The King's Fund

Ideas that change health care

Written submission

House of Commons Health Committee inquiry on the impact of the Spending Review on health and social care

Evidence from The King's Fund

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.

We have submitted joint evidence with the Health Foundation and Nuffield Trust covering a number of the Terms of Reference. This supplementary submission, which should be viewed alongside the conclusions set out in our joint submission, addresses the remainder, focusing on: achieving efficiency savings; the impact and management of deficits in the NHS; integration of health and social care; and achieving parity of esteem between mental and physical health.

Summary

- To reiterate the post-Spending Review context from our joint submission: health spending will not rise by nearly as much as initially implied when the NHS settlement was announced, and social care funding will continue to fall short of meeting need.

- The productivity task facing the NHS over the next five years, in broad terms, means that around £5 billion of additional productivity gains need to be generated every year to 2020/21 across the whole of the NHS.

- The main policy levers used to deliver gains in the past, in particular, national controls over pay and tariff, look increasingly unsustainable. Improving productivity through better engagement of clinical teams, reducing variation, and identifying and eradicating

unnecessary treatments are all possible, but are not quick gains that fit within the current timescale for the productivity task facing the NHS.

- Many NHS providers are now in deficit. Some of the actions proposed to enforce financial control reinforce central control over NHS trusts and undermine the previous autonomy of NHS foundation trusts. Others are likely to have long-term consequences, particularly if they are sustained over a number of years – for example, limits to capital spending.

- We welcome the commitment to achieve integration of health and social care across the country by 2020, although fundamental differences in funding and entitlements between the NHS and social care will make genuine integration hard to achieve.

- While we welcome the additional £600 million allocated to mental health services in the Spending Review, the stark contrast in funding between mental health trusts and acute trusts reinforces the current lack of parity of esteem between mental and physical health.

- Overall, although the Spending Review provides welcome additional funding for the NHS and acknowledges some of the current pressures on social care, it sets a course for continued pressures on quality and access to health and social care services. We therefore reiterate our call for a new settlement that places health and social care on a sustainable footing for the future.

