

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

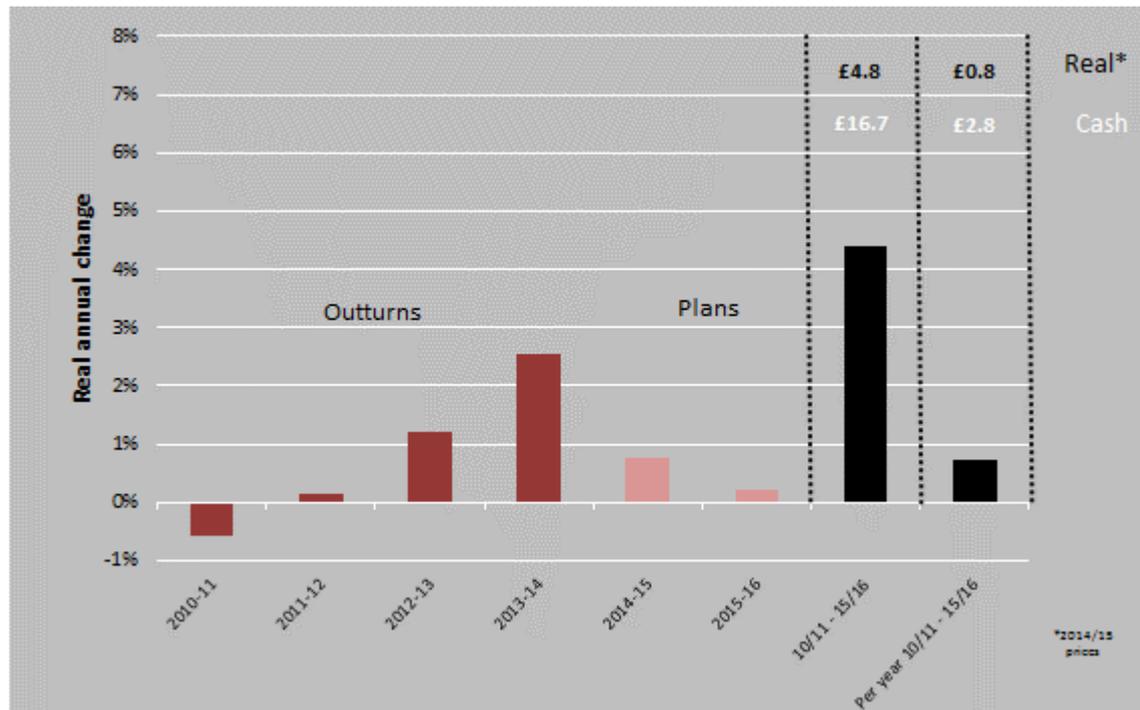
- 1) The King's Fund is an independent charity working to improve health and health care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together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

Summary

- 2) This evidence addresses most, but not all, of the inquiry's terms of reference, focusing in particular on the financial state of the health and social care systems.
 - The NHS faces huge pressures as a result of an unprecedented funding squeeze, rising demand for services and the need to safeguard quality following the Francis report. Social care is also under enormous pressure as a result of significant cuts to local authority budgets.
 - The number of NHS providers reporting deficits is unprecedented – financial distress has now become endemic across the system. It is touch and go whether the Department of Health will be able to balance its books this year.
 - A financial crisis is inevitable in 2015/16. Unless additional funding is found patients will bear the cost as staff numbers are cut, waiting times rise and quality of care deteriorates.
 - There is scope to improve productivity in the NHS. However, even under the most optimistic scenario outlined in the *NHS five year forward view* (NHS England 2014b), an additional £8 billion a year in funding will be needed by 2020.
 - Additional funding is also needed to pay for a transformation fund to help meet the cost of developing new community-based services and cover the costs of double-running during the transition between old and new models of care.
 - While spending on non-NHS providers of community and mental health services is rising, there is no evidence of a significant increase in private sector provision across the rest of the NHS.
 - The UK is not a big spender on health and social care. Increasing spending to 11-12 per cent of GDP by 2025, as recommended by the Barker Commission, would bring it in line with current spending on health care in countries such as France, Canada and the Netherlands.
 - As the Barker Commission set out, in the long term, a new settlement is needed for health and social care that ends the historic divide between the two systems and better meets the needs of 21st century patients and service-users (Commission on the Future of Health and Social Care in England 2014).
 - The King's Fund agrees that the bulk of the funding needed to implement a new settlement should come from the public purse – this raises difficult choices about how to find this money.

