

Dealing with the downturn

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PAPER 4

The greatest ever leadership challenge for the NHS?

Key points

- The NHS is facing a very severe contraction in its finance with an £8–10 billion real terms cut likely in the three years from 2011.
- The need for strong leadership and radical quality and efficiency improvement is therefore greater than ever.
- History tells us that letting waiting lists grow, diluting quality and structural change should be avoided.
- The NHS will not survive the impending spending squeeze unchanged.
- Courageous decisions are needed now to reshape services and help us prepare for the most significant leadership challenge the NHS is ever likely to face.

Introduction

In spite of reassuring political statements suggesting real terms growth, commentators suggest that the NHS will face a real terms reduction of £8–10 billion in the three years from 2011 and the decline could continue beyond this. This means the need for strong leadership and radical productivity has never been greater. Time is short and experience of previous spending crises tells us that failing to rise to this challenge now will have serious consequences for the NHS, its patients and staff.

Work to deal with this unprecedented challenge is needed today with the support and help of all NHS staff and leaders, politicians, policy-makers and the public. This paper looks at the financial situation facing the NHS over the next seven years and suggests how it should

respond to the most severe contraction in its finances it is ever likely to face.

The next two years: tough but manageable

The NHS did comparatively well in the last Comprehensive Spending Review (CSR) although this was tighter than previous settlements. There was a large reduction in the capital allocation in 2010/11, apparently an over-provision for the costs of pandemic flu preparations. The £2.3 billion of additional savings in the March 2009 budget had already been included in primary care trust (PCT) allocations. The Department of Health (DH) has assumed 0.5 per cent extra efficiency for providers and created a reserve through a differential between the total NHS uplift and PCT allocations; and by efficiency savings, for example, in the pricing

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The NHS Confederation annual conference and exhibition, **Local leadership: a national service**, in Liverpool from 10 to 12 June 2009, will offer the opportunity to progress the discussion further. Visit www.nhsconfed.org/2009 for more information about the conference.

Figure 1. Allocations up to 2010/11

	Plan 2009/10	Plan 2010/11
NHS £b	98.2	102.3
Increase £b	7.3	4.1
% change	8	4.1
PCT allocations	80.0	84.4
Increase £b	4.2	4.4
% change	5.5	5.5
Capital £b	5.4	4.7

scheme for drugs. We expect some further announcements to complete the picture.

Some cost pressures for commissioners will be a concern:

- the impact of Healthcare Resource Group (HRG) 4 appears to be inflationary for many commissioners
- the impact of changes to the National Institute for Clinical Excellence in Health (NICE) appraisal process for end of life medicines
- a very likely upswing in flu cases in winter 2009/10
- a requirement to make an even greater surplus.

Providers also face difficulties. There is an efficiency assumption of 3.5 per cent for 2010/11 and the operating framework suggests a tariff uplift of no more than 1.2 per cent. There are a number of significant cost pressures.

- It would be prudent to expect that the Clinical Negligence Scheme for Trusts (CNST) contributions will continue to outstrip inflation by a significant amount.
- The impact of any further fall in the pound may have an adverse impact

on the prices of goods and services from the Eurozone and the USA.

- Pay and price increases will be greater than the uplift in the tariff.

The operating framework states that the total 2009/10 surplus for the NHS is expected to be in the region of £1.35 billion after taking into account the draw-down of £400 million which is permitted from the total £1.8m surplus forecast for 2008/09.

2011 and beyond: unprecedentedly difficult

The position beyond 2010/11 is very different and extremely challenging. The Chancellor announced that public spending will grow by 0.7 per cent over the next CSR period and this does not change in the most likely scenarios for the growth in the economy. Unfortunately, the call on this increase from debt interest and uncontrollable elements such as benefits is likely to consume any growth. The Institute for Fiscal Studies suggests that this could mean a real terms reduction of -2.3 per cent in the resources available for other government departments.

