The Nuffield Trust
FOR RESEARCH AND POLICY
STUDIES IN HEALTH SERVICES

BRIEFING PAPER
JUNE 2009

HEALTH IN A COLD CLIMATE

DEVELOPING AN INTELLIGENT RESPONSE TO THE FINANCIAL CHALLENGES FACING THE NHS

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INTRODUCTION

This paper draws on discussions at a series of seminars held at the Nuffield Trust between March and May 2009 (see back page for details of the series). The aim of the series was to explore the financial context in which the NHS is working, and opportunities for using resources more efficiently. Each seminar was led by experts in NHS management and finance and participants included leaders from the public and private health care sectors. The ideas set out in this paper are based on the presentations at the seminars and the points made in the discussions they generated. The paper also draws on the work of the author, who bears sole responsibility for the views expressed.

Executive summary

- The NHS in England is faced with the prospect of finding savings of around £15–20bn over the period 2011–2014
- the Department of Health and NHS organisations need to adopt an intelligent approach to finding these savings that avoids both 'salami-slicing' and 'slash and burn'
- a comprehensive approach to improving efficiency is needed, encompassing actions at the system, organisation, team and practitioner levels
- at each level, the focus should be on using information and incentives and building capacity to deliver the necessary savings and improvements
- the principal aim needs to be to reduce variations in clinical practice by engaging doctors and other front-line staff in performance improvement
- service line reporting shows promise and is contingent on strengthening both operational management and clinical engagement
- the NHS Institute's programmes also have an important contribution to make through the use of benchmarking and service improvement methods with over £5bn of potential savings available
- the Department of Health should review current policies with the aim of deciding what changes are needed as the NHS moves from expansion to contraction
- experience from other sectors suggests that successful change requires action on several fronts simultaneously and work across a series of 'dualities'
- these dualities include: providing central leadership and supporting NHS organisations to build capacity; using competition and promoting cooperation; supporting commissioners and drawing on the expertise of foundation trusts; valuing clinical engagement and strengthening the role of general managers; emphasising the standardisation of care and ensuring that services are customised around the needs of individuals
- integrated systems have a potentially important role to play in future, in aligning incentives to facilitate the emergence of new models of care
- NHS foundation trusts could play an important part in the development of integrated systems, but only if there are changes to the regulatory regime, payment by results and fast-track support for PCTs.

THE FINANCIAL CONTEXT

Following the 2009 Budget, the NHS faces the prospect of cuts in expenditure from 2011. While the exact scale and duration of these cuts will not be known until the completion of the current spending review, it is likely that NHS spending will decline by around two per cent a year in real terms until at least 2014, and probably for a longer period (Ham, 2009). This suggests that the NHS in England will be required to find savings of the order of between £15 and 20bn over the three years from 2011 (Nicholson, 2009). The prospect is therefore of the longest, sustained period of disinvestment in the history of the NHS, a mirror image of Tony Blair's commitment in 2000 to increase health care spending to bring it into line with the European Union average.

	AUS	CAN	GER	NZ	UK	US
Overall ranking	**3.5**	**5**	**2**	**3.5**	**1**	**6**
Quality care	4	6	2.5	2.5	1	5
Right Care	5	6	3	4	2	1
Safe Care	4	5	1	3	2	6
Coordinated Care	3	6	4	2	1	5
Patient-Centred Care	3	6	2	1	4	5
Access	3	5	1	2	4	6
Efficiency	4	5	3	2	1	6
Equity	2	5	4	3	1	6
Healthy Lives	1	3	2	4.5	4.5	6

Source: Commonwealth Fund (2007)

Figure 1. International rankings of health care performance, 2007

The NHS is entering this period of retrenchment in much better shape than at any time in its history. The programme of investment and reform that has been undertaken in the last decade has resulted in measurable improvements in performance in many areas of health care. Most notably, waiting times for treatments have fallen dramatically and areas of clinical priority such as cancer and heart disease have improved significantly. These improvements have been accompanied by a strong financial performance. After running into deficit in 2005/06, the NHS is now in surplus and enters a much tougher period of funding well-placed to deal with the challenges that lie ahead. Equally important, public confidence in the NHS is now at a high level after a number of years when it seemed that investment and reform were failing to have a positive impact on attitudes towards the NHS.

The improvements that have occurred are underlined by the assessments undertaken by the Commonwealth Fund of a group of six countries showing that the United Kingdom moved from third position to first between 2004 and 2007 on a range of criteria.

Despite the progress made in the last decade, there are no grounds for complacency. This is illustrated below by the United Kingdom's relatively poor standing in rankings of countries on mortality amenable to health care (Nolte and McKee, 2008), and in the OECD's comparisons of health status. The latter indicate that the United Kingdom is in the middle of the pack and falls short of the results achieved in countries such as Australia, France, Iceland and Sweden (Joumard et al, 2008). The United Kingdom's performance on cancer survival compared with other countries is further evidence of the room for improvement.

Alongside evidence from international comparisons, analysis by the Office for National Statistics shows declining NHS productivity (see Figure 3). This reflects the failure to increase output at a comparable rate to the large sustained increases in resources made available to the NHS. With much of the additional funding going into pay increases for staff following the introduction of new contracts for consultants and GPs and the Agenda for Change reforms for other staff, patients have yet to see the full benefits of the investment that has been made.

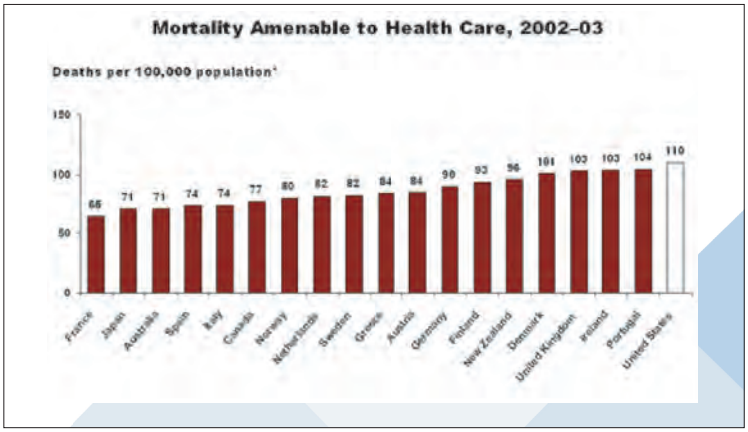

Figure 2. International comparison of rates of mortality amenable to healthcare

SAVINGS TARGETS

The silver lining in these trends is that with the NHS in England now spending over £100bn per annum, there is much greater potential for bringing about productivity improvements than a decade earlier when the budget was only £40bn (House of Commons Library, 2009). History suggests that, almost regardless of actions taken by Government or NHS organisations, productivity is likely to improve as funding becomes more constrained. This is because as input falls output will remain stable or continue to increase in the face of rising demands from patients, leading productivity to rise almost regardless of what Government does.