The current financial state of the health and social care systems, including particular pressures in the system

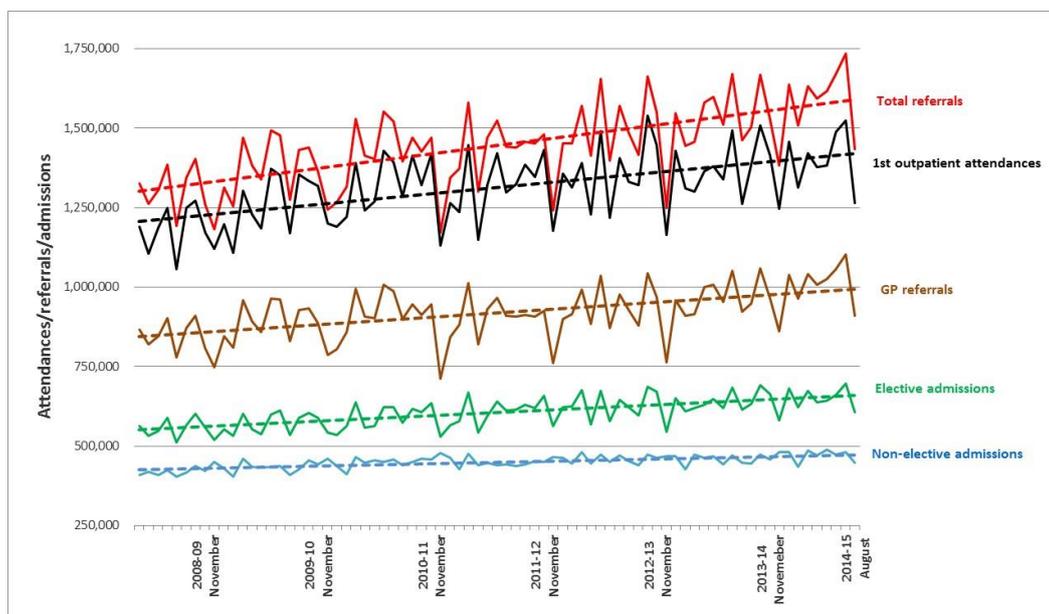
- 3) The NHS is now in the fifth year of an unprecedented funding squeeze. On current estimates, this year's planned spending for the NHS in England will amount to a real-terms increase of approximately 0.8 per cent (£846 million). This follows increases of 2.5 per cent and 1.2 per cent in the previous two years. Over the period between 2010/11 and 2015/16 as a whole, the NHS budget will have increased by £4.8 billion in real terms – an average of 0.7 per cent a year (see graph below). This is higher than the 0.1 per cent increase originally forecast, largely as a result of lower than expected inflation.



Real annual changes in English NHS total departmental expenditure limits: Outturns and plans 2010/11 to 2015/16

- 4) These calculations do not account for transfers to social care and allocations to the Better Care Fund. Since 2011/12, between £0.6 billion and £1.1 billion a year has been transferred to local authorities to support better joint working between health and social care. Next year, £3.8 billion in funding will be deployed through the Better Care Fund. In addition to the existing transfer of £1.1 billion, this will comprise £800 million from other funding streams (carers' breaks, re-ablement and capital funding), and a further £1.9 billion of NHS funding. £1 billion of the additional NHS money allocated will remain within the Fund to be spent by the NHS on out-of-hospital services or linked to a reduction in emergency admissions.
- 5) Social care is also under huge pressure. Since 2010, spending on adult social care has fallen by 12 per cent in real terms. Despite the best efforts of local authorities to protect services, this has led to a reduction of more than a quarter in the number of people receiving publicly funded care, with nearly 90 per cent of councils now only responding to needs classified as critical or substantial under the Fair Access to Care (FACS) criteria. In addition to removing vital support from people in need, this has a knock-on effect on the NHS by increasing emergency admissions and delayed discharges from hospital.