Even at its most optimistic, other analysis seems to suggest either very modest or no cash increases in NHS spending in the next CSR period and probably well beyond. The real terms effect of this depends on the level of demand, the behaviour of pay and price inflation, and the NHS share of the reduction. Demand is likely to continue to increase from long-term trends in ageing, increasing disease burden from improved survival and rising fertility (particularly in older women) as well as from the negative health effects of recession in areas such as mental health and alcohol use. The news is no better in terms of trends in costs and prices. Even if there is price deflation in the wider economy it would be prudent to assume a degree of inflationary pressure in the NHS as:

- health prices tend to rise faster than those in the wider economy
- public spending will be dominated by the need to service debt and so NHS and social care spending will not follow renewed growth in the economy. However, other prices, particularly energy, may start to increase again as the wider economy recovers or there is inflation as a result of monetary policy
- new drugs and devices are generally thought to contribute cost pressures of up to 0.5 per cent
- there is inflationary pressure of up to £640 million built into Agenda for Change, particularly where the labour market may encourage people to stay in posts rather than move (there is some discretion available in how this applies)
- there will be an increase in employers' national insurance contributions in 2010/11 of 0.5 per cent

- CNST fees will increase, particularly if low interest rates lead to a change in the discount rate for settlements
- there are significant cost implications in Modernising Medical Careers and the last phase of implementing the Working Time Directive for some providers
- social care is in an even more difficult position because it has not had the level of increases enjoyed by the NHS. There are likely to be some cost implications for the NHS from problems in social care.

With little or no cash increase, from 2011/12 the NHS will need to plan for real terms funding to fall by 2.5–3 per cent per annum. This is equivalent to a cut of between £8–10 billion over the next CSR and up to £15 billion over five years. It is

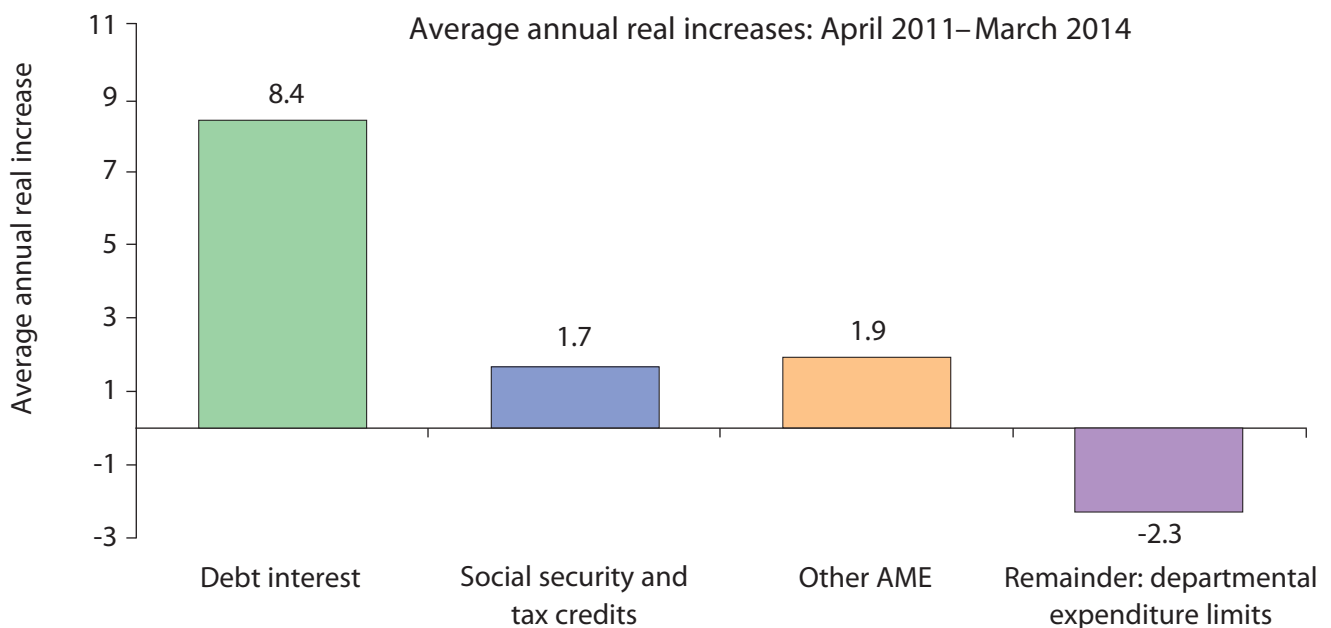
unavoidable that this will also translate into fewer staff. The savings needed to deal with this will need to be realisable as cash and so the level of savings required may need to be very much larger. David Nicholson, NHS Chief Executive, has suggested that this could be as much as £20 billion in the next CSR. Also, unlike other efficiency savings these apply to all NHS expenditure, including GP and dental services, primary care prescribing and other areas that have previously been exempt from these requirements. This level of funding will just allow the NHS to accommodate some increases in demand and some limited adoption of new drugs. Further efficiencies will be needed to support investment in new services and this will mean even more demanding requirements being placed on providers of 5 per cent or more.