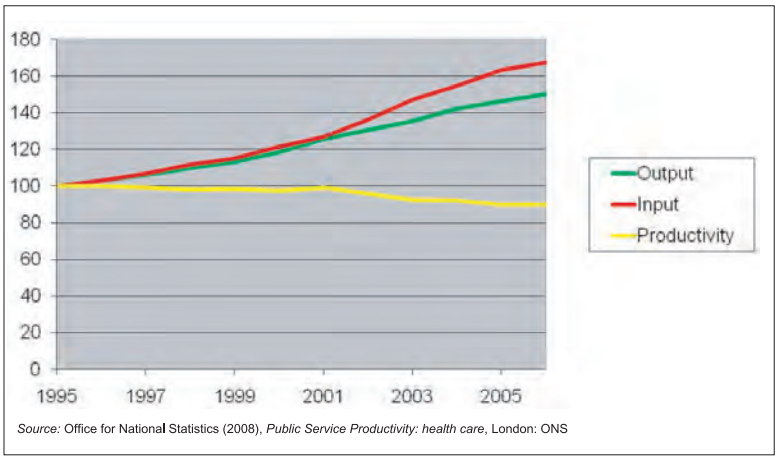

Figure 3. Trends in NHS productivity

In this context it is a safe prediction that the Department of Health will seek to contain costs by exercising tight control over the workforce. With around three quarters of the NHS budget going on staff costs, there are likely to be vacancy freezes in many organisations, steps to reduce the use of agency and locum staff, and action on pay and possibly pensions. There may also be difficulties findings jobs for newly trained staff, especially as more doctors, nurses and other staff qualify from the expanded training programmes that have been put in place.

Other likely targets include:

- achieving efficiency improvements in the procurement of goods and services from external suppliers through the new commercial support units announced in May this year
- rationalising back office functions through greater use of shared services and possibly a reduction in the number of NHS organisations, notwithstanding the stated commitment of politicians to avoid further restructuring
- improving the use of the NHS estate by identifying land and buildings surplus to requirements and acting on the proposals set out in the Operational Efficiency Review commissioned by the Treasury (HM Treasury, 2009).

It is also certain that government will use its control over the payment by results tariff as a way of putting further pressure on efficiency.

As this happens, there is a clear risk that the quality of care may be compromised, especially at such an early stage in the implementation of the initiatives announced in *High Quality Care for All* (Secretary of State for Health, 2008). The question then becomes: can the Department of Health and NHS organisations adopt a more intelligent approach to dealing with the financial challenges that lie ahead that avoids the 'salami-slicing' approaches that have characterised past periods of NHS retrenchment in which incremental amounts are taken away from all budgets? Equally, will it be possible to resist the 'slash and burn' instincts of some NHS leaders, in which the focus is on identifying major areas of spending to be cut back or eliminated?

A FRAMEWORK FOR IMPROVING PRODUCTIVITY

At the seminar series, Peter Smith of the University of York offered the following framework for thinking about ways of improving productivity (see Figure 4).

Alongside these two dimensions, it is helpful to consider the role of information, incentives and capacity in improving productivity.

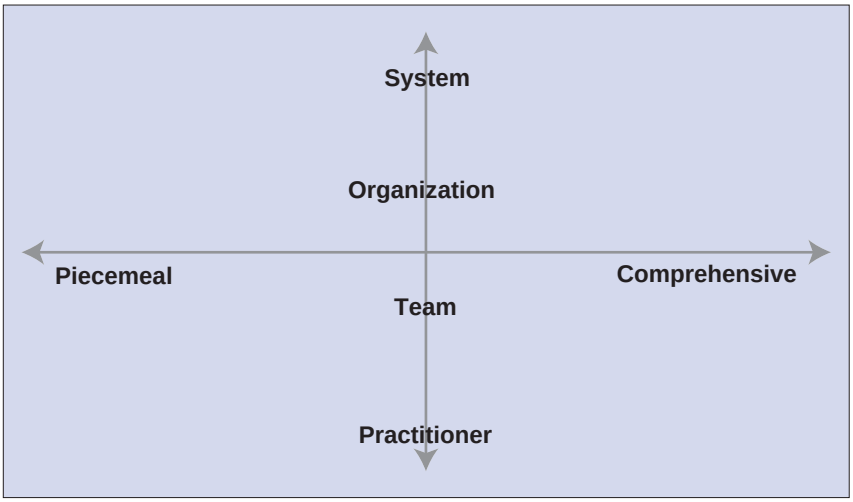

Figure 4. Productivity analysis framework

At the *system level*, the menu of options includes:

- using information to produce cost-effectiveness guidance, for example through NICE, to analyse the use of resources on different areas of care, as in programme budgeting, and to benchmark performance, as in the NHS Institute's Better Care, Better Value indicators
- using incentives to improve performance, for example through payment by results, practice based commissioning, targets and the use of competition
- building capacity through the work of the NHS Institute in service improvement and leadership development and the work of the regulators, such as the Care Quality Commission.

At the *organisational level*, there are various possibilities:

- using information to promote service line reporting in NHS organisations and to develop the electronic patient care record
- using incentives such as the quality and outcomes framework (QOF) in primary care and the use of team-based incentives in all NHS organisations
- building capacity by strengthening the role of boards in governance, developing the finance function, and improving the ability of the NHS to use benchmarking data and undertake statistical analysis

At the *team and practitioner level*, the options include:

- using information to measure and compare performance both in relation to cost and quality of care
- using incentives to reward staff, for example through the consultant contract and clinical excellence awards
- building capacity by development leadership skills among managers and clinicians and through clinical accreditation and training.

The scale of the challenges facing the NHS calls for a comprehensive rather than piecemeal approach at all of these levels. Such an approach was developed by the Department of Health at the time of the last financial crisis in the NHS in 2005, when the Department produced *The Efficiency Map* setting out actions to be taken in different areas to deliver the savings needed at that time.