Achieving efficiency savings: their scale and source

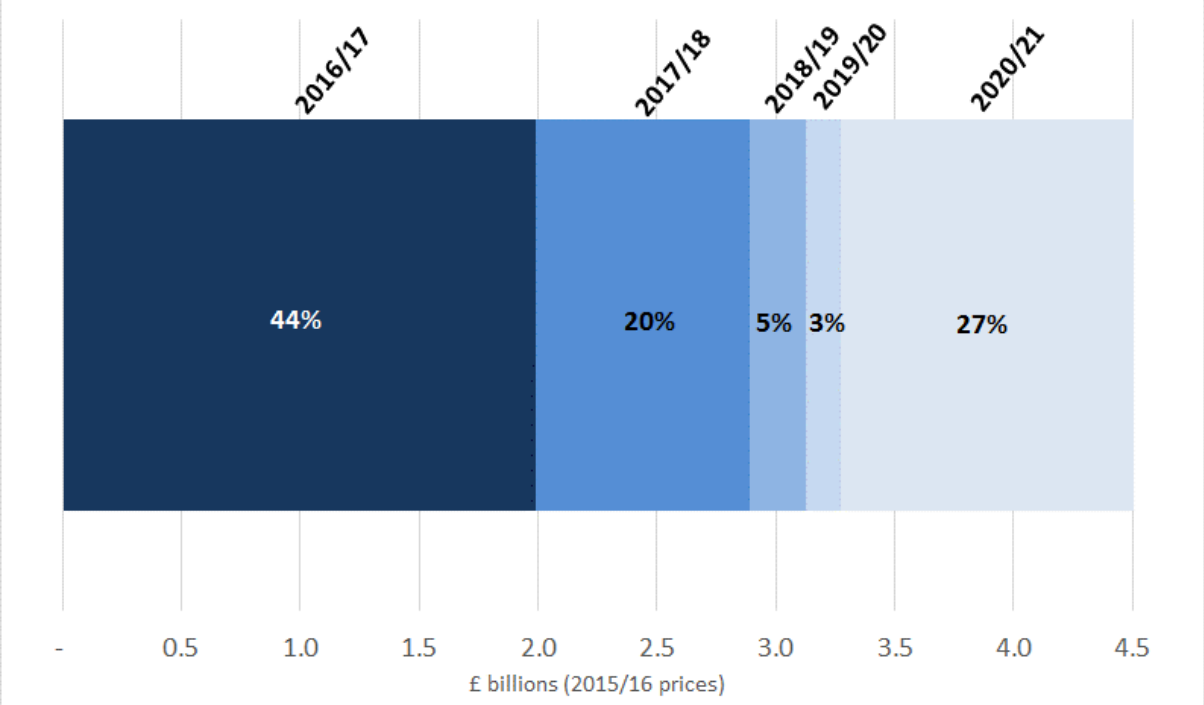
Scale of the productivity challenge

With a challenging settlement agreed, attention will now turn to the need to find £22 billion in efficiency savings by 2020/21, for which there is, as yet, no comprehensive national plan.

As we have argued in evidence to previous inquiries, improving productivity in the NHS should be thought of as 'finding ways to do more with the same' and generating better value for patients with the money the NHS has been given, as opposed to being about making savings or cutting costs.

NHS England has estimated that the NHS needs to achieve productivity gains worth £22 billion over this parliament. This was based on estimated overall funding pressures of £30 billion, of which £8 billion was to be met by additional resources from government. As we set out in our joint submission, the actual real increase in funding for the whole of the NHS (not just NHS England) is £4.5 billion by 2020/21, in effect increasing the productivity challenge.

Figure 1 Percentage of £4.5 billion additional funding available to NHS, by financial year to 2020/21



The productivity challenge is further complicated by the fact that NHS providers were forecasting a full-year deficit for 2015/16 of between £2 and £3 billion (although the Department of Health/NHS England are hoping this will be closer to £1.8 billion). Current plans for 2016/17 are for NHS England to meet a similar shortfall (£1.8 billion) out of the £3.8 billion real-term increase it is due to receive.

These estimates of the productivity task confronting the NHS are clearly broad brush. However, they show the scale of the challenge. On the front line there is considerable pessimism about the ability of the NHS to meet this challenge. Our October 2015 Quarterly Monitoring Report revealed that 85 per cent of trust finance directors surveyed thought that there was a high or very high risk of the NHS failing to achieve the productivity gains set out in the *NHS five year forward view* (Appleby *et al* 2015).

Source of productivity gains

This estimate of the productivity gains required puts into perspective current estimates from Lord Carter's review of efficiency (Carter 2015). This suggests that through various measures hospitals could save around £5 billion by 2020/21. This is equivalent to one year's worth of the productivity gains needed by 2020/21 and covers most aspects of hospitals' functions – procurement, pharmacy, estates and workforce.

Assuming these improvements are actually achieved, this leaves at least another £17 billion (of the original £22 billion) of productivity gains to be found from other sources.

As we set out in our joint submission, The King's Fund and the Health Foundation argued for a dedicated Transformation Fund (comprising around an additional £1.5–2.1 billion a year between now and 2020/21) to be established. The fund's purpose would be to accelerate change – including a drive for efficiencies – across the NHS at scale and pace.

The efficiency strand of this fund would be used to support implementation of plans to achieve higher rates of efficiency growth across all services and organisations in the NHS, to ensure that services are delivered cost-effectively. However, while we welcome the newly created Sustainability and Transformation Fund, we are concerned that there will be little money available to deliver improvements in operational efficiencies, particularly given that, at least in 2016–17, most of the fund will need to be used to restore financial balance in the provider sector.

