



House of Commons

Committee of Public Accounts

Department of Health: progress in making NHS efficiency savings

Thirty-ninth Report of Session 2012–13

*Report, together with formal minutes, oral and
written evidence*

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Committee of Public Accounts

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Dr Stella Creasy (*Labour/Cooperative, Walthamstow*)
Justine Greening (*Conservative, Putney*)
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Eric Joyce (*Labour, Falkirk*)
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Powers

The committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the internet via www.parliament.uk.

Publications

The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the internet at www.parliament.uk/pac. A list of Reports of the Committee in the present Parliament is at the back of this volume. Additional written evidence may be published on the internet only.

Committee staff

The current staff of the Committee is Adrian Jenner (Clerk), Sonia Draper (Senior Committee Assistant), Ian Blair and James McQuade (Committee Assistants) and Alex Paterson (Media Officer).

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Summary

The Department of Health (the Department) has estimated that the NHS needs to make efficiency savings of up to £20 billion in the four years to 2014-15. This should allow the NHS to keep pace with the growing demand for healthcare and live within its tighter means. The Department reported that the NHS made savings of £5.8 billion in 2011-12, virtually all of that year's forecast of £5.9 billion. The Department expects that by the end of 2012-13 the savings made will total £12.4 billion.

The NHS appears to have made a positive start but we cannot be fully confident in the savings figures reported. At local level primary care trusts measure and report savings in different ways. For example, the often significant costs associated with generating savings are not consistently taken into account in reporting the savings achieved. Using national data the Department can substantiate only £3.4 billion of the savings reported for 2011-12.

The NHS intends that the quality of healthcare should not suffer as it pursues efficiencies. While performance against a small number of headline indicators of quality, including waiting times and infection rates, was maintained in 2011-12, we are concerned that the need to make savings may be affecting wider areas of care quality, which are not adequately measured.

The NHS is seeking to make savings by reducing the demand for health services, particularly for acute hospital care. This is not intended to restrict patients' access to healthcare, but there are widespread concerns, from patient groups as well as professional bodies, that access to treatments such as cataract and bariatric surgery is being rationed. Such treatments may be classed as of 'low clinical value' but they can make a real difference to a patient's quality of life. Delaying treatment may also lead to greater cost in the longer term. We welcome the fact that the Department has started to work with the Royal College of Surgeons and others to define appropriate thresholds of care.

Most of the savings to date have been achieved through freezing the pay of NHS staff and reducing the prices paid for healthcare. The more challenging, and risky, part of the efficiency drive requires transformation in the way health services are actually provided. Over the four years to 2014-15, such transformational changes are expected to generate 20% of the total savings, but the Department expects that by the halfway stage—the end of 2012-13 - just 7% (£875 million) of savings will have been generated in this way.

Changing the way services are delivered means in some cases centralising services (as in the case of stroke care in London) or providing more community-based care, closer to people's homes. This is expected to lead to some hospitals reducing the range of services they provide and departments, and even whole hospitals, closing. Such change is usually contentious and what might make clinical and financial sense is often not supported by local people. The Department has not yet convinced the public or politicians of the need for major service change or demonstrated that alternative services will be in place.

The existing payment mechanisms in the NHS were designed to incentivise hospitals to carry out more activity, and do not drive service transformation. The Department highlighted that it has introduced national penalties to reduce emergency admissions and

payments to encourage hospitals to implement best practice and thereby improve quality and efficiency. However, these measures may not be suitable in every locality and the Department has not assessed their impact.

On the basis of a report by the Comptroller and Auditor General,¹ we took evidence from the Department of Health on progress in making NHS efficiency savings.

Conclusions and recommendations

- 1. The Department's data on reported efficiency savings is unreliable.** Just under 60% of the savings reported for 2011-12 could be substantiated using national data. At local level, primary care trusts measure and report savings in inconsistent ways that are not always in line with good practice. For example, primary care trusts do not routinely report savings net of the costs incurred in generating them. To enhance confidence in the reported figures, the Department should set out a clear framework, based on simple accepted principles, and require NHS bodies to measure and report efficiency savings against this framework.
- 2. As the Francis report on the Mid-Staffordshire NHS Trust identified, financial pressures may be causing some hospital trusts to cut staff with damaging effects on the quality and safety of care.** The finances of some trusts are fragile, and they are struggling to achieve a sustainable position. There is a risk that such trusts may resort to simple cost-cutting rather than finding genuine efficiency savings. The important interaction between financial and clinical sustainability may not be picked up by the Department's current focus on a few headline indicators of quality. In overseeing trust performance, whether itself or through Monitor, the Department should make sure that a range of information is brought together to give a complete view of both quality and finance issues.
- 3. We are concerned that the NHS is seeking to make savings by rationing patients' access to certain treatments.** The NHS faces difficult decisions about how to secure most value from its limited resources. In the face of growing demand, primary care trusts (and in future clinical commissioning groups) understandably have to make choices and set priorities. However, at present eligibility criteria for access to services are perceived as arbitrary and inconsistent, and it is not clear how improvements in patients' quality of life are taken into account. Building on the work started by the Department, the NHS Commissioning Board should, as a matter of urgency, set clear, evidence-based eligibility criteria for access to services and make these publicly available.
- 4. The NHS has made the obvious savings, particularly through wage freezes, first but will need to change fundamentally the way healthcare is provided to secure the level of savings needed in the future.** The Chief Executive of the NHS Commissioning Board has yet to take the necessary action in a number of areas to help the NHS transform how services are provided. The existing payment mechanisms do not encourage NHS bodies to work together to change how services are delivered, for example by moving services out of hospitals and into the community. We welcome the small number of new financial incentives that have been introduced—such as best practice tariffs—although the impact of these measures has not yet been assessed. In its reply to us, the Department and the NHS Commissioning Board should set out their plans for delivering the level of savings required from service transformation, including how they intend to redesign payment mechanisms to encourage NHS bodies to work together.

- 5. The public debate about changing how health services are provided needs to be better informed.** Local people are understandably resistant when proposals are made which involve closing their local hospital or reducing the range of services it provides. The Department needs to persuade the public and set out the logic of the case for service transformation from the point of view of the patient, demonstrating the benefits in terms of the quality and safety of care as well as cost savings. Unless this is done urgently, the Department will continue to face resistance to change and the NHS will struggle to deliver the savings it needs. The electoral cycle could also inhibit the ambitious programme of transformation and the Department needs to have regard to that in achieving its savings within the timeframe of the current Spending Review. The Department should develop a coherent, comprehensive and transparent approach to presenting the benefits of service change, to enable it to move forward in this area and achieve the target savings it intends.
- 6. It is not clear who will take strategic decisions in the reformed NHS.** The reforms involve sweeping changes to the structures of the NHS and working together across organisational boundaries will be crucial to service transformation. As was the case when the Committee considered the future financial sustainability of the NHS in Autumn 2012, it remains unclear who will ensure that individual clinical commissioning groups and trusts work together for the good of the NHS as a whole when strategic health authorities have been abolished. The Department should clarify who will provide this vital strategic direction and oversight in the reformed NHS.

1 Making and reporting efficiency savings

1. The Department has estimated that, to keep pace with the growing demand for healthcare and live within its tighter means, the NHS must make efficiency savings of up to £20 billion over the four years, 2011-12 to 2014-15.² This is equivalent to year-on-year savings of 4%.³ The Department expects the savings to be generated in three main ways: 40% from nationally-driven changes such as pay restraint; 40% from improved efficiency in hospitals and other health services; and 20% from transforming how services are delivered, for example, by providing more care in community rather than hospital settings.⁴

2. The NHS appears to have made a positive start.⁵ The Department reported that the NHS made efficiency savings of £5.8 billion in 2011-12, virtually all of that year's forecast total of £5.9 billion.⁶ The Department told us that the NHS is now ahead of the original projections, with savings expected to be £12.4 billion by the end of 2012-13, over 60% of the total needed, halfway through the four-year period.⁷

3. However, the Department does not check that the savings data submitted by local primary care trusts is reliable. Using national data, for example on staff numbers and activity levels, the Department can substantiate only £3.4 billion, less than 60%, of the £5.8 billion savings reported for 2011-12.⁸ The Department has not set clear criteria for reporting efficiency savings, and primary care trusts measure and report savings in different ways. For example, they do not consistently deduct the costs associated with generating savings from the figures reported. These costs can be significant, for instance if the action taken involves staff being made redundant.⁹

4. In addition, the Department does not monitor whether the reported savings are recurrent. If savings are non-recurrent, that is one-off in nature, the NHS will have to find new replacement savings in future years. The National Audit Office estimated that up to £520 million of the reported savings for 2011-12 were non-recurrent.¹⁰ The Department told us that refining data requirements is a constant process. From April 2013, responsibility for data definitions will rest with one organisation, the NHS Commissioning Board.¹¹

2 C&AG's report, para 2

3 Q 13

4 Q 47; C&AG's report, para 1.11

5 Q 46

6 C&AG's report, para 6

7 Q 49

8 Qq 85-89; C&AG's report, para 8

9 Qq 89-93; C&AG's report, para 9, 2.8

10 Q 48; C&AG's report, para 10

11 Q 75

2 Impact of the efficiency savings on the quality of care and patients' access to healthcare

5. Efficiency savings have been generated by reducing the prices primary care trusts pay to hospital trusts for healthcare. The price reductions are intended to force trusts to become more efficient in order to live within their reduced income and avoid getting into financial difficulty.¹² NHS organisations reported a combined surplus of £2.1 billion in 2011-12, but within this overall position there was a large gap between the strongest and the weakest organisations. Thirty-one hospital trusts ended the year in deficit. Some trusts in difficulty were given additional financial support totalling nearly £700 million. In addition, about one third of hospital trusts used their financial reserves to help balance their books and 7% borrowed money.¹³

6. The NHS intends that the quality of healthcare should not decline as it seeks to make efficiency savings.¹⁴ In 2011-12 performance was maintained against a small number of headline indicators focusing on aspects of the quality of hospital care, such as waiting times and infection rates. However, 17 hospitals inspected by the Care Quality Commission did not have enough staff to keep people safe and meet their health and welfare needs.¹⁵ The Department explained that the trusts concerned are required to set out their plans for improving staffing levels.¹⁶

7. One way the NHS is seeking to make savings is by reducing the demand for health services, particularly for acute hospital care. This is not intended to restrict patients' access to healthcare, but to avoid demand arising in the first place, for example by better management of chronic conditions to keep people out of hospital.¹⁷

8. However, there are widespread concerns, from patient groups as well as professional bodies, that patients' access to some treatments is being restricted. The National Audit Office found that over half of primary care trusts had introduced or raised eligibility criteria for at least one common elective procedure in 2011-12.¹⁸ The Royal College of Surgeons gave us the example of restrictions on access to cataracts and bariatric surgery, with only the most extremely ill patients being referred for treatment in some areas.¹⁹ The Patients Association highlighted that, while procedures such as hip or knee replacements are described as 'of low clinical value', people waiting for such operations suffer pain and a

12 Qq 50-51, 124, 168

13 Qq 144; C&AG's report, para 2.21-2.22

14 Qq 150, 173

15 Q 139

16 Q 143

17 Qq 37, 124; C&AG's report, para 2.27

18 Q 53; C&AG's report, para 2.35

19 Qq 173-175; Ev 27

poorer quality of life. In addition, delaying treatment means recovery is likely to take longer and the cost to the NHS to be greater.²⁰

9. The Department highlighted that primary care trusts (and in future clinical commissioning groups) are responsible for setting local priorities and using their resources to best effect. But it acknowledged that people should reasonably expect to get similar treatments in one part of the country as another.²¹ The Department's aim is to get clinical consensus about how the NHS can offer the right treatment at the right time. It has started work with the Royal College of Surgeons and others to develop guidance on appropriate thresholds of care for elective surgery, which it expects should both improve the quality of care and save money.²²

10. An area of particular concern is access to cataract surgery, for which the number of procedures fell during 2011-12.²³ The Department told us that at present most access policies used by primary care trusts to ration cataract surgery are not based on the best evidence. It has therefore asked for cataracts to be part of the ongoing work to define appropriate thresholds of care.²⁴ The Patients Association said that there is a general need for greater transparency so patients can understand why decisions about access to healthcare are being made.²⁵

20 Qq 1-3, 7

21 Qq 171-173

22 Qq 173-175

23 Q 2

24 Q 173

25 Qq 7-9, 12, 122

3 Delivering future efficiency savings

11. Most of the savings to date have been generated through short-term, centrally applied measures including freezing the pay of NHS staff (£1.4 billion of the reported £5.8 billion).²⁶ In addition, hospital trusts have focused on improving their own organisational efficiency, for example by reducing spending on agency staff. Overall therefore the savings made in the first two years have been the more straightforward.²⁷

12. Transforming the way services are delivered and getting organisations to work together effectively will be more difficult, but is key to a financially sustainable NHS in the future.²⁸ Service change includes centralising some services in a small number of specialist centres and providing better services in the community to reduce the number of people who go into hospital.²⁹

13. Over the four years to 2014-15, service transformation is expected to generate 20% of total efficiency savings. However, the Department estimates that by the end of 2012-13 only £875 million will have been generated in this way, just 7% of the total savings made.³⁰ A survey in 2012 found that less than one sixth of organisations were taking action involving service transformation.³¹ The NHS Confederation confirmed that the picture on service change was very mixed.³²

14. The Department told us that service change was happening all the time, with local support, but acknowledged that quite a lot of contentious issues lay ahead.³³ In particular, changing the way healthcare is delivered may lead to some hospitals reducing the range of services they provide and departments, and even whole hospitals, closing. The centralisation of stroke care in London is an example of successful service change, where the demonstration of better outcomes gave people confidence that the changes would lead to a better service.³⁴ However, major change of this kind is likely to be resisted by the public and their elected representatives unless the Department makes a clear, well-evidenced case for change.³⁵

15. Another barrier to service transformation is the existing system of financial incentives. The 'payment by results' framework incentivises trusts to carry out more activity, but does not encourage organisations to collaborate, and works against moving care away from acute hospitals into community based healthcare.³⁶ Funding arrangements need to be more

26 Qq 13, 46, 51

27 Qq 15, 50, 167

28 Qq 19, 124

29 Qq 124

30 Q 54

31 Qq 14, 48; C&AG's report, para 3.14

32 Qq 14-15

33 Qq 59-60

34 Qq 31, 101

35 Qq 14, 57, 95-102

36 Qq 40, 61-62; C&AG's report, para 3.17, 3.19

flexible to facilitate seamless care across organisational boundaries, including between health and social care, for example by pooling budgets.³⁷ As the National Audit Office report set out, there are examples of local bodies working together to integrate care and move activity away from hospitals, but the Department and the NHS could do more to share good practice examples across the NHS.³⁸ A further limiting factor on the Department's capacity to make the necessary changes is its ability to recruit top quality trust chief executives. The Department told us it is working to fill vacancies and provide leadership training.³⁹

16. In recent years, the Department has introduced various 'best practice tariffs', for example on total hip and knee replacements, to promote better clinical outcomes and reduce costs.⁴⁰ However, it has not comprehensively measured the effectiveness of such tariffs.⁴¹ In addition, to control the growth in emergency admissions, the Department has introduced penalties so that trusts are not paid in full for emergency admissions above a certain level. The Department believes the penalties have had a beneficial effect in controlling emergency admissions in some areas, but has not assessed the impact of the penalty system.⁴² Performance across the country varies considerably, which suggests the penalties may not be suitable in every locality. The Department told us that local NHS bodies were free to apply payment incentives and penalties flexibly to suit local circumstances.⁴³

17. The need for the NHS to make efficiency savings coincides with major structural change. From April 2013, strategic health authorities will be abolished and the role of primary care trusts will pass to 211 new clinical commissioning groups.⁴⁴ The Department clarified that the Chief Executive of the NHS Commissioning Board will be accountable for delivering the efficiency savings in the reformed NHS.⁴⁵ It is less clear, however, who will pick up strategic health authorities' roles in overseeing local savings plans, taking a strategic view across a local area, and balancing the interests of individual NHS bodies.⁴⁶

37 Qq 63-64

38 Qq 19, 71-73; C&AG's report, para 3.20

39 Q 120

40 Qq 61, 74

41 Q 119; C&AG's report, para 3.21

42 Qq 61, 117

43 Qq 115-116

44 Qq 19; C&AG's report, Figure 1

45 Qq 153-159

46 Qq 19-20, 156

Formal Minutes

Wednesday 13 March 2013

Members present:

Mrs Margaret Hodge, in the Chair

Mr Richard Bacon
Stephen Barclay
Guto Bebb
Jackie Doyle-Price
Chris Heaton-Harris
Meg Hillier

Mr Stewart Jackson
Fiona Mactaggart
Austin Mitchell
Nick Smith
Justin Tomlinson

Draft Report (*Department of Health: progress in making NHS efficiency savings*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 17 read and agreed to.

Summary agreed to.

Conclusions and Recommendations agreed to.

Resolved, That the Report be the Thirty-ninth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for printing with the Report (in addition to that ordered to be reported for publishing on 14 January).