A similar approach is required to enable the NHS to plan for the savings required after 2011. In this context, it is timely to review the potential contribution of different initiatives and whether the right levers and incentives are in place to enable to the NHS to rise to these challenges. Monitor's work on service line reporting and the NHS Institute's work on benchmarking and service improvement exemplify some of the opportunities.

MONITOR'S WORK ON SERVICE LINE REPORTING

Bill Moyes of Monitor made the case for service line reporting at the seminar series drawing on Monitor's work with 35 NHS Foundation trusts. Experience suggests that to begin with, trusts need to reorganise into distinct and relevant business units. They then have to focus on producing reliable service line financial and other data. Having done so, trusts can develop a portfolio matrix to identify good and poor performance (see below). Other essential elements are strong, capable service line leaders, beginning with one or two evangelists who have the skill and will to lead the change, and devolution of decision-making powers to service line leaders.

Services in the bottom left are those where boards should be considering contraction, repositioning or even exit from services. Those in the bottom right indicate opportunities for expansion. The ones in the top right represent the high income earners.

A similar approach can be used to map patient experience, with the difference being an ability to take what patients say is important and, by structured questioning and cross-referral, produce a list of derived satisfaction scores.

Because service line management is a sequential programme of business management tools, Monitor has embarked on a three-year programme to fully exploit the potential for improvement within trusts, in terms of both efficiency improvement (financial and productivity indicators) and quality improvement (patient satisfaction, PROMs). See Figure 7 on next page.

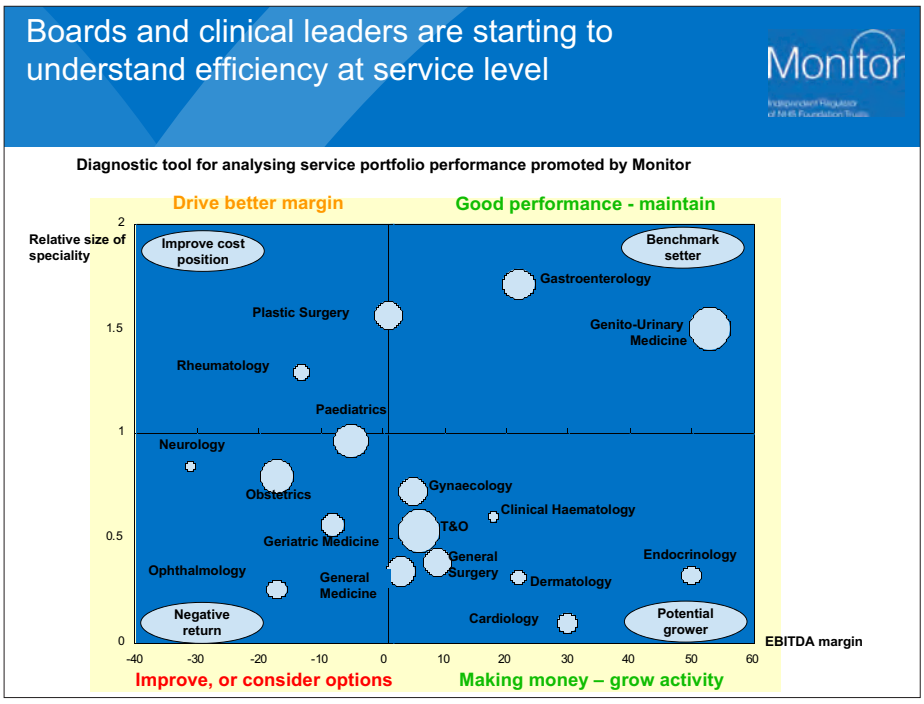

Figure 5. Diagnostic tool for analysing performance

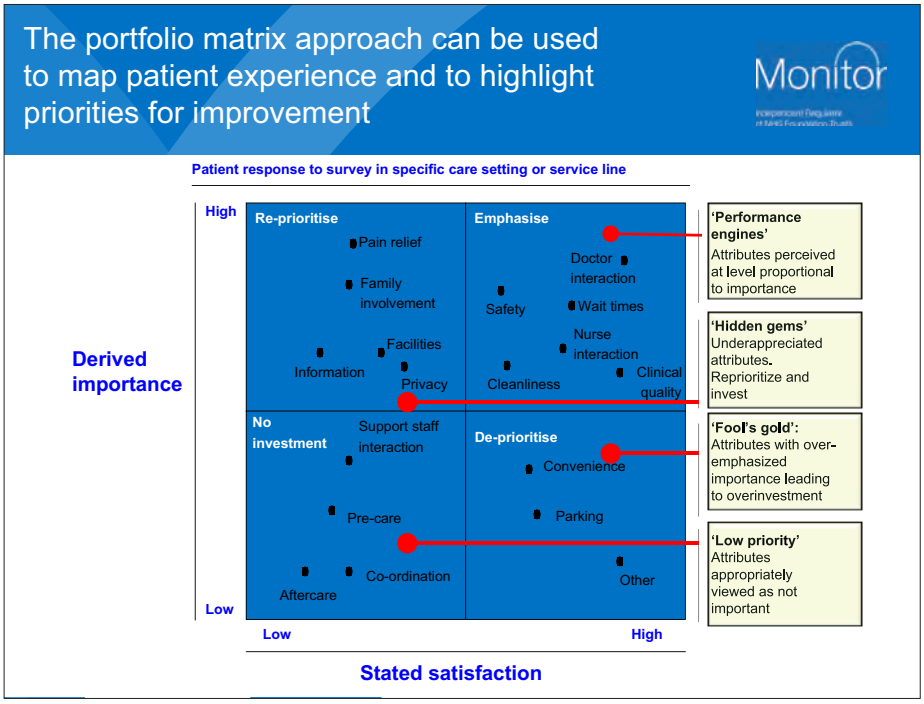

Figure 6. Patient experience matrix

Key elements for 2009/10 include strengthening information systems through patient-level costing, and understanding how to provide a better patient experience and how to ensure accurate and reliable patient-reported outcome measures are generated.

