



House of Commons  
Committee of Public Accounts

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# Management of NHS hospital productivity

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Twenty-sixth Report of Session 2010–  
11

*Report, together with formal minutes, oral and  
written evidence*

*Ordered by the House of Commons  
to be printed 9 March 2011*

**HC 741**

Published on 15 March 2011  
by authority of the House of Commons  
London: The Stationery Office Limited  
£10.00

## Committee of Public Accounts

The Committee of Public Accounts is appointed by the House of Commons to examine "the accounts showing the appropriation of the sums granted by Parliament to meet the public expenditure, and of such other accounts laid before Parliament as the committee may think fit" (Standing Order No 148).

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The following member was also a member of the committee during the parliament:

Eric Joyce (*Labour, Falkirk*)

### Powers

The committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the internet via [www.parliament.uk](http://www.parliament.uk).

### Publication

The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the internet at [www.parliament.uk/pac](http://www.parliament.uk/pac). A list of Reports of the Committee in the present Parliament is at the back of this volume.

Additional written evidence may be published on the internet only.

### Committee staff

The current staff of the Committee is Philip Aylett (Clerk), Lori Verwaerde (Senior Committee Assistant), Ian Blair and Michelle Garratty (Committee Assistants) and Alex Paterson (Media Officer).

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## Summary

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Over the last ten years Government spending on the NHS increased by 70%, from £60 billion in 2000-01 to £102 billion in 2010-11, with around 40% spent on services provided by acute and foundation hospitals. This substantial increase in funding enabled hospitals to invest in more, better paid staff and improve their buildings and equipment. In return there have been significant improvements in the performance of the NHS, particularly in those areas targeted by the Department of Health (the Department) such as hospital waiting times and outcomes for patients with cancer and coronary heart disease. However, the level of hospital activity has not kept pace with the increased resources as hospitals focused on meeting national targets, but not on improving productivity, and productivity has actually fallen over the last decade.

Productivity is defined as the ratio of the volume of resources (inputs) to the quantity of healthcare provided (outputs), adjusted to reflect their relative costs and quality. Figures produced by the Office for National Statistics (ONS) estimate that, since 2000, total NHS productivity fell by an average of 0.2% a year, and by an average of 1.4% a year in hospitals. The taxpayer has therefore seen a better quality NHS as a result of the additional investment but, per taxpayer pound, is getting less in return. The trend of falling productivity will need to be reversed if the NHS is to meet the Department's productivity challenge, to deliver up to to £20 billion of efficiency savings a year, by 2014-15, without compromising services.

One would expect productivity to fall at the start of a period of expansion as the inputs in the form of staff and resources can be increased rapidly, while increases in outputs tend to lag behind. But, in 2002 the Department promised that, in exchange for increased funding, it would deliver annual productivity improvements. The Department failed and we have had ten years of almost continuous decline.

The ONS measure of productivity is the most authoritative there is, although the Department points to its shortcomings. We accept that it is challenging to make accurate adjustments for quality improvements. But, despite previous assurances to this Committee, the Department has failed to reach agreement with ONS on how the measure should account effectively for improvements in quality.

The Department promotes efficiency and productivity improvements in hospitals primarily through national pay contracts and by setting a fixed price, or 'tariff', for individual hospital procedures (Payment by Results). While Payment by Results does seem to have driven some improvements, the system only covers 60% of hospital activity and there is substantial variation in hospital costs and activity. The Department is introducing 'best practice tariffs' to promote greater hospital efficiency. On the one hand, this tariff system can promote efficiency and productivity, but on the other hand could prioritise price over quality. Although potentially positive, the system will need to be carefully monitored to ensure quality is maintained, as the Department acknowledge that cutting tariffs could damage quality. National pay contracts have not yet been used to manage staff performance effectively, and consultants' productivity has fallen at the same time as they

have had significant pay rises.

The report also notes that hospitals have concentrated primarily on meeting national performance targets and not specifically on optimising productivity.

There are risks to the NHS being able to deliver up to £20 billion savings annually, for reinvestment in healthcare, alongside implementing a substantial agenda of reform. Productivity improvements will be key to delivering these savings. The Department points to areas where the reform agenda complements the delivery of savings; for example, by reducing management costs associated with Strategic Health Authorities and Primary Care Trusts, and in the requirement for hospitals to improve their performance prior to becoming Foundation Trusts. The Department and an expert independent witness told us that although the risks to delivering savings have increased in light of the planned reforms, the reforms have also increased its ability to improve productivity in some areas. We expect to return to the issues of NHS efficiency savings and productivity in future reports.

On the basis of a Report by the Comptroller and Auditor General,<sup>1</sup> we took evidence from the Department on NHS hospital productivity in recent years and on delivering improved productivity in future.

## Conclusions and recommendations

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1. The trend of falling NHS productivity will have to be reversed if the NHS is to deliver, by 2014-15, savings of up to £20 billion each year for reinvestment in healthcare. The Kings Fund estimate that this will require year-on-year productivity gains of around 6%. Meanwhile the NHS organisations charged with delivering these savings will be abolished as part of the NHS reforms. The following recommendations are aimed at the transition phase of the planned reforms, during which the Department of Health's central focus on productivity and efficiency will remain vital. We will be reviewing progress in delivering these savings, including productivity improvements, in due course.
2. Since 2000 total productivity fell by an average of 1.4% a year in hospitals as the level of activity (outputs) has not kept pace with the increased resources (inputs). Though the increased money going into the NHS has helped to reduce waiting times, improve facilities, and deliver higher quality care, the Department promised at the same time to improve productivity. It failed and, in future, the Department needs to have a more explicit focus on improving hospital productivity if it is to deliver its ambitious savings targets without healthcare services suffering.
3. The Department has not yet agreed with the Office for National Statistics a measure for NHS productivity, despite previous assurances to this Committee. The Department does not believe that the existing measure sufficiently accounts for improvements in quality. The Department should resolve differences with the Office for National Statistics (ONS) and agree measures for both NHS productivity as a whole and for hospital productivity specifically, which account effectively for changes in quality. This should be done in time for the ONS's 2012 annual report on NHS productivity.
4. The Department has given limited attention to the reasons for differing costs between hospitals for providing similar services, either to identify good practice or the scope for efficiency savings. In some cases, such as specialist hospitals, there may well be good reason for cost variations, but there will also be unidentified cases of good practice and of inefficiencies which could be addressed. The Department should make clear the responsibility of hospital Boards to use and act on comparable data with a view to identifying scope for improvement. Once it has agreed the productivity measure, the Department should then publish hospital level productivity data. We expect the Department's oversight arrangements, under the reformed NHS, to include a role in both facilitating the sharing of good practice and in ensuring that under-performance is challenged.
5. National pay contracts have not yet been used effectively to drive productivity.
  - The Consultant Contract was put in place in 2003 with an expectation that it would deliver year-on-year productivity gains. Yet, while consultants have had significant pay rises, their overall productivity has continued to fall. Few hospitals have used the levers within the contract, such as job planning, to improve productivity.

- Agenda for Change contracts, which cover the majority of other hospital staff, are also designed in part to deliver productivity improvements, but are not yet being consistently used to manage staff performance effectively.

In its response to this Report, the Department should explain what more it will be doing to support hospitals and Commissioners to use national pay contracts to deliver productivity improvements.

6. Hospitals have been unsuccessful in reducing emergency admissions, and those with a relatively high proportion of emergency admissions tend to have higher overall costs. The Department's productivity challenge includes a 10% reduction in the number of emergency admissions, and the National Audit Office estimates a potential saving of £300 million a year from reducing the proportion of emergency admissions in the lowest performing 75% of hospitals. The Department should report back to us by July 2012 on hospitals' progress in reducing emergency admissions and the consequent impact on hospital productivity.
7. The 'Payment by Results' system is a key element in influencing productivity improvements, but there needs to be greater clarity in defining how it will operate during the transition period and beyond. The NHS reforms envisage that Monitor, which currently regulates Foundation Trust hospitals, will become the economic regulator of the NHS and part of this role will be to set the prices of NHS services. Before handing over responsibility to Monitor, the Department should set out:
  - its plans for extending the system to the 40% of hospital activity not yet covered;
  - how tariffs will be aligned with the expected efficiency gains; and
  - how it will mitigate the risk that, were there to be increased price competition, this might reduce the quality of service, or hospitals may decide not to provide some services.

# 1 Performance on productivity

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1. In 2000, the Department of Health (the Department) published the NHS plan, a ten-year vision for reforming the NHS. The plan set out to increase funding to improve the quality of care and outlined expectations that the NHS should improve its efficiency and productivity. Between 2000-01 and 2010-11, NHS funding will have increased by 70% to £102 billion, an average real term increase of 4.5% a year. Over 40% of NHS expenditure is on hospital services. While there have been improvements in the NHS – such as better paid staff, improved facilities, shorter hospital waiting times and better outcomes for patients with cancer and coronary heart disease – productivity has fallen.<sup>2</sup>

2. Office for National Statistics (ONS) figures show that overall NHS productivity fell 0.2% a year and hospital productivity fell by around 1.4% a year from 2000 to 2008. Productivity is the ratio between the volume of resources going into the NHS (inputs) and the quantity of healthcare provided (outputs), adjusted for relative costs and some aspects of quality.<sup>3</sup> If inputs rise faster than outputs, then productivity goes down. In 2002, the Department told Treasury that it would improve annual productivity by between 1% and 2% a year in return for above inflation pay awards.<sup>4</sup> Productivity may fall at the start of a period of expansion as inputs in the form of staff and equipment can be increased rapidly, while increases in outputs tend to lag behind. However, we have now had ten-years of almost continuous decline.<sup>5</sup> The Department sees future improvements in productivity coming from, for example, lowering the tariff for services, staff pay freezes, reduced management costs and treating more patients as day cases.<sup>6</sup>

3. The Department believes the ONS productivity measure is too narrow and does not reflect quality improvements made in the period, such as increases in the amount of face-to-face contact time between clinicians and their patients.<sup>7</sup> The Department has previously told this Committee that it was working with the ONS to agree an NHS productivity measure that reflected, more fairly, improvements in quality, but this work has yet to be completed.<sup>8</sup>

4. In November 2009, the NHS Chief Executive announced that the NHS and Department would need to deliver between £15 billion and £20 billion of efficiency savings per year by 2013-14.<sup>9</sup> The Kings Fund estimates that this will require year-on-year productivity gains of around 6%.<sup>10</sup> The Department pointed to how, in some areas, the reform agenda

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2 Q 1; C&AG's report, paragraph 1.1, 1.6

3 C&AG's report, paragraph 1.7

4 Qq 6, 41

5 Qq 6, 8-9

6 Qq 63 - 64

7 Qq 1-4, 11, 44

8 Public Accounts Committee, *NHS Pay Modernisation in England: Agenda for Change*, 29<sup>th</sup> Report of Session, HC (2008-09) 310.

9 C&AG's report, paragraph 1.3; The NHS has since amended these figures, which now stand at efficiency savings of up to £20 billion by the end of 2014-15.

10 Appleby J, Crawford R, Emmerson C, *How Cold Will It Be? Prospects for NHS funding: 2011 – 2017*, 2009.

complements the delivery of savings; for example, by reducing management costs associated with Strategic Health Authorities and Primary Care Trusts, and in the requirement for hospitals to improve their performance before becoming Foundation Trusts.<sup>11</sup> However, a more devolved NHS will make it more challenging for the Department to drive improvements from the centre and the Department told us that, overall, the risks to delivering savings had increased in light of the planned reforms.<sup>12</sup>

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11 Q 145

12 Q 144

## 2 Implementation of national initiatives

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5. The Department has used a number of central initiatives to influence local hospital productivity including: national pay contracts; a national tariff system for paying for hospital services ('Payment by Results'); and the sharing of innovation and good practice.<sup>13</sup>

6. National pay contracts have not yet been used effectively to drive productivity. The Consultant Contract was put in place in 2003 with an expectation that it would deliver year-on-year productivity gains. Yet, while consultants have had significant pay rises, their overall productivity has consistently fallen.<sup>14</sup> The Department explained that this reflected a wider trend in the developing world as consultant specialisms narrow.<sup>15</sup> However, few hospitals have used the available contract levers, such as job planning to improve productivity.<sup>16</sup> Agenda for Change contracts, which cover pay for the majority of other hospital staff, are also designed in part to deliver productivity improvements, but are not yet being consistently used across hospitals to manage staff performance effectively.<sup>17</sup>

7. In general, the national focus on quality of care has meant that clinical staff have not been performance-managed with regard to the cost or efficiency of their activities. Few hospitals have used staff appraisal systems to demonstrably improve productivity.<sup>18</sup>

8. The Department promotes efficiency and productivity improvements in hospitals through setting a fixed price, or national 'tariff', for individual hospital procedures. While Payment by Results does seem to have driven some improvements, the system only covers 60% of hospital activity and there is substantial variation in hospital costs and activity.<sup>19</sup> The Department is introducing 'best practice tariffs', moving away from an average price, to promote greater hospital efficiency. However, if tariffs are reduced, there is a risk that, were there to be increased price competition, this might reduce the quality of service, or hospitals may decide not to provide some services.<sup>20</sup>

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13 C&AG's report, paragraph 2.1

14 Qq 17, 28; C&AG's report, Figure 5

15 Qq 55-57

16 Qq 19-22, 24

17 Q 77

18 C&AG's report, paragraph 10, Q59-60

19 Qq 94, 98

20 Qq 99 - 108

### 3 Performance in hospitals

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9. There is substantial variation between individual hospitals in the efficiency and in the unit costs of particular treatments: for example, the cost of a first-time elective coronary artery bypass graft varies from £5,000 to £12,000.<sup>21</sup> There is also a wide variation in the number of staff per bed between hospitals, ranging from around 4 to 13.<sup>22</sup> Some of this variation can be explained by the number and types of patients, different practices and differences in the way costs are calculated but there is potential for savings by becoming more efficient and effective and sharing cases of good practice. The Department told us that the amount of variation had reduced in recent years, in part because of the national tariff system.<sup>23</sup>

10. There is also significant variation between hospitals in the number of emergency admissions as a proportion of all hospital admissions. The success of local attempts to control emergency admissions has been mixed and those with a relatively high proportion of emergency admissions tend to have higher overall costs. The Department accepts that, while there are some good examples where hospitals have reduced admissions through better management of long-term conditions, this has not been achieved consistently across the country.<sup>24</sup> The Department's productivity challenge includes a 10% reduction in the number of emergency admissions, and the National Audit Office (NAO) estimates a potential saving of around £300 million a year from reducing the proportion of emergency admissions in the lowest performing 75% of hospitals.<sup>25</sup>

11. Hospitals make limited use of comparative data and benchmarking of their performance against peers.<sup>26</sup> Boards are not benchmarking nationally nor does the Department use the performance information to challenge and hold hospitals to account.<sup>27</sup> Hospitals have concentrated primarily on meeting national performance targets and not specifically on optimising productivity.<sup>28</sup> In addition, hospital managers do not always bring performance and financial data together in a way that enables them to fully understand the relationship between the money they spend and the care they provide.<sup>29</sup>

12. We asked the Department to clarify responsibility for value for money of public spending under the more devolved NHS structure. The Department told us that it was responsible for NHS expenditure as a whole and for balancing the NHS system in totality.