- 6) Last year, around a quarter of NHS providers ended the year in deficit, with the sector as whole recording a deficit of £107 million. This was balanced by a surplus on the commissioner side, despite around one in ten CCGs ending the year in deficit and an overspend of £377 million in NHS England's specialised commissioning budget. Overall, the Department of Health reported a surplus of just over £900 million. This followed two consecutive years when the NHS recorded larger surpluses of £2.1 billion, most of which was handed back to the Treasury under the budget exchange process rather than being reinvested in patient care, an issue the Committee has previously commented on.
- 7) This year, the position looks significantly worse. Monitor's report for the first quarter of the current financial year recorded an overspend of £167 million among foundation trusts, with 86 reporting deficits, more than double the number in the last quarter of 2013/14 (Monitor 2014). This is unprecedented. The NHS Trust Development Authority's report for the four-month period up to the end of July recorded an overspend of £300 million, with around a third of NHS trusts forecasting end-of-year deficits (NHS Trust Development Authority 2014). The position in the acute sector in particular has deteriorated sharply, with around two-thirds of hospitals either already in deficit or forecasting an overspend by the end of the year. This indicates that financial distress has spread well beyond those hospitals with a history of struggling to balance their books and is now endemic across the system.
- 8) This is mainly due to a combination of the funding squeeze, year-on-year reductions in the tariff (which has now been cut by nearly 7 per cent in real terms) and the recruitment of significant numbers of nurses to safeguard quality of care following the Francis report into the tragic events at Mid Staffordshire NHS Foundation Trust. Faced with a choice between safeguarding quality of care and balancing the books, it is clear that acute hospitals are choosing the former. At the same time, as the graph below shows, the number of referrals, admissions and outpatient attendances have been rising steadily over the last few years, adding to the pressures on hospitals.



Monthly referral and admission trends 2008/9 – 2014/15

- 9) Other areas of the NHS are also facing considerable challenges. General practice is under significant pressure due to rising demand from patients at a time when

its share of NHS funding is declining. Between 2005/6 and 2012/13, total investment in general practice fell by 7.6 per cent, including a fall of 2 per cent since 2010/11. While relatively few mental health trusts are reporting deficits, recent analysis suggested that the sector experienced a real-terms reduction in funding of more than 2 per cent between 2011/12 and 2013/14, leading to cuts in staff and prompting warnings from sector leaders about the parlous state of services (Health Service Journal, 14 August 2014).

- 10) The gloomy picture is reinforced by our latest quarterly monitoring report (Appleby *et al* 2014a). Nearly 40 per cent of NHS finance directors in our regular survey expressed concern that their trust will overspend this year – the highest proportion recorded since we began the survey. When asked about the prospects for the financial state of their local health economy over the next year, 90 per cent said they were pessimistic. There are some grounds for optimism on the commissioner side – our survey indicated that around 70 per cent of CCGs are expecting to end the year in surplus, with only 12 per cent expecting to record a deficit. This is in line with papers for NHS England’s board meeting in September which indicated that 20 of 211 CCGs expect to end the year in deficit and forecasted a surplus of £482 million in the commissioning budget, mainly as a result of a large underspend carried forward from last year (NHS England 2014a).
- 11) It remains to be seen whether commissioners will end the year with a sufficient surplus to cover the inevitable deficit on the provider side. With reports that a further £280 million could be made available alongside the £650 million already allocated to help NHS organisations respond to winter pressures and maintain referral-to-treatment waiting times, the scope to find additional funds from central budgets must now be very limited (Renaud-Komiya 2014). This all suggests it will be touch and go whether the Department of Health will be able to balance its books this year.
- 12) Next year, the NHS is set to receive a smaller real-terms funding increase of 0.2 per cent. With financial pressures continuing to build and significant amounts of NHS funding due to be deployed through the Better Care Fund, a financial crisis is inevitable. We therefore welcome calls by the Liberal Democrats to re-open next year’s NHS funding settlement in the Autumn Statement, and hope that the other main parties will also acknowledge the urgency of the financial challenge facing the NHS.
- 13) The extent to which the NHS is able to respond to these pressures in part depends on whether it can deliver productivity improvements. So far, the NHS has made good progress in finding the £20 billion in efficiency savings identified by the Nicholson Challenge. However, the main ways used to deliver savings so far – limiting staff salary increases, reducing the tariff and cutting management costs – have now been largely exhausted. Reflecting the increasing difficulty of continuing to find efficiency savings, nearly 60 per cent of NHS finance directors responding to our recent survey expressed concern about whether their cost improvement programme targets will be met this year. Monitor’s report on the first quarter of 2014/15 also highlighted a decline in the ability of foundation trusts to deliver cost savings (Monitor 2014).
- 14) We examined the prospects for further productivity improvements in a report published earlier this year, based on detailed research in six case study sites (Appleby *et al* 2014b). This found that there is scope to find more savings by focusing on four areas in particular:
 - a stronger national focus on collating and disseminating good practice in improving efficiency

