

Supplementary submission to the Health Committee inquiry on the impact of the Spending Review

This supplementary submission to the Health Committee's Spending Review inquiry draws on the Nuffield Trust's own research, and lays out our analysis on the issues of NHS trust financing, system efficiency and the quality of care. It is intended to accompany our joint submission with The King's Fund and the Health Foundation, which presents our shared understanding of the distribution of funding over the Spending Review period; the basic efficiency challenge; cuts to non-NHS England budgets; social care funding; and access to care.

We have serious concerns about the current financial position of the NHS and how this will affect its ability to find financial and organisational headroom to implement the desired service change and transformation set out in the Five Year Forward View.

Of chief concern are the following:

- The underlying NHS provider deficit (in excess of £2 billion) is structural and will take at least five years to clear at the rate of change currently projected
- Balancing provider deficits in the meantime will cost in the region of £6 billion over those 5 years. These are funds which will not be available for 'service change'
- As a result of the need to balance provider deficits, additional funds for 'transformation' will not be front loaded but will instead be back-loaded, reducing scope for significant investment and change by the end of the Spending Review period
- The last NHS efficiency drive to save £20 billion a year by 2015 relied heavily on extracting efficiencies from the provider sector and pay restraint. The opportunities to extract further efficiencies from this sector are now limited. Lord Patrick Carter's review finds £5 billion of opportunity from the acute sector by 2020. This equates to recurrent cuts to hospital costs of around 2 per cent a year. This is substantially below the level of efficiencies demanded of the sector in recent years
- There are now signs that financial restraints may be undermining care quality and access.

A. Impact of provider deficits

1. Although the settlement nominally awards NHS England with 'front loaded' extra resources – equivalent to 3.7 per cent real terms growth in 2016-17 and falling to 0.4 per cent and 0.7 per cent in 2018-19 and 2019-20 – the impact of NHS provider deficits is likely to mean that additional funds for investment in new models of care or transformation will be anything but 'front loaded'.
2. The Nuffield Trust has calculated that of the £14 billion cash fund NHS England has created to spend on Sustainability and Transformation over the next five years, in the region of £6 billion appears to have been earmarked for provider deficits.¹ We welcome the foresight policy makers have taken in setting aside these funds, but the scale of sustainability funding needed has important implications for the availability of funds for 'transformation'.

¹ This figure is based on an extrapolation from the early announcement that Greater Manchester's share of the transformation-only aspect of the fund is £450m: equivalent to an England-wide transformation-only fund of £8 billion. For more information see: 'Transformation fund' or deficit mop-up? Time for an honest conversation <http://www.nuffieldtrust.org.uk/blog/transformation-fund-or-deficit-mop-time-honest-conversation>

3. The £6 billion figure is far larger than the one-off £1.8 billion fund for 2016–17 generally implied by ministers as being needed for provider sustainability. In fact, £1.8 billion is the minimum that will be needed next year to provide a one-off bridge over the recurrent gap between the income NHS providers earn through the NHS tariff (the list of 1000s of hospital procedures and standard NHS-wide prices) and their costs. We estimate that clearing the gap completely will take five years at a plausible rate of cost reductions and require the full £6 billion apparently earmarked by NHS England to balance provider books in the meantime.

