor ailment as the sole reason for seeking the consultation).
- Almost a fifth of GPs' workloads were for minor ailments alone.
- Overall, minor ailments account for £2 billion of NHS funding a year, £371 million of which are for the prescriptions written in 91% of the consultations.

#### 4. *Rationale for Self Care*

A culture of dependency has built up, whereby patients lack the confidence to manage minor ailments themselves through self care for the appropriate amount of time before seeking medical advice.

This must be addressed if we are to maximise the efficiency of NHS spent in these times of tightening budgets.

The three main reasons why this culture of dependency must be met are:

- To help alleviate current demands on the NHS for minor ailments, in particular, the GP.
- To help people to strengthen their ability to self care thereby empowering them to be more confident and independent in their attitudes and behaviour.
- To make time and cost savings in the NHS amounting to £2 billion.

#### 5. *How can greater self care be delivered?*

Increasing the level of self care will require addressing the culture of dependency, and giving patients the support they need to feel confident in treating their own minor ailments.

There are four clear steps to be taken to ensure self care is increased:

1. Recognise it is time to change the culture of dependency for minor ailment.
2. Develop a training package for healthcare professionals (GPs, pharmacists and nurses) on how to conduct self care aware consultations.
3. Initiate a social marketing campaign to educate people to understand and manage self limiting conditions so that GPs' and practice nurses' time is freed up to look after more complex conditions.
4. Introduce a comprehensive health education package in schools to ensure future generations use the health service efficiently through the PSHE curriculum.

10 March 2010

---

### **Memorandum by Reform (SAV 03)**

#### REDUCTIONS IN THE COSTS OF THE PUBLIC SECTOR WORKFORCE, INCLUDING THE NHS

*(Extract from Haldenby, A. et al (2009), A front line. London: Reform)*

1. The Prime Minister and the Leader of the Opposition have said that they will cut public spending and protect frontline services. They are wrong for two reasons. The basic cost of frontline services means that the deficit can't be sufficiently reduced without tackling the front line. Research for this paper indicates that the public sector workforce needs to reduce by at least one million people (15% of the total) if the structural deficit is to be eliminated, over a period of years. Jobs will fall by the greatest amount in the services that have seen greatest increase, such as the NHS. The rates of natural wastage are so high that relatively few redundancies will be needed, although some will be.

2. Contrary to popular perception, the great majority of the public sector workforce are front line workers. Of the 1.4 million people working in the NHS, for example, only just over 200,000 provide administrative support. Since 1999, the central civil service has grown by 5% compared to a 30% rise in the NHS headcount.

3. More importantly, if public services are to improve radically, as all Parties want, then the front line needs to change radically too. Measures such as sickness absence and staff morale show that the public sector workforce performs significantly worse than the private sector. "Performance management" has meant answering to central targets rather than the real management task of achieving an outcome within a budget. Financial management is extremely weak. The root cause is a lack of accountability whether to the users of services, to local electorates or (for senior civil servants) to Ministers. Tackling the deficit means changing the public sector fundamentally, from unmanaged, bureaucratic, monopolistic and secretive to managed, accountable, competitive (where possible) and transparent.

4. Both Government and Opposition have rightly called for radical reform of public services that makes them accountable to their users. But with the exception of policing, both have fought shy of the actual policies that would deliver it. Both have pledged to hedge around reform of education and in particular health with limits and constraints. Opposition to change in the health service is especially misguided since it is the biggest budget of all and the service most in need of change.

5. It has to be different this time. The next government will have to achieve the radical reform which has eluded every other post-War government. A key lesson is that governments must seize the day and begin reform on day one when their political capital and mandate are at their highest. The challenge is so great that the next government should focus on the following key priorities in its first year:

- Harnessing a united Cabinet to the task. Only a united Cabinet can take through the programme of change across Government that is needed. An unequivocal demand for more for less from Ministers will support public sector managers who want to do the right thing. That means an end to spending commitments and opposition to reform, such as pledges to protect the NHS from change or make the NHS the preferred provider of care.
- Transforming the accountability of public sector workers. For senior civil servants, this means putting appointments in the hands of Ministers. For all public sector workers, it means an end to the culture of a job for life through transparent fixed term contracts and the end of generalised recruitment, such as the civil service fast stream. It means greater transparency over salaries, contracts and performance for every public sector worker and an end to the civil service monopoly of advice to Ministers. And it means removing barriers to competition and private sector delivery. The Bernard Gray review of the Ministry of Defence is a fantastic example of how independent advice can help Ministers understand the costs of departments and how to reduce them. Ministers need to repeat that for every department.
- Reforming the NHS. The NHS is the largest budget (£110 billion per year). Allowing costs to rise in the NHS defeats the purpose of making savings elsewhere. Good NHS managers are ready to reduce costs and improve access by shifting resources from expensive hospitals into more convenient local settings, but face political opposition. The NHS needs to be fundamentally depoliticised by giving people freedom to choose where their share of the NHS budget is spent, in practice by giving them choice of Primary Care Trusts.

6. Good public sector managers are ready to achieve more for less. They take for granted that costs can be reduced by 20% without reducing quality of service, by redesigning the front line. Equally government departments are preparing plans to reduce their spending by between 20% and 30% in the next Parliament. But they need political leadership to explain to the electorate the consequences of greater efficiency in the public sector, and to allow managers to manage. Ministers and their Shadows are not yet making that case for change. They still confuse the performance of services with their inputs, such as the size of the workforce.

7. In fact, reform will be positive for the public sector workforce. The current model traps public sector workers in low productivity employment. Reforming the front line will increase productivity and allow sustainable higher wages in the long term.

#### REDUCTION IN THE COST OF HOSPITAL SERVICES AND SERVICE REDESIGN

*(Extract from Haldenby, A. et al (2010), Fewer hospitals, more competition. London: Reform).*

8. The NHS should not be immune from the drive to reduce public spending. The structural deficit in the public sector is due to sustained over-spending and the largest part of that spending was targeted on the NHS. The NHS accounted for 40% of the increase in inputs across the whole public sector between 1997 and 2007.

9. The closure of hospital services, in most cases due to a redesign of service provision, will be one of the best ways for the NHS to reduce activities and control costs. It is consistent with the long term change in health needs. Since the conquest of infectious diseases 60 years ago, health services have defined their core business as short episodes of hospital-based treatment with the aim of reducing mortality from coronary heart disease and cancer. Now health services face the key challenge of improving quality of life for survivors with longer term conditions and reducing disability.

10. The NHS has been right to reduce hospital beds by over a third over the last twenty years, from 270,000 to 160,000. But these reductions have mainly been achieved in specialist care while the acute sector has only seen modest reductions since the early 1990s.

11. London, the North East and the North West have the highest density of hospital beds and should be expected to deliver the greatest closures of services. The North East has 4.13 beds for every 100,000 people compared to 2.54 beds in the South Central SHA. Similarly there is one acute trust site for every 73,000 people in the North East, compared to a ratio of one site for every 196,000 people in the South Central SHA.

12. The Department of Health asked Strategic Health Authorities to develop proposals to reconfigure services as part of the 2008 Darzi Review and, following the recession and the expectation of zero funding growth from 2011, called for updated plans by March 2010. The London Strategic Health Authority has published a plan to reduce bed numbers in the capital by a third, while other Strategic Health Authorities are currently developing plans to meet the spending squeeze.

13. The reconfiguration of services will be most effective if they are local initiatives carried out by locally accountable managers. But the current policy framework militates against this. While Primary Care Trusts are nominally in charge of individual reconfigurations, the Department of Health has sought to centralise decision-making over the last three years. As such, there is a risk that service redesigns become top-down exercises, which would not answer local needs and would lack local legitimacy.

14. A further constraint on the ability of Primary Care Trusts to effectively reconfigure services is the reluctance of Ministers and MPs to support local hospital reconfigurations. The Conservative Party is wrong to pledge a moratorium on service redesign should it win election. Such a moratorium will hold back the improvement in efficiency that the service needs.

15. The ability of competition to drive up health standards and productivity becomes especially important when service redesigns are being undertaken. Some take the opposite view, believing that greater competition will lead to greater capacity and so increasing cost. But this fails to consider the ability of competition to lead to productivity improvements. These can mean that the supply of health services can expand even when bed, ward and hospital numbers are falling.

16. In recent years NHS leaders have turned to integrated care as a model of health services that has the potential to deliver higher quality at reduced cost. However, without competition and reform on the front line, integrated care threatens to transfer bad working practices to another part of the system without reducing costs. Real innovation will come from reforming the front line, not simply driving change from the centre.

17. Key ways in which better standards and improved productivity could be driven in the health system include:

- Commission the service not the facility. Commissioning should not be used as a mechanism for protecting numbers of beds, wards and hospitals—commissioning should focus on health outcomes not inputs into the service.
- Commit to greater plurality in supply and reverse the “NHS preferred provider” policy. The ability of competition to drive better standards and productivity growth is crucial for ensuring that spending reductions do not lead to “salami slicing cuts” and a decline in quality.
- Commit to plurality of supply within existing settings—such as through approaches like service line management (where decision making and budgets are devolved to specific, clinically-led operational units).
- Ensure the rules for competition are clear, consistent and enforceable. This could involve asking the NHS Co-operation and Competition Panel to review existing provision (as well as changes to that provision).
- Incentivise service redesign through reform to make the NHS locally accountable and by clarifying the ability of Primary Care Trusts (PCTs) to retain some of the financial savings that they achieve from improvements in health outcomes and productivity. > Incentivise service redesign through considering reforms such as giving patients a choice of PCT (to ensure that ongoing pressures for service redesign reflect the preferences and needs of consumers).