- more emphasis on encouraging doctors, nurses and other clinicians to lead changes in clinical practice which improve care and reduce costs
 - stronger leadership at a regional level to plan and implement changes to services
 - more sophisticated approaches to incentivising NHS organisations to improve efficiency.
- 15) The NHS requires real-terms funding increases of around £4 billion a year to maintain quality and meet demand. There is scope to reduce this by improving productivity. We note the funding scenarios outlined in the *NHS five year forward view* (NHS England 2014b). Even the most optimistic of these scenarios – which depends on achieving very challenging productivity improvements of 2-3 per cent a year – would leave the NHS needing an additional £8 billion a year by 2020.
- 16) In addition to this, investment is needed to deliver changes to services – a point also made in the *NHS five year forward view*. A transformation fund should be established to help meet the cost of developing new community-based services and cover costs of double-running during the transition between old and new models of care. We are currently undertaking work with the Health Foundation to quantify how much funding is needed and how such a fund might operate.
- 17) While we welcome the recent commitments from all the main parties to increase funding, it is clear that none of them have yet addressed the scale of the financial challenge facing the NHS. With deficit reduction still a high priority, finding the money to meet this challenge will not be easy. However, unless this money is found, patients will bear the cost as staff numbers are cut, waiting times rise and quality of care deteriorates. In the longer term, the key challenge is how to ensure adequate resources to meet future needs, a question addressed by the Barker Commission's report (see below).

The impact of the Better Care Fund on the health and social care systems

- 18) The establishment of the Better Care Fund is an important step towards delivering integrated care, especially if it is used to support the kind of evidence-based interventions we summarised in our guide to commissioners published earlier this year (Bennett and Humphries 2014). However, its introduction at a time of mounting financial pressure on the NHS carries significant risks, and initial assumptions about what could be achieved, and how quickly, were heroic. Tight timescales made it inevitable that the quality of the initial plans was variable, and many did not demonstrate the engagement of providers or offer robust evidence about how reductions in hospital admissions could be achieved.
- 19) Although the recent changes made to the operation of the Fund go some way to easing concerns about its impact on NHS providers, they represent a substantial shift of risk back to local authorities. And, while the 3.5 per cent target for reducing emergency admissions is much more realistic than the 15 per cent reduction implied when the Fund was originally conceived, it is still ambitious, as the plans submitted by the five areas fast-tracked through the assurance process indicate. Overall, while we welcome the Fund as a stepping stone towards fully integrated health and social care budgets, it is clearly not a substitute for an adequately funded social care system, nor for a transformation fund with new money to deliver essential changes to services (see above).