[Adjourned till Monday 18 March at 3.00 pm]

Witnesses

Monday 14 January 2013

Page

Mike Farrar, Chief Executive, NHS Confederation and **Katherine Murphy**, Chief Executive, Patients Association

Ev 1

David Flory, Chief Executive, NHS Trust Development Authority, **Sir Bruce Keogh**, Medical Director, NHS, **Sir David Nicholson KCB CBE**, Chief Executive of the NHS in England and **Hugh Porter**, Chair, Nottingham City Clinical Commissioning Group

Ev 8

List of printed written evidence

1	Royal College of Surgeons	Ev 27
2	Patients Association	Ev 29
3	Department of Health	Ev 30:Ev 33

List of Reports from the Committee during the current Parliament

The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2012–13

First Report	The Government Procurement Card	HC 1915
Second Report	Mobile Technology in Policing	HC 1863
Third Report	Efficiency and reform in government corporate functions through shared service centres	HC 463
Fourth Report	The completion and sale of High Speed 1	HC 464
Fifth Report	The Regional Growth Fund	HC 104
Sixth Report	HM Revenue & Customs: Renewed Alcohol Strategy	HC 504
Seventh Report	Immigration: The Points Based System – Student Routes	HC 101
Eighth Report	Managing early departures in central government	HC 503
Ninth Report	Preparations for the London 2012 Olympic and Paralympic Games	HC 526
Tenth Report	Implementing the transparency agenda	HC 102
Eleventh Report	Improving the efficiency of central government office property	HC 288
Twelfth Report	Off-payroll arrangements in the public sector	HC 532
Thirteenth Report	Financial viability of the social housing sector: introducing the Affordable Homes Programme	HC 388
Fourteenth Report	Assurance for major projects	HC 384
Fifteenth Report	Preventing fraud in contracted employment programmes	HC 103
Sixteenth Report	Department of Health: Securing the future financial sustainability of the NHS	HC 389
Seventeenth Report	Department of Health: The management of adult diabetes services in the NHS	HC 289
Eighteenth Report	HM Treasury: The creation and sale of Northern Rock plc	HC 552
Nineteenth Report	HM Revenue & Customs: Annual Report and Accounts 2011-12	HC 716
Twentieth Report	Department for Energy and Climate Change: Offshore electricity transmission—a new model for infrastructure	HC 621
Twenty-first Report	The Ministry of Justice's language service contract	HC 620
Twenty-Second Report	British Broadcasting Corporation: Off-payroll contracting and severance package for the Director General	HC 774

Twenty-Third Report	Department for Work and Pensions: Contract management of medical services	HC 744
Twenty-Fourth Report	Nuclear Decommissioning Authority: Managing risk at Sellafield	HC 746
Twenty-Fifth Report	Funding for local transport: an overview	HC 747
Twenty-Sixth Report	The Department for International Development: The multilateral aid review	HC 660
Twenty-Seventh Report	HM Treasury: Annual Report and Accounts 2011–12	HC 659
Twenty-Eighth Report	Department of Health: The Franchising of Hinchingbrooke Health Care NHS Trust and Peterborough and Stamford Hospitals NHS Foundation Trust	HC 789
Twenty-Ninth Report	Tax avoidance: tackling marketed avoidance schemes	HC 788
Thirtieth Report	Excess Votes 2011–12	HC 959
Thirty-first Report	Department for Transport: Lessons from cancelling the InterCity West Coast franchise competition	HC 813
Thirty-second Report	Ministry of Defence: managing the defence inventory	HC 745
Thirty-third Report	The Work Programme	HC 936
Thirty-fourth Report	Managing Budgeting in Government	HC 661
Thirty-fifth Report	Restructuring the National Offender Management Service	HC 717
Thirty-sixth Report	HMRC: Customer Service	HC 869

Oral evidence

Taken before the Committee of Public Accounts on Monday 14 January 2013

Members present:

Margaret Hodge (Chair)

Mr Richard Bacon
Stephen Barclay
Guto Bebb
Jackie Doyle-Price
Chris Heaton-Harris

Meg Hillier
Mr Stewart Jackson
Fiona Mactaggart
Ian Swales
Justin Tomlinson

Amyas Morse, Comptroller and Auditor General, **Gabrielle Cohen**, Assistant Auditor General and **Laura Brackwell**, Director, National Audit Office and **Marius Gallaher**, Alternate Treasury Officer of Accounts, were in attendance.

Report by the Comptroller and Auditor General

Progress in Making NHS Efficiency Savings (HC 686)

Examination of Witnesses

Witnesses: **Mike Farrar**, Chief Executive, NHS Confederation and **Katherine Murphy**, Chief Executive, Patients Association, gave evidence.

Q1 Chair: Welcome. Thank you to both of you. I think people are familiar with our procedures now. This first session is for you as key stakeholders in the NHS to talk to us about the issues that you think we should raise in the evidence we take from the accounting officers and those responsible. It is really for you to highlight what you think is important. I will start with you, Katherine. You have done some work about where you think we are going with the impact of the financial reductions on access of patients to treatment. Can you expand on that and tell us a little about the sort of evidence that the Patients Association is finding in the work that you are doing?

Katherine Murphy: The Patients Association is a national independent health and social care charity. We have been in existence for 50 years. We have a helpline and we hear from thousands of patients and the public every year. We provide information and support around issues with regard to health and social care.

It is difficult for the public to realise that the impact on services is due to the efficiency savings, because the public would not necessarily understand what efficiency savings are within the NHS, so there needs to be much more information given to the public so that they are able to understand why decisions have to be made. The work that the Patients Association undertakes is determined by the inquiries and calls we get to our helpline from the public and from patients. Back in 2010 and 2011, we were hearing on the helpline from people on issues around poor care—the fundamentals of care—and that is why we launched the Care campaign back in 2011. That was around compassion and dignity. In early 2012 we saw a huge increase in the inquiries to our helpline around primary care issues, most notably access and treatment.

Q2 Chair: Access to primary care?

Katherine Murphy: Access to GPs. We have undertaken research ourselves because patients and the public were telling us that their GP had told them that they needed to have a hip operation, or a cataract or knee operation. These are what are described as procedures of low clinical value. We undertook some research back in 2010 and 2011, and the research has shown that there were 30,000 fewer operations carried out in 2011 than in 2009.

Q3 Chair: Than 2009—so you skipped a year.

Katherine Murphy: In 2011 it was looking at 2010, and 2010 was looking at 2009. For anybody who is waiting for a hip or knee operation, or indeed a cataract—we know that obviously the pain people suffer from waiting for a knee or hip operation impacts on the quality of their life. Every day, the pain gets worse, and in the long term it has been proven that if you delay operations like hip or knee operations the chances are that the recovery is going to take longer and, indeed, the cost to the NHS will be greater.

Q4 Chair: In your research, is there a regional element or story to tell?

Katherine Murphy: It is a national picture. We are a national organisation, so we are here for people all over the country.

Q5 Chair: But when you did the research—

Katherine Murphy: It was national.

Q6 Chair: So you cannot say that it is worse in one area than another.

Katherine Murphy: No. We also have Patients Association ambassadors around the country. We have

a very large e-membership, and we have very active social media that we use when we see trends coming into our helpline. We use lots of other methods, and we also ask our Patients Association ambassadors to have listening events and focus groups to get more detail about what is happening at a local level.

Q7 Chair: You said services from GPs. Is there anything you can add on that? Was it just the issue of GPs referring people for treatment, or was it access to GPs? Were there other issues? In an environment where the NHS is trying to get GPs to do more, what are you picking up?

Katherine Murphy: It is access to GPs and referrals from GPs to secondary care. There are other issues as well around patients who have been on a specific medication for many years and suddenly their medication is changed to a different medication. They are the main areas we hear about in primary care. What the Patients Association would like is more transparency and more information for patients and the public so that they can understand why decisions are being made, so patients are actually consulted more widely about decisions on the provision of care and what is meant by low clinical value. Obviously, we have concerns about cost coming before clinical effectiveness.

Q8 Ian Swales: May I clarify one point on access to GPs? Do you mean to get a GP, or are you talking about the delay in waiting for an appointment?

Katherine Murphy: Waiting for an appointment.

Q9 Chair: What would you ask David Nicholson? I do not know if he is here—oh, there he is.

Katherine Murphy: Gosh. I would ask him about our having a much more opaque system with regards to NHS finances. Patients have a right to know where and how the money is being spent, and what is being diverted. What do they mean by priorities and when NHS funding is restricted what happens in terms of public understanding? The public are very often denied access to basic information. We need a more transparent means of informing the public. We need more information on finances. On procedures of low clinical value, where does clinical stop and finance begin?

That is very much of real concern for us at the Patients Association. We recognise that we need an efficient NHS. We need a service that is in the best interests of patients. We recognise that the NHS has to change and that services have to be delivered differently. We urge the improvement of integrated care—care delivered around the needs of the patient, and the patient being more involved and fully informed of decisions.

Q10 Guto Bebb: Just to clarify, when you mention a national organisation, do you mean the United Kingdom or separate organisations in Scotland, Wales and Northern Ireland?

Katherine Murphy: No, we mean the United Kingdom. However, we do get calls from Scotland, Wales and Northern Ireland, but many fewer.

Q11 Guto Bebb: Are you seeing the same picture there? Obviously, we have a very different health service in the Welsh context, so are you seeing the same picture in terms of complaints made by people in the devolved nations?

Katherine Murphy: From Wales, we get many calls on issues around poor care, but I am not in a position to answer about Scotland and Northern Ireland.

Q12 Chris Heaton-Harris: I want to agree 100% with you about how opaque the current system is. I have been trying to find out how an operation in hospitals is offered for selective dorsal rhizotomy for children. I have written to every PCT in England to try to find out this information, and two months after I write to them, they come back saying that this very difficult question will be answered at some point in the near future, so I can understand that you found it difficult to get information.

I wonder if you could quantify your numbers for us. You mentioned the word “many” lots of times. How many patients have come to you saying that they have issues with GPs and transparency and are worried about efficiency on these sorts of things?

Katherine Murphy: The exact numbers, off the top of my head, I would not be able to give you now, but I am very happy to write to you, or to the Committee, to provide you with that information.

Chris Heaton-Harris: Excellent. As a swap, will you help me with my SDR campaign?

Q13 Chair: Shall we move to Mike? You come from a different perspective—from the producer perspective, in a sense; you represent the professionals who work in the NHS. Can you tell us a little about how you have seen the first year on the cuts, where the challenges have been and, looking forward, what your concerns would be?

Mike Farrar: The context for this, for those who are less familiar with QIPP, is that for at least the last decade the amount of inflationary pressure on existing costs, and indeed the extra demand on the health service, has been covered by taxpayers, so effectively the NHS has been fortunate to receive that level of growth. As we go into this period, we have had a level of additional resources sufficient just about to meet the inflationary pressures, but the additional demand that we experience on the service has had to be covered by spending our money differently.

There are effectively only three outcomes I can see on that: we can either keep the NHS budgets in balance, but our service offer is reduced; we can carry on with the service offer in place and the NHS organisations start to deteriorate financially; or we can try to achieve what we are trying to achieve, which is to become more efficient and productive in the way we spend money in order to keep the standards of care that we have achieved—indeed, to try to improve them—and not to have organisations that are overall in deficit.

I think that where we have got to with year one—to a certain extent, this was part of some of the original planning—is that we have made the level of efficiencies that you would expect; the NAO Report confirms a good proportion of what the Department of Health said they achieved. But, actually, we have done

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that with fairly short-term measures and we benefited from pay restraint. A significant amount of money that the NHS receives goes to pay. It goes to work force because when you add training and education of staff, you are probably around 60p in every pound, so pay restraint has been a very important benefit that the NHS has had.

What we worry about is that to meet that kind of 4% efficiency—I am broadly quoting the Health Select Committee's assessment—year on year requires us to change the way we provide those services fundamentally. I am afraid that, so far, we have seen little evidence that on a sustainable basis we have achieved those savings; that is still to be done. Our assessment is that our members have worked incredibly hard, and we have benefited from pay restraint, but we have not really fundamentally changed the pattern of services such that over the next five to 10 years we can say the NHS offer is sustainable and our organisations will still be involved.

Q14 Chair: Let me ask you this question, because it is your guys who, in a sense, are responsible for trying to get us through this system. We are now three quarters of the way through the second year, and although we do not have the data looking back, one would hope that some progress on the ground has been made on re-engineering how we deliver health. Is it your experience from your members that things are happening, or are they still looking at short-term financial fixes to try to meet the financial targets?

Mike Farrar: I am sorry to give you this answer but it is the truth: it is a very mixed picture. There are some areas where they have managed to find ways to benefit from the redirection of people, perhaps with chronic disease, away from our hospital sector to be managed more safely at home in the community; over a period of time, that will give them a long-term, sustainable benefit. But there are other areas where, effectively, we have seen capacity that we had being absorbed and we are seeing additional demand on our services. That is manifest in greater presentations in the acute sector, and it is simply not sustainable. We have seen some of the financial position of hospitals deteriorate and we have also seen some reduction in the service offer; the waiting time for diagnostic testing, for example, has not been hit and has been deteriorating.

It is patchy, but I think it would be universally true that most people are aware that some of the big challenges, in almost every system, still remain: reorganising the way that patients access care, and—this is the big thing—capitalising on this by taking out some of the fixed costs of some of our existing services. This is where we face the biggest challenge. I agree 100% with Katherine's point about transparency; if the public do not understand why we are saying that we need to change the location of services, particularly by concentrating some services into fewer hospitals as well as taking some services back from hospitals into communities, they will not support it. What we are seeing at the moment is, in some cases, an alliance of the public and the political classes finding it hard to agree with the case for

change, which is making it take longer to take costs out, and we are not making the savings that we would need to make.

Q15 Stephen Barclay: The Report says, in paragraph 3.14, that it is worse than patchy; it says that your survey—a survey for the NHS Confederation—found that less than one sixth of organisations were taking measures involving service transformation. In reality, they have just gone, understandably, for the low-hanging fruit—the easy savings, which are often non-recurrent—but the Report says that they have not focused on service transformation.

Mike Farrar: It would be fair to say, in some places, that early on they focused on their organisational efficiency, because that is the easiest thing to do. In terms of the service transformation, because of the way the NHS works, they would have to agree with another organisation. If, for example, you are going to reorientate a service that is currently hospital-based to be more primary and community orientated or, indeed, to have more care in social care, you have to have an agreement with a partner. I am thinking about people with dementia as an example; in order to move some of the people who are currently going into hospital to accommodation that is perhaps more suitable, with better care, the new service has to be in place.

Q16 Chair: Somebody has to put money into the new service.

Mike Farrar: Yes, and the issue there has been reductions in funding through social care, which has had an impact. Our members talk about delayed discharge having a big impact on their services. In primary care we have seen major reorganisation of the players on the pitch, which has clearly been a distraction in terms of trying to build new services and get new partners. That has affected their ability to deliver what we all know has to be delivered. You are right to point out that in some cases, they focus primarily on their inter-organisational issues and perhaps less on their relationship with us.

Chair: It is most cases, not some.

Q17 Stephen Barclay: It is the vast majority of cases; it is not some.

Mike Farrar: And that would be defensible, in light of not being able to find agreement on the changes.

Q18 Stephen Barclay: You yourself quite correctly highlight the difficulty, politically, on the ground. Those political pressures are only going to get worse as you get close to a general election, which is why your organisation should have been flagging the clinical benefits of service transformation. What is staggering from this Report is that they have not done that.

Mike Farrar: I don't think you can conclude that that is not what they have done. What you conclude is that the measures they are taking that have been most effective to date have been about internal efficiencies. I think they are aware and continue to be aware; if you look at the barriers to change that they describe, they talk about the problems of funding around alternatives and about the political opposition to some

of the changes they would like to make. I do not think that you can universally point the finger at them and say that they are not doing everything that they could. I think there is a shared responsibility, and the solutions lie, to be frank, in a single story being told by our organisations, and by the clinicians, where there is a case for change, that is transparent and understood by the public and is supported by the politicians. If we can get to that point, there is a fighting change we can achieve what we need to achieve.

Q19 Mr Jackson: Both the Chairman and Mr Barclay have alluded to the idea that non-recurrent expenditure has been the subject of revenue reduction—that is, easy hits in the first year—and that a great number of organisations are not taking the opportunity to look at service transformation; I know you might argue about that. I wanted to focus on what is going to happen in the wake of the abolition of strategic health authorities and primary care trusts. One of the issues that comes before the Committee, across Government, is a lack of strategic focus going forward. The clinical commissioning groups are working closely with the former primary care trusts and acute trusts, but which body is going to take responsibility for co-ordinating these efficiency savings and this service reconfiguration, against the background of the very difficult political pressure that Mr Barclay alluded to, and, perhaps, without the mechanisms from the NHS centrally, either financially or in terms of governance?

Mike Farrar: I think there is a problem; indeed we flagged this up when the Bill was going through. The idea of a whole-system viewpoint and a holding of the ring between organisations was not automatically apparent in terms of the functions of any single organisation. The National Commissioning Board itself may have some opportunity to try to hold the ring with their local area teams, but equally I think clinical commissioning groups themselves might need to federate, to find a way to share. In terms of geography, that is the kind of footprint that you need to make some of the strategic change or take cost out. I am particularly thinking here not about the relationship between secondary and primary care but between secondary care providers themselves, in terms of managing effectively the organisation of care and secondary care; it will rely on commissioners getting their act together to specify that. I also think that many of the providers themselves will have to bite the bullet and start talking to their organisations in collaboration about how they get a sustainable level of services, rather than having a situation where, effectively, the degree of competition might force them to keep additional capacity that might not be affordable or in the long-term interests of the NHS.

It brings into stark relief the question of where the responsibility is. We in the Confederation have talked to our boards about a shared population governance so you have a shared responsibility not just to look at the health of your own organisation, but to talk to others about how you might come together to get the system transformed in the right way. You are pointing out something that is a question in the new system,

and we will have to see how it evolves, but we will encourage our members to work together.

Q20 Chair: We have not got time for all this, you know. We are nearly halfway through the spending review period, and we have to achieve this efficiency. I want to ask you one thing, and then Chris will come in. First, I do not really understand how these commissioning groups are going to share. Maybe you can explain to me how you think that will happen. Secondly, how are you defining efficiency savings, or are you just talking about cuts in the numbers of nurses and doctors? Is this an efficiency saving or is it a cut? Just demonstrate that to me, with a couple of examples of where you have seen real efficiency savings among your members.

Mike Farrar: Okay. On the first point, about how they will work together, if they buy their commissioning support from a commissioning support unit, they will effectively—

Q21 Chair: What is a commissioning support unit?

Mike Farrar: Commissioning support units have been set up to provide the technical input to clinical commissioning groups.

Q22 Chair: What are they? The old PCTs?

Mike Farrar: They are a variety of people who used to do contracting and support from PCTs, but there are also emerging, new partnerships that they are providing with other people who have been doing commissioning support in other sectors, some of them working more closely with local authority commissioning. Commissioning support will operate on a bigger footprint. In essence, units will be supplying CCGs and will help CCGs to work together.

Q23 Chair: Who pays for them? The CCGs buy their services? Where are they at the moment, these guys? Where have they come from, these people?

Mike Farrar: Largely from PCTs.

Q24 Chair: They are PCT staff who have reinvented themselves, having got their redundancy payments.

Mike Farrar: No, no, no. There has been continuity of support. These people have not been made redundant; they have been put forward into commissioning support units as part of the redeployment of staff.

Q25 Chair: Who has put them forward?

Mike Farrar: It has been handled by the National Commissioning Board.

Q26 Mr Bacon: So by Sir David Nicholson.

Mike Farrar: By David.

Q27 Meg Hillier: But that is not true in every case. I have come across a number of examples—people have also told me this anecdotally—of people being made redundant and then, a few months later, being employed in different clinical commissioning groups around the country. That is certainly true in London.

Mike Farrar: I think it is a question to ask the National Commissioning Board, but I can tell you that

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the vast majority of people who are working for commissioning support organisations have been transferred across and have not been made redundant and re-employed.

Q28 Meg Hillier: There are an awful lot of interims in place. It may be that that skews the figures.

Mike Farrar: Again, that is a question for the National Commissioning Board, but I believe that they are now in a position where, in terms of the 23 organisations going through the process to be accredited as commissioning organisations, they have at least 20 of the chief executives in substantive roles, so I do not think they have a lot of interims there.

Q29 Meg Hillier: Maybe at chief executive level, but I know for a fact that there are people out there who have taken generous redundancy payments—they may genuinely have thought they were not going to work in the NHS again—but there is such demand for their skills and services that they have been brought back in. There seems to be no real ability to have safeguards. I know they are your members, so maybe it is in your interests for them to get these positions, but this is about all taxpayers' money, and in the end it affects everyone.