*Andrew Haldenby*

Reform

March 2010

---

### **Memorandum by The King’s Fund (SAV 04)**

#### **PRODUCTIVITY IMPROVEMENT IN THE NHS**

The King’s Fund is a charity that seeks to understand how the health system in England can be improved. Using that insight, we help to shape policy, transform services and bring about behaviour change. Our work includes research, analysis, leadership development and service improvement. We also offer a wide range of resources to help everyone working in health to share knowledge, learning and ideas.

#### **BACKGROUND**

After a decade of unprecedented real growth in funding for the National Health Service, indications are that for the years up to 2012/13—and possibly up to the end of the next spending round in 2013/14—funding growth will be zero in real terms. Planned spending for the NHS in England for 2010–11 will increase by just 1.6% in real terms, and the Pre-Budget Report stated that for 2011–12 and 2012–13, while 95% of the English NHS budget will be “protected”—that is, a cash rise matching inflation—5% will be subject to small real reduction (HMT 2009). Overall, therefore, the NHS in England is likely to receive a small real cut in its total funding for (at least) the two years 2011–12 and 2012–13.

Both the Department of Health (Nicholson 2009) and an independent joint analysis by The King’s Fund and the Institute for Fiscal Studies (Appleby et al 2009) reach a similar conclusion about the demand and cost pressures on the English NHS up to 2013–14, with estimates of a funding gap valued at between £15 billion to £20 billion (at today’s prices) on a total budget of around £105 billion.

The King's Fund/IFS analysis identified the options for closing the gap between funding needed to meet funding recommended by Sir Derek Wanless's 2002 review (Wanless 2002) of the future funding needs of the NHS as singly or in combination: (i) cuts in other spending departments; (ii) increases in taxation; and (iii) increases in NHS productivity. Our view was that the last of these three was the most likely.

#### THE PRODUCTIVITY CHALLENGE

The KF/IFS analysis indicated that the productivity challenge facing the NHS for the three years from 2011–12 to 2013–14 amounted to around £21 billion by 2013–14. In other words, while the Wanless review suggested that funding for the English NHS would need to rise to around £126 billion by 2013–14 in order to deal with various demand and cost pressures, the likelihood was that actual funding would be frozen in real terms at around £105 billion.

Closing this gap would mean delivering productivity improvements of around 6% a year, each year for three years (including increases in productivity assumed by Wanless in his original review). Sir David Nicholson has noted that such productivity improvements are “extraordinarily challenging” (Health Select Committee 2010).

However, breaking down this gap reveals that to manage demand and cost pressures there are key policy decisions to be faced at national and local level over the next two to three years.

#### THE COST DRIVERS BEHIND THE WANLESS “SOLID PROGRESS” SCENARIO

Applying Wanless's original funding review analysis to the years 2011–12 to 2013–14 and assuming no real growth in NHS funding it is possible to estimate the elements that constitute the total funding gap of around £21 billion (see table 1).

**Table 1**  
DECOMPOSITION OF THE ENGLISH NHS FUNDING GAP: 2011–12 TO 2013–14

<i>Cost driver</i>	<i>Explanation</i>	<i>Value (£bn)</i>
National Service Frameworks (NSFs)	Best practice in five NSF disease areas and extension to other areas	2.4
New NSFs	Costs of new NSFs, improvements to existing NSFs and medical technology	9.6
Waiting times	Costs of ongoing reduction in maximum inpatient and outpatient waiting times	1.4
Clinical governance	Reducing hospital-acquired infections, adverse incidents and avoidable admissions	0.4
Capital	Replacement of NHS estates, equipment and improved facilities, including ICT	1.6
Demand drivers	Including health-seeking behaviour, demographic change and ill health in old age	1.8
Real pay and prices	Growth in pay and prices over and above general inflation	3.5
<b>Total Increase</b>		<b>20.7</b>

These cost drivers are broken down in more detail below.

- *Real pay and prices*: Wanless made assumptions about increases in pay (a 2.5% real pay increase over and above inflation) and the prices paid for products such as medicines. These pay and price increases account for £3.5 billion of the gap by 2014. More aggressive procurement could drive down non-pay costs, while pay could be frozen. In fact, the Pre-Budget Report effectively announced that the intention is for a cash cap on public sector pay rises for two years from 2011 of just 1%.
- *Demand drivers*: demand drivers—such as changes in population, people's health and health-seeking behaviour—represent a relatively small component of the financial gap (£1.8 billion by 2014). Evidence from new models of care in the community suggest there are opportunities to reduce non-elective admissions to acute hospitals and there may also be opportunities through referral management to reduce elective demand.
- *Capital*: assumed growth in capital expenditure to improve NHS infrastructure, etc accounts for £1.6 billion of the gap in 2014, a relatively small component of the whole. Part of the cost growth assumed by Wanless was based on the target that 75% of beds would be in single en-suite rooms. While there is ongoing investment in reducing the level of mixed-sex accommodation, given the funding available it seems unlikely that a move to single rooms on this scale could remain a priority. It can be argued that much of this capital investment has already been met with unprecedented increases in new buildings including in primary care over the last decade (Wanless *et al* 2007).

- *Quality improvement*: Wanless made assumptions that the efforts to reduce variability in service quality and raise standards across the country in a range of disease areas, primarily through the application of national service frameworks, would continue. These quality improvements account for over half of the funding gap (around £12 billion by 2014). The very significant proportion of the increases in funding needed to roll out national standards of care flags the importance of setting clear priorities about where improvement has to happen and how that can be done at lower costs. There may be scope to deliver quality improvements through productivity gains and new ways of working—with some improvements in quality also contributing to savings in resources that can be redeployed to meet other demands and priorities.
- *Waiting times*: Wanless assumed significant reductions in waiting times—to a maximum of just two weeks from GP referral to treatment in hospital by 2022–23. The NHS has achieved a maximum 18-week referral to treatment waiting time, four-hour A&E waits, and urgent cancer patients are seen within two weeks. Given these achievements, it is arguable whether further reductions are a priority (or indeed would be valued by patients over and above other investments in improving quality of care) and hence whether the estimated investment of around £1.4 billion by 2013–14 is necessary.

## CONCLUSION

Although broad estimates, the decomposition of the £21 billion funding gap in table 1 suggest that taking decisions in three key areas—freezing pay and pursuing more aggressive procurement, not pursuing further reductions in waiting times and reducing assumed growth in capital investment—could reduce this shortfall by around £6.5 billion, to a total of around £14 billion by 2013–14. This is equivalent to productivity improvements of around 3 to 4% year, rather than 6%. However, given the NHS record on productivity over the past 10 years, this still poses a real challenge for the service.

## REFERENCES

Appleby, Crawford, Emmerson (2009). *How Cold Will It Be? Prospects for NHS funding 2011 to 2017*. London: The King's Fund/Institute for Fiscal Studies. Available at: [www.kingsfund.org.uk/publications/how\\_cold\\_will\\_it\\_be.html](http://www.kingsfund.org.uk/publications/how_cold_will_it_be.html)

Health Select Committee (2010). "Public expenditure on health and personal social services 2009: Uncorrected transcript of oral evidence". To be published as HC 269-ii. Available at: [www.publications.parliament.uk/pa/cm200910/cmselect/cmhealth/uc269-ii/uc26902.htm](http://www.publications.parliament.uk/pa/cm200910/cmselect/cmhealth/uc269-ii/uc26902.htm)

Her Majesty's Treasury (2009). *Securing the Recovery: Growth and Opportunity. Pre Budget Report, December 2009*. Cm 7747. London: The Stationery Office. Available at: [www.hm-treasury.gov.uk/d/pbr09\\_completereport.pdf](http://www.hm-treasury.gov.uk/d/pbr09_completereport.pdf)

Nicholson D (2009). *The Year: NHS Chief Executive's 2008–09 Annual Report*. London: Department of Health. Available at: [www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_099700.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_099700.pdf)

Wanless D, Appleby J, Harrison A, Patel D (2007). *Our Future Health Secured? A review of NHS funding and performance*. London: The King's Fund. Available at: [www.kingsfund.org.uk/publications/our\\_future.html](http://www.kingsfund.org.uk/publications/our_future.html)

Wanless D (2002). *Securing our Future Health: Taking a long term view. A final report*. London: HM Treasury. Available at: [www.hm-treasury.gov.uk/consult\\_wanless\\_final.htm](http://www.hm-treasury.gov.uk/consult_wanless_final.htm)

*Professor John Appleby*  
Chief Economist  
The King's Fund

March 2010

---

## Memorandum by the NHS Institute (SAV 05)

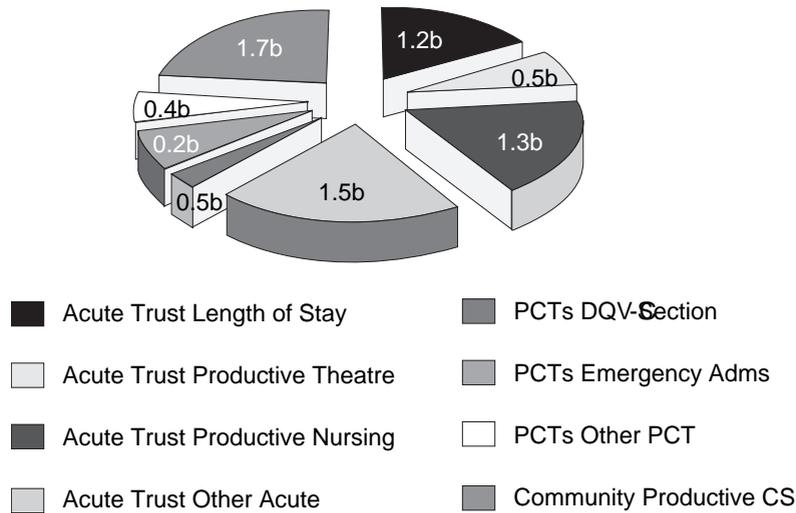
### SAVINGS IN THE NHS

#### BACKGROUND TO THE NHS INSTITUTE

Having been formed four years ago from the merger of the Modernisation Agency, the NHS University and the NHS Leadership Centre, the NHS Institute is a young organisation that has rapidly evolved and developed with a strong reputation both nationally and internationally for producing high quality products and services that drive innovation in improvement in healthcare. Latterly, following both the demands of its customers and the direction provided from its sponsors in the Department of Health the NHS Institute has focused all of its work on supporting NHS organisations to improve quality and productivity in response to the financial challenges facing the country as a whole.