The extent to which patient care and support services are provided by (a) NHS bodies (b) others and how this has changed over time

What types of services are being provided by private sector, voluntary and social enterprises and what is the evidence around quality, costs and outcomes

The impact of competition on the quality of NHS services

- 20) There has always been private and voluntary sector involvement in the NHS. Market-based approaches have gradually been extended over the past two decades, with the Health and Social Care Act going further than previous reforms in applying the principles of the market to the NHS. In 2013/14, just over £10 billion was spent on non-NHS providers of care.
- 21) A recent report from the Nuffield Trust showed that spending on non-NHS providers of acute care has slowed to a halt and now stands at around £1.4 billion a year (Lafond 2014). In contrast, partly driven by the Transforming Community Services programme, spending on non-NHS providers of community services increased by around a third in 2012/13, with almost one pound in every five spent accounted for by independent sector providers. Spending on non-NHS providers of mental health services also increased by 15 per cent in the same year.
- 22) Many of these services are delivered by the voluntary sector, which provides a wide range of services, particularly for marginalised groups and those with complex needs. In 2010, around £3.4 billion was spent on services provided by the sector. A growing number of NHS services are also provided by social enterprises and public service mutuals. The Review of Staff Engagement and Empowerment in the NHS (2014) found emerging evidence that, by giving employees a stronger stake in their organisation, public service mutuals deliver higher levels of staff engagement, a key factor in delivering better quality care.
- 23) There is limited evidence with which to compare quality, costs and outcomes between NHS and other providers. Some studies have compared quality between NHS and independent sector providers of acute elective care, mostly using PROMS data, but these do not point to significant differences in quality. One study found that, even after adjusting for casemix, some outcomes were better in independent sector treatment centres, but the differences were small (Chard *et al* 2011). The lack of data on the quality of community and mental health services makes comparisons very difficult.
- 24) There is also relatively little evidence about the relationship between competition and quality. Studies of the internal market in the 1990s found that incentives were too weak and constraints too strong for it to have a significant effect. While research has suggested that competition on price can reduce quality, some recent studies have indicated that, when prices are fixed, it can have a positive impact, although these findings are disputed (Cooper *et al* 2011; Gaynor *et al* 2010). The King's Fund's research has found that, while it is valued by patients, choice is a weak driver of service improvement compared to other factors (Dixon *et al* 2010). Evidence about the impact of competition should be weighed alongside the transaction costs associated with it. As the Committee reported in 2010, there is a lack of robust evidence about this, with unpublished research cited at the time suggesting transaction costs could be as high as 14 per cent of total NHS costs (House of Commons Health Committee 2009-10).

What changes have there been over time in the proportion of FT income provided by private patients, the uses to which this funding has been put and evidence of impact

- 25) Traditionally, NHS providers have generated a small amount of income by providing services to private patients. A handful of hospitals - mainly specialist hospitals in London with international reputations, such as Moorfields and the Royal Marsden - have generated more substantial sums from private work. For example, Moorfields raised around 12 per cent of its total income from private patients in 2012/13 and the Royal Marsden around 25 per cent. The Health and Social Care Act 2012 increased the cap on the amount that foundation trusts can earn from private work to 49 per cent of their income. This change took effect from 1 October 2012.
- 26) The most recent figures for 2013/14 suggest that, although a small number of hospitals have significantly increased the amount of income earned from private patients, there has been little change in the proportion of income generated from private work across the NHS as a whole - this has remained at around 0.7 per cent since 2010/11. Experience suggests that private work can provide a valuable source of additional income for hospitals to reinvest in NHS services, and that it is possible to provide high-quality care to both NHS and private patients at the same hospital.

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

- 27) In its previous report, the Committee highlighted the tension between the pace of change - the speed with which funding is increased to bring areas up to their target allocation - and maintaining stability by ensuring that areas do not receive cuts in funding (House of Commons Health Committee 2014). We continue to believe that NHS England's decision last year to protect funding for all CCGs was too cautious and that the pace of change is too slow. We therefore welcome Simon Stevens' comments to the Public Accounts Committee that the pace of change will be increased from 2016/17, with the aim of moving all CCGs to within 5 per cent of their target allocation within two to three years. We also welcome his intention to move towards 'place based' funding formulas - this could help reduce some of the complexity and fragmentation inherent in the current process.
- 28) Given the need to focus much more strongly on preventing ill health, we are concerned at the recent decision to cut funding for public health in real terms. We are also concerned that funding set aside for the health incentive premium is insufficient for it to have a meaningful impact. Two other key issues need to be addressed in relation to public health allocations. First, the government has never been clear about the total amount of funding that should be allocated to public health. Second, a cost-based allocation should be included to reflect the fact that local authorities are mandated to deliver some services, such as sexual health and drug treatment. Otherwise, there is a risk that public health will be systematically under-funded.