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21 Q 93

22 Q 122

23 Q 93

24 Q 65

25 Q 121; C&AG's report, paragraph 3.7; [www.dh.gov.uk/en/Healthcare/Qualityandproductivity/indexation](http://www.dh.gov.uk/en/Healthcare/Qualityandproductivity/indexation)

26 Q 124

27 Qq 125-126, 133

28 C&AG's report, paragraph 10, 14.

29 Q 124

However, individual Foundation Trust Chief Executives, as Accounting Officers in their own right, are responsible for the value for money in their individual hospitals.<sup>30</sup>

# Formal Minutes

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**Wednesday 9 March 2011**

Members present:

Rt Hon Margaret Hodge, in the Chair

Mr Richard Bacon	Austin Mitchell
Mr Stephen Barclay	Nick Smith
Dr. Stella Creasy	Ian Swales
Matthew Hancock	James Wharton
Mrs Anne McGuire	

Draft Report (*Management of NHS hospital productivity*) proposed by the Chair, brought up and read.

*Ordered*, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 12 read and agreed to.

Conclusions and recommendations 1 to 7 read and agreed to.

Summary read and agreed to.

*Resolved*, That the Report be the Twenty-sixth Report of the Committee to the House.

*Ordered*, That the Chair make the Report to the House.

*Ordered*, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for printing with the Report.

[Adjourned till Tuesday 15 March at 10.00 am

# Witnesses

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**Tuesday 18 January 2011**

*Page*

**Sir David Nicholson KCB CBE**, Chief Executive, NHS, **Jim Easton**, National Director for Improvement and Efficiency, **Richard Douglas**, Director General, Policy, Strategy and Finance, Department of Health and **Professor John Appleby**, Chief Economist, Health Policy, The King's Fund

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# List of Reports from the Committee during the current Parliament

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The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

## Session 2010–11

First Report	Support to incapacity benefits claimants through Pathways to Work	HC 404
Second Report	Delivering Multi-Role Tanker Aircraft Capability	HC 425
Third Report	Tackling inequalities in life expectancy in areas with the worst health and deprivation	HC 470
Fourth Report	Progress with VFM savings and lessons for cost reduction programmes	HC 440
Fifth Report	Increasing Passenger Rail Capacity	HC 471
Sixth Report	Cafcass's response to increased demand for its services	HC 439
Seventh Report	Funding the development of renewable energy technologies	HC 538
Eighth Report	Customer First Programme: Delivery of Student Finance	HC 424
Ninth Report	Financing PFI projects in the credit crisis and the Treasury's response	HC 553
Tenth Report	Managing the defence budget and estate	HC 503
Eleventh Report	Community Care Grant	HC 573
Twelfth Report	Central government's use of consultants and interims	HC 610
Thirteenth Report	Department for International Development's bilateral support to primary education	HC 594
Fourteenth Report	PFI in Housing and Hospitals	HC 631
Fifteenth Report	Educating the next generation of scientists	HC 632
Sixteenth Report	Ministry of Justice Financial Management	HC 574
Seventeenth Report	The Academies Programme	HC 552
Eighteenth Report	HM Revenue and Customs' 2009-10 Accounts	HC 502
Nineteenth Report	M25 Private Finance Contract	HC 651
Twentieth Report	Ofcom: the effectiveness of converged regulation	HC 688
Twenty-First Report	The youth justice system in England and Wales: reducing offending by young people	HC 721
Twenty-second Report	Excess Votes 2009-10	HC 801
Twenty-third Report	The Major Projects Report 2010	HC 687

Twenty-fourth Report	Delivering the Cancer Reform Strategy	HC 667
Twenty-fifth Report	Reducing errors in the benefit system	HC 668
Twenty-sixth Report	Management of NHS hospital productivity	HC 741



# Oral evidence

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## Taken before the Public Accounts Committee

on Tuesday 18 January 2011

Members present:

Margaret Hodge (Chair)

Mr Richard Bacon  
Stephen Barclay  
Stella Creasy  
Chris Heaton-Harris  
Joseph Johnson

Mrs Anne McGuire  
Austin Mitchell  
Ian Swales  
James Wharton

**Amyas Morse**, Comptroller and Auditor General, and **Karen Taylor**, Director, NAO, gave evidence. **Robert Prideaux**, Director of Parliamentary Relations, NAO, and **Marius Gallaher**, Alternate Treasury Officer of Accounts, NAO, were in attendance.

### Examination of Witnesses

*Witnesses:* **Sir David Nicholson**, Chief Executive of the NHS, **Jim Easton**, National Director for Improvement and Efficiency, Department of Health, **Richard Douglas**, Director General, Policy, Strategy and Finance, Department of Health, and **Professor John Appleby**, Chief Economist, Health Policy, The King's Fund, gave evidence.

**Q1 Chair:** Welcome. Thank you very much for joining us this morning. I think there is a general acceptance, so we don't really have to go back on it, that fantastic things have happened in the NHS over the past decade; lots of extra money's gone in; there has been lots of extra activity; health outcomes are up, although, as you know from one of our Reports, health inequalities have not been the greatest. What we are looking at today, and it's a very specific issue, is hospital productivity, and I know there's a feel that you want to look at productivity as a whole, but I think logically, we need to look at the parts of it. I really want to turn to you first, Sir David, and say I found when I read this report that it seemed to me a tragic missed opportunity that with all these great things happening and massive investment, productivity fell, except for the odd year, when you saw a little bit of a blip. Why?

**Sir David Nicholson:** I certainly don't accept that it was a missed opportunity in the sense of some of the things that you said right at the beginning: lots of really fantastic things have happened in the NHS and in hospitals over the last period. The issue for us is first of all the measure that's being used, which we think is an extraordinarily narrow measure—and I'm sure we'll get on to that in part of the discussion—and doesn't reflect, I think, the value for money improvements that we've made during that period. It's narrow for a whole variety of reasons. We don't believe it sufficiently reflects quality in the system and the quality improvements that we've made.

**Q2 Chair:** But just hang on, before we go down that route, because it seems to me that whatever the arguments, you have been able to negotiate—I said actually, ironically, we could have had an ONS person here today—but that has, as I see it, been up for grabs in negotiation between you for years and years and years.

**Sir David Nicholson:** Yes.

**Q3 Chair:** Let's accept that it's difficult to measure productivity. We all know that. It's difficult particularly to measure productivity in relation to quality. You've had a pretty good bash at trying to get that inputted and ONS have listened to you. So with the current measure, accepting all its faults, productivity is down and the tragic missed opportunity is that in the period of growth when you weren't looking for cuts you didn't take advantage of that period of growth to eke out best value for money.

**Sir David Nicholson:** But I think we did. And I think we did—

**Chair:** The figures show you didn't.

**Sir David Nicholson:**—during that period. It is not surprising, and if you look at health, public sector or private industry, when you put a huge amount of capacity into the system, the initial response of the system is for productivity, in the narrow way that is described, to go down.

**Q4 Chair:** But let me just stop you again, because I want to really focus on the issue. That would be true if we'd only had a couple of years of growth. We've had a decade of fantastic, massive investment. We've had some argument about the indicator that we're using and so on, but set that aside; nevertheless, it's down. You've got to accept that happened.

**Sir David Nicholson:** I can read the numbers. The numbers that are set out, in a very narrow definition of productivity, are down.

**Q5 Chair:** Why?

**Sir David Nicholson:** Inevitably in any organisation where you input huge amounts of resource, productivity goes down.

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18 January 2011 Sir David Nicholson KCB CBE, Jim Easton, Richard Douglas and Professor John Appleby

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**Q6 Chair:** Not for 10 years. That might be true in year one and in year two. You yourselves committed to the Treasury when they gave you the settlement back in 2002—I might be a year out there—that you would improve productivity between 1% and 2%. You failed. Now, I don't want to set aside the good things that you've achieved in your time there, but you have failed on this absolutely critical—for us, for this Committee—measure. Productivity's down. It is not good enough to say, "Too much money was coming in," unless—it was a decade. If you'd said that to this Committee in 2004–05 I think you might have had an argument. You're now in 2011. Why?

**Sir David Nicholson:** But if you look at productivity trends over the period—there are three trends to it really, and the biggest reduction in productivity was around about the time when most money went in. Over the last three or four years, productivity has recovered and is flat in the system as a whole, so that's the first thing that I want to say.

**Q7 Chair:** Well, I don't think John Appleby would agree with that, having looked at his Report.

**John Appleby:** Well, year by year—one of the issues with looking at this is, in the NAO Report for example, there's a figure 4 which presents a change in productivity as a sort of index. And it can give you certain information, but you also need to look at the year-on-year changes, and I've just tried to work out—it's very difficult to see from the line—when, in some years, in the early years, 2001 for example, it looks like productivity actually went up slightly in hospitals. The next year it went down a bit, next year down, then it was flat, then it went up and so on. So, I think you've got to look at some of these year-on-year changes as well, to get a slight picture. I don't think it's been a uniform, steady, downward decline. Overall it has, though.

**Q8 Chair:** I accept that. When I looked—I think it's in your Report, rather than the NAO Report—productivity only went up in the years that money went down, when budgets were in a mess.

**John Appleby:** I won't get into the ONS measures, but when you look at ONS measures for either hospitals or the NHS overall, what seems to drive—and given that productivity is essentially outputs divided by the inputs—changes in productivity is changes in the inputs, if you see what I mean, rather than the outputs. So when the inputs—when the money starts to get turned off or slows down, the outputs sort of carry on, there is a slight inertia, at least for another year or so, and then productivity goes up.

**Q9 Chair:** That's deeply depressing, isn't it? So, you spend less, you get more.

**John Appleby:** Well, there's a sort of good news/bad news in that one, I guess. The good news is that I would suspect—I would predict—perhaps that, for this financial year in England, where the money has slowed down quite a lot and it will slow down in terms of the growth next year, that productivity will go up on these measures.

**Q10 Mrs McGuire:** On these measures. Only on these measures? Not in terms of measuring quality, or the other indicators that we could look at?

**John Appleby:** These are largely measures based on activity so it's the outputs of hospitals and so on with some attempt to adjust for quality using waiting times and some other measures, poorly adjusted in a way.

**Q11 Chair:** Let me get back to the question, and I'm sorry to keep interrupting you, but I want to focus you. So let me accept if you put a lot of money in, in the early years, that's difficult. Let me accept that you've got a quarrel over the definition. Nevertheless, setting those two things aside, for me it is depressing to see that productivity still, over the period, averaged down. Why? Give me an understanding of why.

**Sir David Nicholson:** I don't think you should be depressed about it. One of the things that we've done over the last few years is to increase the amount of face-to-face contact time between clinicians and their patients. So, whether you're talking about consultants or GPs, they now spend more of their time face-to-face with patients than ever before and each individual patient is seeing more time. None of that is reflected in the kind of figures that we have there. There is a whole host of things that I would say.

**Q12 Chair:** It seems to me you're not accepting the original premise of the Report. Let me just quote to you what David Flory said on 9 December at the Health Care Financial Management Association Conference. He said, "We said 12 months ago"—so that's '08, presumably—"that we had an important year to work on this to get ahead of the game to prepare how we were going to deliver to this, so by the time we're getting to the next spending review we're delivering results as quickly as we need to. I'm not sure we've done that. I'm not sure that the actions we're taking across the services to improve our operating efficiency this year that we're doing as much as we said we were going to do at the start of the year. When I look at the headcount numbers from around the country, it doesn't reflect the sort of reductions we would expect from developing new ways of working, from moving forward in the way we had planned to be more productive and more efficient". So your No. 2 accepts you've got a problem. You don't.

