evidence for
better health care

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Health Committee Inquiry Submission: public expenditure on health and social care

Key Points

- Since 2010/11, the NHS has met its headline financial targets, drawn up to reflect a goal of making 4% annual savings each year. The Nuffield Trust and the Health Foundation's QualityWatch programme[1] shows that across the performance indicators examined there has been no general decline in the quality of care delivered to patients, although urgent care and the prevention of emergency admissions to hospital is a serious concern.
- There are signs that many acute hospital trusts face severe and potentially unsustainable financial pressures. These are concentrated in non-foundation trusts, smaller foundation trusts, and certain local areas, and have been partially masked by acute trusts using non-recurrent spending to achieve financial balance.
- Adjusting for non-recurrent spending, earnings before interest, tax, depreciation and amortization (EBITDA), a crucial indicator of viability, show a concerning downward trend for both foundation and non-foundation trusts. Forty three non-foundation trusts are below the levels required for achieving foundation trust status. The number of trusts which will never achieve foundation status may well exceed the 20 previously estimated, and resolving their situation is likely to pose serious challenges.
- Pay restraint, cuts in administrative staff, tariff reductions and other central initiatives have contributed significantly to savings. They cannot be used indefinitely to meet future pressures. Our recent study[2] shows

[1] http://www.qualitywatch.org.uk/
[2] http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/130305_anatomy-health-spending_0.pdf

no sign of a step change in acute sector productivity following the onset of budget restraint.

- There is little evidence that treatment or resources are moving out of hospitals. The volume of care provided in hospitals continues to increase. Spending on the acute sector has risen in recent years while that on general practice has declined in real terms.
- Nuffield Trust evaluations of community-based interventions, telehealth technologies, and health and social care integration show little evidence of cost-effective reductions in hospital admissions. Policymakers should not rely on the capacity of community or social care based programmes to deliver savings in the short term.
- NHS England's assertion that the specialized services it commissions directly face higher upward cost pressures than non-specialised and primary care services, justifying higher funding, should be carefully scrutinised.

1. Savings since the announcement of the "Nicholson Challenge"

1.1 Overview

A gap created by flat real-terms budgets, rising demand for care and continuing upward pressure on costs has created an urgent need for the NHS in England to find large efficiency savings year-on-year. These savings have been identified as equivalent to around 4% of the service's budget each year, first implicitly in Sir David Nicholson's 2009 instruction to the service, and more explicitly since 2011 in the Government's Quality, Innovation, Productivity and Performance initiative (QIPP). These savings must be recurrent – based on permanent and sustainable changes expected to reduce necessary spending every year.

The NHS has so far succeeded in delivering the headline financial targets set out in QIPP. It has done so while under-spending the health budget each year, by 2.1 billion in both 2011/12 and 2012/13. These underspends have had to be mostly returned to the Treasury, and it is reasonable to expect that the same will be true in future years.

Overall activity in the NHS has continued to increase since 2010/11.[3] Research conducted with the Health Foundation for our QualityWatch programme has examined a wide range of quality indicators, and found no general decline in standards of care over this period.[4]

It is clear that many hospital trusts are finding the financial climate very challenging. This is affecting all trusts, but there is a growing divide between Foundation Trusts (FTs) and NHS Trusts. Across both types, financial performance is diverging as weaker providers become ever weaker.

The approach to the financial challenge to date has relied on centrally driven initiatives. Pay restraint has played a critical role: we estimate that it could provide over £5 billion of the total £13 billion of savings we believe is required across services formerly commissioned by Primary Care Trusts, which account for 80% of the NHS budget.[5] Cuts in administrative staff and pressure on CCG management costs have led to further savings. These savings have been partially negated in the short term by the costs of reorganisation and redundancies, estimated at over £1.1 billion[6], but while these costs were non-recurrent, the savings will largely be permanent. Cuts in the tariff prices paid to hospital trusts have delivered savings for commissioners, but may be associated with the difficulties facing provider finances discussed below.

1.2 Evidence of productivity changes

Judgements on whether financial austerity can be reconciled with quality, productivity and access should be based largely on whether there have been improvements in productivity and the reform of services to meet patient needs more efficiently. Productivity measurements in healthcare are especially challenging due to the difficulty of quantifying the quality and value of procedures, but credible recent estimates exist.

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[3] http://www.nao.org.uk/wp-content/uploads/2012/12/1213686.pdf
[4] http://www.qualitywatch.org.uk/annual-statement/2013/detail
[5] http://www.nuffieldtrust.org.uk/sites/files/nuffield/121203_a_decade_of_austerity_full_report.pdf
[6] http://www.nao.org.uk/wp-content/uploads/2013/07/10175-001-Managing-the-transition-to-the-reformed-health-system.pdf

ONS estimates for UK-wide health service productivity in the years leading up to austerity between 1995 and 2010 suggest average improvements of 0.4% a year. A recent York University study of English NHS productivity used a broader range of inputs and adjusted for three quality indicators. It also showed an annual average increase in productivity between 2006 and 2010 of 0.9 per cent a year.[7] These studies show that while productivity has been improving in health services it is typically below productivity growth in the wider economy, with no recent precedent for savings at a rate approaching 4% each year.

