

YCFM event #4

“The recession – the implications for the NHS”

12th April 2010

The Royal College of Surgeons of England

This is the information pack for the fourth event in the YCFM series on the 12th April at the Royal College of Surgeons of England.

We are providing you with an overview of some of the issues that have been discussed recently about the way in which the NHS may have to change to deal with the implications of the recent recession.

Background

The 18-month long recession recently experienced by the UK economy was the most prolonged period of economic recession (negative growth in more than two quarters) since the 1950s. The UK has also experienced a longer and deeper recession than most other developed economies.

NHS spending has doubled in real terms since 1997 to £102.7bn in 2009/10. However, since 2007 it has been 'underspending' against its allocated budget, i.e. spending with the aim of leaving a residual surplus (£1.3bn this financial year). This is to save some of the NHS budget for leaner times, as demanded by the Chancellor's 2008/2009 Budget.

The next financial year (2010/11), though, will be the last year for some time that the NHS sees a real terms increase in its budget (5.5%), for the 2010 Budget has confirmed the NHS budget will be frozen for at least two years. This freeze is likely to continue until at least 2015/16 as public finances are brought into a sustainable position (public debt is forecast to peak at 74.9% of GDP in 2014/15).¹

To put this in context: the NHS has never seen more than two years in a row where there has not been real terms growth. The best estimates are that, in the face of rising demand for treatment and other inflationary pressures, the NHS will have to achieve productivity improvements in the order of 7% per annum in order to close the

¹ The King's Fund/IFS have calculated that if the NHS sees any real increases in funding, spending across other government departments will have to be cut by at least 3.4% p.a.

funding gap and maintain standards. Yet, over the past 10 years, instead of rising, NHS productivity has *declined* by 4.3 per cent (1997-2007).

Budget 2010

As part of the drive to reverse this, in the 2010 Budget it was announced that the NHS is expected to deliver annual savings of £15-20bn by 2013-2014. The Chancellor outlined several areas in which the NHS would be expected to do so:

- £1.5bn through more effective commissioning and reduction in unnecessary prescriptions
- £100m from IT programmes
- £60m from reducing energy consumption
- £555m by reducing staff sickness and absence
- £2.7 billion through best practice in long-term condition care planning and management and reducing emergency admissions

In addition, the Government also announced that there was to be no pay increase in 2010-2011 for consultants, senior NHS managers, self-employed GPs and dentists.

How can these savings be achieved in practice?

These are just a few areas of many to consider:

Management and Administration

Administration costs the NHS in the region of £10-15bn per annum. Many argue that the NHS, unlike the private sector, does not make full use of the technology on offer. It has been suggested that professionals should become more proficient at personal administration, as well as using centralised computer systems across the board to deal with appointment booking.

It has also been suggested that the NHS should invest in dedicated programme managers whose sole responsibility is to implement cost-saving programmes, as opposed to further increasing the workload of existing, overworked managers.

Simplifying the patient pathway

'Lean thinking' was a concept originally developed by Toyota manufacturers in Japan as a way of reducing waste and increasing efficiency in the production of cars.

Applied to the NHS, it has shown that as much as 40% of processes that a patient undergoes during their stay in a hospital are unnecessary, in that they do not add anything to the outcome or experience. For example, patients may be asked the same questions several times by different members of a firm, they may be transferred to several wards, they may be kept waiting unnecessarily as paperwork has not been

filled in. The NHS Institute for Innovation and Improvement has provided implementation tools for hospitals to improve their existing services and there have been positive reports so far.

General Practice and management in the community

Services in the community are vital for managing patients in the comfort of their home and preventing unnecessary admissions. This is particularly true for chronic conditions, where empowering patients to take more responsibility for their own health can both improve outcomes and save money.

At present, the NHS does not do this particularly well. It has significantly higher rates of avoidable admissions to hospital than other developed countries; and provides a disproportionate amount of services in the hospital setting.