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This is a serious situation. In previous expenditure squeezes, most which have been less severe and were less protracted than this one will be, questions were raised about the sustainability of the NHS model and the capacity of NHS management to deal with the challenge.

The question is whether this impending crisis and the 22 months we have to prepare is a sufficient spur to extract very major efficiencies from the system and take some brave decisions to reshape services.

Figure 2. A possible Comprehensive Spending Review 2010 allocation



AME = annually managed expenditure
 Source: Institute for Fiscal Studies.



'Is the impending crisis and the 22 months we have to prepare a sufficient spur to extract efficiencies from the system?'

The NHS did not always make the best use of all the additional money it received and it should not waste the opportunity that the crisis presents.

Learning from history: bad ideas

History suggests a number of approaches should be avoided.

Letting waiting lists grow – this provides very small financial relief since a slip in waiting times only represents a one-off saving of variable costs equivalent to the number of days by which waiting is extended. There are significant additional costs of managing long waiting lists. More importantly, history suggests that this is one of the problems that leads to the whole NHS model being challenged.

Diluting quality – previous experience suggests that, even if reducing quality were possible, it is likely to add to costs rather than provide significant savings, given public expectations and the regulatory framework we have now developed. A number of related false economies such as allowing backlog maintenance to stack up should also be avoided.

Slash and burn and 'salami slice' savings – indiscriminate expenditure

cuts are ineffective and damaging because they focus on cost rather than value. They unduly penalise the efficient and leave the inefficient with untapped savings.

Letting pay get out of line – while pay levels cannot escape attention it will be important not to repeat previous mistakes where pay restrictions led to vacancies, high agency costs, an exodus of staff and a number of problems with long-term consequences (including future pay inflation).

Cutting training – previous experience shows that poorly thought-through cuts in training lead to avoidable shortages as finances

recover and produce demand for additional staff. This is likely to produce further pay inflation.

Cut prevention – reducing public health expenditure to protect curative services is always a mistake and can potentially be disastrous.

Learning from history: caution required

A number of strategies do not always seem to yield the results that are hoped for and should be approached with care:

Centralisation of support functions – some of the experiences of centralising back office, procurement

Key principles

Some important principles will have to be adhered to in dealing with these challenges:

- The NHS underlying principle of social solidarity, in which the better off and well support those in need, should be followed. The NHS Constitution elaborates on this and promises a comprehensive health service largely free at the point of use. This is an important test for any proposals.
- Frontline services come first, but long-term improvement should not be sacrificed for short-term expediency. Sometimes investment in prevention, improvement, information and infrastructure now, may mean that frontline services can be even more productive and effective in the future.
- Where possible quality improvement through innovation and redesign should be the preferred route to improving efficiency. This requires rigorous use of evidence on effectiveness.
- The principles of co-production, subsidiarity, alignment, clinical ownership and leadership are sound. However, their application may need to change. In particular there are questions about whether some of the system reform policies are aligned with the needs of the changed world. A number of them are designed for a system with growing funding.

and decontamination have not always been happy ones. This may be largely due to poor execution and planning, and the scale and risk-averse nature of the procurement. Often they are monopoly providers and so it is difficult to know if value for money is being provided.

Mergers – these are too often proposed as an answer without proper diagnosis. As a result they take longer, produce more disruption and fewer benefits than was initially promised. There are three important lessons here:

- with increasing size the costs of complexity outstrip economies of scope and scale
- if one part of a merger is dysfunctional the resulting organisation will probably be dysfunctional
- the time taken to realise benefits is very significant.

