HEALTH SELECT COMMITTEE: INQUIRY INTO PUBLIC EXPENDITURE

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

**Summary**

2) The King's Fund welcomes the Committee's inquiry into public expenditure. There is a lack of systematic monitoring of the measures being taken to meet the Nicholson Challenge, so it provides an important opportunity to evaluate progress so far and assess the impact of current financial pressures on health and social care services.

- Despite the headlines generated by the government's reforms, meeting the Nicholson Challenge is the key priority facing the NHS. We remain concerned that the structural reorganisation set out in the Health and Social Care Bill presents a real risk to delivering on this challenge.

- Challenging cost improvement targets have been set across the NHS, with many trusts facing targets of 6 per cent or more and emerging evidence suggesting some uncertainty about whether these targets will be met.

- We are concerned that too much emphasis is being placed on delivering financial savings instead of productivity gain, with emerging evidence suggesting that many trusts are restricting access to services.

- More needs to be done to tackle unwarranted variations in NHS performance and major reconfigurations of hospital services are needed if the Nicholson Challenge is to be met.

- High-quality leadership and management are essential to delivering the Nicholson Challenge – the denigration of NHS managers by politicians should stop and the target to cut the number of managers by 45 per cent should be re-visited.

- Despite the additional funding announced in the Spending Review and the best efforts of councils, it is clear that spending on social care will fall in 2011/12, with efficiency savings unlikely to make up for cuts in local authority budgets.

- While the Health and Social Care Bill could provide a platform for improving health and social care integration, a more ambitious approach is needed to align the £121 billion currently spent on health and social care much more closely around the needs of patients and service users.

3) Our responses to the questions set out in the inquiry's terms of reference are set out below.

**The plans being made by NHS bodies to enable them to meet the Nicholson Challenge**

4) In April, The King's Fund published the first in a series of new quarterly monitoring reports, which include the views of a panel of NHS finance directors (Appleby and Poteliakhoff 2011a). A second report was published in July (Appleby and Poteliakhoff 2011b). Although these reports aim only to provide a snapshot of views and the

panel is not intended to be a representative sample, they provide some insight into the plans being made by the NHS in response to the Nicholson Challenge.

5) In July, almost all the finance directors among our panel (27 of 29) indicated that their trust has a productivity target of 4 per cent or more for 2011/12, with nearly half (13) citing a target of 6 per cent or more. This is consistent with other publicly available information. Monitor's annual review of foundation trust plans found that the foundation trust sector is planning to deliver productivity savings of 4.4 per cent in 2011/12 (Monitor 2011), while in April 2011 it revised its 'downside' efficiency requirement to 6.5 per cent for the acute sector and 6 per cent for the non-acute sector (Hay 2011).

6) This shows that many NHS organisations have higher targets than the average of 4 to 5 per cent needed to deliver the Nicholson Challenge over the next four years. The key reason for this is the decision to make 40 per cent of the savings required (£2 billion a year) through reductions in the tariff in the acute sector. As the tariff currently covers around £30 billion of annual income for trusts, this implies a productivity gain of nearly 7 per cent a year. Local factors and requirements to hold back money to meet targets for surpluses to carry over to next year and act as a buffer to meet the costs of the government's reforms also contribute to this.

7) Our quarterly monitoring reports suggest that many trusts may struggle to meet their targets. In our July report, nearly half our panel of finance directors indicated that they are uncertain of meeting their targets, while 8 of the 13 panellists with targets of 6 per cent or more indicated that they are uncertain of meeting them. Similar findings have been reported elsewhere. Information published by *GP* magazine found that 59 per cent of primary care trusts may fail to meet their targets (Sell 2011). A recent survey of senior managers published by the *Health Service Journal* found that 55 per cent of respondents were not confident that their organisation will be able to make the savings needed (HSJ 2011).

**Where changes are being proposed, and whether the NHS is succeeding in making efficiency gains rather than cuts**

8) The lack of systematic monitoring of the measures being taken locally through Quality, Innovation, Productivity and Prevention (QIPP) plans means that it is not yet possible to evaluate the extent to which the NHS is succeeding in making efficiency gains rather than cuts. In the absence of auditable data, we are concerned that ambitious QIPP plans may in part only be achieved at the expense of quality and reductions in volume.