B. Genesis of current NHS provider deficits

1. The current gap between NHS provider income and their costs has been generated by years of extremely high efficiency targets built into the NHS tariff. Although the tariff is supposed to reflect the average cost of providing a given treatment or procedure, the annual efficiency targets built into it effectively ask providers to absorb rising input costs as opposed to increasing prices to reflect them. Between 2011-12 and 2014-15 tariff efficiency targets required providers to reduce their costs by a real terms 4 per cent recurrently, year on year: the equivalent to reducing an input costing £100 in 2010-11 to cost £85 in 2014-15.
2. Such high efficiency requirements were a deliberate policy of the ‘Nicholson Challenge’ era and Sir David Nicholson himself told the Health Committee in 2010 that of the total £20 billion to be saved, approximately 40 per cent – or £8 billion a year by 2015 – would be found through tariff efficiencies.²
3. Although NHS providers have made year-on-year cost improvements, they have not managed to achieve the 4 per cent level recently required by the tariff, and since 2013-14 have missed the requirement by between 1 and 1.5 percentage points a year.
4. Every percentage point gap between the cost reductions required by the tariff and what providers actual achieve is the equivalent of around a £600m to £700m income and expenditure gap for providers.³
5. Thus, in simple terms, we can see that the 1 per cent gap between the tariff efficiency requirement of 4 per cent and actual achievement of around 3 per cent in 2013-14 drove the reported underlying NHS provider deficit of £600m for that year.⁴
6. As tariff efficiency requirements are recurrent – asking providers to reduce costs year on year – so too are any income and expenditure gaps which arise from failures to meet them: The previous year’s deficit simply becomes the starting point for each

² <http://www.publications.parliament.uk/pa/cm201011/cmselect/cmhealth/512/51208.htm>

³ Based on a total NHS provider cost base of between £60 billion and £70 billion a year. The range reflects the fact that not all provider activity is priced directly using the tariff. However contracts for non-tariff activity are standardly priced with reference to the efficiency target within the relevant year’s tariff.

⁴ This ‘underlying’ deficit is after the temporary DH bailout funding has been removed and is as reported in the DH accounts for the year. In practice, the fact providers had exceeded the efficiency requirement in previous years meant that, all other things being equal, they would have had some capacity to absorb initial losses against the tariff. However other factors were also at play which cannot be detailed here, including the rules preventing providers being paid the full tariff rate for emergency procedures and the impact of staff shortages escalating agency costs and demand

subsequent year, as tariff income moves further and further away from covering providers' costs.

7. The gap between provider income and expenditure was then widened again in 2014-15 when the 4 per cent target was missed by around 1.3 percentage points, translating into another £800–900 million gap between provider income and costs, bringing the underlying deficit for the year to £1.5 billion.
8. For 2015-16, the efficiency target in the tariff was reduced to 3.5 per cent. Monitor has reported providers making cost improvements in the region of 2.5 per cent, implying that the £1.5 billion gap will be widened further this current financial year by a further £600–700 million, resulting in an underlying deficit of around £2.1 billion to £2.2 billion – before the impact of any additional pressures such as higher temporary staffing costs and unfunded additional activity.

C. The sustainability fund and trajectory out of provider deficit

1. NHS providers will therefore start their trading with commissioners in 2016-17 with a tariff and pricing structure which leaves them around £2.2 billion behind. That year – and those beyond it – the efficiency target in the tariff will be reduced to 2 per cent. That is half a per cent below what providers are currently achieving. Assuming providers maintain that level of cost efficiencies, their half a percentage point 'gain' over the tariff means they may start to make annually recurrent improvements against the underlying £2.2 billion deficit figure in the region of £300m a year.
2. However, relying on that additional marginal 'gain' over the tariff efficiency requirement alone would leave NHS providers unable to break even until 2022-23.
3. The 'sustainability' element of the Sustainability and Transformation Fund is designed to bring the provider sector into apparent balance quicker – providing a gradually reducing bridge each year between trust income and expenditure by directly financing providers (predominantly hospitals) outside of the tariff.
4. The Nuffield Trust has estimated that well over £1 billion will be needed each year in 'sustainability' funds for the next three years, reducing to £600m only by 2020-21. The implications for funds available for 'transformation' are set out in Table 1 on the next page, alongside our estimated trajectory for NHS provider recovery, based on a tariff efficiency requirement of 2 per cent, and actual achievement by the provider sector of 2.5 per cent.