A practical example of service line management was presented at the seminar series by Grant Kane from County Durham and Darlington NHS Foundation Trust. The approach initially met with scepticism in the trust and there were concerns that commercial disciplines could jeopardise clinical practice and patient care. In general surgery, the starting position was a deficit of £1 million in 2006/07: through service line management this became a surplus of £19,000 in 2008/09. The work involved analysing the composition of costs and the difference between services in the north of the trust and those in the south. The following figures illustrate the results:

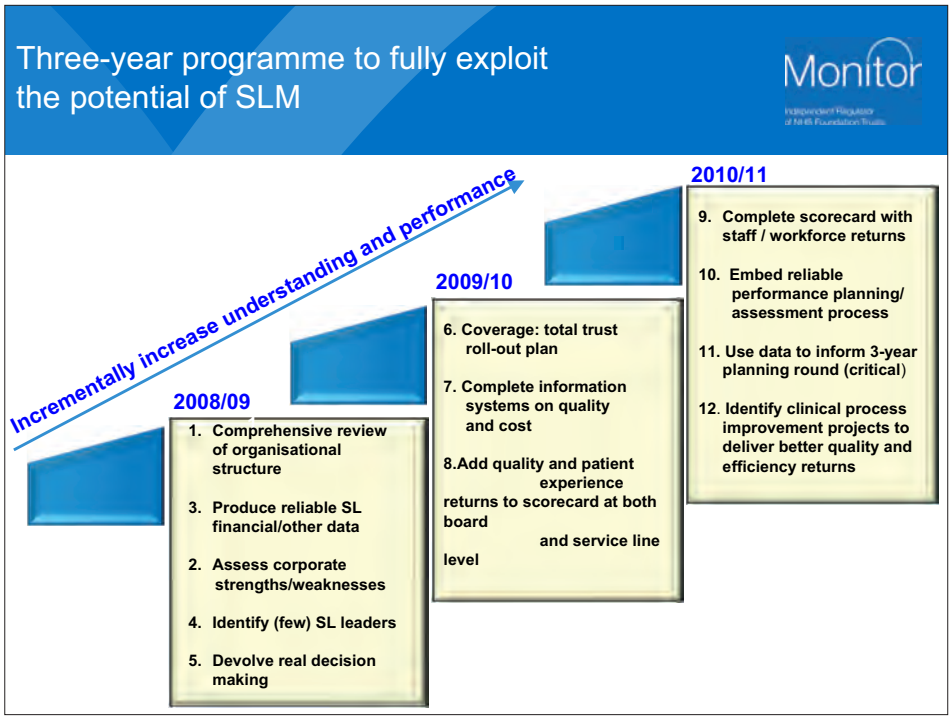

Figure 7. Three-year performance measurement programme

Figures 8a, 8b, 8c, 8d. Service line management profitability analysis: example

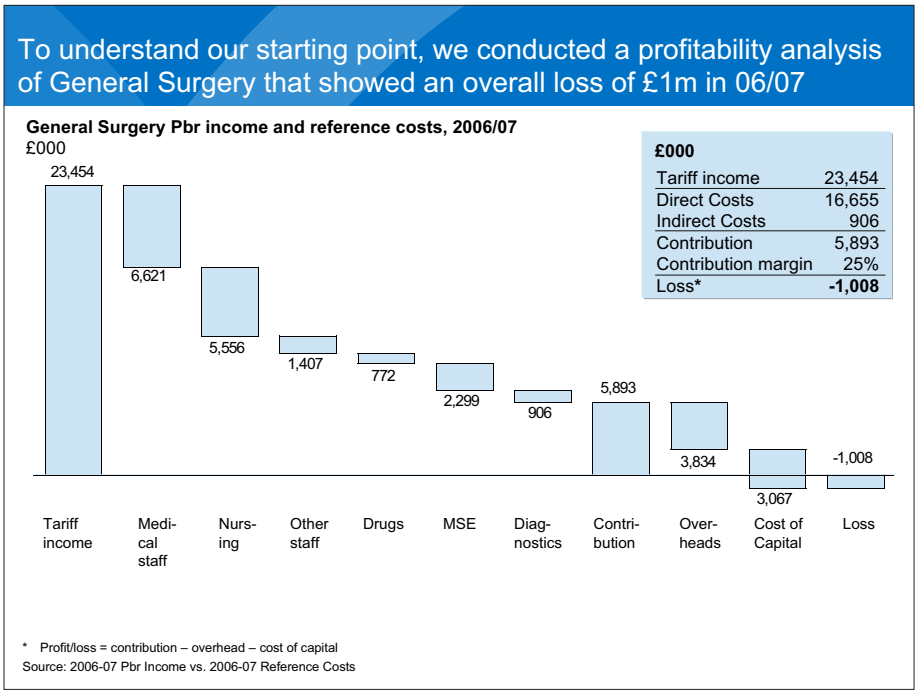

Figure 8a

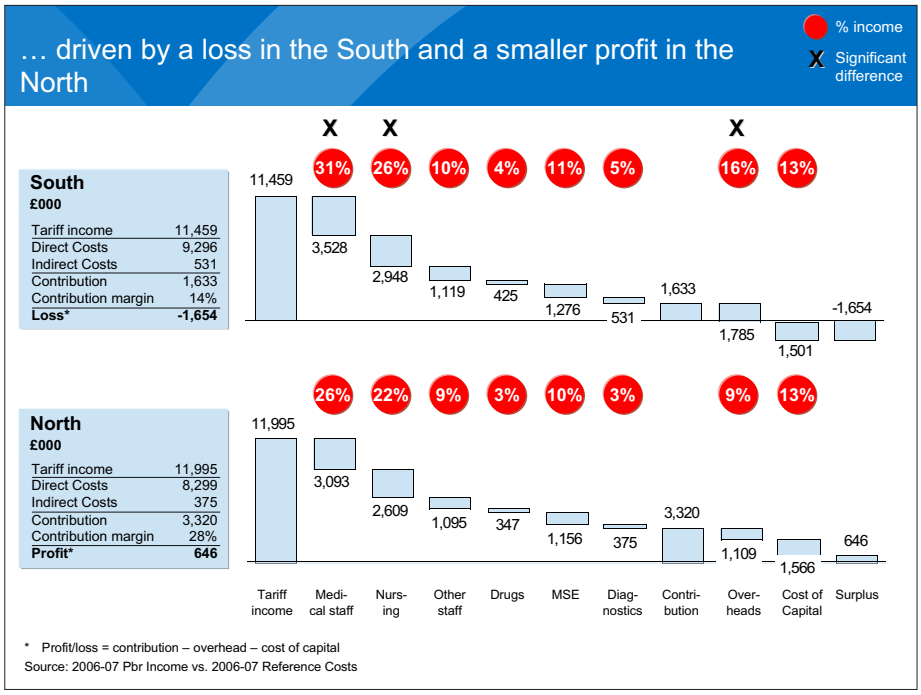

Figure 8b

In the light of this analysis, the trust benchmarked length of stay in general surgery. This showed the trust performing better than the national average. However, if average length of stay were in the top 10 per cent, then there would be scope for improving annual profitability by £900,000. An analysis of the income received by the trust by length of stay illustrated this.