Mike Farrar: We have tried to support the management of people through the system to the best possible place to get the best value for taxpayers; that is what we would want to see. The reforms have abolished authorities and organisations. People have not been able to take redundancy unless they were eligible for redundancy on the basis that their organisation has been abolished. That has allowed management cost savings of a significant level—

Q30 Chair: Well, we do not know, because you might have had a whole load of management costs in terms of redundancy, with people then re-emerging elsewhere. We are very sceptical.

Mike Farrar: I think the reforms of this House are responsible for certain people having been eligible for redundancy. There is a notion that those individuals leapt at the chance to be made redundant in order to deploy their services back, but that has only been created in terms of an opportunity because of reforms passed by the House. Some of these points were made during the passage of the Bill.

Q31 Chair: Okay. I accept that. I want to bring Fiona in, but can you answer the other bit of my question? Give me a couple of examples of where there has been a real efficiency saving.

Mike Farrar: I think you can see real efficiencies in the way in which the reorganisation—this is probably one of the most heralded—of stroke care in London has allowed services to become focused on a smaller number of hyper-acute stroke centres, which have, in the evaluation, been saving lives. Indeed, they have been managing, in the whole-lifetime costs of people's care, to get the better care to the right people, so this has saved lives and taken money out of the system. The last figures I saw for London were around £3.5 million estimated savings per year as a consequence of that.

Q32 Chair: It is a good example, but it all happened a number of years ago. I am trying to pick up what your members have done in the current Nicholson challenge era that you can say is a real efficiency saving for the NHS, rather than what we tend to see in the press about cuts in the number of nurses and, therefore, quality of care, or longer waiting lists, or access to particular elective surgery.

Mike Farrar: Again, I can only give you examples that have been properly evaluated, and almost by definition some of the things in the last year of care would not be—

Q33 Chair: You can give me an example.

Mike Farrar: Let me give you an example of reducing variability in care: the work done across myocardial infarction, congestive heart failure, coronary artery bypass graft, hip and knee replacements, and community-acquired pneumonia in the north-west. What effectively happened there was that by getting compliance with best practice in clinical standards over a three-year period, the reduction in variation of patient experience and compliance with best practice has gone up significantly. That was published in the *New England Journal of Medicine*—

Q34 Chair: You are talking about two years ago. A current report talks about massive variation—a current report. I am trying to eke out of you something that has hit you in your day-to-day work that made you think, “That’s a really clever idea. They are saving money. They are doing it well, and they are not impacting on patient experience or patient access.”

Mike Farrar: The better management of dementia patients as a consequence of having old-age psychiatry and community services working closely together, which is happening in my part of the country, is starting to impact on the number of dementia patients who find themselves in hospital. That is a good example of where in some localities people with dementia are not ending up in hospital, but are being directed into other forms of residential care. The difference in price between a hospital-based stay, which is a very poor patient experience, and a nursing or residential facility reduces the cost by about a third on average, and sometimes half. That is a good example of service transformation: people receive better services, they have a better patient experience because they are not confused on a general ward in a hospital, they have dedicated support staff around them—in some cases it is around their own home—and that reduces the cost of their care by about a third.

Q35 Chair: My colleague has just pointed out that the Report says that “data to assess the quality of... community and mental health services in particular is limited”. That does not fill us with confidence.

Q36 Fiona Mactaggart: The Report says in paragraph 3.14 that a survey conducted by your organisation found that “less than one-sixth of respondents reported that the actions their organisations were taking to make efficiency savings over the next year involved service transformation.”

It seems to be a critical theme that while savings have been achieved, a lot of them have been achieved through shaving bits off the edge of provision. We were sold a vision that if GPs were commissioning services, there would be transformations that moved certain kinds of care into primary care, which would reduce, for example, expensive and chaotic A and E admissions, and so on. I do not think that is what we are seeing.

Mike Farrar: There is a time frame issue, and just as you challenged me on the time frame issue, we have yet to see the impact of GP-led commissioning, because it becomes statutorily in place only in the coming April, not last year.

Q37 Fiona Mactaggart: But in practice it has been in place in lots of places.

Mike Farrar: There is great hope that there are opportunities for managing, particularly chronic disease, better in primary care. It is not just about a different location; it is about avoiding acute exacerbation to allow people to avoid the need for hospital care, rather than just about location of services. It is about people continuing to be managed well. Over the last decade, we have seen improvements in the management of chronic diseases, like diabetes care, in order to keep more people out of hospital, but much more could be done, and with the financial pressure we face we simply have to do more. The big problem is that if you simply redirect care and put resources into the community, but still use your hospitals at the existing level of demand, you do not reduce the overall cost of the service.

Katherine made an important set of points about access to some procedures. I saw evidence of that when I was last in the NHS, which was about 18 months to 2 years ago. We were managing people's hip and knee replacements; we had got the waiting times down and there was capacity in the system. But because we did not have an effective system of threshold management, people continued to get hip and knee replacements, but at a lower level of assessment. The guide was an Oxford hip score of around 40, but we saw people with a score of 20 getting hip replacements. Katherine made the point about pain and all the rest of it, and those people were in pain. But if we do not manage the thresholds of access for care and take out some of the fixed costs, all that is happening is you are spending money and you are still using the same level of services. That is not transforming care. It does not help the taxpayer by meeting the extra demand in the system from the existing resource.

Q38 Chair: I have to say to you, Mr Farrar, that cutting demand by raising thresholds is not getting greater efficiency.

Mike Farrar: No, the point I was making is that the threshold is reducing in terms of access to care beyond what clinicians thought was appropriate.

Q39 Chair: So you are making it more difficult, so people could be in pain longer, as the way to cut money.

Mike Farrar: No, that is not what I said.

Q40 Ian Swales: On that point, the Report touches on the issue of financial incentives. In the example you gave, is it not the case that an organisation providing such procedures has a financial incentive to fill up their activity and deliver more and more procedures, because that is how they pay for their facilities?

Mike Farrar: Certainly for non-elective care, that would be true. In non-elective care, there is a margin for the provider, so certainly that would have been the case. There is an interesting issue about an incentive that was put in place for trying to manage what was perceived to be a problem of supply-induced demand for non-elective work. An NHS trust receives only a third of the tariff price for any people referred over their 2009 baseline. That incentive was created to try to address what was perceived to be supply-induced demand—the problem you described—but in practice it has had no impact. Trusts have continued to see growth in demand, which suggests that the demand is real.

Q41 Ian Swales: Could it also be to do with the difference between fixed and variable costs? If you divide the costs of a unit into the number of procedures, the marginal cost of doing the next one is much lower than the average, so even at a third, they might have an incentive to take on more and more business.

Mike Farrar: I think that is not true, but I take your point that they are not absorbing the whole cost. The important point for the Committee is that the incentives in the system, as they are currently organised, do not support the transformation of services; they work against taking work away. I know there is a lot of work going on, but as yet we are still operating with a payment-by-results system that does not facilitate the management and movement of care away from acute hospitals.

Ian Swales: I am pleased you said that so clearly, because it is something that I want to pick up with the management in the next session.

Q42 Fiona Mactaggart: I want to get on to the point about trusts where there has been a significant increase in the demand through A and E, which is supposed to be being depressed by these squeezes. What representations have your members made to you about changes that they cannot control because of this? What do they suggest that you should do? For example, have there been particular representations from places with growing populations, with more diverse populations, and so on? What would you say would be a better way of structuring the funding for that work, which I think is clearly coming in at my local hospital, which seems to have more such admissions than any other DGH of its size? I am wondering what your members are telling you and what you should be saying to the Department of Health, because I want to ask them about it.

Mike Farrar: That's fine. What they are saying to us is that the system at the moment is not working—it is not working as well as it could be in terms of their ability to change the pattern of services. They are continuing to have to effectively devote resources to

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more support for those people who are coming in as additional demand. They are worried about the social care settlement, which has a big impact on their ability to discharge people. What they are saying is that we should be representing to Government and to the National Commissioning Board the problem around the misalignment of incentives. That is exactly what we have done.

If you ask me what would work—actually, people at local level who are finding ways through this are doing it, despite the way which the finances are necessarily supposed to flow—it is to find risk-share agreements between the commissioners and the secondary care providers, in order to find a way to get the money to the right people as the work moves and you start to be able to take work away from secondary care and do it in primary and community services. That is something that we are reflecting in our conversations with the Department and the Commissioning Board.

In the new system, of course, it is more complicated, because there is now a number of national organisations, such as Monitor, the CQC, the NHS Trust Development Authority and the Commissioning Board, all of whom have a legitimate element of the whole incentive structure and to whom we have to talk. So we are talking to them about how they need so have a coherent view such that, when it is experienced by the NHS and all the assets that they have, NHS organisations can do the right thing, which is effectively to downsize acute provision in order to reinforce and develop more social care, primary care and community services.

Q43 Chair: Final question to the Comptroller.

Amyas Morse: Thank you, Chair. I want to follow up on something. I heard you say something very interesting about the difficulty of the creation of spare capacity just sucking in more demand—that is one point. The other point that I was intrigued by is the problem of interaction with social services. If there is a clash—in other words, if there is a reduction in resources for social services and you are trying to make a deal with them to give more care at home—I do not see how that gets resolved.

Mike Farrar: Do you want me to comment on the last one?

Amyas Morse: Yes.

Mike Farrar: The way the finances work at the moment, it is very difficult. I want to make this point that relates to Katherine and how patients see life. If you ask me what often is the trigger that means that

people cannot continue to live independently in their own home with a health condition, it is not the medical or the nursing input, but the low-level social care inputs. If I think about my own family, before my mother died last year from vascular dementia, she went into a care home. My father and she had been together for 60 years and they had only spent one night apart. In November last year, when we had to say to my father, “I’m sorry. You can’t look after mum anymore,” that was a bad day for our family. She went into a care home, which was fantastic, but it was low-level support that could have made the difference—better continence services and support with aids and adaptations to keep her at home.

The problem for the health service is that very often, for people to stay living independently, there is a care bit of the service that is so important, rather than necessarily more medical support being what is needed. If social care is restricted in its budget and is having to spend in a restrained way, it will have a knock-on impact on the use of hospitals. We know that when people go into hospital because of things like a fractured neck of femur, getting them back out into independent living is highly dependent on having a range and package of services, including care services, available. It has knock-on impacts: people going into hospital who could be cared for at home and people not being able to come back from hospital soon enough because of the element of social care. We still do not have a social care funding solution that allows the local authority to understand what is at its disposal, because we have not had this agreement with the public about what contribution they will have to make themselves. That is a big issue.

Q44 Chair: The final word to Katherine. Is there anything from that last conversation that you would like to draw to our attention from your perspective?

Katherine Murphy: Just to remember that the NHS belongs to the people. The NHS needs to look after and treat people to the highest quality and with the safest care, so that they can enjoy good quality of life. We can never put finances in front of clinical need of any individual patient. We have an opportunity to design services around the needs of the patient. Let’s grasp that opportunity.

We do have huge issues around social care. If you asked the vast majority of people whether they would like to be treated in their community or in hospital, they would say that they would want to be treated in their community supported by appropriate services.

Chair: Good. Thank you both very much indeed.

Examination of Witnesses

Witnesses: **David Flory**, Chief Executive, NHS Trust Development Authority, **Sir Bruce Keogh**, Medical Director, NHS, **Sir David Nicholson KCB CBE**, Chief Executive of the NHS in England, and **Hugh Porter**, Chair, Nottingham City Clinical Commissioning Group, gave evidence.

Chair: Welcome. Thank you all for coming. With the contemporary NHS, we always need lots of people appearing in front of us.

Meg Hillier: Who's in charge?

Q45 Chair: Yes, I was just looking to try to work out who is in charge. Are you in charge?

Sir David Nicholson: I am.

Q46 Chair: Sir David, this Report says, "okay so far." We welcome that. We want to ask a few questions of how you got to "okay so far" and then we want to look at where we are going over the tougher period of the next three years.

If we look at "okay so far", there are some issues in there that do cause concerns for the future. Let us take one: it clearly says in the Report that about a quarter of the savings have come out of the two-year pay freeze. That has enabled you to get £1.42 billion of savings. That is welcome for you, although probably not for the staff who have not had a pay increase when there is high inflation, but it is not a productivity saving. As you move forward, what sort of problems does that lead you to? I suppose it is the wider issue, raised by our previous witnesses, that there seems to be very little evidence on the ground that the efficiency savings, rather than financial cuts, are being secured in a system-wide way.

Sir David Nicholson: Let me say that at the beginning of all this, when we sat down in 2008–09 to think about it—we have been thinking about and planning this for a long time—we did not underestimate, as I am sure you do not, how difficult this is. While we will of course defend the position we are in, and I will advocate for what we have done hopefully explain why we have done it, it is very difficult. We cannot find another health care system in the world that has done what we are trying to do at the moment, so it is difficult. It is in many ways uncharted territory, and we are learning as we go along. We are trying to learn from other industries and other health care systems and all the rest of it; nevertheless, it is difficult to do. As you know, since 1948, on average the NHS has had 4.5% real-terms growth.

Q47 Chair: Is it doable?

Sir David Nicholson: When we sat down in 2008–09 and looked at it, we asked all the big consultancy firms—they did it for nothing, I have to say—whether it was possible, and if it was possible, what sort of thing we needed to do. They broadly came out with the same kinds of solutions. They said that, yes, it was possible, looking at our benchmarked costs and our benchmarked efficiency across to other parts of the world and also within benchmarking within the NHS, you can see the variation—if everyone did it the best way, you could see how to do it. They broadly identified the areas that we would need to tackle. We published that and all the commentators responded to it. There was a broad consensus about what needed to be done, but saying what needed to be done and doing

it are two very different things. While I will advocate for what we have said, it is tough to do it, and if you think about after this spending review, it is even more difficult. That is where we are.

We tried to approach it not by saying, "We're going to have this big efficiency drive," although it was inevitable in the circumstances that people would talk about that; we wanted to talk about—I know it sounds trite in some ways—quality, innovation, productivity and prevention, because we think that those four things together form the basis of how we can go forward.

When we looked at it, we thought we could make the change in three particular ways. We concluded at the beginning that about 40% of the efficiency gains or savings that we could make would be nationally driven; 40% could come out of improved efficiency in hospitals and health services; and about 20% would have to come through service transformation. That was our analysis in the original part. We always knew that at the beginning of this process, the central savings and some of the efficiency savings would come along first and be, in a sense, easier—the low-hanging fruit. Although it does not feel like that, that is what people thought. The fact that the service transformation is towards the end of the period is not a surprise to us, because we absolutely thought that that would be the case.

In terms of the first set, which is the national savings, pay restraint is part of that and some £850 million has come from that. There are major savings on the management costs overhead: as you know, we are engaged in a process of saving £1.5 billion through management costs reductions and we are ahead on that. There is a whole series of savings that could be made nationally by the Department, which held a significant amount of money nationally. Then there are all the things around it that we have considered in this Committee before—a whole lot of stuff around procurement and arrangements for that. That was the national stuff.

The second group is essentially efficiency gains in hospitals and health services—running the service more efficiently and more effectively. That means more patients being treated on a day-case basis and reducing the cost of staff deployment through things such as better rostering and reducing sickness absence and the amount of money you spend on agency staff. It is about all those things that a traditional hospital or health service manager would understand and be able to do.

The third bit was around service change, and there are two elements to that. One is the concentration and centralisation of services—the stroke example given earlier is an example of the sort of thing—on a national scale. Secondly there is this whole thing about how you could provide better and more preventive services in the community, which would stop people being admitted into hospital. If you did those two things, you would get the kinds of service

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transformation that you need. That is the general approach that we have taken.

Q48 Chair: Right, but where are you? We are almost at the end of year two. I know that we are looking back at year one, but you must know what is happening in month nine of year two. Although you have had your pay freeze, the National Audit Office has said that more than half a billion is one-off savings, which is not good enough. You have not hit your target yet. We will come in a minute to the viability of some of the institutions for which you are responsible, but there are some concerns there. Where are you?

The Report seems to say that there is little indication of service transformation and little indication of real efficiencies. You talk about them, but what we are seeing is more cuts—fewer nurses, all that sort of thing—rather than efficiency savings. I want to get a feel from you. What was it that Steve said? Only a sixth of the trusts are actually looking at transforming and changing the way that they do things? That is not good enough almost halfway through the process. That is what I feel. It is not easy—everything is tough, we accept that—but you have done the obvious. Maybe we should talk about the obvious rather than the easy. One feels that you have not made the right progress in driving forward so that you achieve the £20 billion in savings over the four years.

David Flory: If I can summarise where we are to date, and where I think and expect, on the plans and actions that have been taken this year, to be at the end of this year, at March 2013, which will be two years in. In terms of overall numbers, at this stage, we are ahead of where we planned to be.

Q49 Chair: Including the nine months of year two?

David Flory: Yes, and we are certainly ahead of where the original plans were, and ahead on the percentage profile of where the National Audit Office Report, which reflects the plans, said we would be. If we think of the overall number of £18.9 billion, which is referenced in the Report, by the end of year two I expect the savings that will have been made to be £12.4 billion. That will be 65% of the way to the total number at the halfway point in time.

Q50 Chair: How much of that is on service transformation? Or, how much is one-off, how much is service transformation, and how much is actual cuts in increasing thresholds, or however you like to say it?

David Flory: If I can give the breakdown of the main numbers included in this—

Chair: Yes, please do.

David Flory: Sir David referred to the 40% element of the total that we were shooting at being improved efficiency in provider organisations, achieving the 4% each year. That number was achieved in the first year and I expect it to be achieved this year. So of the £12.4 billion, £4.8 billion will be through the year-on-year operational efficiency, which includes greater productivity, reduced spend on drugs, reduced agency spend, reduced sickness absences—a whole lot of efficiencies that are generated within those organisations. That is the first part.

Q51 Chair: Let me just hold you there a moment. I'm sorry, because I know that Justin wants to come in, but it would be useful to get this out. Are you telling us that in that £4.8 billion, which presumably must be driven by the tariff regime, to a large extent—

David Flory: Yes, it is.

Q52 Chair: Right, but are you telling us that there have not been changes in access, whether it is cataracts, hips or whatever—all those things that we have seen in the press—and are you telling us that there has been no impact on the quality of care from cuts in nursing and those sorts of issues? Are efficiencies really coming out of the tariff, or is it actually that the bodies that receive your funding are cutting either access or quality?

David Flory: It is difficult, with such a huge amount of health care business that has generated this level of savings, to give you a categorical assurance of everything that is in and everything that is not, involving so many providers, but this is absolutely driven by—

Q53 Stephen Barclay: With respect, the NAO addressed that point in paragraph 2.35, which states that “56 per cent of primary care trust clusters...had introduced or raised eligibility criteria”. The Report goes on to say that some work is being parked in the community, but that is not being specifically measured. It would be good to get the breakdown for the £12.4 billion, but, as I understand it, a large chunk of that is achieved through the pay freeze, albeit some people do move within bands—consultants, for example, get a raise in each of their first five years, so the pay freeze is not always as it sounds; it is not always that no one is getting any more money—and through using the tariff, which is a pretty blunt instrument. As part of that, we have done well with the things that we measure in hospitals, but on the things that we do not measure, there has been increased rationing and some things have been parked in the community. What the Chair was trying to get at, and what I am very interested to hear about, is that the NAO says that the key to achieving the aim is service transformation. How much of the £12.4 billion of savings so far is from service transformation? Do we have that figure?