Structural change – history suggests that the savings and benefits achieved from structural changes tend to be smaller than predicted and the costs and opportunity costs much larger. There are times when it may be appropriate. However, too often it is the first resort of those with limited ideas, provides a huge distraction from the real business and offers an excellent excuse for later failures.

Demand management – this is an important strategy and will need to form part of the response to this crisis. However, we need to learn from the many attempts that have had limited success or actually led to an increase in activity. There

are several reasons why this might be the case:

- supplier-induced demand – demand management may simply create space that allows a reduction in treatment thresholds
- misaligned incentives – hospitals have little incentive to help reduce demand where they have spare capacity
- neglect of behavioural incentives that encourage work to be passed on to other parts of the system
- demand management that introduces an additional step in the clinical process also has the potential to add more cost than value.

One important lesson is that schemes need to be on a sufficiently large scale to allow fixed and semi-variable costs to be stripped out of the provider. Secondly, schemes need to remove capacity or have controls on secondary care volumes. Without these measures demand management is likely to increase the total costs of the system and, in some circumstances such as emergency care, actually increase demand by creating incentives for patients to take up services.

Many of the strategies to shift care from secondary to primary care have fallen into these errors and shifting care has been mistakenly viewed as an end in itself rather than the wider goal of better-designed, more accessible and integrated delivery.

Price competition – this does not fit with patient choice. The risk is that

‘History suggests a number of strategies should be avoided or approached with caution’

providers can exploit this to obtain increases in prices – particularly when they have a monopoly. It can also lead to ‘a race to the bottom’ which reduces price and quality.

Reducing staff – while it is inevitable that reduced real funding will lead to a need to reduce staff in some areas the costs of redundancy and pensions are often significant and loss of knowledge and experience has hidden costs.

Responding to the challenge

Diluting quality and extending waiting are not advisable and some of the approaches used before have been exhausted. Some of the areas emphasised in the March 2009 Budget such as back office, procurement, the Pharmaceutical Price Regulation Scheme (PPRS) and asset management have already been accounted for; others have potential and require serious attention, but are nowhere near the scale required. While management and infrastructure costs will need very rigorous scrutiny the majority of resources are committed through clinical decisions. This means that a more fundamental look at how the service runs is required. This will need to focus on using quality and process improvement and the adoption of innovative, evidence-based practice.

'A more fundamental look at how the service runs is required, including focusing on quality and process improvement and adopting innovative evidence-based practice'

Improving quality and efficiency

We know that there is still very great potential for major improvements in the way that many services work. In many cases these changes will also improve quality, safety and patient experience. The big gains are most likely to come from the redesign of clinical services. These are difficult areas and need to be done on a sufficiently large scale to release savings. They may also need upfront investment. Not all quality improvement saves money, but a lot does, for example:

- reducing variation – in referral rates, re-attendance rates, length of stay, day case rates, prescribing and other elements of clinical practice
- adopting best practice – in pathway management, operational management, back office and other functions
- improving quality and service design to reduce errors, rework, duplication and overlaps and to improve patient flow through the system
- releasing productive time for staff – through rigorous redesign of methods and skill mix
- creating flow and eliminating the waste from poorly-designed systems and the consequences of demand generated by failures and errors
- reducing complexity – one of the most significant drivers of costs and

errors is unnecessary complexity and the response to this is often to add mechanisms and costs to deal with this.

Cost improvement: support functions

Notwithstanding the caveats above there are more opportunities for organisations to work together to reduce operating costs. NHS Employers operates several examples of this, including NHS Jobs and NHS Careers. Some services have been examined, but a number – for example, pathology – remain stubbornly embedded in hospitals in a way that would not be recognised in other countries.

Strategic changes in provision

Simply improving the efficiency of the system will not release sufficient cash savings unless providers can extract costs in large chunks which allow overheads to be reduced. Without this improved commissioning may just move financial problems around the system rather than tackle their root cause. For example:

- sweating assets – it is still the case that many buildings, laboratories, scanners and other high cost assets are used much less intensively than they could be
- estate rationalisation – including opportunities from using the wider public sector estate
- hospital reconfiguration – this will have to be done without major capital investment or recourse to the private finance initiative (PFI) and in ways that extract major costs from sites
- using market management tools and bringing in different providers,

The Productive Ward – Royal Liverpool Hospital

Royal Liverpool Hospital was one of the first test sites for the NHS Institute for Innovation and Improvement's Productive Ward project in 2006. A 26-bed diabetes/endocrine and general medicine ward was selected because of its longer lengths of stay compared to the national average and relatively high infection rates.

