HEALTH COMMITTEE
INQUIRY INTO PUBLIC EXPENDITURE ON HEALTH AND SOCIAL CARE: SUBMISSION FROM THE KING'S FUND

1) The King's Fund is an independent charity working to improve health and health care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

Summary

2) The NHS is more than two and a half years through the most significant period of financial constraint in its history, with the prospects beyond 2015 looking even more challenging. At the aggregate level, the NHS has so far managed reasonably well, in large part due to continued pay restraint and reductions in the tariff. However, this masks growing pressures within the system, with an increasing number of providers now in deficit and many struggling to meet the A&E waiting time target. The reality for many NHS organisations is that they now face a difficult choice between maintaining quality of care and balancing the books.

- While most NHS organisations have so far met cost improvement targets, confidence that this will continue has fallen and there is little confidence that the Nicholson Challenge target of saving £20 billion across the NHS will be met.

- The potential for continued pay restraint and reductions in the tariff to deliver further savings is now very limited; neither of these are long-term substitutes for delivering genuine productivity improvements.

- Major reconfigurations of services are essential to improve quality of care and have the potential to improve financial sustainability, but progress continues to be slow. It is now clear that transformational change will make only a limited contribution towards meeting the Nicholson Challenge.

- A growing number of provider trusts are now in deficit, with numerous others operating at the margin – many acute providers in particular will find it increasingly difficult to uphold quality of care and maintain financial stability.

- Taken together, with winter approaching, it is clear that the NHS is entering an immensely challenging period, with pressures on providers becoming more intense and widespread, and a real threat that the Nicholson Challenge will not be met.

- The combination of unremitting financial and demographic pressures is having a significant impact on social care services; welcome as the Dilnot Commission's proposals are, implementing them will not solve the social care funding challenge.

- The Integration Transformation Fund is an opportunity to drive forward integrated care but will significantly increase financial pressures on NHS

organisations and will be a key test of whether health and wellbeing boards can provide local leadership.

- A more ambitious approach is needed to align health and social care resources around the needs of patients and service-users; this is why The King's Fund has established an independent commission to explore whether the NHS and social care system can be brought closer together.

The plans being made to meet the Nicholson Challenge and whether the NHS is succeeding in making efficiency gains rather than cuts

3) Since April 2011, The King's Fund has published a quarterly monitoring report that analyses NHS performance against key indicators and tracks progress in improving productivity based on a regular survey of NHS finance directors. Although the survey is not a representative sample, and some caution should be exercised in comparing results between quarters, it does provide valuable insight into how the NHS is responding to the Nicholson Challenge.

4) The reports show that NHS organisations made good progress in meeting productivity targets during the first two years of the Nicholson Challenge. In 2011/12, an average saving of 4.7 per cent was reported by those responding to our survey, against an average cost improvement programme (CIP) target of 5.1 per cent. In 2012/13, an average saving of 4.6 per cent was reported against an average CIP target of 4.9 per cent. These findings are broadly consistent with other evidence about the progress made in meeting the Nicholson Challenge, including the National Audit Office's assessment of savings made in 2011/12.[1]

5) However, our two most recent reports reveal a significant fall in confidence among those surveyed about whether CIP targets can continue to be met. Our most recent report, in September 2013, found that only a third of NHS trust finance directors were confident of meeting an average CIP target for 2013/14 of 4.9 per cent. This contrasts with around 70 per cent who were confident of meeting their target for 2012/13 in our February report. This reinforces warnings that the quick wins have been identified and that savings will become progressively harder to achieve over time.

6) Clinical commissioning group (CCG) finance leads – surveyed for the first time for our September 2013 report – were much more confident than their counterparts in NHS trusts, with nearly 70 per cent expecting to meet an average QIPP (quality, innovation, productivity and prevention) target of 2.5 per cent in 2013/14. NHS England and CCGs are forecasting a combined surplus of £596 million, although the number of CCGs predicting a deficit has increased from nine to 24.[2] With NHS England in particular still finding its feet, it will be vital to maintain financial control – NHS England is expecting to spend £318 million more than planned on direct commissioning and is now forecasting a £93 million deficit in its commissioning budget, mainly as a result of higher than anticipated expenditure on specialist services.[3]

[1] National Audit Office (2013). *Progress in making NHS efficiency savings*.
[2] NHS England (2013). *Board paper*, November 2013.
[3] NHS England (2013). *Board paper*, November 2013.