As the work progressed, a profitability 'driver tree' was constructed for both inpatient and outpatient services. Through this a number of 'quick wins' were identified. As the following figure shows, many of these quick wins relate to clinical practice, including reducing the proportion of patients who come in the day before their procedures, increasing day case rates, and cutting the number of beds. Improving recording was also a significant issue, resulting in the trust increasing income by almost £300,000.

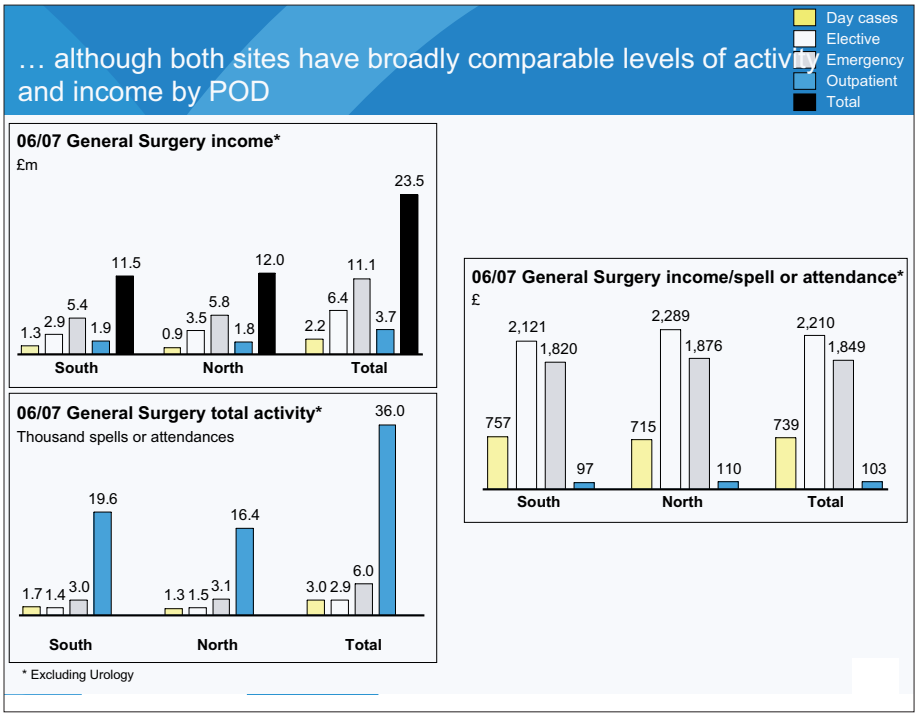

Figure 8c

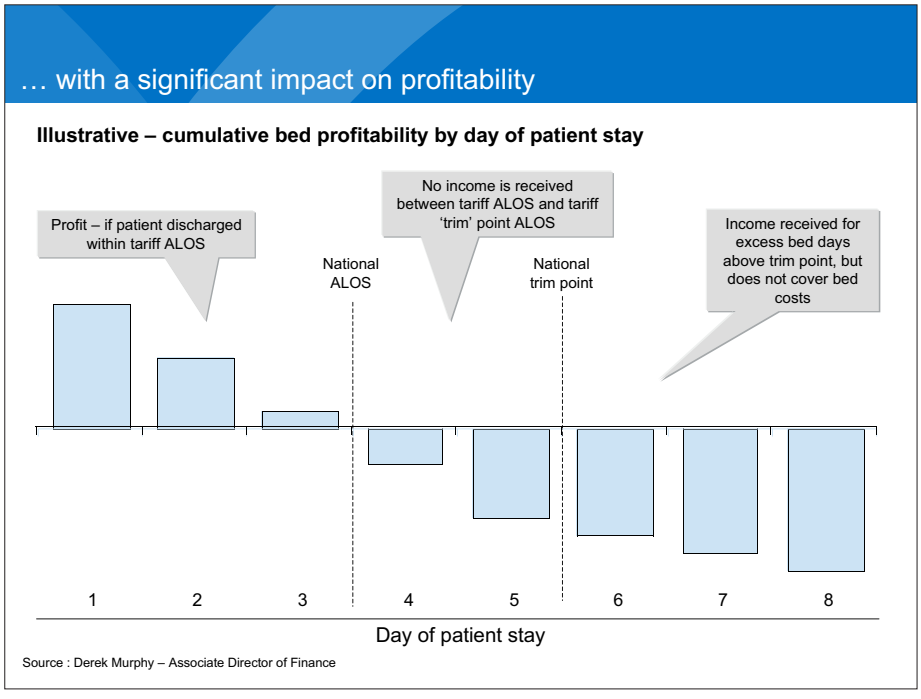

Figure 8d

Action on these ideas led to the turnaround in financial performance.

Stephen Eames, chief executive of the trust, has argued that service line management has had 'a dramatic effect on the development of clinical leadership and business systems'. In the case of general surgery, service line management 'successfully delivered an impressive programme of change which achieves the holy grail of improving quality and reducing costs' (Eames, 2009).

It is important to emphasise that the wider application of service line reporting is contingent on strengthening operational management and clinical engagement, both of which are patchy at best in many NHS organisations. Most of the decisions that determine how resources are used are taken within clinical directorates and primary care practices and the capacity for driving efficiency needs to be significantly strengthened. If this does not happen, then it will be much more difficult for the NHS to adjust to the tighter financial prospects that lie ahead.