In addition, current funding structures encourage a divide between primary and secondary care, when considerable savings could be made if the incentives of both were aligned – for example, it has been estimated that as many as 40% of patients who attend Accident and Emergency could be treated adequately in the community by their GP.

Carl Heneghan, from the Department of Primary Care, Oxford, refers to the Canadian healthcare system where there is significant reliance on community volunteers to ensure that discharged patients have access to transport, meals and visitors, a resource that may become increasingly looked towards as the population ages.

The acute sector

A recent article in the [BMJ](#) asks experts from a variety of different specialities how money can be saved in the NHS whilst preserving quality of care. Although mostly speciality specific, there are three recurring themes: more careful prescribing for indications where the clinical effectiveness of treatment is unproven; more judicious use of clinical tests, especially avoiding repeat tests; and halting procedures where there is no known clinical benefit.

Significant savings, too, could be made if error and adverse harm were prevented by clinicians following clinical guidelines more closely and working more effectively as team. As Professor Martin Marshall revealed at our first event, 10% of patients admitted to hospital experience iatrogenic harm; and 45% of patients fail to receive recommended care.

Innovation

Esther Boserup famously commented 'necessity is the mother of invention'. Although the NHS currently faces a difficult period financially, the reduction in funding, need for increased productivity and increased demands on healthcare may provide just

the environment that is needed to increase efficiency through innovation – i.e. new ways of doing things. This includes ‘disruptive’ innovations, which, roughly speaking, allow access to a product or service historically only accessible at great expense or through those with a lot of skill, such as self-monitoring of blood sugar levels replacing professional-monitoring.

Great hope, in this regard, is held for five academic health science centres (Imperial, UCL Partners, Kings Health Partners, Manchester AHSC and Cambridge University Health Partners), which provide for closer integration between the NHS, communities and biomedical science.

However, it may also depend on the openness of the NHS to new providers, for the history of innovation teaches us that the most significant innovations typically come from new entrants.

The levers

The core issue concerning policymakers is that such savings and improvements in quality will not come about like manna from heaven. Some of the most significant debates thus currently surround the best ‘levers’ to use to in the ‘cold climate’ to drive the agenda forward.

The Department of Health, for example, currently has a Quality, Innovation, Productivity and Prevention (QIPP) programme focused on the implementation of Lord Darzi’s Review in the new financial climate. One of its core purposes is applying best practice ‘systematically’ across the NHS.

The structure of the current system (see briefing for our first event), however, puts the emphasis on competition and Primary Care Trusts acting as effective purchasers of health care.

Also important will be leadership (particularly clinical leadership), effective teamwork, the regulatory framework and the role of financial incentives.

Whatever route is chosen, however, it is clear the NHS will have to make fundamental changes in the way care is delivered in order to maintain standards and preserve public commitment to the organisation.

Our Speakers

Professor Aidan Halligan

Aidan Halligan is Chief of Safety, Brighton and Sussex University Hospitals NHS Trust, and Director of Education, University College London Hospitals NHS Foundation Trust.

In 1999, he was invited to become the first Director of Clinical Governance for the National Health Service and formed the Leicester-based NHS Clinical Governance Support Team.

From January 2003 until October 2005, he served in the UK Department of Health as Deputy Chief Medical Office for England, with responsibility for issues of clinical governance, patient safety and quality of care across the NHS in England. In that role, he was joint Senior Responsible Officer for the National Programme for IT, and the senior director sponsor of the Healthcare Commission, National Patient Safety Agency and National Institute for Clinical Excellence.

Nigel Edwards

Nigel Edwards is director of policy for the NHS Confederation. His role is to influence health policy on behalf of members, develop policy positions on areas of key interest and speak on behalf of NHS organisations, particularly in the media.

He is also an Honorary Visiting Professor at the London School of Hygiene and Tropical Medicine.

Formerly, he was the director of the London Health Economics Consortium which undertook high profile strategic health services research and consultancy in the UK and overseas. Before that, he was a senior manager in the NHS.

He has researched and written extensively on health service strategy and policy.

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