Keen and committed staff collected data on length of stay, meal wastage, infection rates and sickness absence. The ward team and key departments were involved in mapping existing processes and making suggestions for improvement. New processes were trialed within two weeks.

As a result:

- meal wastage fell from 11 per cent in December 2006 to 4 per cent in April 2007
- direct patient care time increased from 27 per cent to 40 per cent for sisters, and from 25 per cent to 45 per cent for staff nurses.

Source: NHS Institute for Innovation and Improvement.

Releasing clinical time

The New Ways of Working programme, led by the National Institute for Mental Health in England, changed the way mental health staff work. It supported mental health trusts to innovate, challenge and develop new fulfilling care delivery roles.

One of the benefits of the programme was service users being seen by the most appropriate team member, rather than consultant psychiatrists having large caseloads of patients to see, regardless of need. In the North West, five mental health trusts engaged in the Creating Capable Teams Approach, which involved investigating reductions in the number of consultants inputting into the units and releasing expensive clinical time by using more administrative and housekeeping staff. In Cumbria careful job planning highlighted the tasks a consultant needed to do, meaning they recruited to four consultant posts, rather than six.

Source: *Moving on: from New Ways of Working to a creative, capable workforce.* NHS Confederation Briefing 177, March 2009.

while being careful not to create supplier-induced demand and overcapacity.

While making existing services better, faster and cheaper will be important, it is unlikely to lead to the radical shifts in efficiency that are required. Experience in other industries suggests that existing providers generally do not produce truly disruptive innovations. In some areas where we need very radical improvements in productivity, such as community services, new approaches and new providers may be the answer.

How resources are allocated

Attention will need to be paid to the following:

- Reduced hospitalisation, higher treatment thresholds and volume management – it is going to be important to ensure that the threshold for treatments are

appropriate. This is however, very difficult to manage in practice.

- Checking that services that have developed over time still add value for their users.
- Removing overlaps from services that have evolved and been added to piecemeal over time.
- Shifting resources from less effective areas and investment to reduce the disease burden – there needs to be a rigorous examination of opportunities to swap between interventions that produce more health gain for the same money or, more importantly, the same for less. In line with a shift from a focus on value rather than cost this means looking at cost effectiveness over the long term.
- Approach to innovations versus existing treatment – generally innovations are required to demonstrate greater value than

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current activity; more treatments and approaches in use should be subject to this type of zero-based approach.

This means that PCTs need the means to control volumes of care and to decommission services. Very little of this can be achieved without clinical engagement.

Organisational readiness

A number of elements will need to be in place if local systems are to be able to weather the challenge. The NHS Next Stage Review contains a useful framework for thinking about this, which we have adapted:

- having a clear and shared vision and values for the organisation and the local system
- having a well-developed methodology for making change happen
- ensuring that all the parts of the system and different policy instruments are aligned
- making sure that the behaviours of the different parts of the system are appropriate.

Vision

While many organisations have worked hard to develop strategies and a long-term vision there is still more to do in this area and it is likely that many of these strategies will need to be revised to take into

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account the changed circumstances. Vision and values are often less well developed at a local system level. This will require attention as it is important as a reference point for when relationships in the system become fraught under the pressure of shrinking resources.

Method for delivering change

Successful change management requires an understanding of the urgency of the situation and a methodology for making the change happen at the front line. *Quality improvement: theory and practice in healthcare*, a review of the literature on change methodology by Manchester University, suggests that there are several methods that work. What is often missing is consistent, long-term implementation and ensuring that frontline staff share a common language to describe what is being attempted. It is not clear that there is yet enough of a sense of urgency. There is a concern that the knowledge and ability to implement change and improvement methods are not sufficiently embedded in enough places.

Policy alignment and system management

Some policy instruments may not now be fit for purpose as they were conceived to operate in a system that was growing.