**Sir David Nicholson:** I was there when he said it. I was there. He was referring to 2010–11—I'm sure we'll go into this in some detail later on—but in May 2009 when we identified that the years of growth were coming to an end and that the financial constraints on the NHS would get greater, we gave the service 18 months to get its plans in order, to make a good start in terms of quality and productivity for 2011–12. I think he was doing what you would expect him to do in those circumstances; he was giving a shot across the bows to the finance community to say, "You're not doing enough," which I think is a reasonable thing that you would expect.

**Q13 Chair:** So what do you think? Can I go back to you? Rather than trying to say, "Actually, it wasn't as bad as you think," have you got anything to say to

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the Committee about why you think these figures, the figures from The King's Fund, wherever we look, and your No. 2, suggest productivity is not as good as it should be and, from the NAO, productivity is down.

**Sir David Nicholson:** I'm a manager like them. I'm never satisfied—

**Chair:** No—

**Sir David Nicholson:**—with productivity and in a sense—

**Chair:** You're evading; you're constantly evading it.

**Sir David Nicholson:** No, I'm not, I'm not. I'm not saying that you would ever say that productivity was sufficient. All I'm saying is that, in the period we're talking about, there was an unprecedented amount of money put into the system and by using the narrow measure that you use there, it is either for the system as a whole flat over the period, or in hospitals, which I think is quite a difficult thing to separate out in the way it's described, it is negative. I would like it to be more.

**Q14 Chair:** So, you are on the whole happy that you are getting value for money over the 100-and-whatever-it-is billion pounds that is going in.

**Sir David Nicholson:** I'm not happy.

**Q15 Chair:** Or the 40% that goes into hospitals; we're looking at hospitals.

**Sir David Nicholson:** No, you would never expect me to be happy. I'm not happy.

**Q16 Chair:** I'm worse than that; I'm depressed.

**Sir David Nicholson:** Yes, I'm not depressed, though. I'm not depressed by it.

**Q17 Stephen Barclay:** I was a little surprised by your comment earlier when you said productivity has recovered and is flat, which doesn't strike me as a huge recovery, but can we focus on consultants, because the report says consultant productivity fell in seven of the eight years from 2000. Why?

**Sir David Nicholson:** Well, consultant productivity, as measured in the measure that you've got, has fallen across the whole of the developed world. All health care systems are going through this process at the moment and it's obvious at one level, because what's happening is first of all the evidence shows that health outcomes are better if it's a consultant-delivered service, so consultants are doing more hands-on work with their patients.

**Q18 Stephen Barclay:** But the purpose of your contract in 2003 was to shift control, so saying it's fallen in the rest of the world is a moot point, because we're looking at the contract you introduced and what happened here.

**Sir David Nicholson:** No, no, no, but you said why is consultant—and the second issue is that there's been a vast increase in the subspecialisation of consultants across the country. So, 20 years ago when I was running a hospital, we had four general surgeons. In that same hospital now you have 25 surgeons, all dealing with very specific conditions and services. So inevitably in those circumstances you haven't grown the number of patients at the same rate. Productivity

in the way it's described would go down. All of that, it seemed to me, was natural and in fact when we implemented the Consultant Contract what we said was that we would increase the productivity above the—let me get the right phrase here—

**Richard Douglas:** The historic trend.

**Sir David Nicholson:**—the historic trend, which is down, and down across the whole country. The big thing about the contract: for the very first time, it gave us management control over the time that consultants spent for the first time.

**Q19 Stephen Barclay:** Indeed. That control was one of the big selling points of the 2003 contract, so why haven't you implemented the PAC's recommendation from 2007 on job planning for consultants?

**Sir David Nicholson:** In what sense?

**Q20 Stephen Barclay:** The PAC made a specific recommendation in 2007; you were in post; you were appointed in 2006. You said what the purpose was in 2003. In 2007 they found that "NHS trusts with their clinical managers did not have the time or expertise to negotiate or carry out effective job planning. The Department and NHS employers should develop training aids and tools, such as electronic job planning software."

**Sir David Nicholson:** All of that is available to the NHS to use at the moment.

**Q21 Stephen Barclay:** So we now have effective job planning for consultants, following that recommendation in 2007?

**Sir David Nicholson:** In most organisations you have effective job planning for consultants. If you're saying to me: have we got it absolutely right in every place, no we haven't, but we have created the tools for people to use, and indeed, that is reflected in the information that we have about consultants.

**Q22 Stephen Barclay:** Well, it's not reflected in this report, because if we look at paragraph 2.4 what it says is, "Managers reported that the job planning process remains primarily a diary exercise and is neither effectively monitored nor tailored to the needs of the hospital, with job plans still not actively linked to the appraisal processes." So, as of this Report, job planning for consultants isn't working.

**Sir David Nicholson:** Frankly, the weakest form of evidence I see from the Report is a kind of, "We talked to a few managers and that's what they say."

**Q23 Chair:** You agreed this Report. In fact, I think it would be a much harder-hitting report if it wasn't agreed with your officials. For example—

**Stephen Barclay:** It's an agreed Report.

**Chair:**—there's a rather funny figure about labour productivity in there, which doesn't fit in with the others, and that's in because you wanted it in, so this isn't an NAO Report; it's an agreed Report.

**Q24 Stephen Barclay:** The Report says, "In 2010, hospitals managers told us that the Consultant Contract is still not used as a lever for change." What I'm asking is when this specific point was highlighted

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to you in 2007, that the original purpose of the Consultant Contract—the first one for 50 years—which was to shift the relationship, that was the driver of the contract—it's pointed out in 2007 that it's not being used to drive the relationship and then we find in this Report three years later that it's still not being used to drive the relationships.

**Sir David Nicholson:** Some managers have said to people in the NAO—I talk to lots and lots of managers and they would say the opposite of all of that. All I would say is look at the evidence.

**Q25 Stephen Barclay:** Okay, let's look at overtime then, because one of the concerns that we have is about where there are consultants gaming the system by, in essence, cancelling a clinical appointment, their clinical surgery, with 50 outpatients, and the administration that then is required and whether they then pick up some of that work in overtime in order to hit the waiting target that the hospital is being measured on. So, is the Department collating nationally data on the amount of overtime that is being paid and the impact that is being had in terms of potentially that gaming that is going on?

**Sir David Nicholson:** No, we don't collect information about that. But all I would say about all of that, and there's been, obviously, press coverage in the recent past, in the recent few days about all of that, is it seems to me there are two or three things. The first thing is the contract gives us the lever that we never had before—

**Q26 Stephen Barclay:** But you're not using the lever.

**Sir David Nicholson:**—which is the first eight hours of extra work that consultants do is given to the NHS at NHS rates. The second thing I'd say is that it's interesting that most of the rates that have been reported in the press are BUPA rates, so they are the rates that the private sector healthcare industry uses at the moment, which gives you an indication of the market value of some of our people and the rates that we get to pay for them working in the—

**Q27 Stephen Barclay:** Who picks—

**Sir David Nicholson:** But can I say that the other evidence that I'd like to get on to is, first of all, over the last three years the—I'll get this right—consultant productivity has bucked the trend by 0.8%, so it's 0.8% better than long-term trends in terms of productivity, and secondly, we've significantly increased the amount of direct patient care that consultants gave, which seemed to me absolutely would show that the Consultant Contract is being used in the way that was intended.

**Q28 Chair:** Stephen, I've got to interrupt that because figure 5 on page 15, which I understand was a figure put in at the request of the Department, I don't think it's that useful, but on that it demonstrates consultant productivity is the worst of any in the labour force.

**Sir David Nicholson:** Yes, but—well, I'm sure Richard can talk about this.

**Chair:** No, no, no. You can't—

**Stephen Barclay:** It's your lever. It's your lever that you've been telling us about.

**Sir David Nicholson:** Because what we said, right at the beginning, we would improve the long-term trend of consultant productivity, which is going down.

**Q29 Chair:** Which it isn't. On your figures, it's down, down, down, down, with no up.

**Sir David Nicholson:** Yes. Yes.

**Chair:** Maybe Richard Douglas can help.

**Richard Douglas:** The figure you're referring to, the one that was at our request, that tried to explain the differences before and after contract, is figure 6 on page 16.

**Q30 Chair:** Let's stick to figure 5. This is yours. Figure 5.

**Richard Douglas:** I don't know whether figure 5 was ours.

**Q31 Chair:** Karen Taylor, whose was it?

**Richard Douglas:** I know figure 6 was—

**Q32 Chair:** You told me in the pre-meeting it was theirs.

**Karen Taylor:** It was developed by us based on information discussed and shared with the Department on labour productivity.

**Q33 Chair:** But you put it in because they wanted it?

**Karen Taylor:** It was included because there are different trends in labour productivity compared with overall productivity.

**Q34 Chair:** Quite. So it was included because actually it was supposed to give a better picture than figure 4 or figure 3.

**Richard Douglas:** But figure 6 is the one that explains the comparison with historic trends.

**Q35 Chair:** So are you saying figure 5 is false?

**Richard Douglas:** No, I'm not saying figure 5 is false; figure 6 explains figure 5, and what that shows you is the historic trend around consultant productivity was an annual reduction of about 1.5%. Since implementation of the contract there has still been, on this measure, a reduction in consultant productivity, but of 0.8%, which is better than the historic trend.

**Chair:** So the reduction is less than it otherwise—

**Richard Douglas:** The reduction is less than historically—

**Q36 Chair:** That's outrageous.

**Sir David Nicholson:** No, but that was always the intention. That was always the intention.

**Q37 Stephen Barclay:** But when Professor Maynard is quoted as saying that consultants don't always keep to their job plans and then get the overtime, how are you collating data on that to measure that and assess that as a Department?

**Chair:** This is getting worse.

**Richard Douglas:** We don't collate that; it's Andrew's Department. We don't collect that.

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**Q38 Stephen Barclay:** But these are your targets, so you're setting the targets.

**Richard Douglas:** What we're doing is we're providing the NHS with the tools; we're providing them with resources, we're providing them with the quality standards they have to deliver.

**Q39 Stephen Barclay:** But we know they're not using the tools.

**Richard Douglas:** But it's then down to the individual organisations how they use those tools. We don't have the power to do it for foundation trusts, we can't stipulate those things.

**Q40 Chair:** Okay. I'm going to John Appleby in a minute, but can I just get this clear: you promised the Treasury in 2002 that if they gave you the extra dosh you'd improve productivity by 1% to 2%. You're now telling us that actually what was absolutely brilliant is that you've reduced the decline in productivity from one point something to 0.8 and you're happy with that?

**Richard Douglas:** No.

**Q41 Chair:** Yes or no?

**Richard Douglas:** No, that's not the case. We agreed with the Treasury that as part of the spending review settlement we would deliver efficiency savings, not productivity savings, of, I think, 1.3% was the figure. What you're referring to is the consultant productivity figure, which is a small subset of overall efficiency.

**Q42 Chair:** So you are happy to see consultants using extra money less efficiently.

**Richard Douglas:** I could argue with whether it's less efficiently; it's less productively—

**Q43 Chair:** Well, less productively.

**Richard Douglas:** It's less productively on this measure, but as David said, one of the issues around that is the amount of time that consultants—

**Q44 Chair:** No, hang on, I'm not going to have this argument about the measure, because the measure is something that you have negotiated with ONS over a long time, and we've just got to settle for it. You haven't been able to get to a better measure. This is the measure we've got and there is a genuine interest in productivity; there has to be an interest, certainly from us as a value for money Committee, in productivity, and simply to say the measure is wrong is a cop-out. Sorry, but it's a cop-out.

**Richard Douglas:** We're not saying the measure is wrong. We're not saying the measure is wrong; we're saying the measure is not a complete measure of efficiency and that's the only point I would make on that.

**Q45 Chair:** John Appleby, can you comment a little bit on this area: on the measure of productivity and why you think, from your observations over time at The King's Fund, we appear to have failed to use the increased money to increase productivity.

**John Appleby:** Are you talking more generally and not just about the labour productivity issue?

**Q46 Chair:** I'm talking about hospitals, of which labour is a component. So I'm not talking about anything else in the NHS; we're looking at hospitals.

**John Appleby:** Very briefly on "is it a good measure", well, it is a measure and I think we all agree that there are certainly deficiencies; ONS know that. Over my entire working life in health care and in the NHS people have been doing work on how to measure productivity and it is very difficult. And it's not just the NHS, by the way, or the public sector; it's the private sector as well. Trying to grapple with what are the outputs of the financial services industry is a difficult one and so on. So it's a common issue and a common problem in economics.

So there are problems, of course, and, as David said, one of the key problems is are we accounting for changes in the nature of the product that the NHS produces, i.e. the NHS, crudely, used to be making Minis and now it's making Rolls Royces, but we're still counting cars, if you see what I mean, and we're missing this change in the product; the quality has perhaps gone up. And I'm sure the quality has gone up and we're not capturing all of that, so the tricky thing I find with all of this is, I don't think any of us actually know, we simply don't have the measures yet, whether these figures are broadly reflecting the truth out there or whether, if we did have some proper quality measures, this would radically alter the graph or leave it roughly the same or leave it—I don't think anybody knows.

One thing I would just say, just around this measurement problem on quality, is that the English NHS, uniquely in the world, has embarked on collecting data from patients. They're known as Patient Reported Outcome Measures; they are on well-validated questionnaires; they're given before and after an operation; they're using clinical trials to capture what the patients feel about their own health status. The English NHS, as I say, is uniquely collecting this data on some common operations and the idea is to roll this out. It's that sort of data, i.e. from patients saying how's their health changed—I've gone in, had an operation—i.e. how's the quality of my life changed. That is going to be the key, it seems to me, over the next few years and into the future in grappling with this quality issue for productivity and a whole bunch of other things.