Two of the key national strategies for improving productivity that accounted for a majority of the savings in the last parliament – freezing pay and reducing the prices paid to hospitals for services (by cutting tariff prices) – look increasingly unsustainable. In fact, the tariff set for next year (2016/17) effectively abandons the policy of incorporating a significant efficiency requirement. And while the government plans for no more than an annual average of 1 per cent increase in public sector pay to 2020/21, there must be growing doubt about its ability to enforce what will amount to a decade of severe pay restraint.

Historically, improvements in NHS productivity have been driven largely by reductions in the length of time patients stay in hospital and other changes such as the increased use of lower cost generic drugs and the substitution of day case for inpatient activity. While these may yet deliver some further gains, their scope is limited and further savings would take time to materialise (Alderwick *et al* 2015).

Our work at The King's Fund has argued that focusing on better value is the most promising way of realising the required productivity improvements. In individual organisations, better value can be pursued by engaging clinical teams in reducing variations in care. In other cases, changes are needed in how services are provided across organisational and service boundaries, for example, in delivering more co-ordinated care for older people to reduce delayed transfers. Successful implementation of these approaches depends on: the use of a tried-and-tested quality improvement method as observed in high-performing health care organisations; sustained and systematic investment in leadership development and culture change; and the collection and reporting of data on variations in care to enable leaders to understand their performance and identify areas for improvement. A good starting point would be for the NHS to develop a national quality improvement strategy to support local leaders. However, there is no quick fix; a strategy for quality improvement needs to be realistic about the time it takes to bring about change as well as the investment in capabilities required.

The scale and management of deficits in the NHS

The scale of NHS provider deficits

Deficits have spread far and wide across NHS providers. In the first six months of 2015/16, the net deficit among NHS providers reached £1.6 billion, with 75 per cent of organisations overspending and nearly two-thirds also forecasting a full-year deficit (Monitor and NHS Trust Development Authority 2015).

In previous years, the Department of Health has managed to absorb deficits without breaking the financial controls set by HM Treasury and voted by parliament. However, in 2014/15 the underspend on revenue was only £1 million from a total budget of more than £110 billion. Even this was only achieved after £250 million in additional revenue was provided by HM Treasury and significant cuts had been made to capital spending with the resources then transferred into revenue. The Department of Health is now looking to hold the net NHS provider deficit to no more than £1.8 billion in 2015/16, from which we assume that it has a plan to manage an overspend of this size through underspends in other health budgets.

Management of NHS provider deficits

The initiatives taken by the Department of Health and national NHS bodies to manage provider deficits have rapidly multiplied in recent months. These fall into two broad categories: actions to reduce pressures on NHS providers and actions to enforce financial control.

Actions to reduce pressures on NHS providers include the front-loading of the Spending Review settlement, thereby enabling the NHS to provide more income to providers whether through the new £1.8 billion Sustainability and Transformation Fund or the range of measures taken to ease the downward pressure on tariff. Central action to further reduce cost pressures on the NHS also includes continued pay restraint for NHS staff, action to reduce pharmaceutical costs through the Pharmaceutical Price Regulation Scheme and action to reduce procurement costs through Lord Carter's review of efficiency (Carter 2015).

The financial controls set out in the NHS planning guidance (NHS England *et al* 2015) and associated documents may have greater long-term significance. The £1.8 billion held in the Sustainability and Transformation Fund can only be unlocked with the agreement of the Department of Health and HM Treasury. Local NHS organisations must apply for this support and it comes with a long list of conditions. In addition, NHS Improvement will set financial control totals for spending for all NHS providers irrespective of whether they are in deficit or not. These controls will extend to an organisation's use of its own reserves and enforce a range of other central must-dos. For example, in an unpublished letter from Monitor, the NHS Trust Development Authority and NHS Improvement (2016), providers are told (among other things) how to manage the carry-over of annual leave, how to manage short-term sick leave and to 'remove prudence' from their handling of bad debts, deferred income and a range of other balance sheet items. These measures reinforce the dramatic extension of central control over NHS trusts and more radically, NHS foundation trusts. At the heart of the foundation trust model was a belief that greater local autonomy and responsibility for operational decision-making was good for both organisations and for the NHS. These controls undermine this independence.