For example, extracting savings from the system while improving care will

require the entire patient journey to be redesigned. Unfortunately the payment system and the way the system is structured are often not designed in a way that will help with this. Organisations are structured so that they only produce parts of the pathway and are incentivised to produce improvement within their compartment, but not to reduce income or activity. Optimisation of individual parts can produce whole system solutions that are very sub-optimal and costly. In the case of long-term conditions there are few incentives for hospitals to deploy their expertise to help reduce demand or to promote changes in treatment approaches to more cost-effective modalities.

Rigid interpretation of the rules can make Payment by Results a barrier to local redesign and service change, and discourage the adoption of techniques that shift work from profitable HRGs to less profitable ones. For example, treating occlusion of the femoral artery with interventional radiology offers a safer and cheaper alternative to many patients than a femoral artery bypass graft. However, it makes a significantly smaller contribution to overheads and in a trust with service line management represents a significant shift in income from one line to another. Community services also tend to be structured in ways that reflect history and staffing groups, rather than in how they add value to patients. Virtual wards and teams specialising in long-term condition management are an emerging response to this, but these and other disruptive approaches are held back by the persistence of the 'legacy' model still in place.

A number of significant changes in current policy are going to be needed:

Change the payment system for long-term conditions – we need a shift to capitation payments for long-term condition pathways. This would require hospitals and other providers to hold more of the risk and take responsibility for case management and co-ordination.

Faster progress to normative tariffs – there will need to be a far more rapid move to normative tariffs, including some value-based tariffs for procedures where we want to incentivise changes in volumes.

Bundled payments for the whole pathway – including rehabilitation and after care for some emergency and elective episodes. In some cases incorporating social care into these would make sense.

Accelerate the development of pathway-based approaches – rather than develop these pathways many different times, developing generic approaches and service specifications that can be customised and adapted locally would mean it is more likely we can achieve some of the changes we need. To allow for rapid development and to ensure that providers can make large enough shifts in activity to release costs, PCTs will need to collaborate much more in the development and implementation of these approaches.

NICE – it may be time to look again at the proposal that NICE should be given a total resource ceiling.

Create more disruptive change – in some cases, where it is thought there are particularly large efficiencies available, an even more disruptive approach to creating change may be required to extract the large productivity dividend that is thought to be embedded in some services. This means much more use of payment and contracting approaches that allow redesign of the pathway and providers and new entrants offering radically different approaches, rather than simply moving staff from one organisation to a new one. History suggests incumbent providers are less able to develop and implement. Whether commissioners can create the headroom to permit new entrants on a sufficient scale to allow entire pathways to be redesigned is not clear. Whether these providers exist is also doubtful and the environment for creating new ones is unpropitious. Care is required not to add additional costs to the whole system. Somewhere, for every new service, there must be a cash releasing reduction in costs elsewhere. This will require a change in the payment and contracting mechanisms to align them with the objectives of a changed world.

Create mechanisms to allow asset rationalisation – the ownership of expensive assets and the need to find funding to pay for them is possibly one of the biggest barriers to rethinking the way that care is provided. Mechanisms are needed to allow organisations to reduce their asset base in an ordered and well-planned way – perhaps using the wider public sector estate to create opportunities for cheaper solutions. A property fund will be

required to take ownership of assets along with some type of set aside scheme or other mechanism to allow NHS providers to reshape their assets and estate, rather than have to work to fill them.

Imaginative solutions for smaller hospitals – some of these will not be able to become foundation trusts and takeover may not always be an attractive option. Vertical integration with primary care, the divorce of clinical operations from assets and other innovative solutions that allow lower cost services which maintain access, will be needed.

Practice-based commissioning (PBC) – there is an important role for PBC, but it is still not clear how to make it operate on a scale large enough to have a major impact on the system. Building integrated systems for commissioning and provision around PBC groups that include specialists might be one way to provide the leverage required to make change. This would create integrated care around specific pathways.

Competition – there is still an important role for competition, choice and other elements of system reform. In some areas more competition will be the answer; in others a range of different approaches will be needed. Different approaches to competition are required to meet the nature of the services being provided and the problems that need to be solved.

Co-operation – given that the scale of the challenge will require collective action across local health systems and across complete

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care pathways, more attention needs to be given to describing what good co-operation looks like and how to avoid collusive ways of operating which exclude new entrants and ideas.