**Chair:** Okay.

**Q47 Mrs McGuire:** Can I just ask though, we've had 60-odd years of the NHS and yet we're hearing today that we still have not developed a set of measures that allow us to judge how well the NHS or how well our hospitals are performing. When are we actually going to get to a position where we can say, if not definitively, as near as dammit definitively, that we are getting best value for money—patients are getting quality of care? And it is back to the individual experience and the general view of the NHS. Ask an NHS patient—most NHS patients—and they will tell you, "I was looked after well, but," and it's the "but" that is created by the headlines, frankly. When are we going to get to the point that 60 years after Aneurin Bevan introduced it—

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**John Appleby:** Well, I think we're pretty close, actually, to be honest. Over the years there've been enormous amounts of research; there was Sir Tony Atkinson, an economics professor at Oxford employed by the Government, ONS, to produce a report on measuring Government activity and productivity. The Department itself has produced reports; economists at York and other places have been developing this, and I think that the measures that we've got in the NHS have improved. We are counting more things that we should be counting and so on. But you can still point your finger and say, "Well, it's missed out this bit of activity and that bit of activity." So I think the measures have got better and I think David's argument is that there are bits at the margin that it's not covering properly, which perhaps explain some of the annual changes that we're seeing over the last 10 years. I would say a tentative agreement to that. As I say, the trouble is none of us have in a sense the real figures. We simply haven't got those data, but I think this gives a pretty good impression about what's been happening with hospital productivity.

**Chair:** Okay.

**Q48 Mrs McGuire:** So this time next year or the year after we will be able to be in a position where we can say, regardless of the politics or the changes that are going to happen, that we have agreed a set of measures across the board that will allow an objective judgement to be made.

**Richard Douglas:** I think the important point is it's a set of measures. You will not have ever one single number that you can use to capture the full performance of everything that the NHS does. What you can have is an improved productivity measure and the things that John was talking about—he's absolutely right—the Patient Reported Outcome Measures, will make a lot of difference on this and we'll build those in, but you have to collect the data first to do it. We're about 18 months away from that measure.

**Q49 Chair:** I find this really a bit depressing, because given the imperfections, and we all know measuring productivity, particularly measuring productivity in the public sector is tough, so we all accept there are imperfections in the measurement, and I was trying to get off that, but given where we are on the measurement, the record looks bad. Or are you saying it is a complete waste of time even looking at productivity?

**John Appleby:** No, no, certainly not. I'm an economist; I couldn't say that. No, of course, it's very valuable to look at this.

**Q50 Chair:** So what do you learn? Why has it gone bad? Why does it look so bad?

**John Appleby:** The period covered by the report is in some sense unusual for the NHS. It's a period of rapid growth in funding; the inputs to the NHS went up; employment in England, I think, went from about 1 million to about 1.3 million over less than five/six years, so a massive increase in the inputs. Outputs also went up, so we put more in, we got more out. The problem is, at the margin the outputs didn't go up

quite as fast as the inputs and hence productivity fell. Just to take one other tack on this, it was a period when managers, hospitals, were getting lots more money; they were being set targets on waiting time and so on. There was huge pressure to employ more people. You may remember media reports: the doctors per thousand of the population in the UK and England were much lower than in other countries and so on. So there was a lot of pressure to actually boost the inputs to the health service. And the way to meet targets, the waiting times targets, was not necessarily to tackle some difficult issues around changing work practices and so on, it was buy more consultants, do more work and essentially that was the mindset, and I would guess to an extent managers did take their eye off the ball of productivity and value for money, because the money was there, the targets were set. They met their targets. The NHS, by and large, met all targets set for it over that period.

**Q51 Joseph Johnson:** You took on more consultants per head, but why did the cost per consultant go up so dramatically, at almost twice the rate of inflation, over this period? Why was that necessary?

**Sir David Nicholson:** Part of the NHS plan, the way it was set out originally, was that we wanted—I think I get it the right way round—it was more staff, better paid, and so there was a deliberate attempt to improve the pay of consultants, nurses, GPs in the system.

**Q52 Joseph Johnson:** Why was it necessary to increase the pay of consultants from £71,900 to £121,000?

**Sir David Nicholson:** Well, that was the plan at the time, to improve it.

**Q53 Joseph Johnson:** Why was that necessary?

**Sir David Nicholson:** First of all because there were significant vacancies in the system at the time, and we had lots of areas where we couldn't recruit staff and, of course, as you know, in lots of specialties, consultant recruitment is global, not just national, so we had to make sure that rates of pay went up. There was a focus on getting a contract, which for the very first time gave managerial control over the time that consultants made, and essentially that had to be paid for. So that was the reason.

**Q54 Joseph Johnson:** Did it represent value for money, that level of increase—the 68% increase over the time period?

**Sir David Nicholson:** In the sense it delivered what we wanted to achieve; it delivered record levels of recruitment; it delivered our ability to increase the medical workforce by 35,000; it reduced the vacancy rates in our system and improved the quality of service for patients.

**Q55 Joseph Johnson:** But it came at the expense of a near 20% decline in consultant labour productivity...

**Sir David Nicholson:** But—well, okay. But of course consultant productivity was going down anyway and continues to go down across the world, but that's much more to do with subspecialisation, so you don't have a general surgeon now who does a breast

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operation in the morning and an appendectomy in the afternoon. People have specialised in particular kinds of conditions, so you need more consultants.

**Q56 Joseph Johnson:** Why does subspecialisation inevitably lead to a decline in productivity? Normally you would assume that comparative advantage would lead to an increase in productivity.

**Sir David Nicholson:** No, no, not at all. So if, for example, you take something like cancer surgery, in the past you would have had a cancer surgeon who would have dealt with it. Now you'll have a multidisciplinary team including a pathologist, a radiologist, an oncologist, who will all sit together and look at that individual patient; they will probably see the patient either in a team or separately and you will have, out of that, a diagnosis, which we know has given us much better outcomes and much better treatment plans for our patients than one individual consultant just seeing that individual patient.

**Q57 Joseph Johnson:** So it's an inexorable trend, the decline in consultant productivity; it's not going to stop?

**Sir David Nicholson:** Well, I don't know if it's inexorable, because circumstances change, but certainly it is international if you look across the developed world. In all countries this is happening.

**Q58 Joseph Johnson:** When do you expect it to taper off and start improving?

**Sir David Nicholson:** Well, of course we have now increased the NHS by a third, over the last few years, so we're not in the place that we were in. We are now closer to European averages of expenditure on health. Our expectations are that that rapid growth in the number of consultants has come to an end. There clearly will be further growth as subspecialisation and techniques take us forward, so our expectation is over the next four years, as we take ourselves through that process, that the productivity story across the NHS as a whole, but particularly in consultants, will improve.

**Q59 Joseph Johnson:** And start to turn positive?

**Sir David Nicholson:** Whether we'll turn it positive—we expect it to turn positive, but only marginally so.

**Amyas Morse:** Just one thing: I think maybe it's understandable that there may not be a focus on raising productivity for consultants as such for the reasons you've given, David, but it is clear that, if you don't have cost reduction and value for money in the objectives, in the individual performance measurement goals of people, you won't get them to act according to it. And the work we did on preparing this Report showed that that was really only present in a very small minority of cases, so you are going to follow this through into a different approach to objective setting for individuals? If we just say, "Oh well, we're now going to be more productive," and if we don't drive that through into individual behaviours and performance management, it's really meaningless, isn't it?

**Sir David Nicholson:** But what we can do from the centre, of course, is create the environment, give people the tools, set the direction. We're not

micromanaging the NHS in every appraisal and every objective-setting process between an individual consultant and their clinical director or their medical director.

**Q60 Stephen Barclay:** But with respect, that wasn't the point the C&AG was making; he wasn't saying you should micromanage every operation or micromanage every hospital. I think I heard him saying: unless value for money and reducing the cost is part of the equation, and you set for hospitals what the equation should be, then it won't happen. That's what he was saying—what I heard him say.

**Sir David Nicholson:** And he's absolutely right.

**Q61 Stephen Barclay:** I just heard you say, "Whether we will turn it around or not," and it all sounded pretty doubtful and at best it would be—your words—marginally positive.

**Sir David Nicholson:** That's for consultants, because of the trends that I've talked about. It's quite difficult to work how that will work out in the next four years.

**Q62 Stephen Barclay:** Where is the productivity gain going to come from, because the Nicholson challenge, you know better than anybody else on the planet, is a big one. So where is the gain going to come from if not from consultants?

**Sir David Nicholson:** Well, first of all hospitals only take up about half of the cost of the NHS as a whole and, of course, we operate it as a system, not as an individual group of organisations in that sense and productivity across the system will improve over the next few years.

**Q63 Stephen Barclay:** I'm sorry, my question was: where will those gains come from?

**Sir David Nicholson:** Well, if you look at the challenge that we have to deliver the gains that we need to make in terms of efficiency and value for money, about 40% of those gains will come from a lot of the input stuff that we have, so the pay freeze, all of those sorts of things, the way we manage the costs of those inputs. About 40% are going to come from that and things that we'll do centrally—so the central changes that we're going to make to the budget of the Department of Health, reducing all of that; the significant reductions we're going to make to management costs across the system as a whole come to about 40% of those savings. Another 40% come from what traditionally would be described as efficiency and are driven through the tariff, so next year we've got an efficiency gain of 4% built into the tariff system being driven through the provider side of the NHS, so that's the way in which we will oversee that.

**Q64 Stephen Barclay:** But where inside the hospitals? If it's not the consultants, where inside the hospitals will those gains be being generated?

**Sir David Nicholson:** Traditionally they've been from the shift from inpatient care to day case care. We've still got a significant way to go to beat the best in the world in terms of the numbers of patients we treat as inpatients rather than day cases, so that means you

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would reduce the bedstock within hospitals; you'd save significant amounts of resource from that. In fact, we think that, if people moved to not even the best performance across the NHS, you'd save about £1.6 billion from doing that sort of thing. So all of that is within that 40% driven by the reduction in the tariff, and then you've got about 20% coming from service change.

**Chair:** I think we'll come back to the reduction in tariff. I'm just conscious that Ian's been waiting.

**Q65 Ian Swales:** Could I pick up a point referred to in figure 11 about emergency admissions? If we look at the line on figure 11, clearly emergency emissions have been going up quite dramatically and one would suspect that emergency-type treatment is more costly and therefore will appear as a negative in the productivity. And in paragraph 115 the very last few words indicate that attempts to control emergency admissions at local level have not been successful, so what's the story about emergency admissions?

**Sir David Nicholson:** Yes, I'm sure Jim can say something about all this, but this is an absolutely critical part of the story going forward. If you look at emergency admissions growth and you look at on any one day the kinds of people that are in our hospital beds who have been admitted as an emergency, a large proportion of them—large proportion of them—are people with more than three long-term conditions, diabetes, asthma, emphysema, those sorts of things, whose care for a whole variety of reasons has not been properly managed in the community. We think on any one day it might be a third of hospital beds are full of these people; it's part of the, in a sense, inexorable rise of emergency services.

Now, there's quite a lot of evidence to show that some relatively straightforward interventions, including better management of these patients, can restrict significantly the number of emergency admissions that you would get, for the benefit of the patients and the benefit of the NHS as a whole, enabling you to reduce your bedstock in acute hospitals. So that is our kind of story going forward. Now, what's happened is that there are some really good examples in some parts of the country where this has been achieved, but it hasn't been achieved across the country as a whole and part of the work that we've been doing over the last 12 months to get ourselves ready is to generate a comprehensive mechanism across the country to enable people with long-term conditions to manage much better themselves their own care.

**Jim Easton:** I think both your question and Mr Baker's question illustrate the conundrum of driving for better quality and efficiency and its relationship with hospital productivity, because I suspect the fact that emergency admissions have risen is a net contributor to hospital productivity as we've put more work through the existing asset base of the hospital, and as we do the things that are better for those patients with chronic diseases and allow them to be treated outside hospital, it is more efficient for the NHS spend in an area, but as scored against the productivity of that hospital.

**Chair:** I can't make head or tail of what you're saying.

**Jim Easton:** If you push more patients, Chairman, through a hospital facility, whether it's the right thing to do or not for those patients, you tend to increase the apparent productivity of the hospital.

**Q66 Chair:** Well, I can't think of any hospital—I mean, you find me a hospital. They are all cutting beds. My own local hospital—and I bet you if you went round here—closed its A&E over Christmas—closed it—and had people waiting on trolleys all over the place for hours and hours and hours. So I don't think there's a hospital that isn't running almost at 100% capacity.

**Jim Easton:** Well, precisely because it's increasing the rate of dealing with emergency admissions.

**Q67 Chair:** Productivity is still down.

**Jim Easton:** Almost, Chairman, you make exactly my point, which is that putting more patients through the facility can be worse for those patients concerned and apparently make a contribution to the apparent productivity by this measure of the hospital.

**Q68 Chair:** It doesn't. It doesn't, because it would show up on the stats.

**Jim Easton:** It will be making a contribution to the measured, by this measure, productivity of that hospital, but is not the right thing for those patients.