7) Overall, this suggests that the strain is being felt most in the provider sector, which is not surprising given the year-on-year reductions in the tariff and other pressures they are facing (*see* below). On the prospects for meeting the target to deliver £20 billion in productivity improvements across the NHS by 2015, only 10 per cent of those surveyed for our most recent report rated the chances as better than 50/50, with the majority (56 per cent) identifying a high or very high risk the target will not be met.

8) We note the assurances given to the Committee's previous inquiry and the findings of the National Audit Office report that the bulk of the savings made in 2011/12 were recurrent. Nevertheless, we remain concerned that a significant element of the progress so far has been delivered through pay restraint, reductions in the tariff and cuts in management costs rather than genuine improvements in productivity. We also reiterate our concern that too much emphasis has been placed on generating financial savings, rather than on improving the quality of services for patients.

9) Pay rises for most NHS staff were frozen for two years from 2011/12 and limited to 1 per cent in 2013/14. It remains to be seen whether the government is successful in deferring the planned 1 per cent pay rise due in April 2014. Opportunities remain to reduce the costs associated with the use of agency staff, locums and staff sickness. However, pay restraint is not a long-term substitute for efficiency gain. With staff costs making up the bulk of the NHS budget and significant pressures on providers to maintain staffing levels following the shocking failures of care highlighted by the Francis report, there is little or no further room for manoeuvre in reducing staff costs.

10) Alongside this, year-on-year reductions in the tariff mean that it will have been cut by nearly 7 per cent in real terms by 2014/15, increasing pressures on providers. As the Committee pointed out in its previous report, the tariff is a blunt instrument for driving productivity improvements that does little to drive efficiencies among commissioners. With providers coming under increasing pressure, the potential to reduce it further is limited.

11) Major reconfigurations of services are essential to improve quality of care and have the potential to improve financial sustainability (although they often result in significant short-term costs, as is the case with the proposed changes to services in South London and Mid Staffordshire). However, progress continues to be slow and has been hampered by notable setbacks such as the failure to bring the long-running review of children's heart surgery to a conclusion. The picture is further complicated by the increased involvement of the competition authorities in decisions about mergers and service changes. There are clearly lessons to be learned for the NHS from the Competition Commission's recent decision to reject the proposed merger between Bournemouth and Poole hospitals. However, the risk is that this and other decisions result in competition law being seen as an impediment to service change.

12) We remain concerned about the lack of capacity in the new health system to undertake large-scale reorganisations across wide geographical areas, especially in London, where the need for change is particularly urgent. We have proposed that NHS England's London office takes on a city-wide planning role, working with CCGs, and that hospitals work together in large-scale networks based on the three existing academic health science networks to drive change.

This would have the benefit of ensuring that major changes to services are overseen by the most experienced leaders and is an approach we believe could be replicated elsewhere in the country.

13) The Department of Health has previously indicated that 20 per cent of the productivity improvements needed to meet the £20 billion target will come from transformational change, with the bulk of this due to be delivered during the second half of the Nicholson Challenge period. Given the difficulties experienced so far in delivering transformational change, the lack of capacity for driving large-scale reconfigurations, the additional complexity created by the interventions of the competition authorities and the political difficulty of agreeing changes to services in the run up to a General Election, the risk is that any change will continue to be incremental and fragmented, when it needs to be urgent and substantial.

The effectiveness of the mechanisms by which resources are distributed geographically in the NHS

14) NHS England is currently reviewing the NHS allocations process, having rejected proposed changes to the current allocations formula as being inconsistent with its duty to reduce health inequalities. While recent debate has largely focused on the relative weight that should be given to age and deprivation in the formula, more fundamental questions should be asked about whether the current process, which has remained largely unchanged since the 1970s, is fit for purpose. At the heart of this is whether the resource allocation process is simply a mechanism for distributing funding or should be a more active policy tool for supporting wider NHS objectives. As we set out in a report on this earlier this year, there is significant scope for it to be used as the latter.[4]

15) In the short term, immediate improvements could be made to reduce the complexity of the current formula, increase transparency and improve the way that need is estimated. The review should also examine the operation of the 'pace of change' adjustment (previously decided by ministers, now by NHS England) which is built in to the process to prevent areas being destabilised by large year-on-year swings in funding. In practice, this has reduced the impact of efforts to reallocate funding and insulated areas from change.