## ACHIEVEMENTS TO DATE

The NHS Institute was assessed independently by the Department of Health as having developed three out of the six interventions within the whole of the NHS with the greatest probability of delivering productivity and quality improvement at scale. Our own research suggests that if these approaches were implemented at scale the gains to the NHS would be of the order of £6–£7 billion:



£7.3 billion potential based on contributions from:

£4.5 billion Acute Trusts

£1.1 billion PCTs

£1.7 billion Community Services

## FROM IMPROVING QUALITY AND VALUE TO RELEASING CASH

### THE POSITION PRE RECESSION

The NHS Institute was founded and did much of its early work in an environment characterised by a benign external financial position and increasing funding for the NHS year on year. In this environment the primary focus of our products and services was to release the time, energy and capability of NHS staff so that it could be better focused on patient care. A range of approaches was used. These included:

1. Benchmarking data—allowing organisations to compare themselves with best in class eg. through the development of the Better Care Better Value indicators.
2. The introduction of Lean techniques into the NHS combined with innovative approaches to ensure buy in and ownership by frontline staff eg. the “Productive Series”.
3. Identification, for some of the highest volume care pathways of those characteristics that differentiate highly productive care pathways from less productive ones—the High Volume Care Series.
4. The embedding of improvement approaches into leadership programmes both for senior managers and clinicians eg. the Delivering Through Improvement programme and the Medical Leadership programme.
5. The use of innovative diagnostics to identify avoidable patient harm and through an organisation wide training programme to develop and support the implementation of a holistic approach to patient safety.

### THE POSITION POST RECESSION

In the current environment it is inevitable that the business case for change will shift towards releasing cash and supporting large scale movement in patient activity from secondary care to primary care settings. We believe that the NHS Institute’s products and services are equally relevant in this environment. However they will only be effective if they are implemented as part of an integrated cost savings programme underpinned by strong leadership and a positive staff culture. Used this way we believe that we will be able to support NHS organisations to reduce cost safely and to reduce the risk of adversely affecting patient outcomes, quality and patient experience sometimes associated with more traditional cost reduction approaches. Nonetheless, it should be pointed out that this case is less established than the pre recession case.

---

## CHARACTERISTICS OF SUCCESSFUL PRODUCTIVITY IMPROVEMENT INITIATIVES

The NHS Institute believes that such change programmes are most likely to be successful when the following components are present and aligned:

- Strong consistent leadership framing the productivity and quality challenge to staff, partner organisations and the wider community in positive and unifying ways rather than simply focusing on cost cutting.
- Measurement at every level in the system which enables staff to gain feedback regarding the impact of their actions and supports them in fine tuning improvement activities to suit their local situation.
- Tools and techniques with a strong evidence base and a proven track record of successful development and implementation within the NHS.
- Capacity building—to ensure that staff, whether clinicians, managers or frontline workers have the right knowledge, skills and attitudes to make the necessary changes.

## SOME EXAMPLES

The Productive Ward is the NHS Institute's best known product. Co-produced with frontline clinicians it draws on the principles of approaches such as Lean and Six Sigma and applies them to the NHS. Ward staff are given tools such as observation (eg. how to video ward activities), measurement (eg. how to create display boards to show patient status at a glance) and improvement methods. This helps them identify and eliminate waste: after implementing the programme, typically around 15% of additional ward staff time is available for direct patient care activities. At the same time patient satisfaction improves and there is strong evidence that the programme contributes to improving patient safety.

### *High Volume Care—total knee*

This programme was co-produced with orthopaedic clinicians from a range of disciplines and takes a total clinical pathway approach to identify those actions which statistically are most likely to contribute to reductions in length of stay and improvements in patient satisfaction. For example, it has been shown that early mobilisation of patients following surgery is one of the single most important actions that differentiate highly productive from less productive units: everything from the first outpatient appointment to discharge embeds that objective and in particular the availability of high quality physiotherapy services is given very high priority.

### *Leading Improvement in Patient Safety (LIPS)*

This programme's objective is to help build an NHS where every member of staff has the passion, confidence in skills to eliminate the possibility of harm to patients, by helping NHS teams to develop the capacity and capability to improve patient safety. This is an organisation wide leadership and skills development programme which promotes the use of the global trigger tool (used for case note reviews) to identify and then reduce preventable harm to patients. The underlying assumption is that safer care is more cost effective care (since patient errors cost money to rectify). As a consequence we see this programme as underpinning the overall objective of reducing cost safely.

## SUMMARY

Much of the evidence created to date has been produced during a benign financial environment when the focus of improvement has been to increase the proportion of time spent on patient care activities rather than to reduce cost. We believe that the same principles should be applicable to much more challenging current financial environment but this will only be effective if the NHS Institute's products and services are implemented as part of an overall cost reduction programme. In other words, the NHS Institute can help organisations reduce costs safely in a way which minimises the impact on quality; it cannot on its own deliver the level of cost savings required.

Our evidence suggests that to deliver sustainable improvement as much attention has to be paid to winning the hearts and minds of staff and ensuring that they are deeply involved in the implementation process as in designing and disseminating technical solutions. The NHS Institute has adapted many successful social movement techniques to suit the context of the NHS; it will require consistent leadership at national, regional and local levels to ensure that as the financial impacts begin to be felt more severely there is not a reversion to traditional pure cost cutting approaches.

Our experience also indicates that although there is much expertise in the NHS there are also many areas where there are substantial gaps in capacity and capability and these will need to be strengthened in order to achieve mobilisation at scale.

March 2010

---

## Memorandum by Professor Alan Maynard (SAV 06)

### SAVING MONEY IN THE NHS

Alan Maynard is a Professor of Health Economics, Department of Health Sciences and Hull-York Medical School, University of York and Chairman of the York Hospitals NHS Foundation Trust.

#### SUMMARY

1. Proposals to increase NHS income by widening user charges are inefficient, inequitable and merely shift cost burdens from government to patients.

2. Proposals to manage more efficiently, existing contracts of employment (ie Agenda for Change, the GP-Quality Outcomes Framework and the new consultant contract) could increase productivity significantly but will take time to implement and will be opposed by labour unions, particularly the BMA and RCN.

3. Proposals to alter skill mix have the potential to economise the use of resource, eg by employing fewer GPs and replacing them with practice nurses. The nice management issue is to ensure that this is real substitution rather than investment in complements which meet previously unmet need and inflate expenditure.

4. With labour typically comprising 70% of costs in primary and secondary care and patient demand continually increasing, redundancy/dismissal/ non replacement of departing staff may affect local capacity to deliver patient care. Consequently strict income controls are inevitable not just to limit incremental drift but also to reduce wage costs by cuts in remuneration, particularly amongst higher earners.

5. Proposals for better management of variations in the type and quantity of health care delivered to patients with similar needs and personal characteristics have been advocated for at least three decades. These could produce significant savings but will take time to implement as powerful “dinosaurs” will have to be confronted by evidence based clinical guidelines, rigorous audit and improved incentive systems.

#### INTRODUCTION

The competing political parties have pledged to at least maintain NHS funding but on occasion there is some ambiguity as to whether their undertaking are for “flat cash” across time, which with inflation would erode funding, or whether this is for at least maintaining real levels of funding. Whatever their intentions, their performance may be dictated by macro-economic factors outside their control.

The Department of Health has “guesstimated” a figure of £15–20 billion that has to be freed up over the next three years in order to manage increased patient demand and the inflationary effects of technological change fuelled by the public’s expectations of longer and better quality lives. These guesstimates are the product of McKinsey’s alchemy using data from the NHS, in particular the NHS Institute for Innovation and Improvement. These data focus particularly on practice variations and assume that these long chronicled characteristics of the NHS can be managed down significantly in the short run, when they have resisted management efforts for a decade!

This short paper deals with three aspects of NHS income and expenditure. Firstly, it addresses the potential for increasing income flows by shifting some of the burden of expenditure to households with “user charges”. The second section addresses the issue of driving down the price of inputs such as labour and pharmaceutical products so that volumes of activity are potentially unaffected. The final section focuses on the quantities of service being delivered and the potential for freeing up resources by reducing variations in clinical practices.

#### 1) *Increasing NHS Income*

Whenever there is a “crisis” in a health care system across the world some “innovator” is prone to resurrect the notion of user charges for patients. The Canadian economist Professor Robert Evans has likened this to “zombie” policy making, in which whenever a policy idea is refuted by logic and evidence, it tends to reappear as “novel” idea from some self interest group!<sup>1</sup>

The reasons put forward by advocates of user charges, or what Americans call copayments (a charge related to the percentage of the cost of care) and deductibles (a charge of a particular lump sum) usually involve the following assertions:

- i) that user charges will raise additional funding for the health service; counter argument: that user charge income will be seen by HM Treasury as a substitute for tax funded expenditure which will be reduced in line with user charge income;
- ii) that user charges will reduce wasteful consumption of health care; counter argument: if there is waste in a health care system it is the product of clinical responses to patients’ demands. The first contact with the NHS is usually initiated by the patient, subsequent use of NHS facilities in primary and secondary care is largely determined by doctors and nurses. If there is waste in the system that is a product largely of clinical behaviour, not the patients;

- iii) that user charges will reduce “unnecessary” patient demand; counter argument: whilst some patient demand may be the product of loneliness and depression, particularly amongst the elderly, most demand by patients is seen by them as necessary and a product of their feelings of illness. Using prices to dissuade patient demand is known to reduce utilisation but has a differential effect on the poor and elderly, and may dissuade patients from early consultation and treatment which raises subsequent costs and may reduce the patient’s length and quality of life; and
- iv) that user charges will reduce the size of the government sector; counter argument: whilst some ideologues continue to assert “government bad, private good” both sectors are funded by the same source: households. Shifting financial burdens from one to another may serve ideological preferences for small government and may also facilitate shifting the financial burden from the more affluent to poorer sections of the community. These distributive impacts should be carefully analysed to determine whether they are consistent with society’s goals.