The nature and extent of management costs in the new NHS structure

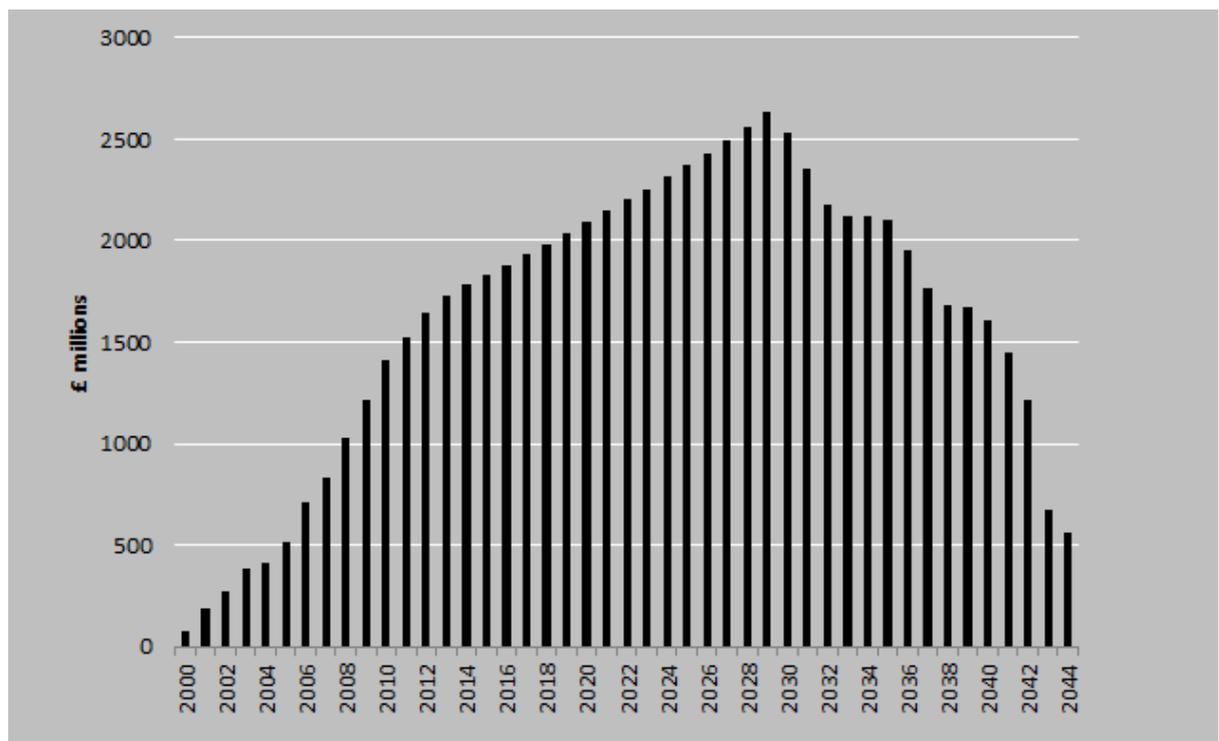
- 29) The coalition government has pledged to cut administration costs by one-third and reduce the number of managers in the NHS by 45 per cent. We are not able to quantify management costs in the NHS from the data available. However, it is worth noting that between April 2010 and March 2013, the number of managers working in the NHS fell from 42,515 to 35,304, a reduction of 17 per cent. A

further 1,600 managers were lost in April 2013, when the reformed NHS structure came into effect. Since then, the number of managers has risen to 34,776.