David Flory: I have a figure, which is in addition to the £4.8 billion that we have just discussed, for reduced costs incurred by commissioners, by which I mean demand management, and—

Q54 Stephen Barclay: I am not asking about demand management; I am asking about service transformation. Within your plan, you have 40%, as Sir David said, that is nationally driven, and 40% that is coming locally—40% from pay restraint and 40% from efficiency; that is all in paragraph 1.11 of the Report—and just 20% from transformational changes, even though the NAO says that, actually, transformational changes are the key. We have already touched on the fact that they are going to be harder to deliver at the back end of this plan, because of the election that will be coming up. Of the 20% savings

in your overall plan, how much, as a cash sum, has been delivered at the halfway stage?

David Flory: £875 million.

Stephen Barclay: £875 million—thank you.

Q55 Meg Hillier: On the opposite side to tariffs you have penalties—readmission penalties, for instance. How much are they raising? That must surely have an effect on clinical care. My particular issue is sickle cell, where readmission is penalised but is often necessary because of the nature of the illness. Is it possible for you to get us or do you have a figure for what readmissions penalties are raising? I think that is quite pertinent to service levels.

David Flory: I do not have the figure to date on total reduced expenditure on that. However, I would say that we introduced the policy two years ago in order to drive better clinical practice and better experiences for patients and to incentivise the system, not to, if you like, organise their care such that patients would need to be readmitted due to a less than ideal first experience. We found that it was a rather blunt rule that needed more sensitive application locally. As a result of that, we piloted in a number of places, and now advise it to be done everywhere, an audit to be done between commissioners and providers about which readmissions were avoidable and which were not. Out of that, we have a much more sensitive position in all parts of the country and more appropriate arrangements on what is and what is not paid for on readmissions agreed between commissioners and providers. Therefore, the headline of the rule is an indicator, but it is applied much more sensitively in different parts of the country.

Q56 Meg Hillier: Perhaps I can write to you for more specifics.

David Flory: Yes.

Q57 Justin Tomlinson: I have a quick point on the service transformation elements. They are often the most contentious parts, because what might make clinical sense and what might make sense on paper is often not supported by the public in their local communities. How much have you factored in that level of restraint in terms of delays and in terms of ultimately having to make decisions that do not make clinical sense and rejecting people?

Sir David Nicholson: What is true is that when we set up our plan in terms of service transformation, we did not take account of the electoral timetable. That was not what we were thinking about. We were thinking about what made best sense for us as we went forward.

Q58 Stephen Barclay: You haven't seen a "Save our local hospital" campaign before?

Sir David Nicholson: I have seen many.

Meg Hillier: Kidderminster is engraved on the heart of everyone here.

Sir David Nicholson: That is where I grew up. In fact I was using Kidderminster hospital myself recently.

Q59 Chair: This goes across political parties. We were trying to make sense of David Flory's figures.

You said £800 million on transformation. I think you would get about £4 billion on your 20%. You have to get £4 billion on transformation, so you are getting more than 75% in the last two years and we are just sitting there thinking, "Really? Which hospitals are you going to close as we are in the run-up to a general election?"

Sir David Nicholson: As I say, when we set out the thing in 2008 we did not know what the electoral timetable was. Service change happens all the time and all around the country. Quite a lot of it gets done without any reference to national bodies or anything. It just gets done because it makes sense. People do it well. They argue the case locally and you get local buy-in to make it happen. So it does happen—quite a lot of the things David was talking about, which is predominantly about better support and help for people who live in the community, who are treated in the community and who are supported in the community without requiring to go into hospital.

Q60 Justin Tomlinson: Let me rephrase the question. What proportion of it do you envisage being contentious? I accept your point that a lot of service transformation is perfectly fine and perfectly acceptable to the public or they simply do not notice it.

Sir David Nicholson: We are just going into a phase now where quite a lot of fairly contentious service change issues are surfacing. If you take south London as an obvious example, north-west London, south-west London—

Chair: North-east London?

Sir David Nicholson: North-east London is always contentious. Staffordshire, Wakefield—

Chair: Peterborough?

Sir David Nicholson: There are a number that are coming to a head. People are doing exactly what we thought they would do. They spent the first 18 months to two years of this getting their act together so that they can now bring forward their proposals. Paediatric cardio surgery is another example. So you will see no shortage in the NHS of people wanting to do transformational change over the next 12 months or so.

Q61 Ian Swales: I would like to return to the question of financial incentives which I asked the previous witnesses. Mr Farrar was very clear that there are issues. We shouldn't be surprised at that because there is a section of the Report which contains some very worrying comments if we are to see delivery of this. Paragraph 3.17 starts: "Most providers (86 per cent) reported... that differing financial incentives between organisations are a major barrier to service transformation." Paragraph 3.19 says "These mechanisms do not always incentivise providers to transform services... it can create perverse incentives now that the NHS is seeking to reduce hospital activity... Conversely, in community settings, 90 per cent of care is reimbursed under block contracts, which do not provide incentives to increase activity". What I am feeling from this is that we have set a framework—it has been set and thought about—

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which appears not to be targeted at delivering the very change that you want to see.

Sir David Nicholson: There are three levels on which I would answer that question. First, you are absolutely right that the basic frame was set at a time when the NHS was getting plenty of growth. So in lots of ways you can see that many of the incentives that have been built into this system were designed for growth and we are not in that position any more. We have dealt with this in two or three ways. First, where it is obviously not in the right place, we have tried to make short-term decisions which rebalance it. The most obvious example is the thing that Mike Farrar talked about, which is giving people the 30% for their extra emergency activity. The reason for doing that was less to do with fining people and more to do with the idea that people would not be able to sustain it, so they would work across organisations with their community services, with their commissioners, to come to solutions that would resolve the issue, and in many places in the country, they have done. We have made some short-term decisions to do that.

Secondly, we have shifted a lot of the tariff around, which is not as blunt as it used to be—what we would describe as a best practice tariff. For many of the conditions, there is a specific tariff that relates to that condition and relates to the best practice for delivering—stroke being a good example of that.

Thirdly, we are starting to work on pilot payment systems, which absolutely take the point you make. For example, the development of year-of-care tariffs; we give organisations an amount of money to care for an individual for a whole year. It is up to them then how they organise it. We are absolutely cognisant that the current access is not all that it should be and we are trying to move as fast as we can.

Q62 Ian Swales: So would I be right in saying that the current system incentivises hospitals to maintain and even grow their activity?

Sir David Nicholson: For some of their activity, it does.

Q63 Ian Swales: To add to that—because this is certainly something I see in my constituency—there is this boundary, which I think was mentioned in the previous evidence, between hospital and social care. I had one case, which I mentioned in Parliament, where one of my constituents was discharged from a hospital in November, but was there until the new budget year started for social care and was discharged in the first week of April. The system—the NHS—paid for four months of a hospital bed for somebody who should not have been in hospital. That can only be to do with budgetary constraints. How are we going to make it seamless? If the NHS wants more things to be done in the community, how can it be seamless and how can the incentives work to make that happen?

Sir David Nicholson: It is a bad story on almost every level you have just described, for the individual and the organisation. I cannot believe that locally there is not a way to solve those problems. In a sense, we need to think about what we can do to help people and give them the flexibility to do it. It cannot be that

the system is so inflexible. We need to think about how we support—

Chair: What does that mean? This is not a new problem. You could go round the table and find that we have all got stories. Local authorities are skint. They are cutting their social care budgets. For your financial savings, you depend on local authorities taking more people out of hospital or stopping them from going in. I just do not see how you are squaring that circle. You tell us you are going to think about it, but we are halfway through. *[Interruption.]*

Sir David Nicholson: No, I certainly don't want to do that. We are creating some institutional ways of dealing with it. The development of the health and wellbeing boards. Bringing people together to make those things—

Q64 Chair: But it's the money. Let's talk about the money.

Sir David Nicholson: Okay. That enables you increasingly to pool budgets and resources. We handed over to local authorities last year more than £600 million; we are building up to almost £1 billion a year that we will be handing over to local authorities.

Chair: And can I tell you what they are doing with it? They are using it to avoid cuts they would otherwise have to make. I do not think my authority is unique in that.

Q65 Ian Swales: I have to say on the good side that I know there is some good joint working emerging in my area in the very way that you describe, but, as Chair says, the issue is how we can make the system responsive enough to deal with the case I mentioned, and indeed many others, so that the freedoms people have to do the right thing are there, regardless of what organisation's badge is stuck on their forehead, because that seems to be the problem at the moment.

Hugh Porter: May I say, I am a coal-face worker, so you are talking about transformational change, I am listening to that and I am expected to deliver your transformational change? As Sir David said, we are actually delivering a lot as we go along. It is not so obvious—yes, we are closing a hospital—but a lot more of it is about change in pathways and change in reducing unnecessary clinical variation. But in terms of that social care process, one of the reasons you may feel transformation has been slow is that it takes time to build relationships with the clinicians, with our patients and with our social care colleagues, and it takes time to build trust and move forward on that transformation. We are talking about complex systems.

Q66 Ian Swales: The answer you are giving is about organisations. The patient is not interested in what organisation they are dealing with. They want a seamless process that deals with whatever their acute needs are, followed by their care needs. The fact that they might be crossing organisational boundaries is of absolutely no interest to them, so the idea that somehow we have to bring people along—the people who need to be brought along are the people who are managing the system. That seems to be where the problems are.

Hugh Porter: There is an example in Nottingham. We talked about CCGs and whether they could manage strategic modelling. We have something called Productive Notts, which is all the CCGs and social care coming together to break those boundaries down, because, yes, we want the patient to be at the centre of the health and social care system.

Q67 Chair: Are you getting there?

Hugh Porter: We are getting there, but it is not easy.

Q68 Chair: What does that mean?

Hugh Porter: For instance, we are currently working on integrated care teams, which will bring social care and health care working around primary care in the community so that we can move people out.

Q69 Chair: And where is the money? Who does the money sit with?

Hugh Porter: The money currently mostly sits with us, in terms of the finance to change that. That is why you have to build trust.

Q70 Ian Swales: When you say it is not easy—the top one or two things that are not easy—what is it that is not easy about this?

Hugh Porter: We have to address the financial incentives that you have just been talking about that are not necessarily aligned to what we want to do. You can locally change those.

Q71 Ian Swales: Is this a wheel that has to be invented a few hundred times?

Hugh Porter: No, there are some great examples. There is a lot of learning there. Sir David mentioned north-west London where they have done a lot of work on this. We have been to visit them, because we do not want to reinvent the wheel. We do not have time to reinvent the wheel.

Q72 Ian Swales: It is interesting. It is clearly progress, but I do not think the Committee is filled with confidence that there is enough drive and incentive to do this at the pace that needs to happen to deliver what you have promised.

Sir David Nicholson: My final point is that no matter how clever we are at the centre and we identify these incentives and the rest of it, it is in local circumstances where they play out, and so part of this has to be giving people like Hugh and his people more flexibility to use the tools more creatively. No matter how clever we are, we will not quite get the tools right for every eventuality, and that is one thing that we want to do.

Q73 Chair: Well, the tariffs are national. I have to make that comment. So there is something that you have in your control. You, through your tariffs, are driving the incentives that make hospitals look for more business. That is your decision.

Sir David Nicholson: Absolutely it is our decision.

Q74 Chair: So it is a national thing that you have to sort out.

Sir David Nicholson: And we are on to it.

David Flory: To drive the efficiencies that we talked about earlier, we need to have the tariff structure that we have in acute care—understanding the price that will be paid for a particular procedure—and some hospitals need to improve their efficiency in order to work in that way. But there is much more to the tariff system than that. I can give one other example. Sir David referred to best practice tariffs. Some of the first best practice tariffs that we introduced were for a total hip and knee replacement. The price in the way it is calculated, with all the clinical expert groups and so on, reflects a five-day length of stay, which is absolute best practice for this type of clinical procedure. This is a way in which it is not just about the hospital getting more in, but the structure of the tariff enables us to recognise what best practice is. That reflects better patient experience, first and foremost, with all the evidence behind that about a better clinical outcome and a reduced cost to both the hospital and the commissioner in that whole experience. The tariff is not just about inflating elective work; it can do a lot more, and I think that is a really powerful example of QIPP.

Q75 Meg Hillier: On the previous discussion that Ian Swales started, I remember being a carer for two people living independently and supporting each other. Thirteen different agencies, a mixture of NHS and social care, and the amount of time I spent organising that—I do not know how anybody would do it if they did not have somebody, and if you are a working carer it is very hard. There is no magic bullet, Sir David, for you or the NHS, but there is an option for you to put financial incentives on getting people out of hospitals. Maybe some of the tariff work might contribute to that. I will leave that as a thought.

I wanted to touch on the bit about data, particularly because in my own area my primary care trust is all but defunct now. It is in legal existence, but the clinical commissioning group has taken over. In paragraph 9 of the Report, that section of the key findings talks about the lack of consistency in collecting data. You say, Sir David, that you are in charge of the NHS, but if you do not know what is happening—if the data is not consistent—how can you be really sure that what you hope is happening is actually happening?

Sir David Nicholson: It is a constant thing. You never get there; you are constantly refining, constantly looking at the data, constantly working it out and constantly defining the definitions that you use. Interestingly, one of the things in the Health and Social Care Act is that for the first time we have one organisation responsible for data definitions in the NHS, which is the Commissioning Board. That has never happened before. We have a variety of organisations that can define things in different ways, and so we have not collected data in the most effective way we can. We are doing all of that. The biggest driver for improving data, in our experience, is transparency—publishing that data and being really open about it. As you can see from the work we are doing at the moment, where on every level we are trying to get that data out into the public domain, we think that is the best way of ensuring that people look

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at it, and they compare each other with it and we can get it better.

Q76 Meg Hillier: We certainly support that. As a Committee—I think I speak for us all—we want to see greater transparency and more data out there. You can put as much data as you want out to the public, but it is not always digestible. Are you encouraging things such as app competitions, where you have these weekend competitions where people come up with an app?

Sir David Nicholson: All of that. We have got a whole train of work in relation to that. Sir Bruce is leading work around getting clinical data in digestible forms for patients and the public as well.

Q77 Meg Hillier: So if I had a heart operation looming—

Sir David Nicholson: Cardiac surgeons.

Meg Hillier: Yes. How would I know which of your colleagues would be the best or which would be the riskiest hospital to go to?

Sir Bruce Keogh: Well, there is a long history around that, and I led the—

Q78 Meg Hillier: Perhaps that is not a good example. Maybe something more mundane would be a better example.

Sir Bruce Keogh: I led the publication of individual heart surgeon data some years ago, which is available at the moment on the Care Quality Commission website. We are shifting it off that website to put it somewhere else in the not-too-distant future, but you will see from the planning guidance from the Commissioning Board that we have now homed in on nine other different specialties and we will be doing the same. I see that as being an iterative process that will help people make that kind of judgment. The most important thing that comes out of publishing that data is not the publication itself but the fact that people then really start to reflect on their practice and how they can be better than their colleagues, frankly.

Q79 Meg Hillier: You are shining a light. That's good. What if, for example, I had an elderly relative who was needing a procedure and I knew that there was this issue about people being in hospital for a long while, perhaps because of the social care issues? Is that yet possible to assess?

Sir Bruce Keogh: No.

Q80 Meg Hillier: Is that something you have plans for? That is the sort of day-to-day stuff that is probably more routine. I do not know how many heart operations happen a year, but as a percentage of the NHS's activity it is not very big, is it?

Sir Bruce Keogh: That is a fair comment and challenge. We are busy working through the sorts of data that we are going to publish and how we are going to publish them. We see the portal for that as ultimately being NHS Choices, and we are working on that sort of data at the moment.

Q81 Meg Hillier: That is the current world, which is confusing enough, with PCTs not doing the same

thing and being a bit variable. What about clinical commissioning groups? You say, Sir David, you had set the dataset requirements centrally. With all these brand new organisations, are they all going to start playing ball from day one, because they are presumably taking on historical data? Do you think the proliferation will ease or make more complicated your task in hand?

Sir David Nicholson: There is a whole load of complex work going on at the moment to ensure that the data streams continue as all the moving parts in the NHS move together.

Q82 Meg Hillier: How much is that costing?

Sir David Nicholson: It is not the cost of it, because there are people currently doing all this work, but it is a high risk for us as we go forward. I can reassure you that we are properly risk-assessed always. We have people working on it at the moment. We are moderately confident at the moment that we will get to the other side of this change with those data streams in place, but it is going to be quite tough to do it.

Q83 Meg Hillier: I have a very good clinical commissioning group, led ably by local GPs—while they still hang on in there, because I think some of them may get disillusioned by the process—but if they were not good, what control will you have over them, if there is really bad performance?

Sir David Nicholson: About data, or generally?

Q84 Meg Hillier: The data would reveal, more importantly, poor performance.

Sir David Nicholson: As you know, we are going through the authorisation process at the moment with each individual clinical commissioning group. We are making an assessment about their state of readiness. We are making some judgments about those which will be able to start on 1 April with their full panoply of powers, and those which will not. We will make a judgment about who we can get through that authorisation. I am very positive about it at the moment; it seems to be going pretty well. We have our statutory powers around the appointment of the accountable officer. We have worked very closely with CCGs around all of that, so we have the powers around the appointment of the officer. We are about to set out our assurance system, which will show how we, as a commissioning board, can assure ourselves that CCGs are delivering what they said they would deliver. If there is serious failure or the potential for serious failure, we have the power to intervene directly in organisations.

Q85 Meg Hillier: That is good, because in the NAO Report, because of the data problem, it was found that only £3.4 billion of the £5.8 billion of efficiency savings reported—less than 60%—could be substantiated using the data. Are you telling me that we are moving from that picture to, from 1 April, a substantially better one? Is that your prediction that we can hold you to in future?

Sir David Nicholson: In response to that particular comment, the thing about all these changes is that if you were a CCG, you would probably have 60 or 70

lines in your efficiency programme. We thought about how you would—it is the same for PCTs—get to a place where you could assure yourself that they were delivering everything they said they would deliver. We tried quite a lot of data collection and we found that it completely stifled people. There was a real danger for us about micro-management and stifling people, so we tried very hard to look at outcomes, and in particular, through the planning process, to identify the things that CCGs are planning to do—high-level things, not micro-managing by any stretch of the imagination—particularly around service transformation and service change, which we are particularly interested in. Part of that, as we know, is that there is quite a long lead time on it. You can do the preparatory work in one year and deliver the savings in the next, but very often in the past, we have just focused on the in-year.

We are trying to collect what I guess the NAO might describe as soft intelligence and soft information about all of these, rather than having significantly large data collection exercises, because at the end of the day, the things that we are particularly interested in are what their financial delivery is in all of that, but more importantly, what the impact on service is.