**Q69 Mrs McGuire:** Does this mean that the other part of the jigsaw, just to hopefully enhance Ian's line of questioning, is that the general practitioner's contract actually isn't delivering? If what you said is that there are numerous people out there who should be getting a better package of care and support in the community so they do not have to be admitted to hospital on an emergency basis, is that a question mark over the productivity of the GP's contract?

**Jim Easton:** Well, the GP contract, again, has delivered what it was set out to do, which was more time for individual patients—

**Q70 Mrs McGuire:** And five days closing over Christmas and New Year.

**Jim Easton:**—and some specific benefits for quality. The thing we want to do going forwards, exactly as you say, is to make a more direct link with the contribution that GPs can make in their contract to helping to manage some of these chronic patients with chronic diseases outside hospital more effectively.

**Q71 Mrs McGuire:** I'm not quite sure if you're saying there is still a great deal of room for improvement from the GPs in terms of the expensive contract that has been negotiated with GPs.

**Jim Easton:** But the GP contract has achieved the ends that it was set out, which was about gaining improvements in the outcomes for patients in terms of their experience of primary care, but it has not produced reductions in emergency admissions. It wasn't designed to do that. That problem has become more significant, just as the Chairman pointed out, and we now need to use those same incentives and levers that we have in the contract to achieve the ends going forward.

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**Q72 Ian Swales:** So what's happening in the parts of the country where this is being improved? Are we seeing emergency admissions going down and will that make hospitals look less productive? Is that the point you're making?

**Jim Easton:** Yes, that's the point.

**Ian Swales:** Right.

**Karen Taylor:** We've taken this into a whole new different discussion, but I just wanted to draw the Committee's attention to both the Cancer Services Report that we had a few weeks ago and also other Reports we've done like Dementia and End of Life Care, which have shown that patients admitted through the emergency route, rather than the elective route, spend longer and have worse health outcomes. So, yes, that translated into productivity would suggest even worse productivity, because they're staying longer and they're not getting the same outcomes. And in both of those Reports and in our Dementia Report, which are not that long ago, we've shown that the support to keep people in the community is still not there. And I know that was what you were just saying, but I think it's a very different argument we'd be looking at on productivity here and we don't actually know, but the indication is that they, as I say, stay longer and get worse health outcomes.

**Q73 Austin Mitchell:** I wonder why emergency admissions are increasing. Sir David's explanation is that a third of them represent failures of care in the community of people with multiple problems. That must have been a constant, and care in the community is getting better, so why are emergency admissions increasing at this rate?

**Sir David Nicholson:** Well, for those two reasons. First of all, that people have long-term conditions, so you're getting more multiple admissions to hospital than we've ever had before.

**Q74 Austin Mitchell:** Why are they suddenly surging forward?

**Sir David Nicholson:** Well, they're not. It's been a relatively constant increase over the last few years. So there's that. There are also the demographic changes in society, of course, because our population is getting older and frailer.

**Q75 Austin Mitchell:** I think that's right; our population is getting older. But wouldn't it be better if you had specialist consultants on the emergency side so they could either tell them to bugger off or decide that they needed to be put inside, because if you've got junior doctors manning the front they're less able to make those decisions with clarity.

**Jim Easton:** It's a trend that has exactly happened. One of the reasons that we have more consultants is that, to serve those patients better, we've increased the number of senior doctors available to assess and initiate treatment.

**Q76 Austin Mitchell:** On the emergency?

**Jim Easton:** On the emergency side, rather than junior, so whilst juniors remain a core part of that service, if you're admitted with a stroke, that's no

longer somewhere where you get parked in an area and slowly assessed. You are immediately under the care of a senior team providing senior expertise, so it's part of the quality growth that has fuelled the growth in consultants.

**Q77 Austin Mitchell:** Okay just one more question. Isn't it a fact really that the cause of this problem is that you didn't use Agenda for Change or the big amount of extra money that you gave doctors under the new contract as levers for productivity improvements in the way you should have done? You might have said, "This gives the hospitals the tools to do that," but the hospitals didn't do it.

**Sir David Nicholson:** Some did it, but I agree that it hasn't comprehensively been adopted across all hospitals and it is taking longer to get the benefits out of that than when we put the contracts in. That is true.

**Q78 Austin Mitchell:** So you trusted the people to who we're now passing power, under the new health service reforms, on Scout's honour, to increase productivity, and they didn't.

**Sir David Nicholson:** Well, in terms of foundation trusts and the powers of individual hospitals, I don't think the reforms we're talking about now are any different to the ones that we had before. There's been a trend for the last 10 years to give more power and control to individual hospitals, but that must be the right thing, because it's in the discussions between individual clinical directors that this be changed.

**Q79 Austin Mitchell:** I meant GP commissioning.

**Sir David Nicholson:** Right. Okay.

**Q80 Mr Bacon:** Mr Easton, very quickly: you mentioned stroke and how stroke patients are now immediately under the care of a senior physician. Is it now the case that such a person will always be scanned?

**Jim Easton:** Well, the National Stroke Strategy sets out how we intend to implement that in every part of the country. I haven't come with the latest figures of the implementation, but there's an impressive steady implementation of that strategy across the country and stroke care is transforming, so that from being kind of a chronic disease management service, as you know, it's becoming an acute and emergency service, with, as you say, immediate scanning, immediate access to a consultant and proper specialised stroke care and there is a process of implementing that in every service across the country.

**Q81 Mr Bacon:** So immediate scanning will become the norm.

**Jim Easton:** Yes, absolutely.

**Q82 Mr Bacon:** I asked because that was a specific recommendation we gave you some years ago. When will that be achieved? February?

**Jim Easton:** Forgive me, I haven't got the figures with me today.

**Sir David Nicholson:** We're over 90%.

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**Q83 Stephen Barclay:** You recently commissioned a large-scale workforce change programme to share good practice on the Consultants Contracts. How much did that cost and how do you measure its performance?

**Sir David Nicholson:** I haven't got that bit of information. I can give you a note for that.

**Chair:** Again, in writing would be helpful.

**Q84 Stephen Barclay:** Yes. So you're not actually measuring the outcome of that major change programme?

**Sir David Nicholson:** No, I'm sure we'll measure it by the number of PAs per consultant, and we will measure it by the amount of time they spend directly with patients.

**Q85 Stephen Barclay:** Where consultants cancel, for example, their outpatient clinic, who picks up the administrative cost associated with that?

**Sir David Nicholson:** Cancelled for what?

**Q86 Stephen Barclay:** For whatever reason. If, with six weeks to go, or less than six weeks, the consultant cancels their outpatient clinic, 50 patients at a outpatient clinic—they all need phoning, booking, whatever—who picks up all the cost associated with that?

**Sir David Nicholson:** The hospital's responsible.

**Q87 Stephen Barclay:** Yes, so the hospital picks that up. How is the consultant penalised on their contract?

**Sir David Nicholson:** They're not directly penalised on their contract if they have to cancel their outpatient clinic.

**Q88 Stephen Barclay:** What I'm driving at is how productivity links into their contract, because if they cancel their outpatient clinic and then it happens that those patients get close to a target and they have to be seen, they, or another consultant, potentially will be paid overtime to see them.

**Sir David Nicholson:** Yes. And I think there is always that potential in the system and I'm sure that we can find examples of that happening. My own personal experience of working with consultants is you spend more time stopping them working than working. They've got a voracious appetite to treat patients.

**Q89 Stephen Barclay:** Do you collate any data on how many hours consultants are doing in terms of their private practice, linked into how much overtime they're doing?

**Sir David Nicholson:** No.

**Q90 Stephen Barclay:** Are there any concerns? We had the case in the media recently of someone paid £105,000 in overtime in Coventry and Warwick, which if you equate it to the number of hours, means that they must be doing about 11 hours of overtime per week assuming they have no holidays in the year on top of their 40 hours basic contract. If they do private work on top, they do a further four hours, so that's 44 hours, plus their overtime of 11 hours, plus their private practice. So what I'm driving at is, if

you're a patient going in, who's assessing how many hours in total a consultant has done between their basic hours, their overtime, their private practice work and how tired they may be when they're operating?

**Sir David Nicholson:** Yes. That's a matter for the board of the individual organisation, whether it be a foundation trust or NHS organisation. It's their responsibility to manage their consultant medical staff.

**Q91 Stephen Barclay:** So they would be gathering those sort of data in terms of measuring how many hours a consultant has done in the round?

**Jim Easton:** When I was a hospital chief executive—interestingly Professor Maynard was my chairman, which is fascinating—the contract gave us for the first time the ability to properly quantify time exactly the way you've described. So pre-contract there was no measure of the time being spent in the different activities, and we introduced, based on some professional standards that doctors signed up to as part of their professional responsibilities, expectations about how much work they would do in total. We didn't monitor their private work, but we had a clear agreement about what was acceptable in terms of tiredness and contribution to work. So the contract gave us the ability to measure and introduce that sort of mechanism to ensure patient safety in hospital.

**Q92 Stephen Barclay:** And in terms of the overtime, because one of the findings in the report is that hospitals don't even understand why there's such variation in cost for the same things between different hospitals, would one of the key factors in that be the fact that some are paying for the same thing to be done as overtime, compared with other hospitals?

**Jim Easton:** It may well be. There will be a huge amount of variation in terms of individual packages of how we cope with additional work in hospitals between work done on a grace and favour basis and then perhaps a higher premium for work above that. So there's a lot of individual variation and I'd go back to Sir David's earlier point, which is in my experience I think in the evidence the rates of overtime that the NHS is paying are in general significantly less than those same individuals could secure doing private work. So they are still choosing to offer the NHS their scarce additional hours at a lower rate than they could secure simply by doing private activity.

**Q93 James Wharton:** Mr Barclay has in his usual masterful way led directly into what I wanted to talk about, which is to get an understanding: there's a lot more money gone in and productivity has not matched that. That is the basic finding of the Report. Now the arguments that I'm getting coming back are that the way that we measure productivity is not necessarily applicable and that working practices have changed, so for example having more consultants doing specialist things will affect that. What that doesn't explain for me and what I don't understand is this very wide variation in the efficiency of individual hospitals and the cost per unit of work done, and there are some examples in the Report. A first time elective coronary artery bypass graft varies between £5,000

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and £12,000. Variation between non-specialist hospitals in average day case rates for all procedures is 35%. Now, the changes that we've heard about from you so far are I assume broadly across the board for hospitals, so why is it that some hospitals are delivering operations and activities for a much less expensive rate than others? I'm happy to hear anyone who feels they have the most appropriate answer to this.

**Sir David Nicholson:** Well, I don't know whether I'll have the appropriate answer, but the first thing is that the amount of variation has actually reduced over the last few years, when you take the totality. All right, there will always be outliers, and examples of outliers that are completely out, but generally speaking, if you look at it, if you do the analysis, you will see that that has narrowed, and that's partly because of the national tariff, so we have a national tariff system now where you get paid, wherever you are in the country as a hospital,  $x$  amount of money for an individual operation or whatever. That has reduced the variation of cost across, but you're absolutely right, there are still variations. But the variations in health care are probably less than those in certainly most other industries.

**Q94 Stephen Barclay:** That's the one you were referring to that only covers 60% or is that covering 100%?

**Sir David Nicholson:** I'm sorry?

**Stephen Barclay:** You were just referring to the fact that there is a national tariff. Are you saying that that covers 100% or only barely just over half, 60%?

**Sir David Nicholson:** No it covers 60%. Yes, sorry.

**Richard Douglas:** 60%.

**Sir David Nicholson:** But we collect detailed information for costing purposes, and if you look at it over the last few years it has narrowed overall quite significantly, and you would expect that, as people can benchmark themselves and it's transparent in the sense that you can look at the cost of others and measure yourself. So you have seen that. At one level we want the average to get more productive and more efficient, but there will always be variation. And one of the things I think that we would encourage is that there's slightly more variation at one level, because innovation and change will inevitably want to drive the top end of productivity and efficiency, so we don't want to crush variation completely but I do think we've made some progress in that.

**Q95 Chair:** John Appleby wants to come in.

**John Appleby:** Yes, a quick point on what's known as the National Reference Costs, which have been collected I think since '98.

**Richard Douglas:** Roughly '98.

**John Appleby:** For some years now. Hospitals have to supply data; they have to cost out down to individual procedures, not just a hip but a certain type of hip for a certain type of person and so on. And we go into hospitals and ask them about how they do that; how do they allocate all their costs down; it's quite a tricky business and it also involves apportionment and so on. So it's not surprising you see some variation, it seems to me, about how different hospitals interpret how

they apportion the costs, and that's something that's been shown in various studies.

The other thing is that there was a study some years ago by an economist at the University of York, who tried to show what variation you would expect between hospitals on different measures of different costs for different procedures, and he seemed to suggest that actually there wasn't any statistically significant difference, although you did see a variation. A large part of that variation was due to chance and a lot of the hospitals' costs were in a sense statistically similar, so there is that work, and in the end there will be some genuine differences, because some hospitals will be more efficient at producing a hip than some other hospitals, but I do think there are some data quality issues with some of this that I think everybody's aware of and that have got better over time.

**Q96 James Wharton:** I want to follow up that comment. If we have different hospitals struggling effectively to measure the cost of different operations or activities, would it not be worth having a standardised way of doing that across the NHS, or at least working towards that?

**Sir David Nicholson:** There is a standard.

**Q97 James Wharton:** There is? So it's the implementation of that that's proving difficult.

**Sir David Nicholson:** It's the implementation, yes.

**Q98 James Wharton:** And, as Mr Barclay pointed out, if 60% is being assessed against this tariff, which means that 40% isn't, when are we going to see that other 40% brought into this system that, according to the evidence you've just given, is one of the drivers for actually bringing this efficiency about?