Information – despite the problems with the national system better information will be crucial to support many of these changes.

Appropriate behaviours

The NHS Next Stage Review stressed the importance of the change programme being underpinned with a strong vision, appropriate method and rules of behaviour. These are even more important in an environment in which it will not be possible for individual organisations to weather the storm without being part of a wider, more resilient system capable of co-operative action. We explored some of these issues in a workshop with PCTs and providers from the West Midlands.

Ways of behaving

While the system is rules-based it has to be driven by a shared vision. This means that organisations which are significant actors in the local system must not walk away, even where solutions may require them to agree to measures that are not in line with their individual

'Local leadership will be key but in some cases national or regional solutions will be required'

short-term interests. This requires high-quality, values-based leadership that has a long-term focus and puts a premium on continuity of leadership. The ability of individuals to take risks in trusting each other was thought to be very important in delivering a complex strategic change. This was particularly true for the large acute trust which had made a decision to change its configuration and to shift from a strategy based on growth and expansion to one based on quality and specialisation.

Our workshop participants suggested a number of important elements in developing high-quality relationships:

- have a clear and shared vision based on population and patient needs – a failure to demonstrate that the values and strategy of organisations is based on this is potentially fatal for staff engagement and public credibility
- deal with risks together where possible
- don't imagine that this will always produce a win-win in the short term
- ensure that there is confidence that all other parties will deliver
- don't revert to defensive institutional silos under pressure
- create trust at all levels of the organisation – middle managers

particularly feel the tensions between organisations and find the balancing of trust with their local objectives most difficult

- develop a high level of transparency in decision-making processes
- ensure that there is a proper voice for other stakeholders who feel that they have a role in the system.

Local leadership

Local leadership will be key to meeting the challenges we face but the principle of subsidiarity will mean that there are also times where it will be more appropriate for PCTs to act collectively at a regional or sub-regional level, or even for there to be an agreed national process for dealing with some issues. In a number of areas the redesign of care will require a new level of collaboration with social care – just at the point where this may be most difficult.

Some treatment restrictions, allocative efficiency changes or demand management measures only make sense at a regional or national level – in some cases because they require a change in the approach taken by NICE; in others because it will be necessary to avoid the development of an extreme postcode lottery. The development of a normative tariff, changes in incentives, developing commissioning approaches and other major changes do not need to be developed 152 times. There is more of a role for PCTs or groups of PCTs to take responsibility for developing some of these elements of policy on behalf of the rest. In some cases national or regional solutions will be required.

Challenging options

It is inevitable that a number of more challenging options will be proposed. The essential test is whether they surrender the key principles of the NHS. A number of the most popular ideas in this area are unlikely to provide an answer to the challenges we face.

Commissioning – some commentators have questioned whether in some cases the commissioner-provider split is likely to yield the results that we need. However, alternative ideas are sketchy and the benefits of any alternative approach need to be set against the dislocation created by further reorganisation. Integrated care approaches may grow organically out of pilots or experiments.

Charges for GP visits, out of hours and A&E (excluding health checks, contraception advice and screening to avoid undermining other important policy goals) – this idea does not fit with the principles we proposed for assessing proposals, but it will undoubtedly be put forward. International experience suggests that a modest co-pay has little or no long-term impact on utilisation and, if payments are large enough to affect it, there is the danger of patients presenting later with higher costs, poorer outcomes and an adverse impact on equity. The potential for other perverse effects are significant – for example, in encouraging out-of-hours use or discouraging GPs from being willing to accept telephone consultations. Children and older people would need to be exempt, but we know

that approximately 45 per cent of consultations are with children or older people and that many attend frequently. Well over 50 per cent are for chronic conditions or for follow up of existing treatment. European experience suggests that systems for exemptions, reimbursement through the welfare system or at least a cap on annual spending would be required. Once the costs of administering these and of collecting the money and holding cash are factored in, the income raised may be significantly less than it might first appear. The cost of meeting a change in expectations in terms of customer service – a possible positive result – could further offset the income raised. Similar arguments apply to charges for hospital stays.