Recent Nuffield Trust research used a measure of crude labour productivity in 110 English acute providers from 2006/07 to 2011/12, with procedures delivered to patients counted as output, unadjusted for quality. To date, this is the only study dealing with the period in which savings were delivered. It focused on the sector expected to make the greatest efficiencies. This showed a picture of stable productivity throughout the period with an improvement from 2009/10 to 2010/11. However, this was followed by a decline from 2010/11 to 2011/12, the first year of savings under QIPP.[8]

Taken together, these studies suggest that productivity improvement is unlikely to account for annual savings of around 4%. This is particularly underlined by our own research, which gives no indication of any step change brought about by austerity from 2010/11 to 2011/12. However, further research is clearly needed.

1.3. Evidence of savings through redesign of services

The NAO and the Health Committee in its inquiry last year found little evidence of substantial savings being secured through services shifting out of hospitals to meet patient needs more efficiently.[9] [10] Rather than pay restraint and the tariff serving as an impetus for service redesign, they have simply been used as the main source of savings in their own right.

Nuffield Trust research shows that resources have continued to move towards rather than away from hospitals from 2009/10 to 2011/12, while spending on general practice has declined in real terms – by 1.2% in 2011/12. Activity in hospitals also continues to increase. Emergency admissions, the key indicator of improved care outside hospitals, rose by 1.9% comparing the most recent months for which figures are available in 2013 to the same period the year before. Outpatient appointments rose even more quickly, by 9.2%, although data in this area is less reliable. [11]

However, we also found continued sharp rises in spending for community health services, with a total increase of around 6% in 2011/12. This may be a sign of service redesign by commissioners, but several important caveats exist.

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[7] http://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP87_NHS_productivity.pdf

[8] http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/130305_anatomy-health-spending_0.pdf

[9] http://www.publications.parliament.uk/pa/cm201213/cmselect/cmhealth/651/65102.htm

[10] http://www.nao.org.uk/wp-content/uploads/2012/12/1213686.pdf

[11] https://catalogue.ic.nhs.uk/publications/hospital/monthly-hes/prov-mont-hes-admi-outp-ae-jul-13-14/prov-mont-hes-admi-outp-ae-apr-jul-13-14-rep.pdf

Firstly, rather than being a response to the need for savings since 2010, this appears to continue a trend going back to 2004/5 which is likely to be associated with long-term government policy. Secondly, lack of standardised data makes it difficult to judge the extent to which activity has expanded in community care.[12] Finally, it is difficult to find evidence of community-based interventions successfully reducing hospital admissions: we cannot be certain which types of activity in community settings actually substitute for hospital care.[13]

1.4. Implications for national and local sustainability

Another area which must be closely scrutinised for the impact of savings to date is the financial sustainability of NHS providers and commissioners. Our research suggests that the reported aggregate financial position of provider trusts did not substantially worsen in 2010/11 and 2011/12. However, the NAO has expressed concern that trusts in difficulty were relying on direct support and other non-recurrent funding from the Department of Health, commissioners and Strategic Health Authorities.[14] This is likely to be unsustainable when the savings need to be recurrent. Recent data from the NAO, Monitor and the NHS Trust Development Authority suggests that the underlying financial position of acute providers is worsening, with greater reliance on non-recurrent support in 2012/13.

At the end of July 2013, 48% of non-foundation acute NHS Trusts are now forecasting a deficit for 2013/14 (31 organisations), and the aggregate net position for all non-foundation acute trusts is now forecast at a deficit of £232 million for the financial year[15]. Crucially, their margins for earnings before interest, taxes, depreciation and amortization (EBITDA), a vital comparable indicator of fundamental operational viability, are falling. Forty-two per cent of all NHS Trusts (43 organisations) ended 2012/13 below the 5% Monitor would normally require to grant FT status. Adjusting for non-recurrent spending, the trend in EBITDA averages since 2010/11 has been downward.

As of March 2013, 32 acute NHS Trusts working towards becoming FTs were rated red in their readiness for this status, and a further 18 were rated amber-red. Unless there is a very significant improvement in financial performance in 2013/14, it appears that the number of all NHS Trusts which will not be able to pass the FT approval process will be significantly more than the 20 previously identified by the NAO.[16] Resolving these organisations' financial difficulties and ensuring that they have clinical and financially sustainable futures is proving very challenging. As the number of NHS hospitals in deficit increases, and underlying financial performance deteriorates, there must be questions about how the NHS approaches these providers, and whether the failure and oversight regime is suitable for the scale of the potential challenge.

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[12] http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/130305_anatomy-health-spending_0.pdf
[13] http://www.nuffieldtrust.org.uk/blog/community-based-interventions-how-do-we-know-what-works
[14] http://www.nao.org.uk/wp-content/uploads/2013/07/10220-001_Indicators-of-financial-sustainability-in-the-NHS.pdf
[15] http://www.ntda.nhs.uk/wp-content/uploads/2013/09/NTDA_summer_report_-FINAL.pdf
[16] http://www.nao.org.uk/wp-content/uploads/2011/10/10121516.pdf

The average EBITDA for FTs is also falling.[17] Monitor's analysis shows that those which are of small or medium size are particularly affected. The EBITDA for acute FTs with a turnover between £200 and £400 million per annum is now at 4.08%: for those with a turnover below £200 million, it is just 3.3%[18]. Twenty-eight per cent of small and medium size acute FTs are subject to enforcement action by the regulator.