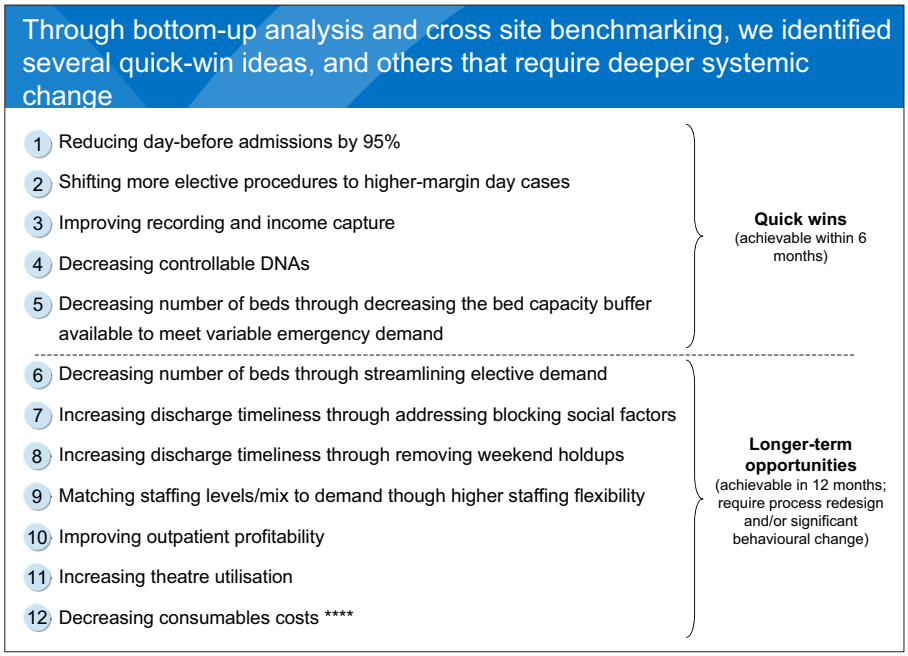

Figure 9. Organisational productivity opportunities

THE NHS INSTITUTE'S WORK ON BENCHMARKING AND SERVICE IMPROVEMENT

Bernard Crump of the NHS Institute spoke at the seminar series on how the Institute has supported the NHS through its work on the Better Care, Better Value indicators, High Volume Care and the Productive Series programme.

The Better Care, Better Value indicators use routinely available NHS data to illustrate variations in performance. The indicators are updated every quarter and each NHS organisation receives a scorecard showing how it is doing. This translates into a productivity opportunity based on the organisation achieving the top quartile of performance. Organisations can choose comparators against which to benchmark. The initial clinical indicators are show in Figure 10.

Analysis had shown the size of the productivity opportunity for the NHS as a whole fell from £2.2bn in the first quarter of 2006/07 to £1.9bn in the second quarter of 2007/08. New indicators were added in 2008/09 and this, together with changes in activity and coding, means that the current productivity opportunity is £3bn. All organisations, including those that are financially stable, have major opportunities to improve performance,

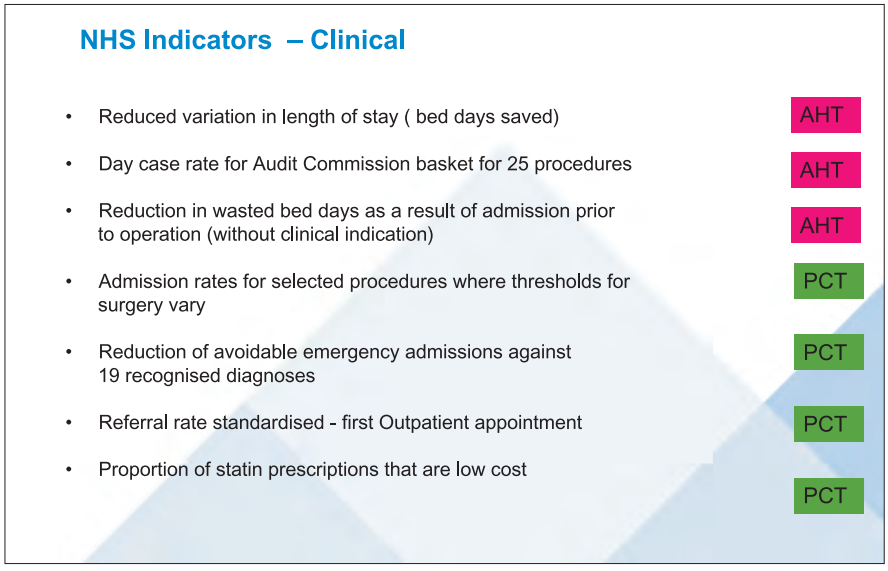

Figure 10. NHS clinical indicators

and it is surprising that the data is not used more.

The Better Care, Better Value indicators led onto the High Volume Care programme focused initially on eight HRGs that account for a high proportion of activity such as fractured neck of femur, acute stroke and cholecystectomy. The NHS Institute visited high-performing and poorly performing NHS trusts to review care pathways and understand what was going on. Interestingly, in many trusts there were examples of both high-performing and poorly performing services in different specialties.

The visits were undertaken by clinically-led teams using structured visits. An example was the work on knee replacement that found wide differences in length of stay. The key here was early mobilisation of patients – within 12 to 18 hours of surgery – and active discharge arrangements. In the second phase of work on high-volume care the Institute worked with 12 trust chief executives and McKinsey in an improvement network. The improvements in stroke and fractured neck of femur were rapid and large-scale. This led into a third phase concentrating on new high-volume areas such as renal care, cancer, and diabetes. The work on diabetes had shown scope for cutting lengths of stay for patients with diabetes admitted for other diagnoses by over two days on average, through better management.

In the Productive Series programme, the Institute had applied lean thinking to release resources for patient care. The Productive Ward 'Releasing Time to Care' initiative was the first in the series and had been followed by work on theatres, the community hospital and the leadership team. Whereas the previous two programmes had been 'pushing' data out to the NHS, this work involved organisations 'pulling' in support to enable them to improve performance. Over 180 hospitals were using the tools and there was also international interest, from countries including Australia and Holland.