Pay and pensions versus jobs – as pay and conditions worsen in the wider economy questions will be asked about what will appear to be very advantageous pay and pension arrangements. This option may disappear if pay in the wider economy picks up, but it is not possible to pretend that the trade-offs and options in this area can be ignored. This requires some national action as it will be difficult for individual organisations to defect because of the need for expertise in this area and the dangers of being a first mover. However, without such a strategy some will defect from the system. Pay and pensions need to be considered as a total reward package and would need to be addressed across the public sector.

Treatment prohibitions – there is some scope for prohibiting

particular treatments, but the difficulty is that the list of areas where there is no evidence of effectiveness is short and the savings available relatively small.

Limiting the NHS basic package – it could be decided that the NHS should exit some areas of care provision. Areas could be selected because they deal with lifestyle or cosmetic problems, they have no evidence base, they are insurable or because non-availability might have little impact on population health. Examples could include *in vitro* fertilisation (IVF), homeopathy, elements of dentistry or free nursing home care, with these areas moving to out-of-pocket payment, any state support only for the most needy and insurance for catastrophic costs. This would be similar to the system in the Netherlands.

These options would require a very significant dialogue with the public and in some cases the development of a new insurance market, and there is little evidence of any appetite for this. We believe it is difficult to embark on this before we have made a major effort to demonstrate that all efficiency avenues have been exhausted.

An unprecedented leadership challenge

In the past there has been a tendency to solve problems by using growth rather than making difficult decisions and there has been very little decommissioning. It is very difficult to create viable

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provider plans that assume a shrinking income base and even more challenging to keep stakeholders and staff engaged. The policies and approach that we have used to manage growth will need to adapt to a new and more challenging environment.

There are several hurdles: firstly, to find ways of achieving significant quality and efficiency improvements and cost reductions that do not damage patient care or compromise long-term success; secondly, to release large amounts of cash for reinvestment elsewhere; thirdly, to do this with little time or capital; and finally, to do this in an environment in which politicians and staff will be reluctant, for different reasons, to hear difficult messages about the future. There is an important question about phasing. Rather than four to five years of large real terms reductions in spending it might be delivering a very significant change in the pattern of services in 2011/12.

Facing this unprecedented challenge throws up a number of hazards. The first is not acting now to prepare for 2011. Secondly, we could repeat previous errors and reinvent solutions that didn't work last time. There is a significant danger of being diverted by structural change.



'The need to address the challenge is obvious, but action is required now and at all levels'

Micro-improvements in provision are important but not sufficient to close the gap – big problems need bold solutions. Changes need to allow providers to strip out real costs for real cash. At some point this will mean fewer staff and keeping the best. Therefore maintaining morale and ensuring quality could be one of the most significant leadership challenges in the history of the NHS.

The need to address the challenge is obvious, but action is required now and at all levels. Many staff will require new skills and approaches to help them do this. We will need to strip away the obstacles that stand in the way of innovation and change and be prepared to challenge much of what we currently do.

It is possible that there will be an upturn in growth which will allow political commitments to real terms growth to be met, but planning on this basis would not be wise. History suggests that failing to deal with the spending squeeze will lead to problems large enough to call the

whole NHS into question. The NHS has survived three of these in the last 25 years. We cannot assume it will survive the next. Only strong leaders who are

prepared to make courageous moves now will get us through one of the greatest challenges the NHS is ever likely to face.

Support for members

The NHS Confederation is keen to support members through these unprecedented challenges. Our programme of work is quickly taking shape. Specifically:

- our website is the place to come for useful resources, including case studies and our *Lean thinking for the NHS, Breaking the rules* and *Priority setting* publications
- we are actively discussing opportunities for joint working with leaders in the medical profession, the DH and other national stakeholders
- a series of seminars to discuss ways through the downturn
- NHS Employers and our networks are working with members on innovative solutions to commissioning and delivering services.

Please email leadership@nhsconfed.org for more information.

The NHS Confederation

The NHS Confederation is the only independent membership body for the full range of organisations that make up today's NHS. Our ambition is a health system that delivers first-class services and improved health for all. We work with our members to ensure that we are an independent driving force for positive change by:

- influencing policy, implementation and the public debate
- supporting leaders through networking, sharing information and learning
- promoting excellence in employment.

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