Table 1: Sustainability versus transformation funding: The long road out of provider deficits

	Estimated income over expenditure shortfall implicit in tariff at start of financial year* (£bn)	Estimated achievable <u>additional</u> efficiency over tariff requirement (£bn)	Announced Sustainability and Transformation Fund for year (£bn)	Estimated 'sustainability' funds needed to balance provider deficits (£bn)	Estimated Sustainability and Transformation Fund available for 'transformation' (£bn)
2016-17	-2.1	0.3	2.1	1.8**	0.3**
2017-18	-1.8	0.3	2.9	1.5	1.4
2018-19	-1.5	0.3	2.9	1.2	1.8
2019-20	-1.2	0.3	3.4	0.9	2.5
2020-21	-0.9	0.3	3.4	0.6	2.8
2021-22	-0.6	--	--	--	--
Total		1.5	14.7	6.0	8.8

Cash figures. Estimated additional efficiencies based on NHS provider cost base in region of £60 billion

* Note that I&E shortfalls at the start of each year are equal to the underlying deficit at the end of the prior year

** NHS England has already announced the split between sustainability and transformation funds for 2016-17

D. Lessons from previous NHS 'efficiency challenges'

1. The emergence of large NHS provider deficits – potentially in the region of 4 to 5 per cent of provider turnover this financial year – raises questions about the recent trend to find NHS savings by squeezing recurrent efficiencies out of NHS providers.
2. Concerns about such an approach were raised by the Health Committee in its 2010 Public Expenditure report, which stated:

"We are concerned that 40% of the necessary efficiency improvements are to be derived from tightening the tariff. There is no guarantee that reductions in the tariff will always result in genuine efficiency gains, and there is a risk that the quality of services could suffer if changes are driven by reductions in the cost of the tariff alone."

3. While it is not currently possible to say whether or not there is a direct or causal relationship between financial pressures and recent declines in NHS performance on access and waiting times (on which, see more below) it certainly appears the Committee was correct to query whether all the efficiency gains of the Nicholson

Challenge era were indeed ‘genuine’. Although the squeeze on tariff prices may well have saved in the region of £8 billion from annual NHS commissioner expenditure by 2015 – cumulating to around £20 billion in tariff savings over the four years - it now seems highly likely that, over the next five years, around £6 billion of that cumulative £20 billion will need to be returned to deficit-struck providers.

E. Implications for the £22 billion challenge to 2020-21

1. Much has been made – particularly by ministers – of Lord Patrick Carter’s imminent report on hospital productivity in which the potential for £5 billion of savings over the next four years are set out. It should be noted however that the rate of achievable efficiencies Lord Carter identifies – around 2 per cent (recurrent) of hospital cost base a year – are at best very similar to the level of efficiencies NHS hospital providers have achieved in recent years, and in many years, significantly lower.⁵
2. Viewed from that perspective, Lord Carter’s review could arguably be taken as a warning that the era in which we could look to the acute hospital sector to extract very significant cost savings is over.
3. It is therefore right that the NHS should look to improve its productivity by redesigning care pathways to ensure patients are treated in the most appropriate and cost effective setting. However, we believe it is easy to overstate the savings opportunities that may arise from such changes and we have concerns about the effectiveness of the approach to realising these savings.

F. Reducing hospital capacity is problematic

1. There is a long history of commissioners making unduly optimistic assumptions about their capacity to manage demand, and thereby the size of savings that can be made by reducing the use of acute care, and ultimately reduce hospital capacity
2. Over-optimistic assumptions about reducing hospital use can lead to both commissioner and provider budgets being overspent, as both make their financial and activity plans on unsound figures, which can increase the need to make ‘spot purchases’ of capacity or staff at premium prices
3. The position is exacerbated by widely held beliefs that community-based care is ‘cheaper’ than secondary care. Yet there is very little evidence upon which to assess the cost effectiveness or otherwise of new models, and what evidence is available

⁵ Foundation Trust providers’ cost reductions are tracked quarterly by the regulator Monitor and reported against their annual Cost Improvement Plans (CIPs)

suggests that community based alternatives rarely save money overall and can inflate costs, at least in the short term.⁶

