The Nuffield Trust
FOR RESEARCH AND POLICY
STUDIES IN HEALTH SERVICES

NUFFIELD TRUST SERIES REPORT

INCREASING NHS EFFICIENCY
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Background

As the NHS works towards achieving financial balance and meeting targets for service improvement, increasing attention is being given to ways of improving efficiency. The focus on efficiency is likely to sharpen in the period up to and after 2008 when the growth in expenditure is likely to slow following the outcome of the comprehensive spending review.

To explore the challenges involved in improving NHS efficiency, the Nuffield Trust held a series of seminars led by experts in this field. The seminars explored three areas: the financial context; where there is scope for using resources more efficiently; and whether the right levers and incentives are in place to bring about improvements in efficiency. This report is a synthesis of the seminars, prepared by Professor Chris Ham, chair of the series.

About the Nuffield Trust

The Nuffield Trust is one of the UK's leading independent health policy charitable trusts. It promotes independent analysis and informed debate on UK health care policy and acts as a catalyst where fresh ideas and information are devised and developed through a programme of activities within four policy themes: Policy Futures; The Changing Role of the State; Public Health; and Quality.

1. ***The financial context***

The NHS budget has grown at an unprecedented rate in recent years. Since 2000, spending has risen by 10 per cent a year in cash terms, equivalent to around 7.5 per cent in real terms, compared with average annual increases of just over 3 per cent in real terms between 1992 and 2000 (Martin and Smith, 2006). These increases mean that the proportion of gross domestic product consumed by health care has risen by 2.5 per cent between 2000 and 2007 (Appleby and Harrison, 2006).

The current level of increase in the NHS budget comes to an end in 2008. The comprehensive spending review will determine the pattern of expenditure growth thereafter, the expectation being that public spending in general and NHS spending in particular will rise more slowly than in recent years. Such an outcome would be consistent with the Wanless review which recommended that, after a five year period of high levels of expenditure increases, the NHS would require more modest increases in order to keep up with other countries.

Despite recent funding increases, the NHS entered the comprehensive spending review with a gross deficit of £1.3bn and a net deficit of £0.6bn in England in 2005/06. Around one third of NHS organisations were affected by deficits and a similar proportion reported deficits in the first six months of 2006/07. Several factors have contributed to deficits, including inadequate costing of new staff contracts by the Department of Health, and weaknesses in NHS management at a local level (Health Committee, 2006; Audit Commission, 2006).

The existence of deficits, coupled with the prospect of slower rates of expenditure increases after 2008, has turned attention to ways of increasing efficiency within the NHS. The immediate challenge facing the government is to ensure that the NHS returns to financial balance and achieves the ambitious targets that have been set for improving performance, such as the maximum waiting time of 18 weeks from GP

referral to hospital treatment by the end of 2008. Looking further ahead, the NHS will have to find resources to fund new technologies and meet the needs of an ageing population with annual expenditure increases of around half the level experienced since 2000.

Two questions arise: first, where is there most scope for using resources more efficiently? Second, are the right levers and incentives in place to bring about improvements in efficiency? These questions were debated at a series of seminars held at the Nuffield Trust in the second half of 2006 and this briefing paper summarises the discussions at these seminars.

2. *Where is there most scope for using resources more efficiently?*

In an organisation spending around £90bn of public funds, there are many potential areas in which to seek efficiencies. The seminars drew on experience from two sources to examine these areas: the health strategy review commissioned by the Prime Minister in 2001/02, led by Adair Turner; and the Financial Sustainability Review conducted within the Department of Health.

The Health Strategy Review

The analysis undertaken by Adair Turner for the Prime Minister in 2001/02 concluded that the greatest potential exists in relation to *core medical processes*, rather than eliminating waste and bureaucracy by cutting management costs and overheads. The challenge throughout the world is to move to a system of medicine which preserves the professional judgement of doctors but surrounds it with clear identification of best practices.

In the UK, there are wide variations in medical practice. These variations affect both outcomes and service utilisation. Examples include cancer survival rates in different areas and the proportion of surgical procedures undertaken as day cases. Prime facie, there is huge scope to improve performance if agreement can be reached on best practices and action taken to implement these practices, as the NHS Institute has shown in its work (NHS Institute, 2006).