The opponents of user charges emphasise that their advocacy can often be identified as either provider groups seeking to maintain their income (eg the pharmaceutical industry) or libertarian groups anxious to reduce the role of government.

A group of Canadian economists have reviewed the evidence on user charges and conclude:<sup>2</sup>

“In the present structure of health care delivery, most proposals for ‘patient participation in health care financing’ reduce to misguided or cynical attempts to tax the ill and/or drive up the total cost of health care while shifting some of the burden out of government budgets”.

Thus if government is interested in disadvantaging the poor and elderly who are ill and potentially driving up the cost of health care, user charges may be a sensible policy! Public opposition to such distributive outcomes has in the case of prescription charges led to large exemptions from charges with only 15% of prescriptions being charged.

Given macro-economic difficulties and the potential demands of the IMF if there is a run on the pound, user charges may yet again become part of policy reform if there are demands to reduce the size of the public sector and shift costs to private individuals.

## 2) *Reducing the prices of NHS inputs*

### i) pharmaceutical pricing and NICE

Since 1957 a series of “voluntary” between the Department of Health and the pharmaceutical agreements have regulated the profits of firms with production facilities in the UK. The regulation, known as the Pharmaceutical Price Regulation Scheme (PPRS), regulates the profits of firms and leaves them free to set prices. PPRS sets a target rate of return on historic capital at usually generous levels around 20%. If companies bring a new product to market they are free to set the price subject to their overall profit level not exceeding the margins of discretion around 20%.

Since 1999 the National Institute for Health and Clinical Excellence (NICE) has carried out economic evaluations of new drugs coming to the market as part of their programme of technology appraisal. The drug firms obviously seek the highest rate of return on investments in new drugs and as part of the appraisal process have to set a price. Thus they model the benefit or QALY gain and then presumably set the highest price possible to come within NICE’s rationing criteria of £20,000–30,000 per QALY. Thus when conflict erupts over NICE decisions it may often be because this price setting is overly “optimistic”.

This tradition of protecting the UK pharmaceutical industry with PPRS subsidies is a rational part of industry policy. Attracting companies to work in the UK employs skilled labour, generates invest and contributes to exports. However leaving NICE as a price taker rather than as a price maker means that it cannot negotiate prices with the industry. When conflict over a NICE decision arises, the NHS regulator is criticised by patient groups when it may be more appropriate for them to focus on the “optimistic” prices set by industry, which is more modest might make products more cost effective and within the NICE rationing ceiling of £30,000 per QALY.

In addition to the expensive drugs that are patented there are also some issues about generics which make up the bulk of NHS consumption, particularly in primary care. Once patents expire competing firms can produce the product. The nice policy issue is ensuring that the multinationals do not try to extend patents by methods of dubious legality and that there is a competitive market in the products supply with incentives for rivals to supply at minimum cost and price. Occasionally it is alleged that measure of dubious legality and the control of generic subsidiaries of the major companies can retard price reduction.

### ii) pricing labour

The major consumers of NHS budgets are hospitals and typically over 70% of their costs arise from paying labour: doctors, nurses, ancillaries, porters, cooks, therapists and managers. During the last five years a series of pay reforms have radically increased labour costs and are characterised by failure to manage the contracts to produce increased productivity and higher quality of care.

Thus the first question to address is how, within these contracts, productivity might be increased without incurring additional costs, or even with cost savings. The second question to be addressed in this section is given that contract enforcement and reform will take time, how can costs be reduced? The succinct answer to this is of course is emulation of private sector economy ie offering employees the choice between either wage cuts (or at least wage standstills for some years) and greater job security or redundancy.

## ENFORCING EMPLOYMENT CONTRACTS

### 1. *Agenda for Change*

Agenda for Change (A4C) integrated NHS pay grades and involved the allocation of all staff to appropriate bands which determined their pay status. The original agreement between unions and employers was that re-banding and pay increases were being given in exchange for skill improvement and increased productivity. The task of banding was complex with many appeals occupying scarce managerial time. Pay increased but the knowledge and skills part of A4C has failed to happen in any significant manner.

Furthermore A4C brought with it an obligation for hospitals to appraise their workforce and use these appraisals to determine progression through incremental gateways. Appraisal has not been developed systematically and as a consequence there is incremental inflation each year as employees' progress automatically up the pay scale.

Between 2005–08 A4C cost over £4 billion to implement (Public Expenditure 2009, table 75a, Select Committee on Health). 2010–11 is the final year of the current A4C contract and pay increases in excess of 2% have to be paid even though, given the effects of recession and likely public spending cuts, many managers would like to save this considerable expenditure.

The rigorous application of appraisal and control of the A4C gateways up incremental scales of pay is now increasingly seen by management as an imperative. This delay has made employees richer and the NHS poorer. There remains the nice issue of the absence of productivity gain through skills and knowledge acquisition pledged by both parties to the A4C contract.

### 2. *Primary care and the GP contract*

GPs are employed either on the old contract which is capitation based or the PMS which is salaried. About 35% are paid on the PMS and the rest are capitated.

The PMS was implemented by the Conservative Government and one of its functions was to attract GPs to under doctored areas. The use of the PMS contract is a PCT function and it is they who can define and enforce its content. There is evidence of continuing variation in PMS performance eg variations in statin prescribing for populations of similar characteristics and need. This is a product of the PCTs' incapacity and/or unwillingness to enforce the contract on GPs in their employment. Such enforcement could produce improved health at little or no cost.

The new 2005 GP contract was negotiated between the BMA and NHS Employees and involved two significant reforms: out of hours (ooh) and the quality outcomes framework (QOF). The traditional NHS contract for GPs obliged them to provide patient cover 24/7 for 365 days a year. They provided out of hours coverage by hiring locums or by forming collaborative cooperatives across practices. This obligation was regarded as onerous by GPs and the BMA negotiated a remarkable change in 2005 which meant that each GP gave up £6000 and in exchange was relieved of ooh duties.

As a result of this bargain, PCTs had to contract for ooh cover at prices of around £100 per hour. They thus incurred considerable additional expenditure and often faced difficulties in recruiting practitioners to work at these times. The new GP contract obliged practices to be open from 8 am until 6.30pm on weekdays. Cynics comment that again they may be "open" but no care may be available! This is a nice challenge for PCT contract enforcement also as real opening hours do vary significantly.

Then QOF is an incentive scheme which pays GP practices to deliver largely preventive screening interventions (which good practices should have been delivering anyway, and of course some were!) The original formulation covered ten clinical areas and allocated unequally 550 points to each area. The achievement of performance levels in each category by the practice generated points each worth £75 each originally and subsequently £125.

The actions required are set out in table 1 and the allocation of points across the 10 clinical areas is set out in table 2.

**Table 1**

## UNITED KINGDOM QUALITY OUTCOMES FRAMEWORK (QOF) FOR PRIMARY CARE, 2004

<i>Disease</i>	<i>Performance indicator</i>
Asthma	% of patients with asthma who have had an asthma review in the previous 15 months
Cancer	% of patients with cancer reviewed within six months of confirmed diagnosis
Chronic obstructive pulmonary disease (COPD)	% of patients with COPD with diagnosis confirmed by spirometry and reversibility testing
Coronary heart disease (CHD)	% of patients with CHD whose last blood pressure measurement was 150/90 mm Hg or less
Diabetes	% of patients with diabetes whose last blood pressure measurement was 145/85 mm Hg or less
Hypertension	% of patients with hypertension with last blood pressure measurement was 150/90 mm Hg or less
Hypothyroidism	% of patients with hypothyroidism with thyroid function tests recorded in the previous 15 months
Mental health	% of patients with severe long-term mental health problems reviewed in the preceding 15 months

**Table 2**

## GP CONTRACT QUALITY FRAMEWORK A: CLINICAL INDICATORS 2004

— CHD	121
— Stroke	31
— Cancer	12
— Hypothyroidism	8
— Diabetes	99
— Hypertension	105
— Mental health	41
— COPD	45
— Epilepsy	16
— <b>Total</b>	<b>550</b>

The effects of this incentive scheme were impressive with most practices achieving their targets and increasing their funding in the first year of the QOF's operation. This gave GPs a percentage real cash increase in income of 19.5% in 2004–05 (Select Committee (2010) Public Expenditure, table 73e) and increased GMS spending by £1 billion. Subsequently government has sought to claw back some of this excess eg in 2008–09 they cut expenditure on the Minimum Practice Income Guarantee, which essentially guarantees practitioners' income but not their activity, from £285 to £130 million.

The scheme has been evaluated quite well and this confirms its success in not only increasing activity in the ten clinical areas but also reducing the variation in performance across GP practices.<sup>3,4</sup>

However the scheme has been criticised:

- the allocation in points (table 2) is related to “experts’” guesstimates of the administrative burden of each activity, rather than the health gain that each intervention might produce;
- in some cases the clinical areas incentivised were not related well to the evidence base about potential health gain.<sup>5</sup> Now NICE has been charged to identify a better evidence set of indicators;
- it remains unclear what the opportunity cost of the QOF may have been ie by incentivising the QOF activities, what activities and health gain (if any) were given?
- the GP-QOF incentivised doctors but the interventions could all have been provide by nurses and in many cases were. Why did government incentivise GPs when nurses may have delivered these services more cost effectively?<sup>6–8</sup> The reluctance of policy makers to innovate radically is an expensive problem.