30) Managers account for approximately 3.3 per cent of the NHS workforce. In a report published in 2011, The King's Fund's Commission on Leadership and Management in the NHS found no evidence that the NHS is over-managed (The King's Fund 2011). As the election approaches, it will be important not to slip into another sterile debate about reducing the number of managers in the NHS. Any further efforts to reduce management costs should be focused on reducing the regulatory burdens on NHS organisations not on cutting the number of managers.

What has been the cost of PFI agreements to the NHS over time

31) There are around 116 PFI schemes across the NHS in England with an estimated capital value of £12 billion. Data from the Treasury provides an estimate of unitary payments by NHS organisations between 1998 and up to 2048 (the last payment for current ongoing PFI schemes). This is incorporated in the graph below. The total estimated payments this year amount to around £1.8 billion – approximately 1.6 per cent of total NHS spending or about 2-3 per cent of total provider spending. Although PFI debt is a significant problem for a small number of trusts, it represents a relatively small amount of NHS spend overall, and has led to much-needed investment in new facilities.



Estimated unitary PFI payments for NHS schemes in England: 2000-2044

The possible funding options for the NHS for the long term, including international comparisons

32) Analysis carried out for the Barker Commission suggests that the UK is not a big spender on health and social care. In 2011, the UK spent 9.4 per cent of GDP on health care, which is marginally more than the OECD average of 9.3 per cent. The Commission recommended that spending on health and social care should rise to

11-12 per cent of GDP by 2025. This would broadly match what countries such as France, the Netherlands, and Canada currently spend on health care alone.

33) The Commission considered a wide range of future funding options, including charges for health care, social insurance and changes to taxation. It rejected charges for NHS services (with the exception of changes to prescription charges) on grounds of equity and efficiency. It also ruled out a switch to social insurance as there is no evidence that insurance-based systems perform better, while it would increase burdens on employers and cause huge upheaval. The Commission concluded that the bulk of the money to pay for its recommendations should come from public funding, with the greatest contribution from those who would benefit the most, namely wealthier older people. The King's Fund agrees that the bulk of the funding needed to implement a new settlement for health and social care should come from the public purse.

To what extent is it a realistic option to merge NHS and social care eligibility and funding as set out in the Barker Review

34) We share the Barker Commission's view that the 1948 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, is not fit for purpose. With so many people living longer with a mixture of needs that cross the boundaries of health and social care, the historic divide between the two systems is not sustainable. The lack of alignment in entitlements, funding and organisation results in unfairness, poorly co-ordinated services and confusion for patients, service users and their families. While the implementation of the Dilnot Commission's report will provide protection against very high social care costs, the financial burdens will still be great for many families.

35) The King's Fund has argued that the long-term ambition should be to move towards fully integrated health and social care budgets, a position also supported by the Committee in previous reports. We therefore welcome the Commission's call for a single ring-fenced budget and a single local commissioner of services. Implementing this would require a staged approach and detailed consideration is needed to understand how a single commissioner could work – we are undertaking further work to explore this. The Commission's recommendations to extend free social care to those with the highest needs are a sensible, modest and affordable first step towards a closer alignment of entitlements between the two systems.

The potential impact of the extensive use of personal budgets on the funding and planning of health and social care services

36) Evaluations have shown that personal health budgets (PHBs) can deliver benefits for patients and are associated with improvements in quality of life and psychological wellbeing. They are likely to work best for patients with fairly stable and predictable conditions who are well placed to make informed choices about their treatment, for example, some patients receiving NHS continuing care or with long term conditions. However, while it is impossible to disagree with the objectives of PHBs – to empower patients to take more control of their health and health care – their widespread use in a universal health system such as the NHS raises some challenging issues.

- PHBs require health care professionals to act as advocates and care co-ordinators, and services to deliver flexible, person-centred care. This requires training for staff and an improvement in the personalisation of many services.

- To ensure that money follows the patient, work is needed to unbundle block contracts for community and mental health services, while the use of PHBs alongside population-based capitated budgets may pose some challenges.
- PHBs require a market in which patients can exercise choice in how to spend their money. This requires commissioners to work actively to stimulate local markets and decommission services that are not well used.
- Clear guidance is needed on access to non-evidence based treatments such as homeopathy and on patients using their own income to top up their PHBs.

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