Previous improvements in NHS productivity were driven mainly by declining average lengths of stay in hospital, a major shift to day surgery and a significant increase in nurse productivity. Future improvements are likely to be more difficult to achieve and will depend on changes in working practices, using the new staff contracts, skill mix changes, and realising the benefits of the investment being made in IT.

The challenges confronting the NHS are common across the world and there is no evidence that other systems, *as systems*, perform consistently better. On the other hand, international comparisons raise questions about the opportunities to increase efficiency in the NHS. For example, comparison of the NHS with Kaiser Permanente in California has identified major differences in the use of acute hospitals. Admission rates and lengths of stay in hospitals are both higher in the NHS, and consequently there is much greater reliance on hospitals than is the case in Kaiser (Feachem et al, 2002; Ham et al, 2003).

Kaiser's model of integrated care is based on medical offices that enable a wider range of services to be provided outside the hospital. Primary care physicians work alongside specialists and have access to diagnostic facilities on site. Hospitals are used only for patients who require the expertise available in an inpatient environment, and elective care is usually separated from emergency care. This model of care is based on using resources to employ more staff (especially doctors) rather than to build more beds.

The analysis conducted for the Prime Minister concluded that the main potential sources of significant productivity improvement are:

- **evidence based medicine**: identifying which procedures (drugs, surgical interventions, processes of care) produce best results relative to cost and generalising the use of those procedures e.g. appropriate best practice in use of day cases and appropriate drug responses by GPs

- **skill mix changes**: e.g. nurses doing procedures presently done by consultants, freeing up scarce consultant time, and health care assistants doing nursing jobs

- **process redesign**: parallel rather than sequential processing of key steps e.g. tests, and better utilisation of nurses, consultants and junior doctors through more tightly scheduled consultant time

- **reconfiguration**: new model of primary care with bigger practices, more specialists, and more equipment. Many 'outpatient' functions could be transferred to primary care, with some collapse of three step process (primary, outpatient, inpatient) to two step (diagnosis, treatment). Separation of emergency and elective care, delivering benefits of specialisation, focused management, reduced hospital acquired infection, etc

- **information technology**: electronic patient record systems which reduce doctor time on data analysis/input/search for records, cut out duplicate and repeated tests, improve bed management, and cut mistakes

The analysis suggested that government has to recognise that reform involves a long slow haul and that there are no quick fixes. Equally, government has to avoid destabilising the reform programme through organisational change and needs to manage the inflationary risks associated with significant expenditure increases, and the rapid implementation of new contracting and payment systems.

Recent restructuring of the NHS in England and the emergence of deficits indicate that these warnings were not heeded.

The Financial Sustainability Review

The importance of focusing on core medical processes has been underlined by the Financial Sustainability Review undertaken by the Department of Health as part of the current comprehensive spending review. The Review has examined the potential for efficiency gains in the following areas:

- pay and workforce
- pharmaceutical spending
- procurement
- whole service realignment
- productivity and variation
- public health
- mental health
- social care

Potential savings of over £6bn have been identified in the Review, with the most significant opportunities being in pay and workforce, productivity and variation, and procurement.

In the case of *pay and workforce*, the opportunities include reducing variations in unit labour costs, tackling variations in consultant productivity across NHS trusts, reducing sickness and absence rates, reducing the use of agency and locum staff, and

exploring changes in skill mix e.g. by using nurses to take on medical tasks. The draft NHS pay and workforce strategy prepared by the Department of Health as a contribution to the spending review, and leaked to the Health Service Journal, also suggested scope for developing a sub-consultant grade, and opportunities to control wage costs by moving towards regional and local pay rates (Mooney and Donnelly, 2007).

There are even greater potential savings in relation to *productivity and variation*. This has been illustrated by the analysis of variations in performance undertaken by the NHS Institute. In a report published in October 2006, the NHS Institute estimated that the NHS could save up to £2.2bn by reducing variations, broken down as follows:

- £975m through length of stay reductions
- £510m through preoperative bed day reductions
- £348m from emergency admission reductions
- £278m from outpatient referral reductions
- £73m from better management of surgical thresholds
- £16m from increased rates of day surgery procedures

There are similar opportunities in relation to primary care, for example through more efficient prescribing. On a conservative estimate, the Department of Health has suggested that the NHS could save £85m a year by using generic rather than branded statins for the treatment of cholesterol, with some calculations suggesting much higher levels of potential savings in this area of prescribing alone (Moon and Bogle, 2006).