Current Productivity Opportunity

	Q1 07/08	Q2 07/08	Q3 07/08	Q4 07/08	Q1 08/09
Reducing Length of Stay	£820,161,000	£839,062,000	£892,013,260	£852,032,063	£1,004,953,563
Increasing Day Case Rate Surgery	£14,723,000	£14,865,000	£15,076,623	£13,149,427	£16,694,233
Reducing Pre-Operative Bed Days	£509,765,000	£528,383,000	£587,676,824	£443,864,071	£711,648,468
Managing Variation in Surgical Thresholds	£62,619,000	£74,789,000	£72,931,685	£90,760,502	£91,268,446
Managing Variation in Emergency Admissions	£270,731,000	£220,202,000	£248,146,793	£369,864,502	£335,599,086
Managing Variation in Outpatient Appointments	£239,304,000	£260,038,000	£260,038,000	£260,038,000	£260,038,000
Percentage of Low Cost Statin Prescribing	£75,960,800	£68,483,990	£67,868,014	£57,494,680	£72,739,733
Reducing DNA Rate	N/A	N/A	N/A	N/A	£189,386,091
Reducing Follow Up Appointments	N/A	N/A	N/A	N/A	£232,069,328
Managing 14 Day Re-admission Rates	N/A	N/A	N/A	N/A	£99,558,080
Total	£1,993,263,800	£2,005,822,990	£2,143,751,199	£2,087,203,245	£3,013,955,027

- New Indicators
- Growth in activity
- Changes in coding

Figure 11. NHS-wide productivity opportunities

Analysis suggested that up to £2.2bn could be saved from the High Volume Care and Productive Series work in England. Most of this is in the acute sector. This is based on an estimate done at South West Strategic Health Authority that has been scaled up to England – see below.

Work has now started on community services where there seems to be huge potential to release resources.

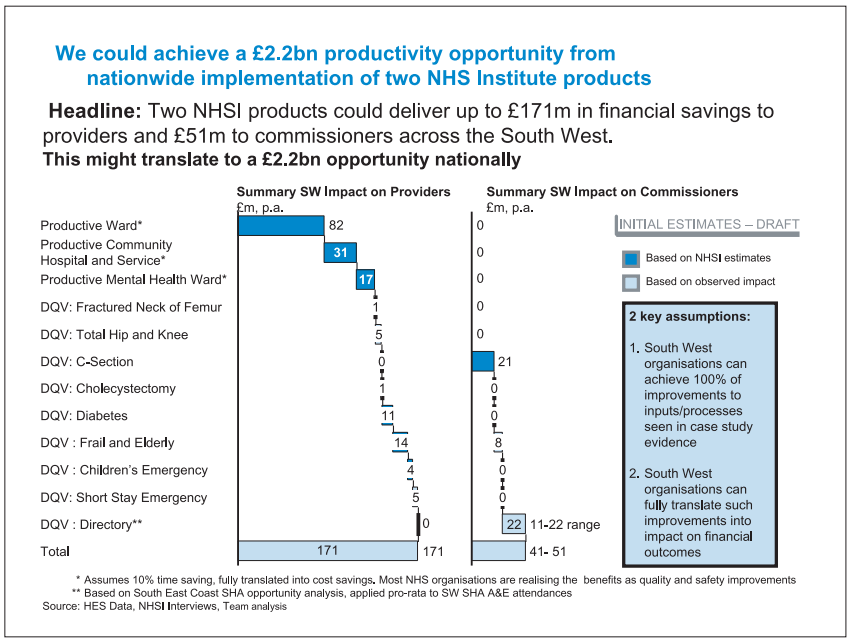

Figure 12. Potential productivity gains from 'scaling up' innovation

POLICY LEVERS

These examples show that there is considerable potential to improve productivity using information and approaches that are already available or are under development. A clear message is that the principal focus should be on reducing variations in clinical practice by engaging doctors and other front line staff in reviewing the performance of the services for which they are responsible. The scale of the savings that can be made, as illustrated by the examples of service line management and the Better Care, Better Value indicators, adds urgency to the work that is already going on in these areas. It also underlines the conclusion of *High Quality Care for All* that doctors need to be much more effectively involved in leadership to enable these savings to be realised.

As previous work by the Nuffield Trust has shown (Ham, 2007a), a key question is whether the policy levers are in place at a system level to support NHS organisations in taking these approaches forward? In addressing this question, it is important to note that many of the current policies (such as NICE, national service frameworks and payment by results) were put in place at a time when the NHS budget was expanding and were designed to support implementation of objectives such as the reduction of waiting times. It remains a moot point whether these policies will enable the NHS to cope with reductions in resources. It is therefore opportune to consider whether any changes in the reform programme need to be made.

As this happens, the time lag between developing new policies and their full implementation needs to be borne in mind. An example is the policy on payment by results, which was first announced in 2002 and which is still being extended to new areas of care. This example suggests that existing levers will continue to play an important part for the foreseeable future, with any major changes having an impact further down the track.

In thinking through these issues, it is as well to remember that the improvements in NHS performance that have occurred to date have been driven mainly by the use of targets linked to performance management. Policies on choice and competition have so far made only a marginal impact (Audit Commission and Healthcare Commission, 2008). Equally important, the agenda set out in Lord Darzi's report, *High Quality Care for All*, of reform being led locally by clinicians, remains embryonic, not surprisingly so as less than a year has elapsed since publication of the report.

It is also the case that providers occupy a more powerful position than commissioners within the NHS. With world class commissioning a work in progress, and practice-based commissioning yet to fully engage GPs on the scale needed to manage demand and deliver services closer to home, is it realistic to expect that commissioners can do most of the hard work needed to rise to the financial challenges that lie ahead? If not, should more emphasis be placed on the role that NHS foundation trusts can play, recognising that nearly all of the most experienced leaders are in NHS foundation trusts rather than PCTs?

Experience of bringing about transformational change in other sectors cautions against a simplistic 'either/or' answer to these questions. Evidence from these sectors suggests that successful change requires action on several fronts simultaneously as well as an approach that recognises the need to work across a series of dualities (Pettigrew, 1999). To be more specific, Ministers and civil servants leading change at a system level need to focus on:

- providing central leadership *and* supporting NHS organisations to build capacity and leadership for change at a local level
- using competition in areas of health care where it is likely to offer the greatest benefits *and* promoting cooperation where organisations need to work together to improve performance
- supporting commissioners to play an increasing role in improving productivity and performance *and* drawing on the expertise of the best NHS foundation trusts to take the actions that are needed
- continuing to emphasise the value of clinical engagement and leadership *and* strengthening the role of general managers at all levels of the NHS
- emphasising the importance of standardisation of care where there is evidence this will bring benefits *and* ensuring that services are customised around the needs of individuals.