**Sir David Nicholson:** The big bits that we've yet to do are mental health and community services. We've started to collect data this year and we'll be running a series of pilots next year for mental health. We're starting to collect the data next year for community services and we'll have a series of pilots the year after to make sure that we can do what we say we can, so over the next three or four years you will find the vast majority of activity that's done by the NHS come under some kind of either national or local tariff system.

**Q99 Chair:** You've talked a little bit about the national levers that you have to try and enhance productivity. I just want to ask you firstly about the tariff and then to go on to others. The tariff appears to be the one that you think is the most potent in enhancing productivity. Have you any comments on Carol Propper's view that cutting the tariff is likely simply to cut quality? It's a quote from her patients study: "Hospitals under financial pressure focused on cutting prices and shortening waiting times at the expense of quality." As a result patients "in hospitals located in competitive markets were more likely to die after an admission following a heart attack." So is cutting the tariff the appropriate way to enhance productivity or will it just damage quality?

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**Sir David Nicholson:** Cutting the tariff on its own is simply not enough, because people will need help and support to do the kinds of things that they need to in order to deliver a more efficient system—hence, Jim and his team, all the various programmes they’re running to support and help people do that. If you are talking about price competition as an issue, that is not what we have at the moment; we have a national tariff system.

**Q100 Chair:** But we’re moving to it?

**Sir David Nicholson:** We have a national tariff system. I think we should be very cautious about price competition in health care for the very reason that you described. The international evidence seems to show that, if you introduce price competition, you can get to a place where quality suffers. In a sense, people reduce quality in order to deliver. But it’s not necessarily the case because the issues are first of all: have you got measures of quality? So, can you say what you expect from them? Have you got real good measures? Have you got real good measures of monitoring quality, and have you got patients who have the knowledge to be able to work out whether the service that they’re getting themselves is the kind of quality that they’d expect? If you’ve got those three things in place, I think it’s possible to start talking about price competition. But it seems to me, until you have that, it’s a very dangerous thing to do.

**Q101 Chair:** That’s really interesting because of course price competition is an element in the health service reforms.

**Sir David Nicholson:** The ability to do it is, but as I say, in my view you need to be very cautious about it.

**Q102 Chair:** Is your view going to influence what’s going to happen in the health service?

**Sir David Nicholson:** In the future, the tariff is set and the arrangements for those are set by a combination of the commissioning board and the economic regulator. It won’t be set by politicians.

**Q103 Chair:** But that will be the new regulator anyway or something, as I understand it, but as I understand it under the health service reforms there’ll be a maximum tariff, there won’t be a minimum tariff. People will compete, so is what you’re telling us today that actually, until you’ve got all these other safeguards in place, that’s extremely dangerous in terms of quality?

**Sir David Nicholson:** That’s what I think.

**John Appleby:** I think the economic evidence does suggest that there’s a potential trade off between reducing price and shaving a bit off quality because it’s very hard to see quality as a consumer of things, especially in health care. We’ve had that debate about how do you include quality in the measure of productivity, so of course there is that danger, so Carol Propper is right on that. There are two things: one just to point out is that the tariff is already—and when it was first introduced—putting quite a lot of pressure on hospitals because it was a fixed price set at roughly the average of all the costs across the NHS, so by definition there would be some hospitals whose costs

would be higher than the tariff and some below. So already it put quite a lot of pressure on some hospitals. One of the ways around that or one of the ways to deal with it is that the hospitals then look at their costs and say, “We’ve got to do something about that.”

But there are other actions that they took. One is to cross-subsidise, so they’ll have other things that they were making a profit on, so in a sense the actual incentive effect was attenuated almost to zero for some hospitals. The Department have this price lever and, correctly, are using it, up to a point, to put pressure on hospitals; they’re squeezing down on the price of it each year, and that’s building in the efficiency. The question is, how do hospitals then behave? How do they react? As I say, one reaction is a good one, which is they then think, “Well, we’re not being very productive; let’s look at our costs. We’ve got too many buildings,” or whatever it is. They also react by cross-subsidising and they also react, I suppose at the extreme, by thinking, “Well, is it worth us even supplying ophthalmology now”—or whatever it is—“because we simply can’t supply at the price?” That’s what happens in private industry and so on.

So there are limits to how much you can use this price lever to squash down. But just on the price competition, that’s actually in the operating framework. It was flagged in the operating framework from last year; it’s in the operating framework for NHS for next year, and indeed, the operating framework warns commissioners that, if they get into this, they have to keep a strong eye on quality because there is a danger that there is a trade off between a lower price and quality. The Department have said this publicly and put this out to the NHS.

**Q104 Mrs McGuire:** Are there any lessons that we can draw across from the private health care sector or is it not big enough in the UK?

**John Appleby:** Lessons in what sense, sorry?

**Q105 Mrs McGuire:** I’m thinking in terms of driving down costs and managing cost and quality, getting the balance right. I appreciate it’s not quite as competitive a market as it is in other countries, most notably in the States, but I’m just wondering if there are any tricks that they have that perhaps could be imported into the NHS.

**John Appleby:** Yes, I would say there are.

**Mrs McGuire:** I don’t mean tricks in a nasty sense, but you get my drift.

**John Appleby:** No, no. One tactic is to pay their medical workforce less. You employ them on a different contract.

**Q106 Mrs McGuire:** Right. That’s not one that I would necessarily endorse.

**John Appleby:** Well, exactly, it may not be desirable.

**Q107 Mrs McGuire:** I was thinking of good practice, as opposed to driving down wages and salaries of hardworking staff. *[Interruption]* I’ll take consultants out of it, sorry. A heckle from the side, here. Just ignore it.

**John Appleby:** One would be to specialise in a more production line sort of way, so specialise simply on

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hips, for example, or simply doing cataracts. It's something the NHS has done in its history anyway. We have quite a lot of NHS treatment centres, which isolate elective surgery away from emergency and so on, so I think there is some cross fertilisation between the sectors. Just one thing on the price competition—we were talking about the private sector—something that quite a few other countries do is allow price competition in the private sector, but in the public sector they have fixed prices. I think that's the case in Norway for example. So private hospitals can charge less.

**Q108 Chair:** And what does that do to quality?

**John Appleby:** I don't know, frankly. But what it does do to prices is they charge quite a lot less.

**Q109 Joseph Johnson:** Was wage inflation for consultants the same in the private sector as for the public sector, NHS, over this period?

**John Appleby:** I don't know.

**Q110 Joseph Johnson:** What's your best guess then? Do you think it's relevant?

**John Appleby:** Well, organisations like BUPA and the private healthcare organisations always try and keep an eye on their costs, and those are the key costs for them. I would guess it's similar. I think there's a general recognition in the NHS that the BMA got a good deal for their members on pay, and I think this year consultants' pay is frozen in real terms. They're now facing another two years of a pay freeze. GPs similarly I think have had two years of essentially a pay freeze, and I don't think we've had too many GPs complaining in the press about their pay freeze, but they will have had a four-year pay freeze by the end of the public-sector pay freeze.

**Q111 Chair:** We've talked about pay. We've talked about the tariff. What are the other national levers that could drive better productivity—national levers?

**Sir David Nicholson:** We only went over one part of the tariff. There are other elements of the tariff that I think are important, like the best practice tariff, so identifying what best practice looks like and then identifying a tariff for that, whereas, as John was saying, in the past we've tended to do averages of what the existing arrangements are. So I think that's quite an important step forward and we've started to do that this year. In leverage terms, clearly there's the issue of pay, and as John has said, we've now got a two-year pay freeze for the public sector against a background of, in real terms, consultants and GPs, GPs in particular, for the last two years having essentially a flat growth in their pay.

**Q112 Chair:** So pay and tariffs are your main levers?

**Sir David Nicholson:** I'm sure there are other levers, but in terms of hospital services—

**Chair:** Has John got any ideas?

**Jim Easton:** They're the hard, direct, economic levers. There are softer levers, but none the less important, that we're also trying to deploy in terms of going forward.

**Chair:** Working practices?

**Jim Easton:** Providing support to change in working practices, dissemination of information, actually getting people involved in programmes of direct change and how to get more productivity out of your nursing staff in the ward, how to get better change in long-term condition care and we're deploying those programmes.

**Q113 Chair:** Is the fact that PCTs are haemorrhaging people at the moment, impacting on the ability of the service to deliver productivity gains?

**Jim Easton:** So what you saw prefigured in the operating framework was how we're going to create some cluster arrangements to protect the capacity for change.

**Q114 Chair:** Are you telling me that the fact that there is a haemorrhaging of staff at PCTs will not impact on your determination, on your ability, to deliver productivity gains as set out by Sir David in his £15 billion to £20 billion?

**Jim Easton:** I don't recognise the word "haemorrhaging." There certainly are reductions; people make other choices.

**Chair:** Well, I can tell you they're haemorrhaging.

**Jim Easton:** Some of them are moving to other parts of the new system and choosing to go and work with their GP surgery or hospital—

**Chair:** Deckchairs on the Titanic, you mean?

**Jim Easton:**—and therefore carrying those skills for change with them, but what we are doing is making sure that we identify—

**Q115 Chair:** Can you just answer the question? Are you satisfied, as the leaders of the NHS, that the loss of staff, if you don't like haemorrhaging, to PCTs will not damage your ability to deliver on the productivity gains set by Sir David?

**Jim Easton:** I agree that if we simply left it and hoped for the best in this change as PCTs are gradually wound down and commissioning groups gradually start, if we just left that, then that would significantly damage our ability—

**Chair:** Are you satisfied the arrangements you have made will protect it?

**Jim Easton:**—and that's why we're putting in place today new arrangements to make sure that we protect that capacity—

**Chair:** Are you satisfied?

**Jim Easton:**—and we believe that will enable us to protect these changes.

**Q116 Chair:** You are satisfied you will be able to protect them, so have you delivered on QIPP, which you are almost a year into?

**Jim Easton:** We've delivered the first year's exactly as we said we would, in terms of local planning, the impact on pay.

**Q117 Chair:** Have you delivered the savings?

**Jim Easton:** The pay impact was the first thing we set out to deliver and we delivered on that, we delivered our efficiency requirement for the year, so we think we had a good first year.

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**Q118 Chair:** How much have you saved in the first year, the first nine months or whatever we're into? How much are we saving?

**Richard Douglas:** The payment was 2.5—

**Chair:** The pay freeze is the easy bit of it; what about the rest? For the pay freeze you don't have to do a lot; I mean, it's terrible for the people whose pay is frozen, but you don't have to do a lot. It's the rest that is the test.

**Jim Easton:** Nevertheless, that was the sequencing of how we intended the money to flow.

**Chair:** Have you delivered on the rest?

**Jim Easton:** In our first year that was the major saving we slated to achieve, and we've delivered the preparatory work for the coming two years, so we have delivered what we set out to do in the first year. You're quite accurate to say that it begins to get more challenging and more difficult as you go into years 2, 3 and 4, and that the change processes we're going through, if they were left simply to their own devices, could create significant disruption to that process, which is why we've responded in the way we have.

**Q119 Chair:** We'll come back to the future, but does John Appleby want to talk about a) national other levers and b) the interim environment?

**John Appleby:** It's right that the two hard levers are price, the tariff, and that's been pushed down, and there are issues around making national decisions about pay as well, and those have been taken, and those were mooted by many people, including The King's Fund, as possible decisions, hard decisions—they're not easy decisions to make and they're not pleasant for people either—but these are some of the national decisions that we made. I thought those were the two key ones.

What I think the NHS is going to need—I think this is generally recognised—a lot of support and help. It's not the NHS's wont to be particularly obstructive and not be productive and so on and just waste taxpayers' money; I don't think that's the case. But they're going to need a lot of support and help, and not just be bashed over the head with a lower tariff as well. It was a bit like when the Government wanted to bring down waiting times, and we all wanted that as a public and patients, and it wasn't that the NHS was deliberately trying to keep waiting times high, it was just that they didn't always know how to actually bring them down. And so we had something called the Modernisation Agency, which actually went out and helped the NHS achieve, and I think in a way the productivity target now is the new waiting times target, if you like, and the whole of the NHS knows this and they want to do their bit and they want to be more productive.

**Q120 Chair:** But we're abolishing the productivity target, aren't we?

**John Appleby:** Sorry, which target?

**Chair:** Any productivity target; are we going to have 'em?

**John Appleby:** There is essentially a target that is well promulgated throughout the NHS, and the value of the productivity gain is going to have to be about £20 billion—the value, not the cost—over four years.

**Chair:** And that will inform even in the new world?

**Sir David Nicholson:** Absolutely.

**Richard Douglas:** The value—it's £20 billion overall efficiency in the system, and we've got to be careful. The only way the numbers would add up over the next four years in terms of saying, "This is the amount of money we've got; this is what we know the demographic and cost prices are. The only way we could make those two numbers come together is by delivering around £20 billion efficiency savings." So you don't need to express it in a target, and performance manage it as a target; it's something we just have to deliver.

**Chair:** What do you call it then?

**Richard Douglas:** Well, it's the Nicholson challenge.

**Karen Taylor:** I just need to clarify something. In our Report, in paragraph 2.8 we have a statement, which is what we believe to be the case and which we also took it that the Audit Commission believes to be the case—that payment by results currently covers 60% of the income of an average hospital. What we're talking about there is not the mental health and community care that don't have tariffs, which I acknowledge are a big challenge, but 40% of hospital activity is not covered by tariff. There was a bit of a difference earlier. I just want to clarify that you agree that that's the case.