4. It should be noted that the provision of a community-based alternative will never release cash unless at least the equivalent resource can be released from secondary care, through closures or capacity reductions which can be politically difficult.
5. Our ongoing research suggests that far from there being a case for reducing hospital capacity, there is a strong argument to increase it: Over recent years the three-decade-long trend for bed occupancy rates to decrease has been reversed. Death rates fall and the number of patients with complex and multiple conditions increases, yet hospitals have continued to cut available beds on their wards.
6. Average occupancy is now above 85 per cent –the figure cited by a number of influential studies as the level above which safety and bed availability may be threatened.⁷ Our ongoing work highlights that unless there is sufficient space to manage the flow of patients through the system throughout the day, queues build up. This dynamic underpins many of the current problems in emergency departments.
7. One of the most effective ways of increasing capacity is to expand out of hospital care which while it may have similar costs in terms of direct care avoids the fixed costs of buildings and supportive services.
8. The financial path laid out in the Spending Review will shape the possible response to this. With continued financial pressure, and capital investment likely to remain very constrained, there is little scope to actually build enough hospital bed capacity to reduce occupancy rates, and insufficient resource funding to increase staffing levels in order to staff any additional beds.
9. Large-scale reconfiguration (typically involving radical changes to the structure and provision of a hospital trust, including closing capacity) is frequently mooted as a potential avenue for significant savings, yet these invariably do not emerge. The greatest potential savings from reconfiguration come when services from one hospital can be absorbed into the available capacity at another and a site is fully closed. Yet opportunities to close sites are limited as many English hospitals and their specialist units – such as maternity – are running at full capacity.

G. Staff pay

1. Pay rates in the NHS have been subject to significant restraint and ‘freezes’ since 2010. The Department of Health told the NAO in 2011 that up to 40 per cent of the

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https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/459414/Moving_healthcare_closer_to_home_financial_impacts.pdf

⁷ <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC28163/>

£20 billion ‘Nicholson Challenge’ savings – £8 billion a year by 2015 – would come from a pay restraint and central budget cuts.⁸

2. After five years of such restraint, there is growing evidence of a recruitment and retention crisis across the NHS, with the most palpable indicator being providers’ growing reliance on temporary staffing, which grew from 4 per cent of the total pay cost in 2009-10 to 7 per cent by the middle of 2015-16, or around £3.6 billion.⁹
3. Although measures are being introduced to ‘cap’ agency expenditure, they do nothing to address one of the root causes of the problem, which is falling real wage rates for NHS staff.
4. Although there is a lack of reliable data on temporary staff costs in the NHS, our analysis of the available data suggests a clear inverse relationship between NHS pay rates and the average unit cost of temporary staff, with real terms decreases in the first leading to real terms increases in the latter.
5. The current position makes it likely that any further attempts to significantly cap NHS pay increases will further undermine staff recruitment and retention.

H. Capital

1. The Spending Review capped the Department of Health’s capital budget at £4.8 billion for the rest of the Parliament. It has subsequently emerged that the department plans to again transfer a significant proportion of this budget – over £1 billion – into revenue spending next financial year.¹⁰
2. Such a move is necessary to help the Department of Health manage the 12 per cent real terms cut to the budgets it manages outside of NHS England next financial year.
3. However the move means it is becoming increasingly hard for NHS organisations to build new facilities – a restraint which threatens to undermine attempts to develop new services around new models of care. Even where organisations have access to their own savings or borrowings (in the case of foundation trusts, for instance), capital spending controls now attached to their receipt of ‘sustainability’ funds means they will be prevented from spending this cash.¹¹

I. Impact of funding restraint on quality

1. Although it is true that there are instances where, as Jeremy Hunt has said, “good care costs less”, there are also clear mechanisms by which financial pressure can mean pressure on standards of care.

⁸ https://www.nao.org.uk/wp-content/uploads/2011/12/NAO_briefing_Delivering_efficiency_savings_NHS.pdf

⁹ Monitor, 2009-10 consolidated accounts, and 2015-16 Q2 report. This figure includes providers’ own ‘banks’ of nursing staff, although the bulk of it relates to agency staff, which typically cost significantly more than bank staff.