### 3. *Primary care delivery by nurses*

This concluding issue raises a nice challenge for an NHS facing financial problems ie should nurses be substituted for GPs in primary care? The evidence base demonstrates that much of primary care may be delivered by suitably trained nurses. The literature on this is long, starting with the work of W.O Spitzer in Canada in the 1970s.<sup>9</sup>

The authors of the Cochrane review conclude that these nurses can “produce as high quality care as primary care doctors and achieve good outcomes for patients”. However they note that this conclusion is derived from a small number of robust studies and that such substitution may not save money if it is not well managed. Cost savings may not be produced if the nurses focus on previously unmet need, in which care costs may increase.

This Cochrane review was published in 2005 and confirms the findings of previous overviews of the literature.<sup>7</sup> Despite their noting the paucity of evaluative evidence, there continues to be poor investment in the robustly scientific evaluation of such skill mix changes.

Given the current economic situation and the casual evidence of continuous and extensive changes being made in skill mix (eg as a result of the GP = QOF) it is imperative that substitution the costs and benefits of substitution possibilities in primary care (and secondary care: see below) are evaluated more extensively. This will be particular so if NHS primary care is put out to tender and private companies enter the market using nurse led provision. Such catalysts for change should be obliged to demonstrate value for money.

### 4. *The consultant contract*

Over the last decade the number of consultants working in the NHS has increased but average productivity in terms finished consultant episodes (FCEs) has declined steadily. Hospital consultants are doing less but as a result of the 2005 contract are being paid more! One possible explanation of this remarkable statistics is that the pursuit of safety and other regulatory controls slows activity rates. Another is that they are being paid more, to do less and we are unsure whether this is of better quality because, as yet, patient reported outcome data (PROMs) are not available.

The consultant contract offers the NHS management the potential to improve the transparency and accountability of practitioners. However these attributes of the contract have not been exploited by the profession or by management colleagues.

The basic consultant contract is for 10 “Programmed Activities” (PAs) of four hours. An additional two PAs can be bought from consultants so that their maximum contracted hours with the NHS would be 48. The basic 10 PA contract is divided into 7.5 clinical PAs and 2.5 Special PAs (sPAs). There are some nice contentious issues about what activities go into these two sections of work, and the transparency of all PAs. Their management is based on “job plans” which indicate what each practitioner is supposed to do but the nice issue is to what extent job plans determine activity. For instance do practitioners do their clinical sessions and within each clinical session what activity is undertaken eg if the session is in theatre, what is the list size and complexity mix?

The nice attribute of the 2005 contract is that these activity issues can and should be managed explicitly by individual practitioners, by clinical teams and by general management. However this does not appear to happen in a systematic manner. For instance sPAs tend to be a “black hole” of clinical discretion where the conscientious may do more patient care and systematic audit (often in excess of their contracted time) and the less conscientious may consume “on the job leisure” and not participate in clinical audit and systematic service improvement.

Given the emergence of comparative activity (from HES), cost (PLICs or patient level individual costs) and outcome data (both standardised mortality rates (SMRs) and patient reported outcome data (PROMs)) it is essential to feed this data to clinicians and get them to manage the problem of poorly performing outliers. This can and should be done through clinical audit where the new 2001–11 Quality Accounts require increased transparency about audit involvement, and through local appraisal and GMC reaccreditation. This should build on the recognition that the principle group allocating resources between competing patients is the doctor body, and it is upon them that reform efforts should focus.

This focus can be enhanced by the reform of the clinical excellence award (CEA) scheme. This consists of local awards of up to nine points cumulatively, initially worth around £3,000 pa and pensionable, and subsequently more, and a national system which can increase income by in excess of £75,000.

At present local CEAs are allocated by colleagues, with minimal input from management. National awards are also dominated by clinical colleagues. Whilst some clinical input is useful, it should not dominate but more importantly the awards should be linked to performance shown in HES, PLICs and PROMs. Currently the CEA system is a scandalously inefficient use of taxpayer’s resources.

### 5. Pay Cuts and Contracts

The suggestions discussed above to improve contractual enforcement will be opposed by unions, will take time to implement and may increase transaction costs. Given the nature of the macro-economic climate, more urgent action may be necessary.

The present government has already announced a 1% pay increase for the public sector in 2011–12. David Nicholson has emphasised before the Select Committee that this should be seen as “a ceiling and not an entitlement”.

The airline industry is a nice example of income-job tradeoffs being made in the private sector. Aer Lingus recently made several hundred employees redundant and cut wages by 10%. British Airways is currently also facing the need for a similar policy. The application of such policies in the UK public sector has been retarded by the forthcoming election. However harsh jobs-pay trade-offs seem unavoidable. The political challenge will be to protect low paid workers, who form the majority of employees in the public sector, from harsh cuts.

A salary standstill for managers has already been decided and the Review Bodies proposals for 2010–11 have been cut by government to minimal levels. The Prime Minister has asked the Review Bodies to scrutinise high public sector pay for June 2010 and this may bring downward pressure on doctors and managers’ salaries.

An additional burden is pensions. It has been proposed in an F.T.Network discussion document that salaries should no longer be pensionable above £100,000. These and other suggested measures (eg the abolition of clinical excellence awards and improved control of incremental drift) will be needed to stem the increases in remuneration and pension costs associated with unavoidable future organisational change.

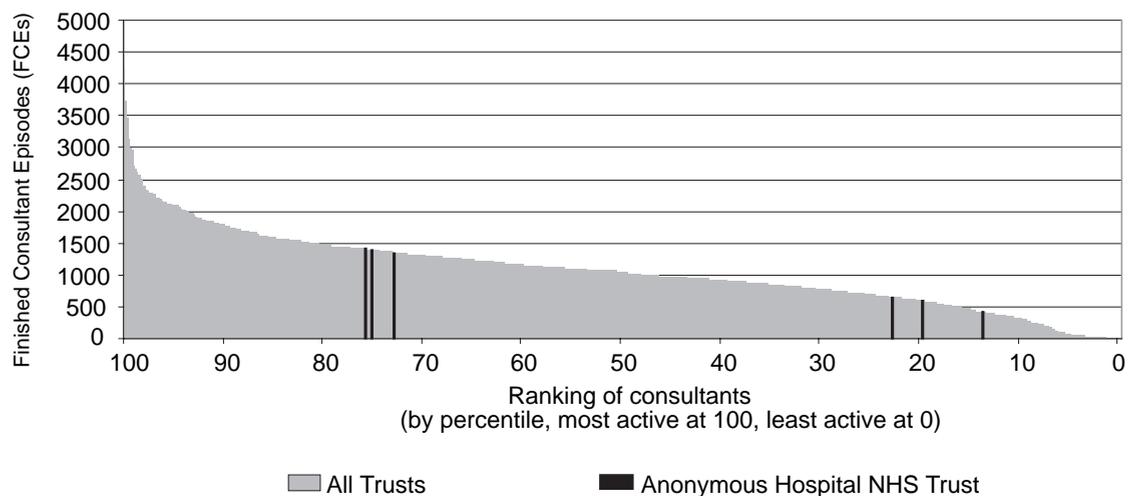
### 6. Reducing variations in the quantity of health care delivered to patients

For decades both researchers and policy makers have emphasised the potential for resource savings in reducing clinical practice variations. Clinicians tend to treat similar patients with similar clinical needs in very different ways. In 1976 the Department of Health and Social Security (DHSS 1976) noted that reductions in variations in hospital length of stay could save £40 million and that surgery for hernia repairs could be carried out as day surgery as shown in a Lancet article in 1955.<sup>10</sup> Since then these messages have been continuously reiterated, most recently in the Darzi report.

Sadly routine NHS information is all too rarely used to analyse variations. Take for instance graphs 1 and 2 which show variations in clinical activity in general surgery. The data from which these are derived, hospital activity statistics (HES), has been collected since 1989 but been largely ignored by NHS managers and clinicians. Table one measures finished consultant episode (FCE) activity on the vertical axis and, from right to left, 10% groups or deciles of surgeons in relation to their FCE activity. Table two measures activity in cost-value (HRG) terms. The six vertical lines in each diagram are the relative performances of six consultants in a particular trust, indicating local variation in the context of national variation.

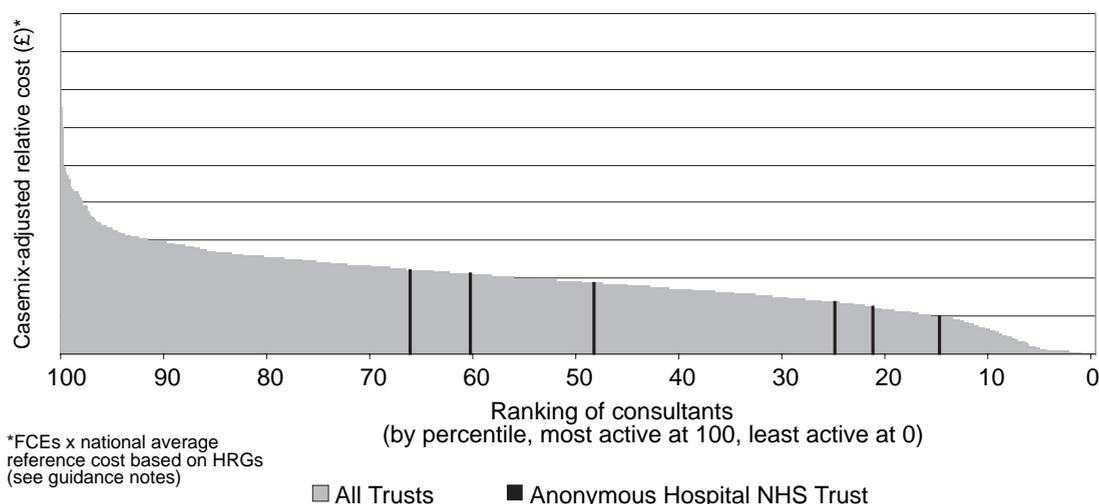
**Graph 1**

VARIATION IN ACTIVITY IN GENERAL SURGERY: FCES



Graph 2

## VARIATION IN ACTIVITY IN GENERAL SURGERY: HRG/COST ADJUSTED



As can be seen from there is considerable variation, begging the questions why and what do local managers and clinicians do to shift the mean/average and reduce dispersion around the mean? Over the last decade average FCE activity of NHS consultants has, according to HES, declined considerable despite considerable pay increases!