**Sir David Nicholson:** Yes. All I would say about that is, if you read the operating framework, it makes it very clear that we expect the same delivery of efficiency gain for those services not covered by the tariff as we do everything else. So this year, the efficiency gain built into the tariff is 3.5%, so our expectation is that across the rest of the services that 3.5% is delivered. Next year it's 4%.

**Q121 Stephen Barclay:** Just flowing from that, one of the levers referred to in the Report is better benchmarking as a way of driving productivity, and it gives two examples—£300 million potential savings on emergency admissions and £500 million a year savings on staff per bed. What sort of date do you think you could get that recommendation implemented by?

**Sir David Nicholson:** Those calculations you've described are built into our savings programme for the £20 billion over four years, so we expect to deliver that over the four years.

**Q122 Stephen Barclay:** Sure, but if we can deliver it more quickly then it obviously makes sense to do so. What I'm driving at is the Report makes very clear recommendations on staff per bed, how many staff we have. There's a very wide ratio. In fact I'd be interested to know which is the hospital, there's one hospital that has 13 staff per bed and a number of other hospitals have fewer than four staff per bed. So which hospital would have 13 staff per bed? Or could you let us have a note, perhaps with a breakdown? There's a massive fluctuation there, isn't there?

**Sir David Nicholson:** Yes.

**Stephen Barclay:** This is figure 16 on page 34.

**Sir David Nicholson:** Partly because some hospitals are more effective and more efficient than others, but also because they use their beds quite differently. So

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there are some parts of the country where you're now in hospital for less than two days for a hip operation, whereas some you're in for four or five days. Now, the intensity in which those patients are staffed during their period in hospital is much greater than that elsewhere, so you've got both. It reflects variation in productivity.

**Q123 Stephen Barclay:** Absolutely; I'm a localist, so I accept as a localist there will be variation, but what I'm asking is, does the Department fully understand why that hospital, which is unnamed—it'd be interesting to know which one it is—has 13 staff per bed when a number of others have fewer than four staff per bed. Is that understood? Are the manager and the chief exec of that hospital getting bonuses when actually their performance isn't good, or is it actually, no, that's excellent performance, they need to have 13 staff per bed; there's a particular reason?

**Sir David Nicholson:** Of course, we don't give out bonuses to hospital management.

**Stephen Barclay:** I know you don't.

**Sir David Nicholson:** We don't do that. The most important thing is, does that hospital know where it fits on the benchmark?

**Q124 Stephen Barclay:** Well, the report says the hospitals don't know. That's exactly my point, Sir David. If one turns to paragraph 3.13, "We've found that hospitals make limited use of comparative data and benchmarking against peers." You're making my point for me. It even refers to, "Our view of hospital board minutes found that Non-Executive Boards generally held hospitals to account using national quality metrics and performance. However, data is not always linked in a way that would enable boards to assess both performance and expenditure and hence productivity." So what this is saying, if I'm reading it correctly, is that the boards are not benchmarking nationally, and I would have thought the Department has a role to play in facilitating those data and challenging, where required, to say, "Just a second here, you've got 13 staff per bed; you've got specific local circumstances, but those only justify having double the number of staff per bed as the other hospital, not triple."

**Richard Douglas:** Can I just say that we do facilitate those data? All these data are data that we put into the public domain; these are not data that are hidden.

**Chair:** Poor hospitals, so they'll know—

**Richard Douglas:** They will know exactly where they stand.

**Q125 Mr Bacon:** But what about the second part of Mr Barclay's question? It's one thing to say, "We make the tools available, we facilitate," but you're not using the tools, challenging them. Do you do that as well?

**Richard Douglas:** Well, the main challenge to the hospital, to an individual foundation trust, has to come from its own board. That's how they've been established. They've been established as independent organisations.

**Mr Bacon:** So the answer to my question is no?

**Richard Douglas:** Well, the challenge should be made locally by that local—

**Chair:** So the answer is—

**Mr Bacon:** So the answer to my question: no.

**Richard Douglas:** Does the Department challenge a foundation trust on these—

**Q126 Mr Bacon:** When you see a chart like this, do you phone the hospital and say, "What are you doing about this?"

**Richard Douglas:** Not if it's a foundation trust, no.

**Mr Bacon:** No, you don't; okay. All you had to do was say no and we'd have moved on 45 seconds ago.

**Q127 Chair:** John Appleby, because we've got one last set of issues to cover.

**John Appleby:** Just a quick one, my suspicion with that graph is that there are issues to do with specialist hospitals.

**Mr Bacon:** I'm sure there are.

**Stephen Barclay:** I accept there are variations, I'm not disputing that.

**John Appleby:** All I'm saying is—

**Mr Bacon:** Intensive care and all the rest of it, we'd expect much higher.

**John Appleby:** So if you saw the names, you'd probably—

**Chair:** Okay.

**Karen Taylor:** I can tell you that the bottom 10 are usual specialist hospitals. That's when it gets interesting, when you get beyond the bottom 10.

**Q128 Mrs McGuire:** Could I just follow this up? How then do you assess at the centre, when you're writing the cheques to the foundation hospitals, or whichever hospital, that they are providing value for money? Because actually, not to pre-empt a discussion that we may be having tomorrow, it's how you track public money and how you assess whether or not that public money—it doesn't matter who's spending it, it's still taxpayers' pounds—is delivering value for money.

**Richard Douglas:** We set the price. Obviously the key lever is that we set the price for the different units of activity. We don't base that on what it costs that hospital itself, we base that on what the average cost is across—

**Q129 Chair:** Can you just answer the question? So you don't track? You don't track?

**Richard Douglas:** But that is the answer. We track the money.

**Chair:** If we said to you, "I know Queen's Hospital Romford doesn't give you good value for money," you don't track that? I just know it as the local MP.

**Richard Douglas:** When we set the budget, we set the budget based effectively on the average cost, because that's what the tariff does. So it isn't based on what the costs are in your local hospital.

**Q130 Chair:** That's outrageous; it's a real indictment. We can't have a system where there's over £100 billion going out and yet the Department is telling us you're not accountable—tracking accountability.

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**Richard Douglas:** We're accountable for the money that goes into the hospital and we're accountable for the delivery of quality standards.

**Chair:** You, Sir David, are accountable for value for money. It's in your job description.

**Q131 Mrs McGuire:** But if you've got some hospitals that are staffing three times the same as other hospitals, delivering services that can be compared, how do you deal with it? This goes to the crux of the new approach: how do you track taxpayers' money when you are so hands-off and have devolved so much authority to groups of individuals, no matter how well equipped and expert they are, at local level? How do you track it?

**Chair:** Maybe Sir David should answer, since it's your job.

**Sir David Nicholson:** First of all, although there are large variations in the number of paid staff per bed and all of that sort of stuff, I think I said earlier that over the last few years the variation in cost, as reported through the costing system to individual hospitals, has got smaller. So that variation has actually shrunk over the last few years, not got greater. I think that's the first thing I'd set out. In terms of value for money for the system, clearly we set a price that we think is the right price.

**Mrs McGuire:** I understand all of that.

**Sir David Nicholson:** But the philosophy behind it is that then it's up to individual organisations to use the resources they have in the most creative and innovative way they can to deliver the product to their patients.

**Q132 Mrs McGuire:** So you don't provide a medical equivalent of a dating agency and say, "Hospital A, would you like to speak to hospital B and see whether or not they have areas—" Do you facilitate that?

**Sir David Nicholson:** Yes, we have a thing called the Institute for Innovation and Improvement.

**Q133 Mrs McGuire:** Do you force the discussion if you see statistics, such as Stephen has highlighted, that some hospitals appear to be well overstaffed compared with others?

**Jim Easton:** We would only force it for those hospitals that are not foundation trusts that we're directly responsible for the management of where we see those issues. For foundation trusts it would be PCTs concerned about the value of the outcome that would encourage that to happen.

**Chair:** But you're accountable.

**Mrs McGuire:** This line comes up to you.

**Chair:** You have got to have system whereby you can carry out what are your statutory duties as the Accounting Officer.

**Mrs McGuire:** But the line comes up to you eventually. Whether it's foundation hospitals or PCTs, ultimately the buck stops somewhere. >

**John Appleby:** Monitor has a big role in foundation trusts, and they take very severe action when they see things are going wrong financially or performance wise and they have strong powers to deal with them.

**Chair:** But they're changing. Sir David is ultimately the Accounting Officer.

**Q134 Stephen Barclay:** Could I at least ask, for consultants, do the foundation hospitals and other hospitals now have all the tools they need to benchmark consultants' performance?

**Jim Easton:** Yes, I believe so. Those data exist, we make them available and foundation trusts are actively joining together into benchmarking organisations to check their costs against where we don't provide some of the—

**Q135 Chair:** So in the new world, when they're all foundation trusts, where will the buck stop?

**Sir David Nicholson:** The buck stops in the foundation trust.

**Q136 Chair:** So if a foundation trust delivers badly, what happens?

**Sir David Nicholson:** In the new world?

**Chair:** Well they're all going to be foundation trusts. So we've got some of them now, and we're moving to a position where they'll all be foundation trusts. With whom does the buck then stop?

**Sir David Nicholson:** With the foundation trust.

**Q137 Chair:** So what happens? Bad value for money? What happens?

**Sir David Nicholson:** Let me get the wording right: the chief executive of a foundation trust is a...?

**Richard Douglas:** Accounting officer.

**Sir David Nicholson:** Is an accounting officer in their own right.

**Chair:** He/she will come and give evidence to us?

**Sir David Nicholson:** If you want them to, yes.

**Q138 Chair:** And you have no role?

**Sir David Nicholson:** My role is in the total system. I have to make sure that the total system balances.

**Q139 Stella Creasy:** So in terms of our role in ensuring value for money: who do we talk to? Do we have to talk to every single hospital? Do we then have to interpret this data in this new system?

**Sir David Nicholson:** They are the accounting officers. They are now, not in the new system, but in the old system the foundation trust was set up in that way.

**Q140 Mr Bacon:** So, just to give you an example for the help of the Committee, when you refused to allow the Norfolk and Norwich Hospital Trust to include a refinancing clause in their PFI contract, and refinancing increased their internal rates of return from 18% to over 60%, it was the Chief Executive of the Norfolk and Norwich Hospital who had to come and explain it, not anybody from the Department of Health, even though it was the Department that refused to allow the clause to be included and the hospital had wanted it to be included? That's how it works, isn't it? So you set the rules, you make it more difficult for them, then they come along and explain why they weren't able to do everything they wanted to.

**Sir David Nicholson:** PFIs are slightly different, because of course the existing PFIs are all underwritten by the Secretary of State so we have an

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interest directly in those that we wouldn't have in other bits of the foundation trust regime. Fundamentally this is a shift in power and accountability out to foundation trusts.

**Q141 Stella Creasy:** Do you think that's sustainable? We're all concerned here about value for money, and you're then telling us that we have to go through every single hospital in this country in this new system to secure that. Does that sound sustainable or practical? It's really troubling to us.

**Sir David Nicholson:** It's not for me to tell you what your responsibilities are, but in one sense, what you're interested in from me is—

**Q142 Stella Creasy:** Forgive me, I thought this was your responsibility. That's why I'm trying to understand what you think the new system will be.

**Sir David Nicholson:** I'm the Accounting Officer for the NHS vote. So you hold me to account for the way in which we operate, but you hold me into account against a background of a structure, a mechanism, that Parliament has put in place, and that's what I'm doing.

**Q143 Stella Creasy:** So you will come to us and say, "Yes, there are underperforming hospitals but I can't do anything about it"?

**Sir David Nicholson:** No, I'll say there are underperforming hospitals and these are the things that I can do about it and these are the results that I will expect to get out of that. That's absolutely the case. One of the levers I don't have is to tell people how many staff they've got to have for each hospital bed. What I can say to them is, "This is the amount of money we're prepared to give you for treating a particular condition"—a hip replacement or whatever. So that absolutely is that, and having a contract between the purchaser of services and the providers, the nature of that contract, you could absolutely hold me to account over all of that. But the minute detail about how you run the hospital is a matter for the accounting officer.

**Chair:** We're not interested. Nobody's into the minute detail. We really need the whole. We will have to come back to that.

**Q144 Chair:** Finally, as we've been going on a long time, we've got the Health Select Committee Report published today and they say that the reforms blunt the Service's ability to achieve the savings that you consider to be necessary, Sir David, and that the reforms, also the risks of "an already high-risk strategy" for making efficiency savings have risen, so the risks have gone up. I could quote endlessly from it, but basically their view is that the Bill you're publishing tomorrow, the reforms you're embarking on, will make it even less likely that you'll get your £15 billion to £20 billion efficiency savings or any improvements in productivity, and we'll therefore get cuts in services because there won't be any more money. Comment.

**Sir David Nicholson:** Sorry, I thought you were just telling me that. Fair enough. I'll not sit here and tell you that the risks have not gone up. They have. The risks of delivering the totality of the productivity

savings, the efficiency savings that we need over the next four years have gone up because of the big changes that are going on in the NHS as a whole. But that's not to say that you can't deliver it, and in fact I would argue—

**Chair:** You're going to be responsible for delivering it.

**Sir David Nicholson:** Absolutely, and I would argue that actually they can enhance our ability, in some areas, to do that. So, for example, critical to delivering the quality and productivity gains of the future will be our ability to manage long-term conditions and therefore control emergency care. It seems to me that GP commissioning, general practitioner commissioning, gives us a real opportunity to align general practitioners with that endeavour in a way we've never been able to do before. So I think that could enhance. Secondly, if every hospital is to be a foundation trust by 2014, that essentially means that you need to take all those hospitals, including the ones you know very well, and make them efficient and sustainable clinical and financial entities over the next few years.