Procurement is the third area in which there is significant opportunity to achieve efficiency improvements. This is an area in which the Department of Health's commercial directorate has been active and has been exploring the scope for delivering savings through smarter procurement e.g. by using national contracts and collaborative procurement in the supply chain excellence programme.

3. *Are the right levers and incentives in place to bring about improvements in efficiency?*

Identifying the potential for savings is not the same as delivering these savings. Research going back over 30 years has highlighted the existence of wide variations in productivity and performance in the NHS, and successive governments have sought to reduce these variations in the quest for improvements in efficiency. Although the performance of the NHS at an aggregate level has improved during this period, variations in core medical processes remain. The question is whether the levers and incentives being put in place under the current reforms will have a bigger impact on these variations than previous policies.

To date, the government has relied on extra spending linked to targets and performance management to drive improvement. In parallel, it has published a series of national service frameworks (NSFs), drawing on expert clinical advice, to set out standards to be achieved in the major areas of medical priority. The government is now seeking to drive change bottom up through the actions of patients and providers, rather than top down through directives from Whitehall.

To this end, patient choice and competition between providers are being given greater emphasis, supported by payment by results (PBR) and practice based commissioning (PBC). The aim is to create a 'self improving system' (Hewitt, 2005) in which there is less reliance on targets and performance management and a stronger dynamic within the NHS for staff and the organisations they work for to

be responsive to patients and efficient in the use of resources.

A key component in the emerging system is the encouragement given to new providers to enter the market, particularly through the use of independent sector treatment centres (ISTCs). The impact of increased competition in health care through the ISTC programme has been felt most strongly by incumbent private sector providers who have been forced to cut their prices to the NHS and negotiate lower fees with consultants in the face of the challenge thrown down by new market entrants and smarter procurement by government.

As time goes on, and the second wave of independent sector provision comes on stream, NHS providers may be faced with a similar challenge. Not least, it can be anticipated that ISTC providers will achieve efficiency improvements through standardising clinical practices and using staff more effectively, thereby stimulating the NHS to follow suit. Research has shown that in other sectors of the economy, productivity growth is highest in sectors that face the greatest competition, and the government is banking on the same applying in health care.

Choice and competition have focused mainly on elective and diagnostic services and it is doubtful whether they can be applied in the same way to unplanned care and care for people with long term conditions. In these areas of care, the aim is not to increase hospital activity in order to improve access, but rather to provide care closer to home and to avoid the inappropriate use of hospital services. Among other things, this requires the development of urgent care networks and closer integration between primary care and secondary care.

The white paper, *Our Health, Our Care, Our Say*, recognised the need to adapt the direction of the reforms to support improvements in these areas of care. Specifically, the white paper included a commitment to unbundle the PBR tariff to support alternatives to hospital. Subsequently, guidance on PBR for 2007/08 set out examples of how this might be done. Notwithstanding these initiatives, the incentives to support the development of care networks and integrated services remain weak, certainly when compared with the incentives to increase elective and diagnostic activity to reduce waiting times.

What will be the impact of PBR on efficiency? In fixing prices paid for treatment, PBR creates incentives for providers to reduce their costs and improve productivity. International experience suggests that these incentives will reduce lengths of stay and encourage the further substitution of day surgery for inpatient treatment. They may also assist in the reduction of preoperative bed days. On the other hand, PBR may increase the financial pressures on commissioners if it leads to more complete and accurate coding of treatments.

PBC provides a counterbalance to payment by results by offering incentives to practices to manage demand and examine more closely referrals to hospitals. These incentives could help to reduce emergency admissions and the use of outpatient services. Over time, PBC could also lead to the use of more explicit referral criteria, for example in relation to elective surgery, to avoid the risks of inappropriate over treatment under PBR. Prescribing in primary care may be affected too if practice based commissioners see opportunities to make and redeploy savings e.g. by switching to generic statins.

In assessing the likely impact of the health reforms, it is clear that much depends on the ability of commissioners to negotiate on equal terms with providers. The main emphasis of the reforms to date has been on strengthening the supply side through the procurement of additional capacity from the

independent sector and the introduction of NHS Foundation Trusts. By comparison, the demand side, represented by Primary Care Trusts (PCTs) and PBC, is relatively under developed.