The impact of these actions on NHS deficits

The impact of these changes is yet to be seen but there are likely to be major implications for patients. First, there will be a sustained and deep squeeze on capital spending. If this is limited to a year or two, across the NHS as a whole the impact may not be very great. If it needs to be sustained, however, then the NHS risks running down its estate and amassing a big bill for later years as the quality of its buildings and equipment deteriorates.

Second, costs in all health services are primarily accounted for by the workforce. At present the primary goal of cost reduction has been to reduce reliance on expensive agency staff. However, in a recent unpublished letter (2016), the national bodies were clear that headcount reduction may be inevitable for challenged providers.

Third, a significant proportion of NHS provider deficits are located in the acute sector, where they are widespread. It is also clear that the NHS must try to recover and maintain the key performance targets of 18-week referral-to-treatment waiting times and A&E. This creates a risk that the service will be forced to prioritise traditional acute services over mental health and community services, despite the clear strategic intention to achieve parity of esteem and invest in out-of-hospital settings. This risk is potentially compounded by the arrangements for accessing the 'general' element of the Sustainability and Transformation Fund in 2016/17, which will be focused on providers of acute emergency care, meaning that mental health and community health service providers are unlikely to be eligible for these funds (Monitor *et al* 2016).

Behind many of these changes lies the implication that the deficits have been caused by mismanagement within NHS providers. It is important to put this into context. The NHS is halfway through the most austere decade in its history and as a result, funding is failing to keep pace with the rising demand for health care services. During this period (in particular since the publication of the Francis Inquiry report (Mid Staffordshire NHS Foundation Trust Public Inquiry 2013)), the message from the government and the national bodies has placed the emphasis on quality of care and, in particular, on ensuring that providers have the staff necessary to treat this rising numbers of patients. These costs have had to be met primarily by efficiency rather than by rising expenditure. Unless the centre proves more able to reduce these rising cost pressures than local NHS organisations have been, then the only way to reduce deficits may be to reduce either the quality of treatment provided by the NHS, or the numbers of people treated.

Impact on the integration of health and social care

We welcome the commitment set out in the Spending Review to achieve integration of health and social care across the country by 2020. The government has made clear that it will not impose how the NHS and local government deliver this, setting out a range of models it supports, such as accountable care organisations, devolution deals and lead commissioner arrangements. However, it requires all areas to have a plan for integration in place by 2017, implemented by 2020. This echoes the recommendations of our work on

how to achieve a more integrated approach to commissioning (Humphries and Wenzel 2015).

The new NHS planning guidance (NHS England *et al* 2015) heralds a shift away from planning by individual institutions towards place-based planning for local populations. By June, every local health system must produce a five-year sustainability and transformation plan which will include plans for better integration with local authority services and for prevention and social care, and reflect agreed health and wellbeing strategies. We welcome this move to a place-based approach as a potential tool for progressing the integration agenda (*see* Ham and Alderwick 2015). For this to succeed it will be essential for the planning process for sustainability and transformation plans to fully engage local authorities as well as the NHS.

As we set out in our joint submission, while the Spending Review provides some recognition of the pressures facing social care, the additional money will not be enough to close the social care funding gap. As Simon Stevens, Chief Executive of NHS England, has pointed out, this makes genuine integration of health and social care commissioning budgets difficult: 'Until we have clarity and a viable social care funding proposition I see no way in the real world in which you could blend £100 billion plus of NHS funding with, in effect, an open ended liability for local authority financing' (Williams 2015).

While the fundamental differences in funding and entitlements between the NHS and social care identified by the Barker Commission remain (Commission on the Future of Health and Social Care in England 2014), genuine integration will be hard to achieve. The need for a new settlement to end the historic divide between health and social care has never been greater.