**Q145 Chair:** But you can't because you have no power them. We've just heard this.

**Sir David Nicholson:** Well, no, what happens is before they become a foundation trust Monitor authorises them, makes them a foundation trust. Before that, they are directly accountable, through the various managements of change, to the Department. So we have to get them into a place where they're capable of becoming a foundation trust. In order to do that we have to make them clinically and financially sustainable. So if you see the reforms in that way, you don't see the reforms over here and the productivity gains over here; I think there are ways you can mesh them together.

The second thing I would say is that a big part of the reforms is of course the reductions in management costs across the system as a whole; we've got to take £1.9 billion out of the way we run the system at the moment. And it seems to me the changes—we've got the abolition of SHAs and PCTs—will significantly help us do that as we go through the process. So there are ways in which the reforms can enhance our ability, but I think the general point about risk is absolutely right.

**Q146 Stephen Barclay:** Why then, if that's the case, have so many hospitals not even implemented the e-rostering that was recommended back in 2006?

**Sir David Nicholson:** Sorry?

**Stephen Barclay:** This was a recommendation back in 2006 in terms of the way hospitals managed their costs: sickness absence, staff turnover, agency. You were just talking about the levers the Department has, and stripping out management costs. But staff costs obviously also flow from sickness rates, staff turnover, agency costs. There's a recommendation in 2006 to put in e-rostering, yet many hospitals haven't done so. Why haven't they?

**Sir David Nicholson:** Because they've found better ways, or they think they've found better ways of managing their staff costs.

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**Q147 Stephen Barclay:** So they're not going to?

*Sir David Nicholson:* I'm sure some of them will.

*Jim Easton:* We have as part of our QIPP support programme on improving staff productivity a specific stream of work to further spread e-rostering, because we think even if you've been able to manage to date, the agenda going forward means that most of those hospitals that have yet to implement will benefit from implementing.

**Q148 Stephen Barclay:** What's the different cost and what are the savings, or could you let us have a note on that?

*Jim Easton:* I'm sure we have some useful information

**Q149 James Wharton:** Could I have a quick point on this looking forward at where we're going with staff improvements? Jason, when asked this question about progress for improving practices for staff, you talked about information dissemination, sharing best practice and so on. I'd just like to briefly understand how that is different from what the NHS Institute has been doing already. What's actually going to change going forward?

*Jim Easton:* We're trying to address this differently by linking the support programmes with the hard incentives. So in the past there's been a less direct connection between how the tariff programme works, how pay works and some programmes of support for change, and now we're trying to link them all. In other words, the tariff puts on direct pressure for efficiency. We say in our communication to PCTs and trusts where we think that reduction in tariff can come from—what the evidence tells us in terms of the things you could do for better procurement, better management of your staff, to respond to that tariff change. We put in place some measures that tell us what's happening, and we then add the support programmes. So the difference is the coordination and the scale of the response.

**Q150 Chair:** John Appleby, would you comment on the findings of the Select Committee in relation to the way that it blunts the capability of the NHS to deliver its efficiency and productivity?

*John Appleby:* Yes. There are two issues here. Finding 4% to 5% productivity gains year on year for four years is going to be tough enough. On top of that there are changes going on, structural reform and so on, some of which may help, I think, but I would suspect that the NHS would prefer not to have embarked on a big reform just as it's also trying to embark on getting much greater value for money for every pound spent. I have to say, just picking on one example, I can't quite see where the incentives are for GP consortia to get better value for money, to be honest. One of the things to ask about incentives is, "Where's the motivation here?" And I can't quite see; we'll wait to see what the Bill says about exactly how the GP consortia will be structured and so on, but they're going to have to be given some incentives. At the moment the Department can work through the primary care trusts, and they can bear on them quite

strongly in terms of encouraging productivity and more efficient purchasing and so on.

**Stephen Barclay:** But GPs aren't in hospitals, are they?

*John Appleby:* Sorry?

**Stephen Barclay:** We're looking at hospitals.

*John Appleby:* No, but one of the ways of squeezing some productivity out of hospitals is for the purchasers or the consumers, if you like, to start demanding better value for money and so on, so that's one way of doing it. You've been talking about some direct levers; a more indirect lever is through the consumer shopping around, for example, all that sort of thing, and through their contracts. I'm just saying that for GP commissioners, GP consortia when they come into being, it's a bit hard to see quite what will motivate them on that side of things.

**Q151 Mr Bacon:** That's interesting. May I just ask you: what motivates the PCTs?

*John Appleby:* I'm sorry, I didn't catch that.

**Stephen Barclay:** You say you can't see what will motivate the GPs. Currently the PCTs are doing the purchasing. What motivates the PCTs?

*John Appleby:* Well, managerial pressure from above through the strategic health authorities. They're told to do it. There's been a trend to devolve to local decision making and so on, and of course that has some upsides. Perhaps one of the downsides is that people like David and his team start to lose some of the levers that they can really bear down on the system to persuade the system to change and do good things, so I think there's a hope that this new system will also encourage value for money.

**Mr Bacon:** You don't think that under the new system there'll be, if you like, to use your phrase, managerial pressure from the Department of Health on to GPs?

*John Appleby:* That's not how the reforms have been promoted and advertised, no.

**Q152 Austin Mitchell:** Let me ask you about the next question, I'm asking it anonymously.

**Mr Bacon:** Let's just hope your phone doesn't go off, otherwise we'll guess who it is.

**Austin Mitchell:** Sir David's just given us a pious vision of what's likely to materialise from the reforms. I think that it's not lacking really in that way because we're heading for a period of chaos, in which the abolition of those primary care trusts and the strategic health authorities means nobody's got the ability to drive the challenge of QIPP forward. So that's going to founder. But the period of chaos means a situation in which we've got the hospitals, which I picture are dominated by the consultants, and that's why they've been able to frustrate their productivity improvements on the ground because of their weight in the system and on the ground, and now we're turning commissioning over to the GPs, who've also let us down because they got more money for doing less and didn't seize the opportunity. And the GPs are now going to control the amount of money that goes to hospitals. They are going to be able to starve the consultants. Now what are we to expect from this battle between the two fraternal arms of the medical profession?

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**Sir David Nicholson:** I don't recognise the way in which you've set that out.

**Austin Mitchell:** You don't think GP commissioning is going to mean cutbacks in provision to hospitals to force them to close wards?

**Sir David Nicholson:** We know, because we need to, we do need hospitals to reduce their costs, and we would expect commissioners to do that. But don't forget the GP consortia don't get their budgets until 2013, and we've got to make quite a lot of those savings long before they come on the pitch in terms of accountability, so I don't see it like that at all. And if it is like that, it's a real problem for us, but one of the things that we need to do is to make secondary and primary care clinicians work more closely together over the next period, not further apart.

**Q153 Chair:** Okay. You want to say one final thing do you John?

**John Appleby:** One final thing, which goes back right to the beginning, about how we measure productivity, and my worry about the future is that we'll get four years down the line here, and the notional target is £20 billion. Will we know that the NHS has actually achieved that? I'm a bit worried about that. It's not just about savings and cutting and so on; it's about creating better value for patients, and that would be my worry for the future.

**Chair:** Well, I agree and what I want us to do, if the Comptroller and Auditor General agrees, is return to this issue, accepting maybe this new patient consumer survey will give us a different perspective on productivity, which I gather everybody wants to use, so good on you. But I think you've got to use the measures you have. The fear that we have is year one you've done the easy thing, cut the wages; year two you're going to try to get more out of the system, 4% not 3% or whatever it is from the figures you've sent, and you've got to do it in a way that really enhances productivity and doesn't slash services. So we will want to come back. Now I'm going to be really indulgent with the rest of the Committee, because Richard wants to come in on one other thing, but I think that's the main thing, so we would like to thank you for coming and want to see you again, but let Richard just come in on this final thing.

**Q154 Mr Bacon:** One final question. Paragraph 1.11 refers to 47,000 extra nurses, midwives and health visitors or full-time equivalents. Do you know how many of those extra 47,000 are midwives?

**Richard Douglas:** Sorry, where are we?

**Mr Bacon:** This is paragraph 1.11 on page 17. It refers to extra staff: 6,000 extra consultants, 47,000 nurses, midwives and health visitors. Do you know how many of those 47,000 are midwives?

**Sir David Nicholson:** I don't think we would off the top of our head.

**Q155 Mr Bacon:** Do you know what the total number of midwives is?

**Sir David Nicholson:** We could provide you with that number. We could provide those data for you.

**Q156 Mr Bacon:** Do you know what the total number of midwives is? In your planning, are you taking it that there is currently a shortage of midwives? And what's your figure for the shortage?

**Sir David Nicholson:** Over the last three or four years it's become clear as the ONS has been revising its figures on the birth rate that our planning for midwifery services was not as it should be. We launched a campaign to train and produce the 4,500 midwives<sup>1</sup> to help us to do—

**Q157 Mr Bacon:** But the Royal College of Midwives says there's still a shortage of 4,000. I declare an interest in this, as I'm sure Mr Barclay will too, because in the last three or four years, to use your words, my wife and I have had two children, and I've noticed enormous pressure. When we had our last baby, which was last year, the staff were terrific, but the unit closed while we were there; women were being sent away. I'm sure you will have seen the article in the Sunday Telegraph where they interviewed anonymously 20 midwives from around the country and it's a description of a service in crisis, basically.

**Sir David Nicholson:** I don't accept it's in crisis. I think some places are really pressed. Interestingly, this afternoon I'm seeing the President of the Royal College of Gynaecologists, who has made some comments about all of this recently as well. We do need more midwives.

**Q158 Mr Bacon:** What's your number for the shortage?

**Sir David Nicholson:** 4,500.

**Q159 Mr Bacon:** You recognise the Royal College's number?

**Sir David Nicholson:** Yes, I recognise that number.

**Q160 Mr Bacon:** By when will you get up to the number that you need to be at?

**Sir David Nicholson:** Well, of course it's not a straight—you can't just turn midwives on and off.

**Q161 Mr Bacon:** I appreciate it's a combination of recruitment, retention and training. Our first baby was born in the Chelsea and Westminster where they went over to Athens and recruited a job lot of midwives from Greece because they had a surplus there, so you can do things other than training them here. But when are you expecting, planning, to get up to the number that you need so that you're at establishment rather than below it?

**Sir David Nicholson:** I think we're working through what that means at the moment.

**Mr Bacon:** So you don't know?

**Sir David Nicholson:** I don't think we've concluded how we can do it, yet. So we're working through that at the moment. What I would say is over the last couple of years we've increased the tariff for maternity services significantly greater than inflation generally, so for example, not last year but the year

<sup>1</sup> This figure was given in error; there is no nationally recognised figure for the shortfall in midwife numbers. The campaign is to recruit 4,200 health visitors, not midwives.

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before we increased it by 10% to give hospitals the resources they would need to employ more midwives using the kind of examples that you gave me from there.

**Q162 Mr Bacon:** I know John Appleby may want to comment, because I know The King's Fund did something on midwives recently, didn't you?

**John Appleby:** Sorry?

**Mr Bacon:** The NAO just told me that The King's Fund did something on midwifery recently and it was one of the reasons that a possible NAO study didn't go ahead because there was so much else going on at the time, but do you have any comment on this?

**John Appleby:** Thanks, NAO. That was a colleague of mine, and I know broadly, but I don't know the details.

**Chair:** Maybe we should invite the NAO.

**Q163 Mr Bacon:** Can I invite the NAO to think about revisiting this issue?

**Stella Creasy:** I've got Sure Start centres in Waltham Forest at risk of failing Ofsted because they can't get health visitors, and it's the same issue about the recruitment of—

**Sir David Nicholson:** We definitely have a plan to increase the number of health visitors by 4.5—

**Q164 Chair:** I think this is an issue for the NAO. It's for you, really, to come back to us at some point in time on all these early years—midwives, and I know it from grandchildren.

**Amyas Morse:** The NAO will have a look at that, and at the same time, Chair—

**Stella Creasy:** I have no children; I just want to get that one out there.

**Amyas Morse:**—I was very impressed with what Mr Appleby said about the importance of how—we've just gone through a long change process of huge increase in the NHS, and it's not clear to me that we set out to put measurement for how successful that would be in at the beginning of that process. Now we're at the start of another change process. It'd be really great if, instead of having ex post facto arguments about how that could be measured, we could actually start out agreeing how things should be measured from the beginning, and we'll be talking about that with you next week, I imagine.

**Sir David Nicholson:** All I can say is: we did. At the beginning of this process of extra money we made it very clear, the Government made it very clear, what the measures were, and we've delivered on all of those measures.

**Chair:** The problem was that productivity was not—

**Sir David Nicholson:** These are other measures that you're now suggesting we should in hindsight have been managing. That's absolutely right; at the end of any process we can be very clear about what the way you evaluate is.

**Chair:** We're wandering on. Thank you very much, all of you, for your appearance this morning. See you next week, and we'll see you on this again in a year or so's time.



ISBN 978-0-215-55685-1