Although steps are being taken to strengthen commissioning, it is not yet clear whether the PCTs that have emerged from the recent restructuring will be more effective than their predecessors, nor whether there will be sufficient interest and expertise among practice based commissioners to enable them to realise the potential of PBC. *Our Health, Our Care, Our Say*, sets out an aspiration to develop 'world class commissioning' but as yet there are few grounds for believing this will be realised.

In view of this, government may rely on regulation and inspection to drive improvements in performance in the next phase of reform. This would build on the role that Monitor has established in relation to NHS Foundation Trusts and that the Healthcare Commission is developing in relation to all providers. Whether regulation and inspection will be sufficient to release the potential efficiency gains that exist is unknown.

4. *Report Summary*

The seminars identified a series of opportunities and threats in the quest for improvements in NHS efficiency.

The principal opportunities lie in the potential to release resources through a focus on core medical processes, including tackling variations in clinical practice, focusing on pay and the use of the NHS workforce, and reconfiguring services to enable more care to be provided outside the acute hospital. The levers and incentives that have been put in place, especially those involving patent choice and competition, are likely to contribute to efficiency improvements, particularly in relation to elective care. It is much less clear that they will support improvements in unplanned care, care for people with long term conditions, and public health.

The main threats relate to the risk that the government's reforms will suck more resources into hospitals and make it harder to implement the vision set out in *Our Health, Our Care, Our Say*. Specifically, the weakness of commissioning, uncertainty over the extent to which practices will embrace PBC, and the lack of incentives to support the development of care networks and integrated services may make it difficult to bring about improvements in unplanned care and care for people with long term conditions. In view of the fact that up to 80 per cent of hospital bed days result from unplanned admissions, and many of these admissions arise from acute exacerbations of long term conditions, this is a serious concern.

What this suggests that in the next phase of NHS reform there should be a renewed focus on the following issues:

- **commissioning**: overriding priority should be given to the development of PCTs and PBC to make a reality of the aspiration to develop world class commissioning in the NHS

- **integration and incentives**: the emphasis on competition and choice in elective care needs to be matched by the development of collaboration and integration in other areas of care, supported by appropriate incentives

Equally important is the need to engage doctors and other clinicians in the quest for gains in efficiency. The rationale for this follows directly from the analysis of the health strategy review and its emphasis on core medical processes as the principal source of potential performance improvements. In a professional service organisation like the NHS, the

use of resources is strongly influenced by the clinical teams delivering care to patients. Managers have limited control over the decisions of these teams and core medical processes.

To refer back to an earlier example, Kaiser Permanente achieves high levels of performance by involving doctors and other clinical staff in leadership roles throughout the organisation and by using peer pressure to reduce variations in practice. Within Kaiser, doctors in particular work closely with managers in running hospitals and medical offices, and in seeking to continuously improve performance. There is a close alignment of purpose and objectives, to that extent that doctors can see how their actions benefit themselves, the Kaiser health plan, and the members who are being served. Alignment is underpinned by an arrangement in which doctors are shareholders in the Permanente Medical Group with the latter having a mutually exclusive relationship with the Kaiser health plan.

An important characteristic of Kaiser is the existence of multispecialty medical practice in which general practitioners work alongside specialists. The divisions between primary care and secondary care that bedevil the NHS are not present to the same degree, and this facilitates the provision of high quality integrated care, particularly for people with long term conditions. Also, the fact that medical specialists have been decoupled from hospitals and work mainly from medical offices is strongly supportive of the provision of care closer to home, with acute hospitals being used only when appropriate.

The important point about Kaiser from the point of view of this paper is that doctors lead the search for improvements in performance. Within the Permanente Medical Group, the emphasis is on securing these improvements through a culture of commitment and not compliance. In other words, doctors are committed to the provision of high quality care at reasonable cost and they are instrumental in making this happen. Change does not derive from compliance with externally imposed targets and objectives because in effect the Permanente Medical Group is a self-governing medical partnership that uses peer and collegial processes to bring about improvements.

The biggest challenge facing the NHS is how to adapt this culture and way of working as it enters a much more difficult financial climate.

Chris Ham
Advisor to the Nuffield Trust
Professor of Health Policy and Management
Health Services Management Centre
University of Birmingham

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The Nuffield Trust
59 New Cavendish Street
London
W1G 7LP
www.nuffieldtrust.org.uk