In the USA Jack Wennberg of the Dartmouth Medical School first courted peer disapproval for his analysis of clinical practice variations in Medicare in 1973, His colleagues such as Elliot Fisher and David Goodman continue to advocate policy reform to reduce these variations, emphasising that the waste they involve if eradicated would free up billions of dollars.

Whilst government initiatives through the NHS Institute for Innovation and Improvement, Quality Accounts and CQUIN bring greater policy focus on clinical practice variations, the benefits of this work will take time to emerge and their costs are unknown. Investment in reducing variations is vital if carried out with care and evaluation, thereby prioritising expenditure efficiently.

## CONCLUSION

It is time to challenge the dinosaurs that resist contract enforcement, challenges to clinical practice variations and innovative and potentially cost effective changes in skill mix. Engineering these changes will be difficult in a period of wage restraint if not wage decline. But hopefully we can do better than over the last three decades when established inefficiencies have been left unchallenged.

## REFERENCE LIST

1. Evans RG, Barer ML, Stoddart GL, and Bhatia V. Who are the zombie masters, and what do they want? Vancouver, BC: Health Policy Research Unit, University of British Columbia, 1993.
2. Stoddart GL, Barer ML, and Evans RG. User charges, snares and delusions: another look at the literature. Toronto: Ontario Premier's Council on Health, Well-Being and Social Justice. 1994.
3. Doran T, Fullwood C, Gravelle H, Reeves D, Kontopantelis E, Hiroeh U, and Roland M. Pay-for-performance programs in family practices in the United Kingdom. *N Engl J Med.* 2006;355(4):375–384.
4. Doran T, Fullwood C, Kontopantelis E, and Reeves D. Effect of financial incentives on inequalities in the delivery of primary clinical care in England: analysis of clinical activity indicators for the quality and outcomes framework. *Lancet.* 2008;372(9640):728–736.
5. Fleetcroft R and Cookson R. Do the incentive payments in the new NHS contract for primary care reflect likely population health gains? *J Health Serv Res Policy.* 2006;11(1):27–31.
6. Lankshear AJ, Sheldon T, Maynard A, and Smith K. Nursing challenges: are changes in the nursing role and skill mix improving patient care? *Health Policy Matters.* 2005;(10)
7. Horrocks S, Andersen E, and Salisbury C. Systematic review of whether nurse practitioners working in primary care can provide equivalent care to doctors. *British Medical Journal.* 2002;324(7431):819–823.

8. Sibbald B, Shen J, and McBride A. Changing the skill-mix of the health care workforce. *J Health Serv Res Policy*. 2004;9 Suppl 1:28-38.
9. Spitzer WO, Kergin DJ, Yoshida MA, Russell WA, Hackett BC, and Goldsmith CH. Nurse practitioners in primary care. 3. The southern Ontario randomized trial. *CMAJ*. 1973;108:1005.
10. Farquharson EL. Early ambulation; with special reference to herniorrhaphy as an outpatient procedure. *Lancet*. 1955;269(6889):517-519.

March 2010

---

**Memorandum by Dr Jonathan Fielden (SAV 07)**

**VALUE FOR MONEY AND THE CONSULTANT CONTRACT**

*The following comments are personal, based on my understanding of the contract and involvement from 1998 initially peripherally and increasingly centrally to the contract implementation and on going training. The comments relate mainly to the English contract. There are similarities to the Scottish contract (other than in clinical excellence awards—they retain the discretionary points system); and the Northern Ireland contract. The Welsh contract remains very similar to the 1948 consultant contract.*

**BACKGROUND**

The 2003 consultant contract (England) was explicitly an NHS contract with “something for something” as the deal. Consultants gained greater control over their hours and workloads, with recognition of the work they did in financial terms. There was also better recognition for on call work and the impact of un-social hours working (premium rate (1 and 1/3) 1900–0700 M–F, weekends and bank holidays). Employers gained clarity of what was done, additional work if private practice was undertaken, and the tools to engage and align consultants work and activities to those required by the trust and patients.

Transition to the contract, after the initial rejection then later agreement by the profession was smoother than many expected (by that there were fewer mediations and appeals than were expected) and rapidly gained high take up—over 97% now. Whilst some of this was due to the efforts made to encourage and aid transition, some was due to the lack of “interest” or ability on the hospital/trust management part to realise the benefits of the contract to employers.<sup>2, 3, 4</sup> Lack of “engagement” from employers in use of the contract was a key feature and early missed opportunity. Ironically, the BMA has probably pushed “use of the tools in the contract” more consistently than many employers.

**THE CONTRACT**

There are five elements to the “contract”:

1. The job plan—varies on an (at least) annual basis. Made up of job schedule, objectives and supporting resources and any local variations/additions.
2. The statement of particulars—the bit the consultant signs.
3. The terms and conditions of service; to which locally agreed employment policies are appended.
4. Good medical practice—implied terms in the contract, necessary to remain licensed to the GMC.
5. National law.

Understanding and utilising all five elements, but mainly the tools of job planning, is the best way to deliver best value for money from the contract.

The contract remains a professional contract—schedule 2 paragraph 1<sup>5</sup> “*A consultant has continuing clinical and professional responsibility for patients admitted under his or her care or, (for consultants in public health medicine) for a local population.*” However it retains hours’ protections. The agreed number of hours worked is divided into Programmed Activities (PAs) each of four hours duration (unless in premium time being three hours). These are:

Direct clinical care (DCC)—all work directly pertaining to patients—eg operating lists, ward rounds, Multidisciplinary team (MDT) meetings.

Supporting profession activities (SPA)—the work underpinning the quality of care for patients—audit, teaching, job planning, appraisal, general management etc.

---

<sup>2</sup> Williams S, Buchan J Assessing the new NHS consultant contract Kings fund 2006  
[www.kingsfund.org.uk/document.rm?id=6365](http://www.kingsfund.org.uk/document.rm?id=6365)

<sup>3</sup> Pay modernisation A New contract for NHS consultants NAO 2007  
[http://www.nao.org.uk/publications/0607/pay\\_modernisation\\_a\\_new\\_contr.aspx](http://www.nao.org.uk/publications/0607/pay_modernisation_a_new_contr.aspx)

<sup>4</sup> Pay modernisation A New contract for NHS consultants in England PAC 59th report 2006–07.

<sup>5</sup> Terms and conditions—Consultants England 2003

[http://www.nhsemployers.org/SiteCollectionDocuments/Consultant\\_Contract\\_V8\\_Revised\\_Terms\\_and\\_Conditions\\_220808\\_aw.pdf](http://www.nhsemployers.org/SiteCollectionDocuments/Consultant_Contract_V8_Revised_Terms_and_Conditions_220808_aw.pdf)

Additional NHS activities—usually related to specific internal roles eg management, clinical tutors etc.

External Duty PA—work for the wider NHS—high commitments to Royal colleges, professional associations etc.

Failure to recognise the professional nature of the contract and over reliance on the job schedule (ie the day to day work of the contract) is the commonest reasons for not realising the benefits of the contract.

The basic contract is made up of 10 PAs, “typically and on average” 7.5 DCC to 2.5 SPA. Consultants can work more PAs and these tend to be DCC by local agreement or work less than full-time on a flexible contract.

DCCs should be carefully matched to the needed activity, all too often this is an area over looked. SPAs should be both for personal and professional development (typically around 1–1.5 should allow for most things that a consultant needs to be up to date and (ultimately) revalidated). The additional 1 SPA should be for projects or activities required by the trust, be it educational supervision, specific management duties, service redesign etc. Few organisations utilise this resource effectively. However just reducing consultants to delivery of DCCs denies the trusts the abilities of consultants to innovate and redesign services. It also will reduce the satisfaction of consultants, who, as generally highly motivated individuals thrive better when given the leeway to innovate and push services forward.

#### EMPLOYER BENEFITS

Employers benefit from the clarity in what consultants are doing—in the job schedule and in having explicit agreement on work undertaken in supporting professional activity time. The pre 2003 contract had much poorer tools to define what was accountable in “non-fixed notional half days” (the nearest equivalent). Both the productivity of Direct Clinical Care time AND SPA time should be agreed as objectives in the contract. Currently very few employers set clear objectives for their consultants. As such it is not surprising that they fail to achieve the benefits from the contract, or realise best value for money.

Setting objectives (and agreeing the necessary supporting resources) was a key part to the contract (schedule 3 paragraph 10). For many organisations this has been omitted. For some consultant personal objectives from their appraisal Personal Development Plan (PDP) have been included. Only a few and only more recently have trusts begun to use this essential aspect of the job planning process. Without objective setting it is very hard to align the vision and values of the trust with those of the consultant and as such hard to maximise the benefits for patients, the organisation and patients; alignment of vision and values with senior personnel being a key criterion for success in any organisation.