9) We are also concerned at the emphasis being placed on the financial value of the productivity gain being sought – the £20 billion. While this provides a legitimate broad brush target (and is in line with previous analysis provided to the Committee by The King's Fund (The King's Fund 2010)), we are concerned that many in the NHS have interpreted this figure as the *financial savings* to be made over the four years to 2015, rather than simply a *monetary expression of the value of the productivity gain to be achieved.* Improving value for money for patients does not just involve reducing unit costs – in many ways, and perhaps more importantly, it means identifying where value can be improved for a given level of spending.

10) We have previously argued that there are opportunities to improve productivity by reducing unwarranted variations in performance. For example, the NHS Institute for Innovation and Improvement has estimated that £4.5 billion in efficiency savings could be delivered in acute hospitals by bringing performance up to the level currently achieved by the top quartile (Crump 2009). There are significant opportunities to improve workforce productivity – for example, savings of up to £400

million could be made by tackling poor performance among GPs (McKinsey and Co 2009). Significant savings could also be delivered by improving the prescribing and management of drugs, which account for 12 per cent of the NHS budget (Appleby *et al* 2010).

11) Major reconfigurations of hospital services are essential to meet the Nicholson Challenge and to improve the quality and safety of care. We remain concerned at the lack of clear responsibility for driving forward this agenda under the Health and Social Care Bill. We have recently published proposals to improve the decision-making process for hospital reconfigurations (Imison 2011), which is complex and bureaucratic and often undermined by resistance to change from local MPs and councillors, even when there is strong clinical and financial evidence of the need for it.

12) Emerging evidence suggests that a combination of efficiency savings, restrictions to services and cuts in staff are being used to meet productivity targets. For our April monitoring report, we asked finance directors to identify the top three ways in which productivity targets will be met in their organisations. Responses were as follows:

- frontline efficiencies (eg, reductions in length of stay): 20
- workforce changes (eg, reducing agency staff, reducing headcount): 16
- whole system efficiencies (eg, redesigning or reconfiguring services): 13
- closing wards and services: 12
- back office efficiencies: 6
- reducing activity (eg, demand management): 5
- external contracts (eg, improving procurement): 3.

13) This mixed picture is supported by other emerging evidence which suggests that access to some treatments and procedures is being restricted. *GP* magazine (Moberly 2011) recently reported that two-thirds of primary care trusts (PCTs) are restricting referrals for treatments that are non-urgent or of low clinical value, with a third increasing the number of procedures they will restrict funding to over the next year. *Pulse* (2011) also recently reported that two-thirds of PCTs have expanded procedures classified as low clinical priority.

14) Data also shows the number of redundancies is increasing. The six months to March 2011 saw an almost three-fold increase in the number of compulsory redundancies, with 1,250 NHS staff made redundant in the last quarter of 2010/11, of whom 234 were clinical staff (Department of Health 2011b).

15) Restricting access to treatments may, in some cases, reduce variations in procedures that offer little benefit to patients. For example, our research (Appleby *et al* 2011) shows that the rate of tonsillectomies – a procedure that has been questioned since the 1930s – is 10 times higher in Coventry PCT than in Kingston PCT. However, reports that access is being restricted to procedures, such as hip and knee replacements and cataract operations, is a significant concern as this is likely to harm patient care.

16) Our research also highlighted opportunities for delivering productivity improvements by reducing variation in the way some procedures are carried out. For example, although most operations on varicose veins can be undertaken as day cases, with some PCTs doing this in 90 per cent of cases, some PCTs only manage this in 30 per cent of cases.