Q86 Meg Hillier: In summary, would it be that if it is a good organisation, you give it a fair wind—if a few indicators show it is doing okay—but if you have worries, you go in deeper?

Sir David Nicholson: That is probably—

Q87 Chair: Having data that you can then compare does not mean that you have to vet the data all the time. You just want data that can be compared, and we have not got that. It is not an issue about putting an extra burden on everybody or duplicating how you do it, you just want comparative data and we have not got that. I think you are wrong to say it would have been burdensome—just wrong.

David Flory: On the £3.4 billion?

Chair: Well the £3.4 billion is one way of taking this.

Q88 Meg Hillier: Chair, may I make an offer to Sir David? If you are really interested in the app proposal, I am the MP for Tech City and I am happy to facilitate connections if you would like one of those special weekends with us.

Sir David Nicholson: Yes, that would be very helpful.

Q89 Chair: Let us just have an answer, because I do not accept your argument.

David Flory: On the £3.4 billion, we assured on £3.4 billion out of the 5.8, which is recognised in the Report. The fact is not that we do not know where the other 2.4 is; it makes the point, rightly, that the national assumptions about pay freeze and what we can see in terms of changing activity can, if you like, prove the point for 3.4 of the 5.8. The other aspects, which are happening locally and are more at local discretion, are happening, being reported and signed off by accountable officers in PCTs. All the information is there; it is not that half of it has been in a black hole and we do not quite know where it has come from.

Laura Brackwell: What David says is right, but the question is to what extent there was assurance around what is being reported locally. We found inconsistencies in simple things, for example, whether costs were being consistently netted off. That is a fairly basic principle of measuring savings.

Q90 Chair: What is your answer to that?

David Flory: I absolutely agree the point that the NAO make on this, but the 18.9 number, which we have referenced and are chasing, is a gross number. Ultimately, the net position on this is zero, because all the savings that we are making are being reinvested elsewhere in the service.

Q91 Stephen Barclay: With respect, that is not what the Report says. It says: “For example, one primary care trust reported savings of £2.2 million,” but ignored “one-off redundancy payments of £1.1 million”, so what they reported was factually incorrect. You are giving the Committee figures and what the NAO are saying, in paragraph 2.8, is that you have not “set clear criteria for what types of savings should be reported”, and you have not asked whether those savings are recurring or non-recurring, which is obviously material to the future. There are trusts not including one-off costs even though they are considerable within the savings being reported.

David Flory: The £18.9 billion is the gross recurring cost that needs to be saved, and the money released for reinvestment. The example—

Q92 Chair: Answer the question.

David Flory: Yes, I will. In the example that is given, there are costs to be incurred in effecting some of the changes to make the gross savings, but that does not net off against the 18.9; it is a one-off redundancy cost, and the PCTs are providing for it.

Q93 Stephen Barclay: You are answering a totally different question. You have a target saving—we understand that. You said £12.4 billion of savings have been achieved so far, but with this Report we are questioning how accurate that figure is if the trusts are reporting those savings in different ways. If some trusts are not including one-off costs, how reliable is the £12.4 billion?

David Flory: The £12.4 billion is gross of one-off costs.

Chair: You don’t know because you don’t have comparative data.

Laura Brackwell: I think it is inconsistent; some PCTs were netting off and others were not.

Q94 Chris Heaton-Harris: May I, not particularly helpfully, follow that up? On page 36, under figure 16 it says, “Forty-seven per cent of primary care trust clusters reinvested less than a quarter of their cash-releasing savings in transforming services in 2011–12.” Is it realistic to expect that in following years, enough will be reinvested to generate further sustainable efficiency savings?

David Flory: I reference back to the discussion that we had before about the extent to which savings from transformational change have contributed to the total

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so far. What the conclusion that you have quoted suggests, and I would recognise as being right, is that much of the savings have been reinvested not in what we describe as new care models, but in terms of making further investment in what exists, recognising the growth in demands on the service. They have been reinvested, but not necessarily in what we would have recognised so far in the service transformation.

Q95 Chris Heaton-Harris: We had a wonderful “Yes, Minister” moment earlier, when Sir David told us that you do not take into account electoral cycles in delivering service transformation. You don’t really have to take into account electoral cycles. There was a by-election in Corby, with which part of my constituency shares Kettering hospital. We had a “Save our Hospital” campaign when the hospital was not going to be closed and we had a “Save our Services” campaign, because it is all part of a service transformation called “Healthier Together” to bring better specialist services to individual hospitals. It is one of five hospitals in a group now forming in the south-east midlands. It sounds like a good idea, but on the doorstep in any election campaign it is politically toxic. Labour might have done it that time, but we might have done it in other campaigns in a general election. I wonder how or why you did not consider the electoral timetable.

Sir David Nicholson: In 2008, we did not know what it was. That was the only point that I was making. It was before fixed-term Parliaments and all the rest of it.

Q96 Chris Heaton-Harris: Is there any good time in the electoral timetable for this?

Sir David Nicholson: There is no doubt that the closer you get to a general election the more difficult it is to make service change in the NHS. That is not because Governments tell you that you should not do it; it is because of the environment you operate in. I said 18 months ago to the NHS overall that the next 18 months are the window to make service change—if there ever is a window. For significant service change that potentially requires national and independent review panel activity, now is the time to do it. You get that period in the electoral cycle during the first part of a new Government or regime when all the promises that people made on the doorstep around the election campaign mean that you can’t do very much. At the end of the process you get to the point when people are worried about the general election. There is a middle bit that is probably historically for the NHS the best time to fit it in.

Q97 Chris Heaton-Harris: I do understand and I quite like the idea of the service transformation that might be delivered for my particular area. Equally, of those five hospitals, four of them are financially okay and Monitor is having some issues with one of them. There are concerns that we are going to be taking on a hospital that is not performing, and that we are going to be taking on someone else’s deficit essentially, so there are concerns about that. But that is by the bye. Are you not also finding it difficult to sell this to your staff within the NHS? There is some stuff in the

Report about the number of primary care trust clusters concerned about staff in general, service transformation, how comfortable they are with it and whether they are going to have a role in future: 71% of PCT clusters think that the NHS reorganisation has created uncertainty regarding roles and responsibilities.

Sir David Nicholson: Well, it has.

Q98 Chris Heaton-Harris: I know.

Sir David Nicholson: Because we have abolished them all.

Q99 Chris Heaton-Harris: You are struggling in a very tight limited time frame, because of, alas, the political constraints that we throw on you, to sell a very complex message of change and, at the same time, you are struggling to take your staff with you. Staff talk to patients and visitors, and everybody talks to their GP. GPs are leaving. I am told that if you are a GP over 50 you are becoming a bit of a rare species at the moment. There are some issues that we need to deal with, aren’t there?

Sir David Nicholson: Nobody said it was straightforward, did they? It is complicated and difficult.

Q100 Chris Heaton-Harris: And we also had the Nicholson challenge, I seem to remember, at the beginning of this process.

Sir David Nicholson: It wasn’t my title. I did not call it the Nicholson challenge, I can assure you. It is necessary to do. In order to sustain a universally available, free at the point of use health service, we need to change completely the way in which we deliver care. Interestingly, my experience in terms of staff—particularly clinical staff—is that virtually everyone signs up to the need for change and the case for change.

Where we obviously have difficulties is when that translates to your individual department, unit or whatever. That is what you see played out in London and in the rest of the country, but that is not to say that we should not do it. Our experience is that if you can get senior clinicians to lead the discussion and the debate with the public, you can get a lot done, and you can get a lot of change to happen.

Q101 Chair: I want to come in, because in a way you have turned the attack on us. This is from my own personal experience, and I am sure it is true of other MPs around the room. Stroke is a very good example: you demonstrated a better service in specialised units; people then had confidence in it and it was therefore easier to reorganise. When you are talking about a lot of these A and E closures, the campaigns are not just by MPs; the *Mail* has been running a massive campaign, the *Telegraph* is running a massive campaign—everybody is running campaigns. It is because you cannot demonstrate to our local people that the alternative services are in place. That is your management job, Sir David.

Sir David Nicholson: I am not trying to turn the attack on you at all, because it is our responsibility to explain to the population—

Chair: It is not explaining; once you demonstrated that the alternatives were there, you would have all of us with you saying that it therefore makes sense to go with a closure or a redirection of services. But you never, never get to that point. That, I am afraid, is an NHS management issue, not a political issue.

Chris Heaton-Harris: There are other examples of services that are specialised, such as neonatal care, which is specialised in certain places. It means that babies and mothers are rushed around the country, but when they get to the place where they should be, they have some of the best care you could possibly get in the world. There are good examples out there.

Fiona Mactaggart: The average qualification for nurses in baby care units has gone from level 8 grade or level 6 grade to the majority of those nurses being much less well paid. There are hidden cuts that we don't hear about.

Q102 Chris Heaton-Harris: There are always issues. I work with Bliss, the charity that campaigns on this. I think everybody buys into the principle of having a better specialist service that will help you; but we need the material, although it may not necessarily be part of this Report.

Sir Bruce Keogh: We do have very powerful examples. Children's heart surgery would be one: we have a relatively small speciality, which treats only about 4,000 to 5,000 patients a year, with only 29 consultants involved, and we have rising expectations, because babies are getting smaller but technology is getting more complex and post-operative care is becoming more tricky. In those cases, we try to future-proof the NHS by saying, "Let's shift from having 11 units down to six or seven." The patients groups accept the arguments, the profession accepts the arguments and independent reviews think it is good, but when it actually comes down to it, personal, professional and political forces conspire to perpetuate mediocrity and inhibit the pursuit of excellence. When it comes down to it, people are interested in preserving the status quo. We see that with some of the surgeons involved. We see it with the politicians, who accept the case for change, but "Not in my unit." We need the support of our political colleagues in some of these changes; we need them sometimes to step above personal and local interests. I implore the Committee to try to help us with that in some of these endeavours.

Q103 Stephen Barclay: Thank you for that, Sir Bruce. It is exactly where I wanted to go. There is a very positive case for service transformation. It has almost all been talked of in financial terms, but if we have better, quicker operations, there is less time on repeat visits and less impact on clinical negligence; but to get that case across to people, they have to understand where it is going wrong—where the operation they are being offered at the moment is of a significantly inferior quality. The Royal College of Surgeons talked of fewer, safer specialised facilities. Why is there such resistance to publishing the data that make that case? If you take your own example of individual surgical performance, you have been

debating this for over a decade, yet, with the exception of heart operations, we still do not have the data.

Sir Bruce Keogh: There are two parts to that question. The first part was about demonstrating that something is inferior, in order to move forward. I think we all share the view that even when services are okay, that is not good enough for the aspirations for the NHS. We need to pursue excellence. If we take children's heart surgery, I would not for one moment say that any of the units are bad. I am simply saying that it is going to get more complicated in the future. I want to avoid another Bristol in that debate.

Then we come to the business about publishing individual clinicians' results. It was a complex, tricky and emotional issue for the heart surgery profession, but there was a burning platform in terms of Bristol and there was a direction of travel in the United States towards publishing. We did it in heart surgery and then we looked to see what the impact was. The naysayers said surgeons would get suspended, patients would be denied high-risk surgery, the data are not up to scratch and you cannot compare surgeons who do high-risk cases. I think we have put most of those arguments to bed. We can now demonstrate that adult heart surgery in this country is a statistical outlier in terms of good performance compared with the rest of Europe. We are in a very good position.

The Commissioning Board, in terms of setting the agenda for the next year or so, has committed to seeking the publication of results in other areas. This is going to be a tricky area. I have already started to get letters saying that the data are dodgy and you cannot compare apples with oranges—the same arguments that Florence Nightingale faced in 1864, when she wrote her book *Notes on Hospitals*, which you are obviously familiar with. We will get there, but it will be tricky. But it is a good thing to do because it will focus people on improving their service.

You might be wondering why I am describing this at a Public Accounts Committee. What has it got to do with money? We have pretty hard evidence, particularly from a colleague of mine in the US who looked at all the heart surgery units in Virginia, all of which were performing better than the national average. The cost of coronary bypass surgery in a good unit was \$30,000, and in a very good unit it was \$20,000. That makes intuitive sense because if you operate on the right patient and do a good operation, there are fewer complications, a shorter stay in hospital and so forth. Taking that knowledge, we have been out to consultation with colleagues in the NHS and said, "Send us your examples." We now have a section on the NICE website with examples of better care costing less; they are available for the public and others to see and work on. I hope that this will set a new cultural dimension in the way we tackle the issue—the recognition that better care does not necessarily cost more, and, in fact, may save money.

Q104 Stephen Barclay: I absolutely agree that better care does not cost more. The clinical negligence bill has gone up £10 billion in five years. But that is a different budget and behaviours are not necessarily aligned. My frustration is the visibility. If there is a bad surgeon, people inside the NHS will know and

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will ensure that their family member does not go to that surgeon, yet our constituents continue to be sent to surgeons that people in the NHS know perform badly. I tried, ahead of today, because it was more geared to efficiency, to get some comparative data for surgeons doing comparable operations in their public and private work. It seems to be unavailable. Sir David, I don't know whether you collect that. Why not?

Sir David Nicholson: We only collect data around heart surgery.

Q105 Stephen Barclay: As the accounting officer and the person responsible for service transformation, would you look at the productivity of surgeons, and, in particular, the same surgeons doing similar work privately at twice the rate that they get for the NHS? Do you look at that?

Sir David Nicholson: We don't.

Q106 Stephen Barclay: Who looks at that in the system?

Sir David Nicholson: I would expect local managers of hospitals to look at their surgical efficiency between the two. We have said that in July we are going to publish consultant-level data for 10 specialties based on the data we already have, so it will have all the irregularities and concerns that people have, with the assumption that every hospital has to produce that data from 1 April 2014.

Q107 Stephen Barclay: That is welcome. I pay tribute to the work that Sir Bruce has done on that. I know you worked on it for many years. In a previous exchange, Sir David, you said that if a hospital is employing three times the staff of another one, that is just an issue for them locally, and not for you as the accounting officer. However, you are heading the Commissioning Board that is directly commissioning specialist care worth £12 billion, a third to half of the income of the country's largest trust, so surely you can't just say that. As you said in your interview, when you were quoting Lenin, you are sitting there on the commanding heights.

Sir David Nicholson: Who said I quoted Lenin? I have never quoted Lenin.

Stephen Barclay: There was a paper circulated to the Committee ahead of this.

Chair: *The Health Service Journal*.

Q108 Stephen Barclay: The Health Service Journal.

Sir David Nicholson: Can I say that I never quoted Lenin. I quoted Harold Wilson, who is slightly different from Lenin.

Q109 Stephen Barclay: Harold Wilson was quoting Lenin.

Sir David Nicholson: He was talking about the commanding heights of the economy.

Stephen Barclay: It is in the piece. All the Committee Members have read it because it was circulated.

Chair: I always think that Sir David is more of a Stalin figure than a Lenin one.

Q110 Stephen Barclay: A communist. The point I come back to is that once again you are saying that it is a local issue, but surely if you are directly responsible for £12 billion—you are the commissioning body—you can't just say, "Well, it's just local data."

Sir David Nicholson: I agree with you. I wouldn't. That is completely—

Stephen Barclay: That's passing the buck.

Sir David Nicholson: No, no. At the moment, I sit in a particular position in the NHS, which has statutory bodies, strategic health authorities, PCTs that are responsible for commissioning services. I do not commission services nationally. From the Commissioning Board perspective, absolutely, I would want all of that data: I would want to see comparative data across the country; I would be interested in how they organised themselves, what their costs structures are—all the things that you would expect a commissioner to be responsible for.

Q111 Stephen Barclay: You are the overall accounting officer. This is not my field, but everyone knows that some surgeons—not all—work more productively and get through more operations when they do their private work than when they do the public work. I get the point, Sir Bruce, about being risk averse—if you publish data, are they going to be more risk averse? There needs to be a degree of explanation around it, but it is staggering that that sort of thing is not being gripped.

Amyas Morse: We have a report coming out next week on the consultants' contract¹. It doesn't always show that, to be honest. There are some surgeons who work like machine guns no matter whether they are on private or public practice.

Q112 Stephen Barclay: I did not say all, Amyas. I made a point of not saying all. Does the Report show that some are more productive in their private work?

Amyas Morse: It seems to.

Q113 Stephen Barclay: Thank you. I made a point of not saying all. I said some are more productive in their private work than in their public. If you are saying the Report backs that up, the question for the accounting officer, who is responsible for the money, is that that is surely an easy outlier to identify, so why has it not been identified so far?

Sir David Nicholson: No doubt we will have the discussion when you get me in front of you—

Q114 Chair: You don't need the Report; you can answer the question.

Sir David Nicholson: I do not routinely look at relative productivity between consultants in their private work and their NHS work. That is true. I can't say that I do when I don't, and I don't.

Sir Bruce Keogh: That is a really good point. We will take that away and think about it. When we were publishing the heart surgeons' results, there were many who said, "Can you please include my private practice?" I am meeting in July with the leads of the

¹ Note by the C&AG: The report is scheduled to be published in February 2013.

specialties that we are trying to persuade to do this and I will share your concerns and aspirations with them.

Q115 Fiona Mactaggart: We have been talking about the tools you have to get national service transformation. I am concerned about one of them, which is the cap on admissions through A and E at 30% above 2009 levels. If you look at paragraph 2.31 of the Report, it shows that the result of this change varied from a reduction of 22% of activity in one setting to an increase of 11% at different PCTs. That suggests to me that this national tool does not work locally in different kinds of communities. I do not believe that the setting where it increased by 22% wasn't trying to reduce it. I am quite sure that that is a reflection of a fact that a tool, which is not stupid—I completely accept that there is really good merit in trying to reduce admissions through A and E—does not fit every community. For example, my local DGH probably has the largest number of admissions through A and E of any middle-sized DGH and hospital. I believe that that reflects a migrant community with a hugely growing population. I think it is not because they are not trying—they have lots of other things to concentrate on as you know, but they are trying—but because this national tool does not work locally in the same way everywhere. I am concerned that some of your transformative tools are like that. I have used one particular example, but I want you to say how you measure the tools. What do you do if they work randomly, as this one seems to? If you want to get effective value for money, you need tools which really work in the places where they are operating.

David Flory: I agree with the point. What we see here is that, as I think you said at the start, the objective that we are trying to achieve has widespread—I would say almost unanimous—support through the service. The fact is, to make the sorts of efficiencies that are the subject of this hearing today, we could not continue to afford and cope with the increasing amounts of non-elective activity that was a pressure on the system. We simply had to change that trend line.

The introduction of this 30% marginal rate, as I think Sir David said earlier, was to bring commissioners and providers together to take some responsibility for the fact that we needed to work it differently. In some parts of the country that has worked well: we see evidence of how they have come together and changed the direction of the line which, if it had continued as it was, would be simply unaffordable both at national and local level in this economic environment. They have managed it, typically by doing things: one is to look at ways in which patients' needs can be addressed better. Secondly, where that isn't the case, the 70% is the saving for the PCTs—it is money that is still in the system; it is not being paid to the hospital. That works well because the system comes together with that 70% and invests it in different models.