Employers also benefit from various flexibilities in the contract such as annualisation and team job planning. Furthermore there is a requirement on consultants to clarify their time undertaking private practice (a right confirmed in the terms and conditions and reconfirmed recently by the cooperation and competition panel in 2009),<sup>6</sup> preventing any clashes with their NHS work, and to comply with a code of practice for private practice.<sup>7</sup> There is also the requirement to “offer up” an 11th PA to the employer should the consultant wish to undertake private practice. The employer can decide to take this up, or not, to do so flexibly—with due notice—usually accepted as three months. Currently most consultants work around 11 PAs and thus this flexibility is limited. However employers could use this to provide some matching of activity to demand if they so wished.

#### THE PROCESS

Consultants will have an (at least) annual job plan review, to which consultants bring information and their clinical manager brings the outline job plan for review and agreement. In many circumstances the job plan is drawn up by the consultant and presented to the clinical manager for agreement, already turning the tables on what should be an employer driven process. Whilst in well run organisations this may well work, in many it fails to allow the organisation and the clinical leadership of the organisation to drive forward innovations and changes in practice related to evidence or service need, or the commissioners intentions require. They are thus reliant on the consultants to do this. Whilst many consultants are able to do this, there is a missed opportunity if the employer does not take a lead.

In addition to clinical data, the consultant will also bring their PDP from their appraisal (a separate, formative process—also currently under review). This should contain agreed personal objectives, however in many circumstances the appraisal will not have been done by their clinical manager and thus not necessarily tie into the needs of the trust, the team or the wider patient requirements.

Whilst the job planning process could be a driver for substantial change and benefit to all parties, this relies on accurate information. Sadly, few trusts have accurate enough information to advise the job planning process. Thus many job plans are agreed in a vacuum, or with data provided only by the consultant. Another opportunity to enhance value for money missed.

---

<sup>6</sup> Cooperation and Competition Panel  
<http://www.ccpnl.org.uk/content/press-releases/Media-Release-consultant-restrictions-160210.pdf>

<sup>7</sup> Code of conduct for private practice [http://www.nhsemployers.org/SiteCollectionDocuments/DH\\_085195.pdf](http://www.nhsemployers.org/SiteCollectionDocuments/DH_085195.pdf)

When there are service changes, the clinical manager should use the job planning process to review any necessary changes to work patterns and possible PA allocation. This step is often not taken or delayed, thus again missing potential opportunities.

#### FLEXIBLE MODELS

The contract has great flexibilities. In particular the annual contribution in PAs from a consultant can be calculated (on average around 42 weeks a year when leave, bank holidays, stat days and reasonable study leave is allowed for). Thus each PA in the schedule should be delivered 42 times in a year (for example 42 operating lists, ward rounds etc). This allows for better contracting and costing (such as in Service line reporting/management) of consultant time. Also the PAs can be worked more intensely at peak times (eg in winter for chest physicians/ orthopaedic trauma surgeons) and fewer at lower intensity periods. This allows close matching of staff costs (typically 60–70% of NHS costs) to activity and thus better budgeting.

Similar flexibilities can be found through team job planning, where the job plans of a whole team are amalgamated to ensure most even cover and fare distribution of workload.

#### COST OF CONSULTANTS

Whilst some believe that consultants are an expensive resource, there is considerable evidence that shows the benefit to patient care of early and effective consultant intervention.<sup>8, 9, 10, 11, 12</sup> Furthermore, the process of negotiating a new grade to replace consultants is fraught with problems, unlikely to bring considerable savings (the pay scale would be close to that of a consultant due to employment law if of comparable clinical standard); patients wish to have the opinion of the consultant (Picker Institute data) and this is a considerable “brand” selling point. Additionally employer ability in local negotiations is weak and there is little track record of success. Finally when given the opportunity to do so in 2003, indeed when instructed to do so by the then Secretary of State (Alan Milburn) employers declined the ability to go for local contracts. When Sir John Tooke reviewed medical training in the wake of MTAS,<sup>13</sup> he also concluded “*If the consultant contract is used as intended to facilitate pay progression primarily on the basis of contribution rather than seniority this too does not need to change, not does as new specialist grade and contract need to be negotiated*”. The key however is that the tools within the contract are utilised.

#### INCENTIVISING HIGH QUALITY AND SAFE EFFECT PATIENT CARE

Appended to the consultant contract is the Clinical Excellence Awards (CEA) scheme. This is open to all consultants from over one year of employment as a consultant. There are 12 awards, 1–9 available via local awards committees, and four (national 9–12) via a network of local, regional and ultimately national Advisory Committee on Clinical Excellence Awards (ACCEA) committees. Whilst the system has its critics where well and transparently managed it provides considerable financial and “kudos” incentive to those who are successful. To achieve an award consultants must show excellence “over and above” the norm, in five domains covering delivery of high quality services, developing high quality services, managing high quality services, research and education and training. Using CEAs as part of a “talent management” program should further enhance the quality of care and thence the efficiency and value for money.

#### DELIVERING PRODUCTIVITY AND VALUE FOR MONEY FROM THE CONSULTANT CONTRACT

1. Improve the information to both parties in the job planning process. The vast amount of information gathered for financial costing and Payment by Results payments could relatively simply be refocused to deliver the information required for job planning and enhancing the productivity of consultants. Furthermore, in so doing this information would then be available for driving the quality of patient care and improvements in safety and outcomes.
2. Trusts should enhance the training of their clinical (and non-clinical) managers in job planning and their understanding of the process and benefits realisation.
3. The focus on job planning should move to agreement and assessment against objectives rather than merely focusing on the job schedule.
4. “SMART” (specific, measurable, agreed, relevant and tracked) objectives will allow greater realisation of productivity benefits from SPAs as well as DCCs.
5. Failure to make all reasonable efforts to achieve the time commitments in the contract, or achieve the agreed objectives should result in failure of pay progression. Currently only a handful of consultants have ever failed pay progression.

<sup>8</sup> NCEPOD Trauma who cares [http://www.ncepod.org.uk/2007report2/Downloads/SIP\\_summary.pdf](http://www.ncepod.org.uk/2007report2/Downloads/SIP_summary.pdf)

<sup>9</sup> Enhancing quality—Promoting consultant expansion across the NHS [http://www.bma.org.uk/images/Evidencedocument\\_tcm41-156763.pdf](http://www.bma.org.uk/images/Evidencedocument_tcm41-156763.pdf)

<sup>10</sup> Academy of Royal Medical Colleges report on Acute Services: <http://www.networks.nhs.uk/news.php?nid=1794>

<sup>11</sup> NCEPOD publication: Emergency Admissions- a journey in the right direction: <http://www.ncepod.org.uk/2007.htm>

<sup>12</sup> The Royal College of Physicians—Acute medical care. The right person, in the right setting—first time: [http://www.rcplondon.ac.uk/news/news.asp?PR\\_id=375](http://www.rcplondon.ac.uk/news/news.asp?PR_id=375)

<sup>13</sup> Tooke, J Aspiring to Excellence finding sand final recommendations of the independent enquiry into modernising medical careers [http://www.mmcinquiry.org.uk/Final\\_8\\_Jan\\_08\\_MMC\\_all.pdf](http://www.mmcinquiry.org.uk/Final_8_Jan_08_MMC_all.pdf)

6. The flexibilities of the contract should be used to move consultants onto “annualised” contracts that will allow both personal flexibility, but also better matching of the PAs available from consultant to when the organisations need that work. This would allow better cost and income matching through the year. Tracking this work would also allow assurance that the number of agreed PAs to be worked was delivered. Even well managed departments can suffer from “targeted leave” where leave is preferentially taken on days when there are clinical rather than SPA commitments.
7. Trusts should ensure that consultants account for work done in SPA time. This should be used to develop the consultants, their teams and deliver the service, train junior doctors and others, change management/leadership and patient safety improvements desperately needed in the NHS.
8. Consultants should expect to account and evidence all their paid work, but particularly that in SPA time. Where the agreed outputs/accountabilities are not seen then there should be agreement that an outcome will be delivered for this SPA time; that the time will be used for DCC, or that the time will not be paid.
9. Consultant pay progression is not automatic. As such all trusts should have an explicit “sign off” process assuring that all elements of the contract, objectives and adherence to the various codes appended to the consultant contract, including having an appraisal have been delivered before sanctioning pay progression.

Vast majority of consultant work very hard and over an above contract, this “discretionary work” would be at risk if this task is not undertaken in a coherent, fair and transparent manner. However in these straightened times we must align the incentives in the contract, with the controls and tools available to ensure that the approximately 5% of the total NHS budget that is spent on consultants delivers for patients.

These outline views are the personal views of  
**Dr Jonathan Fielden BSc (Hons) MB ChB FRCP FRCA**

Currently

Chief Medical Officer Royal Berkshire NHS Foundation Trust.  
Consultant in Intensive Care Medicine, Royal Berkshire NHS FT

Formerly:

Chairman, Central Consultants and Specialists committee BMA 2006–09  
Deputy Chairman CCSC (negotiators) 2004–06  
Member of advisory groups to high quality care for all, PbR, quality accounts and Secretary of State Sounding boards.

March 2010

---

**Memorandum by the Royal College of Nursing (SAV 08)**  
**VALUE FOR MONEY IN THE NHS**

1. INTRODUCTION

1.1 With a membership of 400,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

1.2 The RCN welcomes the opportunity to submit evidence to the one off Health Select Committee inquiry on value for money in the NHS.

1.3 This submission will demonstrate how the nursing profession can deliver value for money and high quality care whilst illustrating the hugely detrimental effect cutting frontline services will have. The RCN firmly believes that efficiency and value for money in the NHS can be found through investment and support for services like specialist nursing that focus on quality. This submission highlights specialist nursing as a case study in which the nursing workforce demonstrates cost saving measures whilst delivering the highest quality of care.