The prospects for the long-term viability of NHS trusts and NHS foundation trusts

16) Despite the challenging financial environment, NHS providers have so far held up reasonably well at the aggregate level. Overall, the NHS in England reported a surplus of jslightly more than £2 billion in 2012/13. Our latest quarterly monitoring report found that nearly 90 per cent of NHS trust finance directors and CCG finance leads surveyed expect to break even or record a surplus in 2013/14. However, these figures obscure the fact that an increasing number of trusts are struggling – s7 of 42 NHS trust finance directors reported that they are forecasting a deficit.

[4] Buck D , Dixon A (2013). *Improving the allocation of health resources in England: how to decide who gets what*. London: The King's Fund.

17) These findings are echoed by other evidence. Monitor's latest quarterly monitoring report found that, in the first quarter of 2013/14, 48 foundation trusts were in deficit (41 of which were acute trusts), up from 36 in the same period last year.[5] It noted that trusts are finding it increasingly difficult to deliver efficiency savings and that some of those reporting deficits have not done so before. It also noted that many of those planning a surplus are forecasting that this will be less than 2.5 per cent of income, suggesting that more organisations are in a potentially vulnerable financial position. The NHS Trust Development Authority recently reported that 31 NHS trusts (30 of which are acute providers) are planning a deficit by the end of 2013/14, an increase of 5 on the beginning of the year and potentially leaving the NHS trust sector with a deficit of around £150 million.[6] Overall, this means around half of all acute providers are now either in or predicting a deficit.

18) These pressures are partly due to reductions in the tariff but have been exacerbated in the acute sector by other measures such as the 30 per cent marginal rate for 'excess' emergency admissions, which our last quarterly monitoring report suggested has resulted in a significant loss of income in many trusts, without having much, if any, impact on admissions. These pressures are reflected in EBITDA margins for trusts which have steadily declined from 7.1 per cent in 2008/09 to 6 per cent in 2012/13. Smaller hospitals face particular challenges because they have a higher proportion of fixed costs and lower margin non-elective work. We note that Monitor is looking at the issues faced by smaller providers we will be undertaking our own work in this area.

19) An added pressure for many acute trusts is caused by CCGs seeking to shift outpatient activity into community settings. While this can make care more accessible to patients, evidence suggests that initiatives to move care closer to home can drive up costs. Much greater scrutiny of commissioning strategies is needed to ensure that they reduce costs for health economies as a whole.

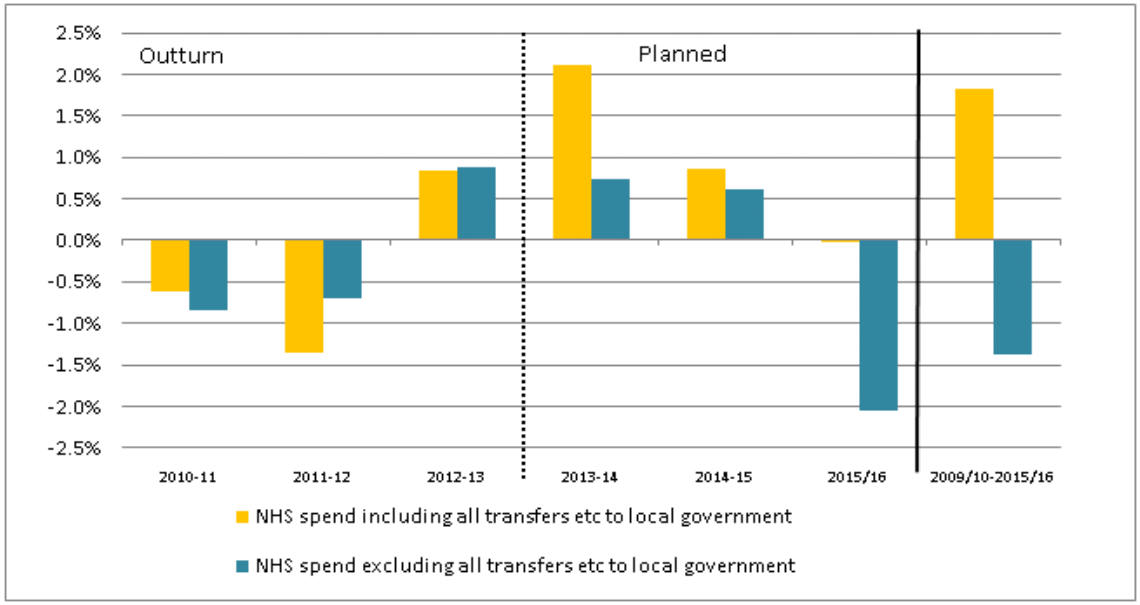
20) With a growing number of trusts in deficit, others may be forced to follow the recent example of Barts Health NHS Trust which has been forced to cut staff, including 161 nursing posts, in the face of significant financial difficulties.[7] Meanwhile, many hospitals are struggling to meet the four-hour A&E waiting time target, underlining how difficult it will be for providers to continue to maintain quality of care and balance the books. There are also significant pressures in the mental health sector, with recent evidence suggesting that more than 1,700 mental health beds have been closed since 2011.[8]