Q116 Fiona Mactaggart: Absolutely, but that requires the patient to be registered with the GP,

whereas in Slough they are not. Therefore that saving, in a place which is diverse, does not work in particular communities. I am not saying that it is not a sensible thing to do. What has happened on the whole has been good, and some of these attempts have been made locally, but they work differently in different communities. I am saying to you that your national tools have inappropriate results in different kinds of places, even when the energy, which you describe quite rightly and I support, is being put in. In some places, it is not possible to do it in the way that it is in other places. What are you doing about that?

David Flory: An important thing that we are doing about that is that we do not expect commissioners and providers to slavishly apply something that is not in the best interests of patients and is not appropriate to them locally. Therefore, places where this worked well recognised that the circumstances were different and agreed an arrangement between them. Where the relationships were good and the trust in that was good, they could work out an arrangement to support payment for a system that works for the provider, the commissioner and, more importantly, for the patients involved. It does not have to be slavishly applied when it is not in patients' best interests.

Q117 Fiona Mactaggart: I understand that, but I suppose that I expect you, if you are doing a value-for-money system, to measure how these things work. If one of them works in this almost random way, because of the extremes of difference of its impact, I expect you to judge what that means in terms of whether there is an appropriate alternative measure that could be used in particular places. I am asking you whether you have done that.

David Flory: We have not done that comprehensively in all parts of the country. It is clear that there is a debate going on again. A number of hospital trusts have raised with us questions about the impact of this policy on them and some of the unintended consequences. We simply cannot find one rule—

Q118 Fiona Mactaggart: There isn't a one size fits all, so I am asking what you are doing to look at where one size doesn't fit all.

David Flory: We are learning from those places where the size doesn't fit them and they are making their own arrangements that suit locally between commissioners and providers. The CCGs that are coming on stream will pick this up. Simply spreading the knowledge and experience from that is one of the ways that we do it, but I don't pretend that this is working well in all places; it isn't, for varying reasons. We need to continue to learn from where it is working well to try to spread that and support others to make it work well for their patients.

Q119 Fiona Mactaggart: Paragraph 3.21 says that you need to measure the impact of some of these best practice tariffs. I would ask the Department to look at how it measures the impacts of these things. I have picked on one example, but we can get good value for money only if we know what consequences the present tools produce, and at the moment we have no

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measurement tool, as far as I can see, unless you can tell me that you have one.

David Flory: I agree. We don't have a comprehensive measurement tool, but what we are doing is learning from where it works well and comparing that with where it works badly.

Q120 Jackie Doyle-Price: I look at what Fiona has just explained to us through a rather different prism. I am really impressed with where you have got to so far and with the messages we have been hearing from you today and the real determination to make sure that this all gets done because, frankly, we can't afford for it not to; but that is not replicated in the discussions that I have locally with my health providers who are, frankly, hiding behind the need to make savings and using it as an excuse for future failure. What I am interested in—it follows on from what you just said about there being difficulties in delivering this transformation due to varying reasons—is the extent to which poor local leadership is an inhibitor for you in delivering this next set of transformational change.

Sir David Nicholson: There are three things I would say about that. First, there is no doubt that a limiting factor in our ability to make the changes and to deliver all of this is our ability to recruit really top-drawer people to be chief executives, particularly of provider hospital trusts. We have a whole load of vacancies around the system at the moment. We are working really hard to place them, but they are not attractive jobs for people at the moment. Getting our best people both from inside and outside the NHS to do it is a big issue for us, which we are tackling.

Secondly, we have identified the top 1,000 people in the NHS in leadership positions in the big organisations across the system. They have all been going through development programmes and support and help to improve the quality of their performance—even people like me and David have been going through all of that. One of the things that you find is that, without going through the management speak in all of this, in leadership terms there is a whole variety of approaches that you can take to something, from being very directive on the one hand right the way through to being very facilitative and coaching on the other. There are various categories that you can put yourself in. Really great leaders are able to use the right set of approaches to deal with the right kind of issues.

In the jargon, what we have found in the NHS is that the vast majority of leaders are what you might describe as pace setters. They are people who, when you give them a target, something to deliver, they go off and deliver it. That is great because it has delivered a whole load of things for the NHS, but it is not fit for purpose going forward. Many of these service transformations involve working in partnership, working across organisations, working in very different ways. That is in a sense why we have set up our leadership academy and that is why we are investing in leadership development to get people to get the right kinds of skills to make the change that we need to make. It is a big issue for the NHS and for us generally. We are absolutely cognisant of it.

Q121 Jackie Doyle-Price: To be fair, it is a big issue across the public sector; it is not just the NHS that suffers from this. From your perspective, obviously you have a flatter structure now with which to deliver, and when we have spoken to you before about other issues, you have given an indication that the flatter structure that we are now seeing emerge will make it easier for you to give direction. Is that also true in this sphere?

Sir David Nicholson: It makes you much closer to the front line, and there is no doubt that that is part of the way in which the system has set it up, but the real difference is that we have brought inside the accountability and management system a whole set of people who were outside it—that is, a whole load of general practitioners. One of the things we know is that the more clearly you can connect accountability with clinical activity, the more likely you are to get those changes to happen. Bringing general practitioners into the accountability system is a really important step forward for us, and we need to get lots out of it to make it worthwhile.

Similarly, in the secondary care organisations, we know that the best-performing hospitals are ones that give clinicians the maximum amount of delegated responsibility and power to make things happen. We are bringing all of those in. Interestingly, I had a meeting with a group of general practitioners recently, and they were fantastic about their ideas, about the way they could take the service forward and how they wanted to improve things for patients. I said, "Where have you been all my life?" and the answer was, "Opposing almost everything you've done," because they were outside the system. So this is a big opportunity for us.

Hugh Porter: In a way, it is about the benefit of clinical ownership of the system, both in primary care and in secondary care. That is very important. That is another thing that I have worked on in CCGs: it is not just empowering GPs, it is empowering the whole clinical community. It is not just doctors, either; it is all health care professionals. It is a very powerful tool.

Q122 Jackie Doyle-Price: I want to go back to the point made by the previous witness, Katherine Murphy, when she was talking about the fact that, for patients, it all seems very opaque. People start to get nervous when information is not clear and when they do not know what they can legitimately expect. Locally, I have an example: all the blood testing has been consolidated up in Bedford, and everyone in Southend, Basildon and Thurrock is running around saying, "Oh, this is a disaster," when actually it doesn't matter where they test your blood as long as you get your test results back. From your perspective, where do you see the leadership in reassuring people in that context? I can see that clinical leadership in that context would do a lot to reassure.

Sir David Nicholson: It absolutely has to be. In any measure of public confidence in those sort of messages, people put clinicians—particularly GPs, interestingly—right at the top.

Q123 Jackie Doyle-Price: GPs inflame it sometimes.

Sir David Nicholson: Well, GPs do all sorts of things, but there is a large degree of public trust in clinicians generally, and we find that when they make the arguments, people are much more likely to understand and trust them. That is why we are trying to develop the kind of system that we are.

Q124 Chair: Amyas, then Ian.

Amyas Morse: This is going to be slightly more financial in tone than some of the recent discussion. Is this a reasonable way to summarise the whole programme? Centrally driven savings are something you can pretty much decide to get—they are centrally controllable. Looking at provider-driven savings, you have the power over the tariff, and providers will either adjust or they will get into trouble financially, so that is all in the bag. Those two bits of the savings are pretty controllable, are in the bag and are deliverable—there is no criticism involved in what I am saying. Then, quite a substantial chunk of the savings are to be from transformational changes. First of all, I think it is probably fair to say that they are therefore the most risky element in the whole programme—I do not think I am saying anything controversial in saying that. Secondly, although all the things that you are doing in training and encouraging is all good stuff, because of the short-term nature of the programme, which has fairly tight objectives and quite large numbers to be achieved, these actions have to be happening now. If it looks like it is not happening or if you are not seeing reassuring information, is there anything, apart from being more encouraging, that you can really do? I am genuinely asking, because I do not know the answer.

Sir David Nicholson: If you take the two elements of service transformation that I talked about—I use it for shorthand—one is the concentration and centralisation agenda, and the other is providing better service in the community and preventing people from going into hospital, which stops the demand going into the system. We can track how various parts of the NHS are tackling the first element; we know broadly where those arguments are going on around the country and we can see whether people are making the amount of progress that they need to. As you know, between January and March the NHS is going through the planning system, so we will be able to tell pretty well where we are on the concentration and centralisation thing. We have a pretty good handle on that. The risk factor there is whether we get a whole load of stuff referred up to national politicians for decisions, to be frank. However, a new system is now in place with local government being much more engaged in the way the NHS operates, which will hopefully avoid much of that.

The tricky bit is how you get your community services in the right place to avoid admissions to hospital. In the first year, we had a reduction in the number of emergency admissions to hospital. In the second year, we have had some growth. It is still below trend growth, which is our plan. Again, through the planning system, we are going through, CCG by CCG—we have done it through authorisation—identifying what plans they have in place to make it happen. The real risk is whether those plans get put

into action. We cannot find many places in the world that have done it on the scale that we have. The ability to manage emergency admissions is our biggest risk. It is more difficult to identify a national response to that, other than reinforcing the incentives to enable you to do that. That is our worry.

Of course, our real worry about all of that is that what happens in the absence of that is that we just try to take more money out of the hospital sector. We are very cognisant of the implications for quality of service for patients on wards and all the rest of it. We are putting in a whole set of measures and systems next year, as part of this process, to ensure that we have a really good handle nationally on what is happening to the quality of care in hospitals and wards.

Q125 Chair: There is a number of things in what you said there. First, we know that over 500,000 more people are waiting more than four hours in A and E, so what is that telling you? I saw a Department of Health PQ answer that said that 500,000 more people are waiting more than four hours in A and E. What does that tell you about quality?

David Flory: I am not exactly sure what the before and after dates are. If the before date was when the standard for trusts was that 98% of people were seen or treated or admitted within four hours—

Q126 Chair: I do not really care about standards. All I am saying is that 500,000 more patients—I know many from my constituency—are having to wait more than four hours to be seen in A and E. That is one of the impacts. You sit here speaking theoretically, but that is the reality for individuals on the ground.

David Flory: One of the reasons why there is more is that the standard moved from 98% to 95%, based on clinical advice that we received that suggested it was not—

Q127 Chair: So it's okay for people to wait for more than four hours, is that what you are saying?

David Flory: The clinical advice is that, for a small number of people—

Q128 Chair: What do you mean by “clinical advice”?

David Flory: Doctors working in the service day by day tell us that it is better for some patients for trusts not to be driven by the four-hour deadline, but to wait and see for longer. Therefore—

Q129 Chair: What?

David Flory: To wait and see for longer—to keep them under observation, or keep an eye on them—

Q130 Chair: Is that your clinical advice?

Hugh Porter: Essentially, what it is saying is that some patients—

Q131 Chair: It is okay to wait for more than four hours.

Hugh Porter: It's not called waiting—this is not waiting in ED, this is the time in the emergency department. They are different beasts, aren't they?

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Because some people with serious trauma, for instance—

Q132 Chair: Of course you want to see the serious first, but you do not want anybody to be sitting around in a rotten old A and E department for more than four hours.

Hugh Porter: The target is not about people sitting around. It is their time in the emergency department.

Q133 Chair: Sorry. This is a Department of Health answer that I referenced. You talk about wanting the quality to be the same, but the Department of Health answer said that there are, I think, 432,000, nearly half a million people—

Laura Brackwell: I think you are both right. There were 499,000 people spending more than four hours in A and E, but you are right that the time spent is from arrival to either admission, transfer or discharge.

Hugh Porter: It is not waiting; it is spending time.

Q134 Chair: That is a worsening of the position from where it was a year ago.

Laura Brackwell: It is an increasing number of people spending more than four hours.

Q135 Chair: There is an increasing number of people sitting around A and E. Everybody gets triaged the moment they get in.

Sir Bruce Keogh: Can I try to explain how we got to that position?

Chair: I am shocked.

Sir Bruce Keogh: The College of Emergency Medicine, the guys who are on the shop floor in this area, felt that a 98% target was too high. The arguments behind that were that there were some patients who it would be better to keep in A and E departments for a little bit longer, so that you could have their investigations—

Q136 Chair: You guys are just theoretical. Honestly, I have been very, very restrained this time.

Sir Bruce Keogh: Let me be absolutely clear: I am not a theoretician in this.

Q137 Chair: Just think about yourself. Would you, Sir Bruce, like to sit around because some ruddy academic clinician tells you that it is better for you to stay waiting for more than four hours to be dealt with?

Sir Bruce Keogh: I am not talking about waiting to be seen, what I am talking about is that this target is about the time, the four hours, in which you get dealt with. There are some patients who might require an ultrasound, an X-ray, and so on and so forth, and what was happening was that they were being admitted to hospital in order to have those done. People were kind of gaming the system. The reason for reducing the target was to try to reduce that gaming. Of course, there are some people who wait for a long time in A and E, and none of us—none—is supportive of that.

Q138 Chair: Well, I can tell you that in my neck of the woods—it always is in my neck of the woods—they are actually hanging around waiting and not being treated. It is not of this efficient use of, “We

won’t admit them, we will get them having their MRI scan,” it is actually that they are hanging around waiting.

Meg Hillier: My hospital has a very good electronic record system that speeds things up.

Q139 Chair: Mine has that too, but it doesn’t speed things up.

The further point was something that no doubt you saw in *The Sunday Telegraph* over the weekend. This is why I was trying to get this efficiency thing out of you. The CQC has said that some of the cuts in staffing mean that there are now 17 hospitals—again, surprise surprise, mine is one of them—where, as a result of inspections that have taken place as recently as November, each has been told that it did not have enough staff to “keep people safe and meet their health and welfare needs.” That is a CQC judgment.

Sir David Nicholson: This information has been around for quite some time. It is part of CQC’s responsibility that it inspects places and makes judgments on their arrangements. Overall, of course, the number of clinical staff in the NHS has gone up, not down—[*Interruption.*] It has. The numbers of doctors, the numbers of radiographers—all those have gone up.

Q140 Chair: Nurses?

Sir David Nicholson: Nurses have gone down by 5,000, but that is against the background of having another 50,000 over the last—it is 1.8%.

Q141 Fiona Mactaggart: There have been 100,000 extra births in the last year, which requires a lot of input from nurses and midwives².

Sir David Nicholson: Oh, the number of midwives has gone up by nearly 1,000, and the number of health visitors has gone up as well. It is not completely the picture you describe. This was normal business from CQC. It asked for improvement plans from all of those organisations. It did not put improvement notices on them and it did not say that they are unsafe to carry on doing their work. These things will happen. As CQC goes round and looks at organisations, it will make judgments.

Q142 Chair: You can tell me whether this is incorrect, but, as I read it, the CQC said in the *Telegraph* article that those hospitals do not have enough staff to “keep people safe and meet their health and welfare needs”. The Secretary of State said that there was no excuse for hospitals not providing adequate staff. Given that my hospital is there and I know its financial situation, my question to you is whether it is the finance that in those instances is driving the lack of staff, which impacts on quality and then gets the CQC saying that people are not being kept safe and are not having their health and welfare needs met?

Sir David Nicholson: There are hundreds of hospitals that manage to provide safe and secure staffing levels

² Note by Fiona Mactaggart MP: There has been an increase of 748 births in the last year. The increase of 100,000 births has been over the last eight years.

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for their patients within the national tariff, and they do it pretty well.

Q143 Chair: What are you doing about these 17?

Sir David Nicholson: All 17 have been asked to set out their plans for getting themselves back into a place where they hit the staffing levels that are required by CQC. We expect them to do that straight away.

Q144 Chair: On wider financial resilience, if you look in the Report—we have had evidence from you on this before—we know that 21 foundation trusts ended up in deficit in 2011–12 and that 10 NHS trusts ended up in deficit—about £300 million—in 2011–12. We know that SHAs and PCTs put in over £400 million of extra financial support and that the Department of Health provided capital support—I can't remember what you call it—of about £1 billion. We also know from the Report that a third of providers used reserves in 2010–11, and we know that 7% borrowed money in 2010–11. That was all to meet your financial targets. This all feels to me like very fragile resilience in the system.³

David Flory: I cannot speak about the number of foundation trusts that will be in financial difficulty at this year end, but some of the—

Q145 Chair: You should be able to speak for them. I can't bear nobody being accountable. You should be. You, or at least Sir David, is accountable for the whole ruddy system. I am not having this—you saying that we have got to have the foundation trusts in. Last time we had them, we had all five of you and nobody was responsible for anything in Peterborough, as far as we could tell. Across the system, there is a lot of fragility—this is all taken from the Report—that I think should be of concern.

David Flory: Yes, and there is some improvement that we can see in this year. It is not all moving in one direction of heightened financial risk. A significant organisation that has had financial problems in previous years, Imperial College hospitals, has improved its financial position; it will balance this year. The deficit at Barking, Havering and Redbridge remains a significant concern for us, but there will be an improved financial position this year compared with previous years.

Q146 Chair: Yes, but it then goes on to the CQC list because it does not have enough staff. That is the tension. Again, I do not want to talk about that because I think this is a much wider, systemic issue. The figures in the Report are scary. SHAs are disappearing, so they are not going to be able to put in the half a billion pounds. I don't know how much longer you are going to be able to put in your quarter of a billion pounds. I don't know whether you know how much was used in reserves by the 32% of trusts. I don't know whether you know how much the 7% borrowed. Do you? You probably don't even know.

³ Note by the Chair: The Department of Health provided capital support of around £250 million in 2011–12 (not £1 billion). Also, a third of providers used reserves in 2011–12 (not 2010–11) and 7% borrowed money in 2011–12 (not 2010–11)

David Flory: Those that borrowed were foundation trusts?

Q147 Chair: Foundation trusts. And how much did they borrow? Do you know?

David Flory: No.

Q148 Chair: You don't know. And do you know how much was used from reserves?

David Flory: I do not know specifically how much FTs used from reserves either.

Q149 Chair: It is very fragile.

Sir David Nicholson: It is a big system going through complicated change, and you are absolutely right that relatively small changes can make a big difference. On the quality of service and care that people are getting, there is a whole series of measures that we use, including the A and E one, and I am sorry you do not—we did it with the best intention. We were given advice; the Royal College of Nursing and a whole series of organisations said to us that the 98% was not the right level to hold it on and that we should go for 95%, because of this odd thing where we were getting loads of people admitted who really did not need to be admitted. I know it was a relatively blunt mechanism, but we did that. In terms of cancer waiting, 18 weeks, waiting for diagnostics, hospital associated infection and all those sorts of things—

Q150 Chair: Cataracts, hip replacements, knee replacements—

Sir David Nicholson: Doing more hip replacements, doing more knee replacements, doing all those things—but on top of that there is this issue about people being assured that the nature of the cost reduction programmes in hospitals is not hitting directly the quality of care for patients. We are tackling that in two ways. One is to say that all the cost reduction plans for each individual organisation should be signed off by the doctor and nurse within that organisation, so we have clear transparency about the effect that it has on patient care—or not. We are expecting the clinical staff of all CCGs to assure themselves that the cost improvement programmes are not affecting patient care in that kind of way.