Progress on achieving parity of esteem through funding for mental health services

The Spending Review and recent pledges

We welcome the additional £600 million funding allocated to mental health services in the Spending Review, and see this as a stepping stone towards establishing 'parity of esteem' between mental and physical health services. Equally, the national recognition and support explicitly given to the forthcoming Mental Health Taskforce report is also a positive step.

We note, however, that much of the additional funding has been allocated to specific service improvements and models of care. Our own analysis demonstrates that mental health trusts, the largest providers of specialist mental health services, have experienced ongoing reductions in their income in recent years. Uncertainty over funding has led the majority to embark on large-scale transformation programmes aimed at shifting demand away from acute services, and delivering care focused on recovery and self-management in order to reduce costs. However, there is evidence to suggest that the scale and pace of some of these initiatives have had a negative impact on patient care, resulting in increased variation and reduced access to services (Gilburt 2015). Unless core funding is stabilised across the sector there is a distinct risk that the impact of funded improvements

may be undermined by further service reductions and reconfigurations as providers seek to balance their finances.

Given that the initiatives recently announced by the Prime Minister exceed the additional £600 million committed in the Spending Review (and with no new money attached), there is a need for clarity on the total funding allocated to improving mental health services. Additional clarity on how these spending commitments relate to previous pledges (such as the £1.25 billion for children's mental health announced in March 2015) would also be welcome.

Finally, the plans for the distribution of the £1.8 billion Sustainability and Transformation Fund in 2016/17 appear to favour providers of acute emergency care over other types of provider, including mental health. While this approach may be necessary in order to target deficits (which are at their worst in the acute sector), it risks penalising providers of other services, including mental health trusts that have not built up deficits, and running counter to the move towards greater parity of esteem.

Ensuring additional funds are spent as intended

A substantial portion of the additional money announced in the Spending Review will be funnelled to clinical commissioning groups (CCGs) in their allocations from NHS England, and the 2016/17–2020/21 planning guidance states that 'Commissioners must continue to increase investment in mental health services each year at a level which at least matches their overall expenditure increase.' A similar instruction was included in last year's planning guidance.

There is no national data available for spending on mental health services. NHS England has provided assurance that around 90 per cent of CCGs' plans reflected real-term increases in investment for 2015/16 as mandated. However, there is widespread scepticism in the mental health sector that this is the case and that funding is being allocated effectively. The arrangements outlined in this year's planning guidance (NHS England 2016) provide greater assurance that funding allocated to CCGs for mental health provision cannot be diverted to support care in other clinical areas. However, freedom of information requests made to NHS commissioning bodies last year revealed wide variations in the funding CCGs had set aside for mental health, demonstrating that there remains a fundamental lack of transparency around where funding is being allocated and how this relates to services on the ground (BBC 2015).

While spending on the mental health provider sector may be increasing, the stark contrast in funding allocation between mental health trusts and acute trusts remains. Our analysis shows that between 2011/12 and 2013/14 around 40 per cent of mental health trusts received a reduction in income compared with less than 14 per cent of acute trusts. Recent investment is a step forward, but is unlikely to counteract the sustained decline in funding for mental health services that underpins the current lack of parity of esteem.

Outstanding workforce challenges

One of the key remaining challenges in implementing improvements is workforce capacity. Our analysis highlights that providers are struggling to meet workforce requirements for existing services (Addicott 2015; Gilburt 2015). Work undertaken by NHS England to implement the new access standards in early intervention in psychosis services found that insufficient staff numbers and limited skill-mix meant that no service had the capacity to deliver National Institute for Health and Care Excellence-concordant services to more than 50 per cent of new first-episode cases by 2016 in line with the standard (Khan and Brabban 2015).

Ensuring that there are adequate staff and capacity to deliver the recommendations of the forthcoming Mental Health Taskforce report will be fundamental to implementation. This includes staff on the ground and appropriate capacity at a national level to ensure systematic oversight and support for commissioners and providers.

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