21) The pressure will increase in 2015/16 following confirmation of another year of essentially flat funding and the announcement of the new £3.8 billion Integration Transformation Fund (ITF). While this provides an opportunity to drive forward integrated care, it will result in an average reduction in funding for CCGs of approximately £17 million, adding significantly to pressures in the provider sector. As the graph below shows, while 'health care' spending will have increased over the period up to 2015/16, once the ITF and transfers to

[5] Monitor (2013). *Performance of the foundation trust sector: quarter ended 30 June 2013*.
[6] NHS Trust Development Authority (2013). *Summer report for the period 1 April to 31 July 2013*.
[7] *Newham Recorder*, 5 November, 2013
[8] BBC News and Community Care survey, October 2013

local authorities are accounted for, this translates to a 2 per cent real-terms cut in 'NHS' spending in 2015/16 and a 1.4 per cent cut over the period from 2009/10 to 2015/16.

Real changes in NHS spending with and without transfers to local government



22) Beyond this, the prospects look even more challenging. Overall, NHS England has forecast a potential funding gap of £30 billion by 2021, based on current trends in funding and demand. While this may be unduly pessimistic, it is clear that the NHS will remain under significant financial pressure and will need to continue to find year-on-year productivity improvements for the rest of the decade. Many NHS organisations now face a difficult choice between ensuring quality of care and balancing the books

The impact on adult social care of the 2010 Spending Review settlement and ability of local authorities to make efficiency savings

23) While the government's decision to allocate additional resources to adult social care in the 2010 Spending Review was welcome, this has been more than offset by an overall reduction in financial support to local government of more than 30 per cent. 2013/14 is the fourth consecutive year that local authorities have reduced social care budgets, with a planned reduction of £795 million contributing to a cumulative reduction of £2.68 billion over the past three years.[9]

24) Although councils have a strong track record of delivering efficiency savings, it is clear that their room for manoeuvre is now severely limited, with £104 million of this year's savings coming from the direct withdrawal of services. 87 per cent of councils now only respond to needs classified as substantial or critical under the Fair Access to Care (FACS) criteria. The decision in the 2013 Spending

[9] Association of Directors of Adult Social Services (2013). *ADASS budget survey 2013*.

Round to impose a further reduction in grant funding of 10 per cent in 2015/16 will add to these pressures.

25) As a result, the number of older people receiving publicly funded services has fallen by 26 per cent since 2009/10, with an equivalent reduction of 21 per cent among working age adults over the same period. Given the overriding imperative to provide care closer to home and reduce the need for residential care and hospital admissions, it is particularly worrying that the largest reduction has been in the use of community-based services such as home care (down 25 per cent) compared to nursing home care (down 4 per cent) and residential care (down 1.7 per cent).

26) Since the Committee's previous report, the government has announced its decision to implement the Dilnot Commission's proposals, albeit with a higher cap on individual costs than the Commission recommended of £72,000. We welcome this as a significant milestone and a stepping stone to wider reform. However, implementing the proposals will be challenging, with high risks of confusion, complexity and complaints. Without a major public awareness campaign, there is a real danger that many people will see the reforms as worse than the current system, rather than an improvement on it.

27) Implementing the Dilnot Commission's recommendations will not solve the social care funding challenge. As the Commission concluded '…the government must devote greater resources to the adult social care system. As well as funding for new reforms, additional public funding for the means-tested system is urgently required'.[10] The central challenge is to assess the total quantity of resources needed to ensure that people have access to the right level of support. For many people it is eligibility for help, not protection from costs that is the primary issue. Setting the national eligibility threshold at the moderate level under the FACS criteria would increase the number of people helped by 23 per cent. However, at an estimated cost of £2 billion, it is hard to see this happening in the current financial climate.

28) The combination of unremitting financial and demographic pressures is undermining the government's aim of putting social care on a stable footing through the Care Bill and the additional resources from the NHS. The House of Lords Committee on Public Services and Demographic Change was not exaggerating when it concluded that the social care system is in crisis.