¹⁰ <http://www.hsj.co.uk/topics/spending-review-2015/exclusive-dh-agrees-12bn-raid-on-its-2016-17-capital-budget/7000725.article>

¹¹ These controls are set out in the as yet unpublished letters from Monitor and the TDA to organisations dated January 15, 2016. The rationale behind limiting self-funded expenditure is that such spending still scores against the DH’s capital expenditure limit, as set by HMT

2. Access to care is an important aspect of quality. Because it is often easiest to measure, it is often the most prominent measure of it. If patient demand for treatment rises faster than the volume of treatment the NHS can fund, then the proportion of patients who can access treatment must fall. Where cuts are expressed through reducing payments to providers, this also weakens or reverses their incentive to do more.
3. The financial situation also has implications for the number of staff that can be employed. After 2010, the number of nurses employed by the NHS in England fell: it then rebounded sharply from 2013, after the Francis Report called more attention to issues of adequate staffing.
4. Having sufficient numbers of staff relative to numbers of patients has been shown to be an important determinant of safety and outcomes, most clearly in hospitals,¹² but NHS trusts sometimes struggle to provide this. It is almost inevitable that providers struggling to meet challenging financial control totals will do so by cutting back on their single biggest cost base: their staff, particularly if their regulator is seen to be encouraging such actions.¹³
5. Waiting times are a crucial measure of access to hospital. Often the most highly visible quality indicators in the NHS, they have seen a systematic decline despite intense pressure from the health service leadership to maintain performance.¹⁴ For planned care, the growth of the waiting list and longer waiting times over the past three years represent the NHS failing to deliver as many treatments as there are referrals.¹⁵ It will continue to grow as long as this is the case. Our ongoing research underlines how growing pressure on beds helps drive A&E access problems.¹⁶
6. Although there is much less available data, non-hospital sectors of the NHS have seen similar financial pressure and some appear to be experiencing similar trends of worsening access. The GP Patient Survey shows a slow but steady decline since 2010 in almost every measure of access to primary care.¹⁷ Our QualityWatch reports with the Health Foundation in 2014 and 2015 have highlighted worsening access to mental health care, as well as significantly worse physical outcomes for patients with mental health conditions compared to those without.¹⁸ While commitments to increase spending in both areas have been made,¹⁹ the Committee should ask how much of this will and should be used to simply reverse these existing declines in access.
7. There have also been signs of tension relating to the NHS's ability to pay for new drugs and technologies. Last year, NHS England had to delay commissioning of the hepatitis C drug Sovaldi for cost reasons.²⁰ The Cancer Drugs Fund, which paid for cutting-edge drugs that are less cost-effective than would usually be approved, is to be ended in its current form because its rising cost has become unaffordable.²¹ The Spending Review's continuation of a similar funding path, with drug costs expected

¹² <https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf>

¹³ <http://www.theguardian.com/society/2016/jan/29/hospitals-told-cut-staff-nhs-cash-crisis>

¹⁴ <http://www.nuffieldtrust.org.uk/media-centre/press-releases/no-quick-fixes-growing-hospital-waiting-times-nuffield-trust-warns>

¹⁵ <https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2015-16/>

¹⁶ <http://www.nuffieldtrust.org.uk/blog/lessons-last-years-ae-winter-crisis>

¹⁷ <https://gp-patient.co.uk/>

¹⁸ http://www.qualitywatch.org.uk/sites/files/qualitywatch/field/field_document/QW_Annual_Statement_2015_WEB.pdf;

<http://www.qualitywatch.org.uk/focus-on/physical-and-mental-health>

¹⁹ https://www.england.nhs.uk/wp-content/uploads/2015/12/04.PB_17.12.15-Allocations.pdf

²⁰ <http://www.pmlive.com/pharma-news/nhs-england-sets-up-new-190m-hep-c-fund-755898>

²¹ https://www.engage.england.nhs.uk/consultation/cdf-consultation/user_uploads/cdf-consultation-doc.pdf

to rise by up to 10 per cent in some cases, is likely to mean these issues intensify. Specialist commissioning spend continues to rise at a very rapid rate due to the fast pace of innovation and improvement across a range of disease areas.

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Nuffield Trust is an independent health charity. We aim to improve the quality of health care in the UK by providing evidence-based research and policy analysis and informing and generating debate.

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