On the other side, we are measuring some key indicators around what we think are about the quality of care, so pressure ulcers, VTE and infections around central lines. Those three measures together are described in the system as the safety thermometer. We are going to measure that all the way through the year to make sure we get early indication of systemic shifts in those areas, and we think they are good measures to do that. We are also instituting, as you know, the friends and family test.

Q151 Stephen Barclay: Sir David, you said a moment earlier that you do not know how much foundation trusts are borrowing and how much reserves they are using to deal with their short-term pressures. If the service transformation changes are not achieved, who is accountable for that across the system?

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Sir David Nicholson: That is an interesting question. Clearly the Commissioning Board—this is next year?

Q152 Stephen Barclay: It is 20% of your savings plan.

Sir David Nicholson: This is next year. Next year, the Commissioning Board will be accountable to make sure that those service changes happen.

Q153 Chair: Would it—or would the Department of Health or Monitor?

Sir David Nicholson: All the changes are delivered through commissioning. It is commissioning that plans and organises services in that way, and it is the Commissioning Board's responsibility to make sure that they deliver.

Q154 Stephen Barclay: I am confused. What I am driving at is: if we do not make those savings, who do we hold accountable? Is it you, or is it someone else? It is 20% of your plan. It is the riskiest bit, as the NAO has highlighted. So we have got the riskiest bit of the plan—who is accountable?

Sir David Nicholson: The totality of the plan is the accountability of the accounting officer of the Commissioning Board.

Q155 Stephen Barclay: Yes, but I want to really focus on the service transformation. We have got to achieve four times the rate of savings in the last two years compared with the first two years. If we do not do it, who is accountable?

Sir David Nicholson: The Commissioning Board. Me. The accounting officer, I would imagine.

Q156 Stephen Barclay: So you will need to find out quite quickly the extent to which the likes of foundation trusts are under pressure and using short-term fixes.

Sir David Nicholson: That is a slightly different question. What I am not accountable for is ensuring that all foundation trusts are in financial balance. I am not responsible for that. What I could be responsible for is ensuring that there is a proper, comprehensive stroke service across the whole country, which centralises stroke care to get the best outcomes for patients.

Q157 Stephen Barclay: But if foundation trusts are under pressure and say that they have done short-term fixes such as raiding their reserves or borrowing money, that will have an impact within the locality—Peterborough compared with Hinchingbrooke compared with Addenbrooke's. Surely that will have an impact in the locality on other hospitals, other services and service transformation.

Sir David Nicholson: What I cannot be held accountable for is the way in which individual foundation trusts manage their own financial affairs. I can absolutely be held to account for the service transformation required.

Q158 Stephen Barclay: I was not suggesting that you were being held accountable for that. Their structure is that they have an accounting officer in

their own right to Parliament, as you and I know. What I am driving at is, in the *Health Service Journal*, you said—

Sir David Nicholson: I haven't seen this. I don't know what you are quoting.

Stephen Barclay: They were quoting you in this.

Sir David Nicholson: It must be true then. Go on. I will bury my head in my hands.

Stephen Barclay: This was circulated to members of the Committee.

Sir David Nicholson: Not by me, in some festive self-publicity.

Stephen Barclay: I feel almost reluctant to quote your own words back to you.

Sir David Nicholson: Please feel free.

Stephen Barclay: "It's hard to imagine a service change that's going to take place over the next few years that the Commissioning Board is not directly involved in." That suggests it is pretty centralised.

Sir David Nicholson: No, not at all.

Q159 Stephen Barclay: So you accept that those were your words?

Sir David Nicholson: They are absolutely my words, but I want to explain the context in which I said them. The context you have described is some kind of sitting at the centre, sorting everything out. That is not what I was saying at all. At the moment, you have a situation where PCTs drive service change with their local organisations. Strategic health authorities stand above them and make a judgment on whether what they have done is okay. The Department then stands above that, because we have to give advice to Ministers if in any way the service change is contested. That is a kind of hierarchical system with different tiers.

In the world we are going into, the Commissioning Board commissions primary care directly. We are responsible for the direct commissioning of primary care. So the idea that we can stand above that in some way is impossible. The Commissioning Board—our staff—has to be in there making the change happen in practice through commissioning primary care and specialised services. The Commissioning Board is absolutely in the local health communities, working with people and making change happen.

Q160 Ian Swales: You said near the start that one of the things that convinced you that the £20 billion might be possible was benchmarking, and you had got professional firms in to do that. I am intrigued to know what was done with all that information and how it works now. The Report is reasonably complimentary on the sharing of good practice, but it does say that, in primary care trusts in particular, a lot more could be done. I certainly was not filled with a warm feeling by David Flory's input, which sounded a lot more like it was serendipity—something happens in one part of the country and maybe other people find out. Can you give us some confidence that best practice and benchmarking are being driven with the kind of force that is needed to deliver what you have to deliver?

Sir David Nicholson: In about three or four months' time, we will publish—[*Interruption.*] Aliens have landed. In the next few months, we will publish a

dashboard that will be available to everybody, including the public, that gives huge amounts of benchmarking data, from how many nurses individual organisations have on wards right the way through. We are planning to publish that later. In the interim, we have produced a set of information for every CCG that benchmarks them against all the major outcomes with all the other CCGs in the country, to give them, in essence, a start before we can get the full benchmarking information available.

Q161 Ian Swales: Will there be any financial data?
Sir David Nicholson: Yes.

Q162 Ian Swales: Good, because I think that meets some of the needs of the Patients Association witness earlier.

I have one final question. I think the C&AG talked earlier about the various things that were happening and might be under your control. I respect the fact that, initially, the £20 billion was probably not even your number; it was more of a "Let's see what we can do." This far in, if you are to deliver this, presumably you have a plan that adds up to £20 billion. Is that right? Do you know how you will get the £20 billion?

Sir David Nicholson: We have got a broad idea of the areas we will have to deliver. We know that.

Q163 Ian Swales: But is it costed, and at what level of detail?

Sir David Nicholson: Each region has put together their own plan, which is costed at a relatively high level, but it is all there. The real issue is the detailed plans that people deliver year on year. That is what we are working on at the moment for the CCGs. As part of the authorisation process, we have asked each CCG to produce a three to five-year look forward. We are working through those and they are of variable quality. That is the basis on which we are doing it.

Q164 Ian Swales: You've got the £20 billion broken down into regions, is that what you are telling us?

Sir David Nicholson: Yes.

Q165 Ian Swales: And is there any contingency in there, or do an awful lot of things have to go right for you to get anywhere near? How does it feel, as the person responsible for delivering it?

David Flory: For consistency with what we discussed before, the plan is for £18.9 billion. It is not for £20 billion.

Q166 Stephen Barclay: Would you be able to share the document with the Committee?

David Flory: Yes. The breakdowns are all published.
Sir David Nicholson: Yes.

Q167 Ian Swales: What I am really pushing on is that I perhaps do not share the C&AG's comfort that the total of the tariffs and your central activity gets you a long way there, and that you have only a few more things to do and that is it. It does not feel to me like it is that certain, even with things like the tariffs. In other words, I am asking what level of confidence we have that this will be delivered, based on the work

that has been done. What level of confidence should we have?

David Flory: As we described earlier, we are ahead of where we expected to be, but as Sir David said earlier, none of it is easy to do. The more straightforward things to do have been done, which has contributed to us being ahead of where we should be.

Q168 Ian Swales: But you've got a price tag on the more difficult things, and you can see how, if these various things happen, you will deliver this saving. Is that right?

David Flory: Again, a big part of what is still to come is the 4% efficiency in providers. It is easy to set that in tariff. The real challenge is for the providers to respond to that and exactly how they will do it next year will be a product of the planning process that we are now going through. We do not know exactly how they will all achieve the 4%, but we have set it as that.

Q169 Chair: Will you accept more rationing if they do that?

David Flory: That is not part of the provider efficiency requirement.

Q170 Chair: So you will not accept more rationing? You will or you won't?

Sir David Nicholson: Each individual CCG, with their health and wellbeing board, will have to work out how to use the money that they have got to best effect locally.

Q171 Chair: Will you accept more rationing?

Sir David Nicholson: In terms of whether we expect them to deliver a universal system, free at the point of use and available to their population, there may be priorities in individual parts of the system that mean that more of something is done than something else.

Q172 Chair: So you will accept more rationing. It is a simple yes or no. I know that you do not like doing it, but it is part of the honesty with patients and the public. Will there be more rationing? Will you have to wait longer for your cataracts and hip replacements?

Sir David Nicholson: We certainly do not see people waiting longer for hip replacements.

Chair: Cataracts are down, even in the Report that we have today.

Q173 Stephen Barclay: The Royal College of Surgeons wrote to the Committee ahead of this hearing talking about obesity and certain things. Paragraph 2.36 talks about tightening eligibility. I absolutely agree with Mr Swales, how it looks to me is that we are facing a fiscal cliff. We have done very good work to date, in terms of meeting the savings now, but it is increasingly difficult in the years ahead. It is unclear what contingency there is. The riskiest element is the service transformation, and yet the ground has not been prepared with the public, in terms of giving them the information. It is very difficult for us to get comfort on how the remaining, harder savings are going to be achieved without trusts either

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raising eligibility criteria or parking some of their costs elsewhere in the system.

Sir Bruce Keogh: People do not like, as you have gathered, talking about rationing, but people have to make choices, particularly those who are responsible for delivering health care.

May I share with you some of our thoughts about the direction of travel? Around about the end of 2010 and early 2011, I started to get deluged by letters from people saying, “This PCT isn’t paying for that”, or that one PCT takes a different view on hips or cataracts to another, and that started to ring alarm bells with us in the Department. We started to think about how we could bring some level of consistency because, in a sense, once that starts to happen the N in NHS starts to go into lower case. People reasonably expect to get similar treatments in one part of the country as in another. The whole business of QIPP is really about how we maintain clinical and service quality in the face of increasing demand and relatively static resources. That means that we need to ensure that we have the right supporting infrastructure for the delivery of our services, and also that we need to start looking at appropriateness of care and value.

Appropriateness of care is about the avoidance of over-treatment of people and of under-treatment. We know that where you have increased supply the threshold for referral goes down, and vice versa. The clinical issue that we are trying to get to the heart of is that diseases generally have a spectrum, in that you start off with some minor symptoms and then you end up in bad shape. If you offer treatment too early in a disease, the benefit to the patient is minimal—and, therefore, in terms of value for money—and if you leave it too long, it is bad for the patient and it is a disaster really. What we are trying to get to is how we can get a clinical consensus around the country about how you offer the right treatment at the right time.

As we started to think about that, it became clear in the United States that probably somewhere between 10% and 30% of their cost is related to over-treatment. The BMJ tackled this by saying that there is also some over-treatment going on here. What we need to do is to get some consistency of threshold levels. So the main area that I get confronted with is around—as you rightly say, Chair—hips, cataracts or, as another example, varicose veins, which are pretty common surgical procedures. Some of the letters were coming from the presidents of specialty associations—I am guilty of being in that position myself in the past—and what I have tried to do is to engage them in the process.

Working with the Royal College of Surgeons, we have started a programme that we call the value-based commissioning of elective surgical care. In conjunction with NICE, we have established a process that will define the appropriate thresholds of care. That process will be overseen by the Royal College of Surgeons, and quality assured, but the work will be done by the specialist associations—so, for example, the vascular surgeons, the plastic surgeons or whoever. We are just entering into the second phase, so the processes and the methodology have been worked out. By June this year, therefore, we will have 28 bits of guidance.

Interestingly, and one of the things that excites me the most, we will have a thing called a procedures explorer, which will be open to the public and to people in the NHS. You will be able to see which procedures are being conducted, in what volume and, hopefully, with what outcome—that is more complex for some procedures—for each CCG, and it will be divided into a series of different regions: providers, CCGs and regional levels.

May I say something about cataracts, because it bothers me? The story around cataracts is not quite as simple as it might seem. There is still squabbling in clinical arenas about the level at which cataracts should be referred. We know that about 50% of PCTs have restricted access to cataract surgery, and we know that the bulk of policies used by PCTs have not used the best evidence to ration that care.

I have raised that with our SHA medical director and the new medical directors of the Commissioning Board, and I have asked for cataracts to be one area that the programme of value-based surgical commissioning works on. If we can get this right, and if we can get the surgeons and the commissioners into the same place for the thresholds of referral, I think we will not only improve the quality of care, but save a considerable amount of money. What is really different is that we now have one commissioning board that will oversee this and work with PCTs, not 151 organisations with independent boards and different ideas.

Q174 Stephen Barclay: Could you deal with the point in the letter from the Royal College of Surgeons, which I presume you have seen and which refers to the fact that NICE recommended that bariatric surgery should be offered as a first-line option for obesity? However, the bar has been raised to a BMI of 50 or 60, and as a result of that people are twice as likely to get type 2 diabetes. In other words, not only are they getting a worse standard of care, but there is a significant cost implication. People not being aware of that impedes their willingness to accept service transformation.

Sir Bruce Keogh: I have not seen that letter, but I am familiar with the issues of bariatric surgery, which treats people who are what is called morbidly obese. A side effect—it was surprising that people did not expect it—is that almost within hours of having the operation, your diabetes disappears and your requirement for the associated drugs and diabetic treatment diminishes. We are just about to embark on some economic analysis, because I think there is probably quite a strong case for changing the threshold at which we offer bariatric surgery, and that is something I had hoped we would take on relatively early in our deliberations.

Q175 Stephen Barclay: It is already a NICE recommendation, but it has gone the other way because it is not a legal obligation. That is what the RCS is saying. We knew it was useful and we knew it was valued, but it has been increasingly rationed although we know that there is a deferred bigger cost in the longer term. That is the issue. We already know this.

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Sir Bruce Keogh: I think this is something that we will have to take to the new clinical leaders and the Commissioning Board because one of our problems with NICE guidance is that although it is significantly evidence-based and is excellent, we have no way of enforcing adherence. We can enforce things that go through its technology appraisals guidance, but not its regular guidance.

Q176 Guto Bebb: I will be quick. I am the only member of the Committee today without any constituency examples because we have a very different health service in Wales, but I want to ask a few things. A key issue is the fact that you were arguing that there is a need for politicians to come on board and to argue the case for change to make better use of scarce resources. That is certainly the case in the Welsh context.

One of the issues that I would like your views on is the discussion that we have had all day today on whether we are making efficiency savings or cuts. Would you be prepared to offer your view, in simple language which we could use to explain changes to the general public, on what is an efficiency saving as compared to a cut?

Sir David Nicholson: An efficiency saving is where you use the same, or less, resource but get a better outcome.

Q177 Guto Bebb: And that would be your simple response to the general public?

Sir David Nicholson: Yes. That is what efficiency is all about.

Q178 Guto Bebb: So why do you think this creates such an issue? Invariably, when we talk about efficiency savings, we tend to get the issue confused with cuts. Is that the fault of politicians, or is there a general failure to explain on behalf of the professionals?

Sir David Nicholson: I am sure that it is partly our problem about explaining it and, indeed, sometimes it is counter-intuitive. We used the stroke example earlier, with 31 hospitals admitting acute stroke worst outcomes in the country, but eight admitting sites with the best outcomes, I understand, in Europe, now. Intuitively, people do not understand that because they think, "If I have a local stroke service, why can't we make that better". In fact, we know that to get improved outcomes, you need to do more of something; the more you do, the more specialised you are and the better your outcomes. We have had difficulty getting that over to people generally.

Q179 Guto Bebb: We have seen this debate in relation to the differences between the health service in Wales and in England; we engage in this party political game in relation to why things are working better or worse. When we try to justify the success of the health service in an English context, we tend to look at things that are easily measurable—waiting times and so forth. One of the concerns from the Report, which is reflected also in a Welsh context, is on mental health services. Is there any way in which you can build a measurement procedure into your

figures in relation to the impact of efficiency savings on services such as that?

Sir David Nicholson: We do collect that information so that we can show where the efficiencies are landing on mental health, and what proportion they have got compared to others. We can do that.

Q180 Guto Bebb: That is interesting, because paragraph 2.25 of the Report highlights that those measurements are not easy to make.

David Flory: Is this the reference to tariff for mental health services?

Guto Bebb: If I have misunderstood that and you could clarify it for me, I would be more than happy to get a clarification.

Q181 Chair: Ian has a final point, but I just remembered—you did not give £1.4 billion back to the Treasury, did you? I suddenly remembered that there was a bit in the papers. You never gave £1.4 billion back? The whole point of this programme is that you reinvest the savings. I am asking you to confirm that that is not true—or is it?

David Flory: The NHS did not give back £1.4 billion.

Q182 Chair: You mean that the Department of Health did. From which budgets—not from the NHS budget?

David Flory: No, the savings that the NHS make stay in the NHS. The surpluses in NHS organisations stay in those organisations.

Q183 Chair: Where does the £1.4 billion come from? Most of the money in the Department of Health—I cannot remember the figures—goes on the NHS. What proportion of the DH budget is the NHS?

Laura Brackwell: About 90%, or more.

Amyas Morse: Last year it was £1.8 billion.

Q184 Chair: It must be NHS funding.

Sir David Nicholson: From our perspective, all the money allocated to the NHS stays within the NHS. Any surpluses—

Q185 Chair: Explain to me what was the £1.4 billion?

David Flory: I can give you some more detail on it: £566 million was a 13% underspend on the capital budget, and £829 million was an underspend on the revenue budget.

Q186 Chair: Whose revenue budget?

David Flory: The overall Department expenditure.

Q187 Chair: Including the NHS?

David Flory: In the way that the accounting works between the Departments and the Treasury, some of that will have been reflected as NHS underspend, but the Department protects the NHS underspend to go back into the NHS the following month.

Chair: Can you give us a note which really explains this? It is gobbledegook at the moment and I do not get it.

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Q188 Ian Swales: This time last week I was about to lead a debate in the Chamber on corporate tax avoidance. Imagine my surprise today to see the headlines in *The Guardian* saying that private health care providers were concerned that they had to pay tax—VAT and corporation tax—and that that was stopping them competing in the NHS. Have you had any representations from companies in that regard? What do you think of the idea that those companies ought not to pay tax?

Sir David Nicholson: I am sorry but I have not read the story, and I have never had any representations on that matter. I am not aware that they have had a meeting.

Q189 Ian Swales: To be totally clear, you have not had health care providers saying, “We would love to work with you but, because we have to pay VAT and corporation tax, we can’t.” That has never happened.

Sir David Nicholson: No.

Q190 Chair: Who would the discussions have been with?

Laura Brackwell: Discussions with Monitor, according to the paper.

Ian Swales: It’s a game for a future date, no doubt.

Q191 Meg Hillier: There is an impact in my local area with out-of-hours services, where some providers did not have to pay NHS pensions. Those who were in the system had to pay NHS pensions. Similarly, for any of the private providers of GP services, presumably this would apply if you had a similar gap. Does that not have an effect on the general ability of the NHS to provide services?