Experience in other health care systems underlines the relevance of these observations. High performing health care organisations such as the Veteran's Health Administration, Intermountain Healthcare and Jonkoping County Council owe their success to the adoption of sustained strategies of improvement, in which medical leaders work hand in hand with experienced managers to bring about change and in so doing are supported by timely and accurate information about their services. These organisations also make judicious use of incentives to support their strategies (Baker et al, 2008), thereby lending support to the framework of 'information, incentives and capacity' proposed by Peter Smith and discussed earlier in this paper.

One of the common characteristics of high-performing organisations is that they value the role of medical leaders and use information and incentives as part of an integrated approach to health care. The same is true of other organisations such as Kaiser Permanente and the Geisinger Health System that have been recognised as leaders in quality improvement. While the precise form that integration takes varies, it usually encompasses the coming together of funding and most elements of service provision within the same organisation. Integration enables these organisations to align incentives to facilitate the provision of care in the most cost-effective settings.

The benefits of integration were recognised in the Health Strategy Review undertaken by Adair Turner at the request of the Prime Minister in 2001/02. Ongoing work by the author and by the Nuffield Trust is exploring how these benefits can be exploited in the next stage of NHS reform. The opportunity created by integrated systems is to enable more care to be provided closer to home and to reduce the use of expensive and often inappropriate hospital services. This has been demonstrated in comparisons between the NHS and Kaiser Permanente that show the latter using only one third of the hospital bed days as the NHS for people aged 65 and over (Ham et al, 2003). With the NHS chief executive highlighting opportunities for reducing the use of hospitals by people who no longer require specialist facilities as one of the most promising means of delivering the improvements in efficiency required in the NHS (Nicholson, 2009), it appears that the value of integration is at last being recognised.

Making progress on integration depends critically on primary care practices collaborating in federations or networks and investing in the buildings, equipment and infrastructure needed to support these developments. Fragments of what a new configuration of services might look like are beginning to emerge in parts of the NHS, both through the initiative of NHS organisations and through joint ventures between the NHS and the independent sector. To return to an earlier point, integration may gain greater traction as the NHS migrates from expansion into a cold financial climate, not least because the risks in the current system of cost-shifting and blame-shifting between organisations may be too great for the system to bear. The challenge now is to convert the small-scale examples of integration that currently exist (Ham, 2007b) into more ambitious approaches covering entire health communities.

One way of doing this is to support innovators in primary care to reach into hospitals and to form stronger links with community health service and social care providers (Ham, 2007b). Another approach is to support experienced and successful leaders in NHS foundation trusts to lead the development of integration. The risk in such an approach is that an 'acute services mindset' may dominate primary care and community health services and suck more resources into hospitals.

To avoid this risk, there must be changes to the regulatory regime for NHS foundation trusts and to payment by results. Monitor's oversight of foundation trusts has brought many benefits but has had the consequence of creating strong incentives for trusts to increase activity and income in order to meet the financial targets set under the regulatory regime. These incentives are reinforced by payment by results, which was designed to reward trusts that treat more patients in order to achieve the policy aims of cutting waiting lists and waiting times. The combined effect has been to turn acute hospitals into profit centres whose leaders are focused on increasing income and surpluses.

As the NHS moves from expansion to contraction, and as the policy focus shifts from improving access to planned care to achieving improvements in unplanned care and care for people with long-term conditions, a different approach is needed (Ham, 2008). Acute hospitals will continue to play an important part in the provision of care within the NHS but much more emphasis needs to be put into delivering the vision set

out in the 2006 White Paper, *Our Health, Our Care, Our Say* (Secretary of State for Health, 2006), of care being provided closer to home with resources directed towards prevention and services in the community. Implementing this vision requires a fundamental reconceptualisation of acute hospitals as cost centres rather than profit centres. It also means adopting the philosophy of integrated systems like Kaiser Permanente, in which 'an unplanned admission is a sign of system failure' and where the focus is therefore on admission avoidance through prevention and early intervention.

Alongside changes to the regulatory regime and payment by results, there needs to be a strong countervailing force able to act as guardian and sponsor of the vision set out in *Our Health, Our Care, Our Say*. In theory, this is the role of PCTs but the results of the world class commissioning assurance programme demonstrate that PCTs are on a long-term journey of improvement and in many areas have much work to do to perform to the standards expected of them (Department of Health, 2009). Part of the challenge facing PCTs is how to acquire the people and skills they need to commission to world-class standards. The development of arrangements such as those emerging in London, where six commissioning hubs are being established to support the work of 31 PCTs, may be one way of addressing this challenge, alongside further intensive support to PCTs to enable them to fill the gaps identified in the world class commissioning assurance programme. The support provided to PCTs now needs to be fast-tracked, as the 'NHS recession' has arrived too soon to allow current programmes simply to run their course.

The key policy question then becomes how to calibrate the role of competition and cooperation in the next stage of reform, at a time when the recently established Cooperation and Competition Panel is actively seeking to open up the market in health care, and when integrated systems might appear to limit choice and competition. Addressing this question needs to be at the heart of the reassessment of policy that must now take place.

CONCLUSION

It is clear from the work reported here that there is considerable scope to use the current budget for the NHS in England of over £100bn more efficiently. The principal focus should be on reducing variations in clinical practice by engaging doctors and other front-line staff in performance improvement. The work of the NHS Institute has highlighted opportunities to save over £5bn in this way, even before the productivity gains in the community health services are quantified. Realising these savings requires a strengthening of operational management and clinical engagement and the systematic use of incentives and information.

An intelligent response to the challenges facing the NHS would entail action on several fronts simultaneously and work across a series of dualities. As this happens, there is a need to support the most experienced and successful NHS leaders to develop integrated approaches to care to facilitate the provision of services in the most cost-effective settings and to avoid cost-shifting and blame-shifting. These approaches need to go beyond the small-scale examples of integration that currently exist to embrace more ambitious initiatives covering whole health communities.

Alongside integrated approaches to service provision, there is a need to ensure that there is a countervailing force able to avoid 'provider capture' and to promote the delivery of services in the most cost-effective settings.

The Department of Health must urgently review current policies, many of which were devised to support the considerable expansion of provision that has occurred in the last decade. This includes reassessing the role of competition and cooperation in contributing to service improvement.

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Topics to be explored in the New Frontiers programme include:

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- new frontiers in the use of data; and the implications for the future of commissioning in the NHS.

Further details will be announced on our website www.nuffieldtrust.org.uk, or contact Dr Judith Smith, Head of Policy at judith.smith@nuffieldtrust.org.uk

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