1.4 The RCN recognises that an effective way to cut costs is to reduce hospital admissions. One way to do this is to treat more patients effectively in the community by skilled staff who are able to keep patients as healthy as possible in their own homes. Making the shift to treating more conditions in the community will require a long term consideration of what patients need and an assessment of the impact on the quality of care.

1.5 The solutions to this will be complex, involving all parts of the health service working together in the shift from acute to community care. With many hospitals already running at capacity, simply cutting bed numbers without planning for the long term would be irresponsible.

1.6 The economy is changing and as we move out of a recession we must look to protect health care spending at the same time as focusing on the services which provide value for money and will in the long term bring down health spending. The NHS is a massive economy and change will not be seen overnight or even in the short term.

1.7 In order to see long term reform and reduction of the huge costs involved with issues such as smoking, obesity and expensive long stays in acute trusts there must be consistent and continued funding of services now. This can only be done through examining fields such as specialist nursing and public health which take a holistic approach to patient care.

## 2. NURSING AND THE ECONOMIC CONTEXT

2.1 The RCN recognises that the NHS is facing one of the most significant financial challenges in its history. Government borrowing and economic conditions have resulted in significant public sector borrowing and a massive budget deficit that the Government will have to address. The NHS Chief Executive David Nicolson has stated the need to secure substantial “cash releasing efficiency savings” in the NHS budget of between £15 billion and £20 billion between 2011 and 2014, a message that was recently conveyed directly to clinicians by the Department of Health.<sup>14</sup>

2.2 There is concern that funding cuts and the drive for efficiency savings could result in “slash and burn” tactics, bed closures, cancelling of new services and staffing reductions. During the NHS deficit crisis of 2005–06 training budgets were one of a number of targets for savings. This resulted in periods of “boom and bust” workforce planning with consequent knock on effects for the nursing workforce.

2.3 Staff could not be replaced quickly when the cycle returned to “boom”. Vacancy freezes resulted in fewer jobs for newly qualified nurses and nursing roles considered expensive, such as specialist and nurse consultants, were also targeted for savings. Lessons must be learned from the past about the damaging effects to the entire health sector caused by short term cuts in order to achieve financial gain.

## 3. CASE STUDY—SPECIALIST NURSES

3.1 An example of nursing innovation and how the nursing workforce can actually save the NHS money, whilst delivering the highest quality of care, is in specialist nursing posts. A recent RCN report<sup>15</sup> set out the benefits that specialist nurses provide, benefits in the quality of care and also the economic savings which can be made by their employment.

3.2 During the NHS deficit crisis of 2005–06 specialist nursing posts were hit hard by trusts attempting to save money. The RCN is concerned that under current financial constraints history will repeat itself in the shape of cuts to these highly skilled and highly valued nurses. Cuts to these services would effectively result in a down-skilling of the nursing workforce and the undermining of patient care.

3.3 Specialist nurse posts save millions of pounds from health budgets through a variety of means including:

- reduced waiting times;
- avoidance of unnecessary hospital admission/readmission (through reduced complications post-surgery/enhanced symptom control/improved patient self-management);
- reduced post-operative hospital stay times;
- the freeing up of consultant appointments for other patients;
- services delivered in the community/at point of need;
- reduced patient treatment drop-out rates;
- the education of health and social care professionals;
- the introduction of innovative service delivery frameworks; and
- direct specialist advice to patients and families.

<sup>14</sup> *The NHS Quality, Innovation, Productivity and Prevention Challenge: an introduction for clinicians*. Department of Health, March 2010.

<sup>15</sup> *Specialist nurses, Changing lives, saving money*. Royal College of Nursing—February 2010.

3.4 For example, the Parkinson's Disease Society states that specialist Parkinson's nurses save the NHS £56 million.<sup>16</sup> By treating multiple sclerosis flare ups at home rather than in hospital an estimated £180 million could be saved<sup>17</sup> and £84 million could be saved by using epilepsy specialist nurses rather than using GP services to manage the condition.<sup>18</sup>

3.5 Today's specialist nurse takes a leading role in making sure patients get the best care possible. Several studies have shown that as a substitute for other health care professionals, including doctors, specialist nurses are both clinically and cost effective. As an increasing number of people in this country are diagnosed with long term conditions, these experts will become even more invaluable to the health of the nation.

#### 4. FINANCIAL CONSTRAINTS ON SPECIALIST NURSING

4.1 The potential of specialist nurses to drive up safety and the quality of care, and to improve patient outcomes is under threat. Specialist nurse posts should be supported through robust long term funding. Short term funding of up to two years, which is increasingly popular, makes these posts extremely vulnerable to cut backs by trusts looking for immediate savings.

4.2 Despite the evidence of the positive impact in terms of patient care enshrined in national guidelines, no other group has been targeted to such a degree in the wake of NHS financial pressures. Specialist nurses were one of the groups hardest hit by the NHS deficits crisis of 2005–06. A poll of specialist nurses (RCN, 2008) showed:

- more than one third of specialist nurses reported their organisations had a vacancy freeze in place;
- 47% reported they were at risk of being downgraded;
- 68% reported having to see more patients;
- one-in-four faced risk of redundancy;
- half were aware of cuts in services in their speciality; and
- 45% were being asked to work outside their speciality to cover staff shortages in general clinical settings.

4.3 Two years later, a further poll (RCN, 2010) has demonstrated that more than a third of respondents to the RCN survey have seen cuts in services over the last 12 months, and 57% are concerned that posts will be threatened in the near future. 95% of the respondents who have seen cuts in services say it is the NHS who have cut or reduced funding for specialist nurses. This raises significant concerns that posts and services could be lost altogether as funding streams dry up.

4.4 As we enter another period of constrained public spending, many specialist nurses now face serious organisational and funding challenges that are inhibiting their ability to deliver high quality care. Specialist nurses add value to patient care, while generating efficiencies for organisations through new and innovative ways of working and must be protected.

#### 5. THE VALUE OF NURSING

Nurses are involved in almost every facet of care. Over recent years nursing teams have reengineered their roles to assume a higher range of clinical responsibilities, and successfully adapted to using new systems to improve patient care. Therefore, the nursing contribution to care needs to be explored further in the context of the incentives described above and not just aggregated as a simple workforce cost.

5.1 The total “value” of nursing will depend upon the current number, skill mix and the ways that the workforce is deployed. There is increasing weight of evidence showing the negative consequences of reducing nurse numbers leading to increased mortality rates. In order to combat this, the RCN has called for regular staffing reviews, which are then reported to Trust Boards, to guarantee safe staffing numbers and the highest level of care for patients. Skill mix is just as vital, it is not just overall numbers which matter.

5.2 In this new challenging financial climate the NHS will have to make even more difficult trade off decisions about what it will and will not offer. Decision makers must avoid making short term decisions, ensuring that they consider the full value of nursing, and the negative consequences when nurse numbers are reduced, when considering how to best allocate scarce resources in the health care system.

5.3 Alongside this, it is vital that the voice of nursing is adequately represented at all levels of governance of the NHS to identify how the NHS can become more efficient and to curb any unnecessary and inappropriate changes to staffing levels.

<sup>16</sup> Parkinson's Disease Society, 2006.

<sup>17</sup> Estimate based on a saving of £1,797 per patient from a scheme to treat patients at home, developed by the University College London Hospital Foundation Trust.

<sup>18</sup> Estimate based on a saving of £184 per patient per year from correct specialist diagnosis and reduced GP visits.

## 6. BENEFITS OF INVESTING IN PUBLIC HEALTH

6.1 Nurses have a significant ability, and are ideally placed, to influence behavioural change within a health promoting environment.

6.2 Nursing achievements in the public health sphere are visible and measurable, impacting on individuals, specific groups and the population at large. The RCN Document *Nurses as partners in Delivering Public Health* identifies a number of aims in delivering public health through nursing services:

- increased life expectancy by influencing healthy behaviours;
- reduced health inequalities—for example, targeting vulnerable populations to improve health outcomes and access services;
- improved population health—For example, reducing obesity, alcohol abuse, improving sexual health behaviour;
- increased awareness of positive healthy behaviours in communities; and
- engaging with individuals, families and communities to influence service design.

6.3 The benefit from achieving these goals is significant and reduces the future burden to the NHS by delaying or preventing illness. Alcohol misuse, smoking and obesity is largely calculated at costing the NHS over £11 billion per year. While there are many visible examples of public health nursing that make a substantial contribution to this, there is a lot of good public health nursing practice that is carried out locally but does not achieve the widespread recognition which it deserves.

## 7. PAYMENT BY RESULTS AND NURSING

7.1 Although efforts have been made within the Payments by Results system to wholly quantify nursing, nursing costs are still too often treated purely as workforce costs, allocated on the basis of the amount of time spent with the patient, for example, theatre hours or bed days. There is little recognition of nursing efforts/inputs, patient dependency and skills. The RCN believes that this absence of a full and comprehensive understanding of nursing costs and contribution to the overall process of patient care, may lead to nursing workforce numbers and skill mix being subject to inappropriate cuts as was seen during the deficits crisis of 2005–06.

7.2 The costs of nursing are all too often identified simply as the wage bill for nursing staff. The precise costs of nursing reflect both central and local decisions about wage rates, nurse numbers, skill mix (a higher skilled workforce will typically cost more), education, training, and international, national and local labour market conditions.

7.3 The benefits of nursing are somewhat more difficult to identify. The term benefit is used interchangeably with value. There are a number of reasons why identifying the value of nursing is a challenge:

- the value of nursing includes both tangible and non-tangible components and intangible components are inherently difficult to identify and measure;
- it can be difficult to separately identify the contribution of nursing to health (alongside the wider issues of measuring the contribution of the health care system in general, to the production of health); and
- the value of nursing includes the impact on patients, their carers, the health care system, and the wider economy. This poses a challenge to capture the value to each of these stakeholders in the system.

Royal College of Nursing

March 2010