Sir David Nicholson: There is a general issue about what might be described as the level playing field, between the private independent and the public sector. Monitor is leading some work on what would need to happen to make that playing field more level.

Amyas Morse: That makes more sense than saying they were asking to be let off corporation tax.

Ian Swales: That is the implication of the article.

Chair: Okay. We will ask Monitor next time. You will let me know where that £1.4 billion has been grabbed from. I bet it’s from you.

Sir Bruce Keogh: Happy new year.

Chair: Happy new year to you.

Written evidence from the Royal College of Surgeons

INTRODUCTION

The Royal College of Surgeons’ prime responsibility is the maintenance and improvement of surgical standards to deliver high quality patient care. While it is not our role to decide how savings are best made in the NHS we have concerns that some cost-saving measures are undermining patient safety and quality of care and may, in fact, increase expenditure in the long-term. This is happening on several levels including reductions on professional time which is essential for education and training, rationing of available treatments and services, and financially-driven redesign of services. This briefing to members of the Public Accounts Committee sets out our concerns primarily around rationing decisions, and addresses how we believe service redesign—which the National Audit Office report says is necessary for larger savings—can be supported without undermining patient care.

EVIDENCE OF RATIONING DECISIONS

The RCS agrees with the National Audit Office report that despite the significant financial pressures facing the NHS it continues to perform well against *certain* measurable “headline indicators of quality”. For example, referral to treatment waiting times as of October 2012 are historically low.¹

Despite such successes, the College is aware of factual evidence and anecdotal information from our members which indicates many NHS commissioners are rationing clinically necessary services. For example, a 2012 study by *GP magazine*² said that over 90% of Primary Care Trusts (PCTs) were rationing care in some form for cataract surgery, joint replacement, tonsillectomies, or bariatric surgery. Restrictions on access to surgery can affect the outcomes of surgery and patient safety, with evidence that patients are less mobile and suffer more pain if their operation is delayed or denied.

This is despite the fact that the Government has repeatedly said restrictions should be based on clinical and not financial criteria:

- At Prime Minister’s Questions Time Foreign Secretary Rt Hon William Hague MP said: “It is totally unacceptable if trusts are rationing on the basis of financial considerations”.³
- On 21 September 2011 the NHS medical director Sir Bruce Keogh wrote to Strategic Health Authorities⁴ to say that “Any decision to restrict access to a treatment or intervention must be justified in relation to a patient’s individual circumstances” and that “decisions should not be made solely on the basis of cost, and any refusal to offer the intervention in question must be fair and consistent.”

¹ <http://transparency.dh.gov.uk/2012/06/29/rtt-waiting-times/>

² <http://www.gponline.com/News/article/1136671/Exclusive-90-PCTs-rationing-care/>

³ HC Deb, 20 June 2012, c855

⁴ The letter is available here: <http://www.hsj.co.uk/Journals/2011/10/10/k/d/d/Keogh-letter.pdf>

- In November 2011 the Department of Health announced that it was requiring PCTs to cease imposing minimum waits, activity caps, and inappropriate constraints on elective activity by no later than 31 March 2012.⁵

Case study: access to bariatric surgery

A high profile example of where access to surgery has been restricted is bariatric surgery. In 2010 the College surveyed bariatric surgeons about access to weight-loss surgery. NICE clinical guidance (CG43) on obesity recommends—but does not legally require—that bariatric surgery is offered as a first-line option for different groups of patients dependent on Body Mass Index (BMI). A study published by the College in 2011 highlighted the many clinical benefits of bariatric surgery;⁶ 12 months after surgery, for instance, the number of patients with type 2 diabetes and/or high cholesterol had halved.

However, our survey found that while some Primary Care Trusts adhered to the guidelines, others were raising the bar so that only the most extremely ill patients—those with a BMI of 50 or 60 with obesity related illness—are being referred for surgery even though there is no clinical evidence to support this practice. Our members also told us that some PCTs were refusing to commission *any* obesity surgery.

There is compelling evidence that weight-loss surgery (bariatric surgery) is one of the most cost-effective treatments in acute health care which cannot be ignored. Restricting patients' access to surgery to save money in the short term by raising the threshold on BMI over and above NICE recommendations is irrational and not in patients' best interests. In the long term restriction are likely to cost the NHS more money since obesity associated healthcare costs are estimated at £7.2 billion per annum.

The College's view

The NAO report notes that NHS savings so far have been primarily generated through contractual levers applied by the Department. £520 million of the reported savings for 2011–12 were also non-recurrent. While we appreciate the unprecedented scale of the financial challenge facing the NHS, there is therefore a danger that further rationing of clinically necessary services and treatment will take place in the future as commissioners look for other short-term ways of saving money.

Patients' access to treatment should be driven by need based on clinical assessment, and must not be compromised by financial pressure. Most methods to restrict access to surgery use unproven and arbitrary thresholds which unfairly deny patients some of the most successful operations which vastly improve quality of life. Efficiency must not lead to shortcuts on quality and patient safety.

The RCS and the surgical specialty associations are also playing their part to help reduce unwarranted variations in services by developing evidence-based guidance on surgical service commissioning. This aims to improve the health and wellbeing of patients and reduce differences in commissioning standards across the NHS.

Commissioners should, however, additionally look at reducing access to clinically unnecessary procedures. The "Clinical responses to the Downturn"⁷ report in 2010, which brought together NHS managers and clinicians, set out some areas for potential savings.

Monitoring rationing decisions

The Health and Social Care Act 2012 requires clinical commissioning groups (CCGs) and the NHS Commissioning Board "to have regard to" NICE's quality standards. These will set out aspirational but achievable areas for quality improvement in a defined care or service area, including for obesity. However, they will not be mandatory and it remains to be seen how the legal duty to "have regard to" will be interpreted locally.

The RCS welcomes the recent announcement from the Department of Health that will require CCGs from April 2012 to publish their level of compliance with NICE technology appraisals.⁸ However, it is important to note that NICE technology appraisals only cover a small proportion of the services provided by the NHS so rationing of clinically necessary services may still occur. NICE guidance on bariatric surgery is not classified as a technology appraisal so there is therefore no legal requirement on the NHS to fund bariatric surgery.

⁵ http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131089.pdf

⁶ <http://www.rcseng.ac.uk/news/obese-patients-suffering-avoidable-disease-and-disability-reveals-first-ever-uk-bariatric-surgery-audit>

⁷ http://www.aomrc.org.uk/publications/statements/doc_details/9319-clinical-responses-to-the-downturn.html

⁸ <http://www.dh.gov.uk/health/2012/12/ihw-creating-change/>

Recently published secondary legislation⁹ will also require CCGs to comply with relevant NICE technology appraisals (although not all advice NICE provides), and to publish on their websites policies on providing medicines, medical devices, diagnostic techniques, surgical procedures, or other therapeutic interventions. This will improve transparency around rationing decisions.

We encourage PAC members to ask the witnesses:

- In the new NHS system how will the Department of Health and/or the NHS Commissioning Board monitor access to clinically necessary services and monitor performance against NICE quality standards?
- Has the Department of Health analysed the impact of Sir Bruce Keogh's letter to strategic health authorities on 21 September 2011?
- Do they agree that more needs to be done to ensure commissioners are following NICE guidance on bariatric surgery?

REDESIGNING SERVICES

The NAO report argued that "Service transformation is key to making future savings, but only limited action has been taken to date". We agree that service transformation has been slow. To an extent, health service staff must take some responsibility for slow progress on reshaping services. Too many reconfigurations have failed to win the support of doctors, nurses or the public. Consultations have sometimes been a loaded tick-box exercise designed to secure token support, rather than engage in a genuine conversation with the public. We must ensure the public understands the substantial clinical benefits that can be achieved, while addressing natural concerns regarding the availability of emergency care and transportation issues. We also agree with the report's recommendation that the DH and the NHS Commissioning Board should work with the NHS to reduce barriers to transforming services.

However, as the College made clear in "Reshaping surgical services"¹⁰—published at the start of January 2013—it is essential that any service change is based on clinical evidence, not purely financial motives especially where that may lead to a reduction in available services.

The College strongly supports service change where there is evidence that this will lead to improvements in the outcomes of surgery. The focus when reshaping services must be delivering improvements in patient care, and patients and their families must be fully involved in this process.

There is a strong clinical case for reshaping some surgical services. Scientific and medical advancements mean it is no longer necessary or appropriate to deliver certain operations or procedures in acute hospital settings. At the same time we know from the comprehensive evidence currently available that for many procedures and conditions concentrating specialist surgical services into fewer, larger centres of excellence can improve outcomes, and often save lives.

2013 is an important year for service redesign

Our President, Professor Norman Williams, recently addressed NHS managers¹¹ noting that 2013 has to be the year when politicians, clinicians, and managers come together to support historic change in the NHS and create a long-lasting legacy for all of our population. As we get closer to an election in 2015 there is a danger that some service changes will be swept up in election campaigning. It is important for politicians to engage with the clinical case for reshaping services as much as public concerns and support solutions that improve patient treatment and care. Once a decision has been made, it should be implemented quickly as delays can affect future planning of services.

January 2013

Written evidence from the Patients Association

Thank you for giving me the opportunity to speak at the Public Accounts Committee on 14 January 2013.

I hope that you took away some useful information from the session. I promised to forward some further data on the evidence base underpinning my comments.

You will recall that in the course of our evidence I raised my concerns about the rationing of treatment, as determined by our surveys of procedures of "low clinical value" conducted in acute trusts. In 2011 60 acute trusts responded to our Freedom of Information request, and in 2012 93 trusts responded.

⁹ <http://www.legislation.gov.uk/ukxi/2012/2996/part/7/made>

¹⁰ <http://www.rcseng.ac.uk/publications/docs/reshaping-surgical-services/>

¹¹ <http://nhsvoices.nhsconfed.org/2013/01/07/2013-its-now-or-never-for-service-change-jeremy-hunt-must-deliver-says-norman-williams/>

During the course of my evidence I also mentioned our concerns in relation to the impact of efficiency savings on the relationship between patients and their GP. Our report in September 2012, which showed that patients have significant concerns in this area, was based on a survey of 458 patients.

With regards to the number of calls to our Helpline on the matters I discussed, I am now in a position to respond to your request. In 2011 the Helpline were contacted by 148 callers who were worried that their medication was being changed by their GP's to generic from branded. 396 callers mentioned that they were unhappy that they could not get a referral from their GP.

In 2012 we received 285 enquiries relating to medication being changed from branded to generic. 667 callers were unhappy that they could not get referrals from their GP.

Katherine Murphy
Chief Executive

25 January 2013

Katherine Murphy, Chief Executive of The Patients Association, said

“The sad conclusion of this report is that far too many patients are being shockingly let down by the NHS every day. These appalling and tragic cases serve to highlight the devastating consequences when poor practice is left unchallenged and unchanged. Behind each one are many more unheard voices.

Whilst there is a lot to be proud of about the NHS, including the overwhelming majority of staff who are skilled and hard-working, these cases are a tragic wake-up call for those in Westminster as well as on hospital wards.

Of the relatives and patients who contact our Helpline most wish their experiences could have been different, but they all want to use their stories to influence policy makers. On the eve of some of the most radical NHS changes, a new culture of care needs to be put at the heart of the health service.”

NOTES

- In November 2011 The Patients Association launched a Care Campaign, which called on Hospital Trusts to sign up to improve care in four fundamental areas: providing adequate pain relief, support with eating and drinking, communicating with compassion, assistance going to the toilet. Over 80% of Trusts have signed up to the Care Campaign. Find out more about the Campaign here
- In September 2012 The Patients Association published a good practice report highlighting examples of high quality care and innovative initiatives in hospitals across the Country. You can read the report here—....
- Info on CQC pilot....
- For further information or case studies please contact The Patients Association on 020 8423 9111.

The Patients Association is a healthcare charity which for almost 50 years has advocated for better access to accurate and independent information for patients and the public; equal access to high quality health care for patients; and the right for patients to be involved in all aspects of decision making regarding their health care. By listening to patients, we are able to campaign to improve services. We will work with all healthcare providers to improve services. Very often patients think they are alone with the problem or complaint they have. When patients talk to us we are able to track problems arising in more than one place and realize there is a nationwide issue that needs change.

Written evidence from the Department of Health

Question 166: *Breakdown of Regional SHA QIPP Plans*

1. In preparation for meeting the QIPP challenge, each regional Strategic Health Authority (SHA) outlined their plans to achieve the necessary savings for reinvestment in frontline services.

2. Nationally it was estimated that “up to £20 billion” of savings are required by 2014–15. The exact requirement will depend upon local assumptions and plans, and will change over time (for example as inflation and demand forecasts change).

3. The table below identifies the planned QIPP savings at an SHA level. The total £18.9 billion planned QIPP savings also includes £1.5 billion of central Department savings; this is in addition to the £17.4 billion NHS QIPP savings.

<i>SHA Name</i>	<i>Total QIPP Plan £m</i>
London	2,700
South West	1,801
South East Coast	1,756
South Central	1,106
East of England	2,091
West Midlands	1,800
East Midlands	1,321
North West	2,370
Yorkshire and the Humber	1,633
North East	829
Total NHS	17,407
Central Department initiatives	1,500
Total NHS & Central Department Savings	£18,907m

Question 180: *Information on mental health efficiencies*

Reporting of mental health efficiency savings

4. The Department publishes QIPP savings as reported by the NHS on a quarterly basis in the Deputy Chief Executive's NHS performance update, "the quarter". The total savings reported are based on information submitted by Primary Care Trust's (PCTs) to the Department, outlining the level of efficiency savings made locally in the commissioning of healthcare.

5. The total does not include efficiency savings generated by the Department itself, its Arm's Length Bodies (ALBs) and Strategic Health Authorities (SHAs).

6. The QIPP savings are reported in broad categories of PCT expenditure. Efficiency savings for mental health services are collected explicitly as part of this PCT reporting. These are shown in conjunction with efficiency savings made for learning disability services.

7. The NHS QIPP savings achieved for 2011–12 and the forecast NHS QIPP savings at quarter two 2012–13 are included below.

TOTAL 2011–12 NHS QIPP SAVINGS

<i>QIPP Category</i>	<i>£m</i>
Acute Services	2,843
Ambulance Services	74
Community Services	463
Continuing Healthcare	159
Mental Health & Learning Disabilities Services	440
Non-NHS Healthcare (inc reablement)	157
Prescribing	417
Primary Care, Dental, Pharmacy, Ophthalmic	255
Specialised Commissioning	307
Other	700
Total	5,815

FORECAST 2012–13 NHS QIPP SAVINGS

<i>QIPP Category</i>	<i>£m</i>
Acute Services	2,677
Ambulance Services	77
Community Services	357
Continuing Healthcare	127
Mental Health & Learning Disabilities Services	404
Non-NHS Healthcare (inc reablement)	80
Prescribing	472
Primary Care, Dental, Pharmacy, Ophthalmic	194

<i>QIPP Category</i>	<i>£m</i>
Specialised Commissioning	269
Other	379
Total	5,036

Data on the quality of mental health services

8. The reporting of mental health efficiencies by PCTs to contribute to QIPP is distinct from the finding in paragraph 2.25 of the NAO report that “*data to assess the quality of primary, community and mental health services in particular is limited*”. The Department is already undertaking several initiatives to address this in the area of mental health. For example:

- *Mental Health Minimum Dataset*: The Health and Social Care Information Centre (HSCIC) routinely publishes a data quality release of key data items by organisation, which provides an indication of how well trusts are recording key mental health data. In addition the Community and Mental Health team within the HSCIC has a data quality improvement programme which includes working with provider, commissioner & user groups. The HSCIC also publish information as experimental statistics to give provider organisations the opportunity to review aspects of data quality for elements of new analyses eg coverage, accuracy and completeness. The HSCIC plan to take the same approach to improving the Child and Adolescents’ Mental Health Services (CAMHS) data set when that starts to flow later in 2013.
- *Development of Improving Access to Psychological Therapies (IAPT) data*: IAPT psychological therapy services for adults collect extensive data on patient outcomes which allows the effectiveness of individual services and practitioners to be evaluated. The Children and Young People’s IAPT project is introducing measures that will demonstrate for the first time the outcomes CAMHS IAPT sites are achieving and the complexity of the cases presenting. This will also feed into the development of CAMHS Payment by Results.
- *Payment by Results*: The development of Payment by Results in mental health means contracting and payment arrangements between commissioners and providers will be increasingly based around information about individual patients and their care needs. In 2013–14, contracts will be constructed on this basis, and will also include mandating the use of indicators related to the quality of care and the outcomes which patients achieve. Both providers and commissioners will therefore have financial incentives to ensure this quality-related information is as reliable and up to date as possible.
- *Recovery indicator*: The Department of Health has recently begun work to develop an indicator of recovery in mental health. Currently we are able to measure some outcomes related to recovery—for example whether people with mental health problems are employed. However, we know that this is only one small part of what “recovery” means to people, and therefore what they want from services. A new recovery indicator will allow us to measure progress in supporting the full range of outcomes which people with mental health problems say matter most to them.

Questions 183–187: *Department of Health Underspends in 2011–12*

9. The Department underspent against its 2011–12 Departmental Expenditure Limit (DEL) by £1.4 billion as published in October 2012 in the 2011–12 Annual Report and Accounts and set out in table one below. The Department’s year-end underspends are returned to HM Treasury and contribute to the overall fiscal position.

	<i>Final Budget £m</i>	<i>Final Outturn £m</i>	<i>Under/ (over) spend £m</i>	<i>Under/ (over) spend %</i>
Revenue DEL 2011–12	102.4	101.6	0.8	0.8%
Capital DEL 2011–12	4.4	3.8	0.6	13.0%
Total	106.8	105.4	1.4	1.3%

10. The total DH underspend is made up of £829 million revenue and £566 million capital. Of the £829 million Revenue DEL underspend, £674 million related to the NHS and mainly because of higher than planned surpluses in the NHS Provider sector.

11. NHS providers are allowed to keep the cash that they have accumulated from their generated surplus and spend it in future years—subject to Monitor’s regulatory regime.

12. For the NHS commissioner component of the underspend, the Department has committed to return surpluses to Primary Care Trusts and Strategic Health Authorities in subsequent years. It would not be prudent for these bodies to use the entire underspend in the following year, therefore expenditure plans are agreed to ensure a steady use of the underspend over a number of years. These expenditure plans are accommodated each year from within the overall DH budget.

13. Expenditure by NHS Bodies (PCTs, SHAs, NHS Trusts and Foundation Trusts) made up approximately 94% of total Departmental expenditure in 2011/12.

14. The First Mandate to the NHS Commissioning Board 2013–14 to 2014–15, published on 13 November 2012, sets out the NHS Commissioning Board’s allocation for 2013–14 and this includes an allocation for the carry forward of forecast underspends for 2012–13.

15. Department of Health officials would be happy to meet with PAC members to explain this further if required.

January 2013

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