The impact on NHS plans of decisions made by local authorities and the use of the additional funding for social care from the NHS budget

29) The 2010 Spending Review announced that £1 billion would be transferred to local authorities from the NHS over the four years to 2014/15, with further transfers of £100 million and £200 million pledged for 2013/14 and 2014/15 in the White Paper *Caring for our future*. Evidence suggests that CCGs and local authorities are working well together to agree how the transferred money is used. However, of the money allocated this year, £366 million (46 per cent) is being used to offset cuts to services and help meet demographic pressures,

[10] Commission on Funding of Care and Support (2011). *Fairer care funding: The report of the Commission on Funding of Care and Support, July 2011.*

rather than to drive transformational change. This is another indication of the pressure on budgets and a lost opportunity to promote integrated care.

30) Delayed transfers of care have remained largely stable over the past three years with the proportion of delays attributable to social care having fallen to 27 per cent in September 2013. Although we share the Committee's concern about the reliability of the national data given the strength of anecdotal evidence that delayed transfers are a significant problem in some areas, this does suggest that local authorities are prioritising hospital discharge, possibly at the expense of support for people living in their own homes.

31) As set out above, the creation of the Integration Transformation Fund from 2015/16 represents a major opportunity to drive forward integrated care, although it will increase pressures on NHS organisations. Expectations about what the ITF will achieve are high – national conditions that must be addressed in local plans include protecting social care services, relieving pressures on emergency care and ensuring seven-day working to support hospital discharge. Robust plans to achieve this will almost certainly involve reductions in hospital activity, adding to financial pressures in the acute sector.

32) The Committee's previous report was enthusiastic about the potential for health and wellbeing boards (HWBs) to be the forum for developing integrated care, a view that we share. Our recent report based on a national survey of HWBs found that they have made good progress in establishing themselves.[11] However, there is little sign that they have begun to grapple with the most pressing local issues, such as service reconfigurations, and only 9 of 65 responses in our survey identified integrated care as a priority. Boards appear to recognise the need to change gear, with 62 per cent of respondents saying they would like to play a greater role in commissioning services. The requirement that boards sign off local plans will be an important test of their readiness to take on a stronger commissioning role across all services.

33) The long-term ambition should be to plan with 100 per cent of NHS and social care resources, not just the 3 per cent represented by the ITF. This raises bigger questions about whether the post-war settlement, which established the NHS as a universal service, free at the point of use and social care as a separately funded, means-tested service, remains fit for purpose. This is why we have established an independent commission, chaired by Kate Barker, to explore whether and, if so, how the NHS and social care system should be brought closer together.

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

34) The Committee's previous report emphasised the need to increase the scale and pace of integrated care. Since then, the government has signalled a more ambitious approach to delivering integrated care with key national bodies signed up to a shared definition and commitment on integrated care, the creation of the ITF and the recent announcement that 14 pioneer areas will lead the way in developing integrated care.

[11] Humphries R, Galea A (2013). *Health and wellbeing boards: one year on*. London: The King's Fund.

35) Integrated care not only improves patient outcomes and experience, but also offers significant opportunities to make more efficient use of resources by reducing waste, duplication and fragmentation. However, it is important to recognise that transformational change takes time to demonstrate results. The potential for integrated care to deliver financial savings remains to be seen, and there may be a need to invest in new models of care before resources can be released from existing models.

36) Progress in implementing integrated care locally remains variable. Anecdotal evidence indicates increasing interest, with some parts of the country making good progress in developing and delivering ambitious plans. However, the finding from our survey, that most HWBs have not identified it as a priority, highlights the need for them to take a much stronger lead in driving it forward locally.

37) Despite high-level political commitment, there has been little, if any, progress in addressing the policy barriers that undermine the development of integrated care. There is a need for much greater urgency in addressing these.

- While Payment by Results should continue to have a role, local areas must be actively encouraged to test alternative, complementary payment systems that put in place the right financial incentives for integrated care, including capitated or global budgets.

- The implementation of the Health and Social Care Act has resulted in the fragmentation of commissioning, with the population-based budgets formerly controlled by primary care trusts now divided between CCGs, NHS England and Public Health England. Ways to re-integrate commissioning budgets must be found to make a reality of integrated care.

- Regulation of financial performance and the quality of care by Monitor and the Care Quality Commission should support the development of integrated care by focusing on system performance, not just organisational performance.

- We continue to believe that a single outcomes framework for the NHS, social care and public health is needed to incentivise health and social care organisations to work together to achieve common outcomes for the populations they serve.

- The application of competition policy risks hindering the development of integrated care; Monitor should have a greater role in supporting organisations to navigate and understand competition processes.