**The cost of the continuing reorganisation of NHS structures in line with the provisions of the Health and Social Care Bill**

17) There is currently no up to date estimate of the cost of the structural reforms outlined in the Health and Social Care Bill. The Regulatory Impact Assessment published alongside the Bill estimated the cost 'attributable to the changes in the system architecture' as £1.4 billion (Department of Health 2011a). The *Health Service Journal* (West and Williams 2011) recently reported that the Department of Health business plan includes an updated estimate of the cost of the 'transition programme' as £1.49 billion. No independent assessment of the cost of the structural reforms has been published, although in July 2010, Kieran Walshe, Professor of Health Policy and Management at Manchester Business School, estimated it to be between £2 billion and £3 billion (Walshe 2010). The government has indicated that a revised Regulatory Impact Assessment will be published shortly.

18) More broadly, we remain concerned that the scale of the structural reorganisation set out in the Bill and the challenges associated with implementing it present real risks to delivering on the Nicholson Challenge. The uncertainty of the past few months has caused significant instability within the NHS. It is essential to move on from this so that it can focus on delivering the productivity improvements needed to maintain quality and avoid significant cuts to services.

19) High-quality leadership and management are essential to delivering the Nicholson Challenge. Nevertheless, senior members of the government continue to denigrate NHS managers as 'bureaucrats'. This should stop. As the report of our Commission on Leadership and Management in the NHS (The King's Fund 2011) showed, while there is evidence that the NHS is over-administered as a result of extensive and overlapping demands from regulators and performance managers, there is no persuasive evidence that it is over-managed. While reductions in management costs must play a part in meeting the Nicholson Challenge, the arbitrary target to cut the number of managers by 45 per cent should be re-visited and a more sophisticated approach should be taken to assessing the leadership and management needs of the NHS.

**The impact on the provision of adult social care of the 2010 Spending Review settlement and the removal of ring-fencing for social care grants**

20) The King's Fund prepared a supplementary memorandum for the Committee's previous inquiry which explored the implications of the 2010 Spending Review for adult social care (House of Commons Health Committee 2010). On the basis of a reduction in local authority spending on social care of 7 per cent a year, it concluded that a funding gap of £1.2 billion could develop by 2014, unless local authorities are able to find efficiency savings of 2 per cent a year. This estimate was based on a number of assumptions, including the budget decisions made by 152 local authorities.

21) It is now clear from local authorities' actual budget settlements for 2011/12 that they are reducing expenditure on adult social care by £991 million – a 6.9 per cent reduction in spending in a single year (ADASS 2011). In the context of a 10 per cent reduction in overall spending by local authorities, this suggests that councils have sought to prioritise adult social care and that the removal of ring fencing has not had a deleterious impact on spending.

22) The planned reduction in expenditure includes explicit decisions to reduce services by £226 million and generate additional income through charging of £84 million. The intention is that the remaining £681 million will be delivered through efficiency savings and the redesign of services. This would amount to a 4.7 per cent efficiency gain and seems very optimistic (see below). Some of the reduction in expenditure will be mitigated by the £648 million made available in 2011/12 from the NHS budget

to spend on social care services. Nevertheless, it is clear that the key question is not whether adult social care spending will fall this year, but by how much.

23) In its previous report, the Committee expressed doubts about whether local authorities would be able to deliver sufficient efficiency savings to avoid restricting eligibility criteria. A further 15 local authorities changed their eligibility criteria for services from moderate to substantial in 2011/12, meaning that 82 per cent now offer services only to those with substantial or critical needs.

24) The squeeze on local authority budgets over the next four years suggests that the gap between needs and resources will continue to widen, despite the additional £2 billion announced in the Spending Review and the best intentions of local authorities to protect social care. It seems likely that access to services will be further restricted in response to these pressures. The need to secure a sustainable long-term funding settlement for social care has never been more urgent – the government must move quickly to undertake detailed work on the recommendations made by the Dilnot Commission and honour its pledge to publish a White Paper followed by legislation in 2012.

**The impact on NHS plans of decisions currently being made by local authorities**

25) We would expect the pressures on social care budgets to produce knock-on consequences for the NHS, for example, in terms of increased emergency admissions, delayed discharges from hospital. However, there is no evidence that these pressures are feeding through yet. Delayed transfers of care are stable and remain significantly below the very high levels recorded in 2003/4.

**The ability of local authorities to make the necessary efficiency savings**

26) Local authorities have a mixed record in delivering efficiency savings. Historically, efficiency in adult social care has declined, with productivity falling by 15.3 per cent between 1997 and 2008 (Office for National Statistics 2010). This trend has been reversed recently, with local authorities finding more than £940 million in efficiency savings in the past three years (ADASS 2010). However, it is very optimistic to expect adult social care services to deliver efficiency savings of £681 million in a single year.

**The use of the additional £1 billion funding for social care made available through the NHS budget**

27) We are not in a position to evaluate how the additional £1 billion in funding for social care made available through the NHS budget is being spent, although anecdotal evidence suggests this has been a useful spur for initiating local discussions between the NHS and adult social care. We note that the Department of Health has recently written to PCTs to collect information about this (Flory and Behan 2011).

**Progress on making efficiencies through the integration of health and social care services**

28) Evidence suggests that significant efficiency gains can be made by improving integration between health and social care. For example, analysis of Torbay's Integrated Care Project (Thistlethwaite 2011) has highlighted low rates of emergency admissions, emergency bed day use and discharges into residential care compared with other areas in the South West. As a result of the project's work, the average number of daily occupied hospital beds fell from 750 in 1998/9 to 502 in 2009/10.

29) It is too early to judge progress in delivering efficiencies by integrating health and social care under the coalition government's policies. Anecdotal evidence suggests that significant barriers remain. In our quarterly monitoring report published in July, eight of our panel of finance directors identified integration between local partner organisations including social care as one of the top three barriers to achieving productivity improvements. This was the second highest response.

30) The Health and Social Care Bill could provide a platform for rectifying this, with the requirements on clinical commissioning groups to promote integrated care providing an opportunity for local initiatives to be clinically driven. The amended Bill includes stronger duties on health and wellbeing boards to deliver health and social care integration and the government has indicated that the boundaries of clinical commissioning groups should not now cross those of local authorities, unless this can be justified in terms of benefits to patients and integration of services.

31) However, the legislation is only the starting point. Experience shows that the key to delivering integration is stable leadership and an evolving vision and trust between local partners. We are concerned that the complex organisational change now being implemented in the NHS could disrupt existing relationships. For example, the advent of clinical commissioning groups and the move to PCT clusters potentially threatens the shared management arrangements which have developed between some local authorities and PCTs.

32) Integrated care has been a recurrent goal of public policy under successive governments for more than 40 years. However, despite some notable successes, progress has been limited with less than 5 per cent of NHS and social care budgets subject to joint arrangements with wide variations across different parts of the country in the quality and achievements of joint working.

33) Making significant progress on this agenda demands a more ambitious approach. In our view, this should be centred on aligning the £121 billion currently spent on health and social care much more closely around the needs of patients and service users by pooling local budgets and, potentially, moving towards a single, strategic assessment of the funding needs of the NHS and social care. We welcome the inclusion of a workstream on integrated care in the next phase of the NHS Future Forum's work and hope this will provide an opportunity to explore radical options.

**Progress on and implications of changes to the tariff structure**

34) The policy decision taken by the Department of Health to make 40 per cent of the savings required of the NHS through real reductions in the tariff in the acute sector is very significant (see above). We cannot comment extensively on the implications of changing the tariff structure at this stage.

35) However, we believe that perverse impacts may result from some specific changes such as the decisions not to reimburse hospitals for emergency readmissions within 30 days of discharge following an elective admission and for all other readmissions within 30 days of discharge to be subject to locally agreed thresholds, and to pay providers to support people for 30 days following discharge from hospital. Care pathways should be redesigned to reduce unplanned hospital admissions and make care closer to home a reality, but the focus should be on ensuring commissioners redesign care pathways to make this happen.

36) More radical changes to the tariff system, for example, using bundled payments across pathways of care and linking payments to improvements in quality and patients' health outcomes instead of activity, could improve incentives and benefit patients. However, it should be recognised that there are limits to the ability of

Payment by Results or any pricing system to unambiguously direct providers' behaviour.

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