Our research has also pointed to regional clusters of financial stress in the West Midlands and outer London, which may represent local health economies under increasing pressure.[19] The number of PCTs which required financial support increased in 2012/13, with 12 PCTs having received £157 million of support from SHAs or other PCTs. The Committee should ensure that it considers the prospects for the long-term viability of acute providers with respect to these clusters of concentrated pressure, rather than only in aggregate.

2. Future plans and the sustainability of savings

2.1. The need for further savings

The Government has committed to holding the NHS budget roughly flat in real terms at least up to 2015/16, implying continued annual savings of around 4% at least up to this date.[20] Nuffield Trust research forecasts intense pressure on the health service budget beyond this up to 2021/22.[21]

Based partly on the implications of our work, Monitor and NHS England now assume broadly flat funding up to 2021/22, and a need to find further savings of at least 4% per year and possibly more in some years.[22] [23] We welcome this realistic assessment of the future outlook for funding.

2.2. Savings from tariff cuts, wage restraint and administrative staff reductions

Reductions in the tariff, wage restraints and reductions in administrative staffing have been central in achieving savings so far. However, we welcome NHS England's acceptance that in these areas "there is a limit to how much more can be achieved without damaging quality or safety".[24] We urge the Government to set out how the further cut of 10% to administrative staff in the 2015/16 Spending Round will be implemented without reductions in NHS managerial capabilities.[25]

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[17] http://www.nao.org.uk/wp-content/uploads/2013/07/10220-001_Indicators-of-financial-sustainability-in-the-NHS.pdf
[18] http://www.monitor-nhsft.gov.uk/home/news-events-publications/our-publications/browse-category/reports-nhs-foundation-trusts/nhs-fou-0
[19] http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/130305_anatomy-health-spending_0.pdf
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[23] http://www.monitor-nhsft.gov.uk/sites/default/files/publications/ClosingTheGap091013.pdf
[24] http://www.england.nhs.uk/wp-content/uploads/2013/07/nhs_belongs.pdf
[25] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209036/spending-round-2013-complete.pdf

Since 2010, real terms NHS wage reductions have been less than the decline in private sector wages: the NHS has been able to continue to attract skilled workers in most areas. This private sector trend could be reversed in the event of a sustained economic recovery, and the scope for further NHS pay savings over the coming years should be assessed with this possibility clearly in mind.

2.3. Comments on forecasts and planning from NHS bodies

Cost Improvement Plans (CIPs) by NHS providers are essential in setting out how savings can be achieved without compromising standards of care. We note with concern that for FTs, the average level of savings laid out in CIPs every year up to 2014/15 is projected to fall well below the level Monitor typically demands from new applicants for foundation status.[26]

NHS England has argued that the specialised services it commissions directly face far greater upward expenditure pressure than non-specialised and primary care services.[27] It has used this to justify funding allocations for 2013/14 which include a substantial increase for these services, in addition to an extra allowance to support their move towards national standards.[28] It is not clear that any intrinsic characteristic of these services or those who use them should result in greater cost pressures, and we urge careful scrutiny of this decision.

2.4. Potential savings through integration

Monitor has recently estimated that £2.4 billion to £4 billion in savings could come from shifting care to more efficient settings, reducing hospital admissions and supporting self-management of long-term conditions. This is around 10-15% of the total required, a cautious assessment of the potential for delivering savings by redesigning services and treating patients closer to home. Despite evidence of limited productivity improvement in the past, with little sign of a step change due to austerity, Monitor predicts considerably larger savings could be made from technical efficiencies.[29]

The Government's £3.8 billion Integration Transformation Fund (ITF), scheduled for implementation in 2015/16, is an important recognition of the support needed to enable integrated care to happen at scale. There are already concerns that the large cuts seen in social care spending are weakening the capacity to provide social care for vulnerable people before they develop the most severe needs[30] and the impact on the NHS of further cuts to adult social care budgets up to and including in 2015/16 must be addressed. However, the decision to take funds from the NHS budget means that their re-allocation through the ITF must result in enough savings to pay for itself, as well as making a substantial contribution to savings within the NHS.

Reductions in emergency hospital admissions and hospital occupancy are the central mechanism by which this could be achieved. However, recent Nuffield Trust evaluations

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[26] http://www.monitor-nhsft.gov.uk/home/news-events-and-publications/our-publications/browse-category/reports-nhs-foundation-trusts/rev
[27] http://www.england.nhs.uk/london/wp-content/uploads/sites/8/2013/10/tso-call-to-act1.pdf
[28] http://www.england.nhs.uk/allocations-2013-14/
[29] http://www.monitor-nhsft.gov.uk/sites/default/files/publications/ClosingTheGap091013.pdf
[30] http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/120529_reforming-social-care-options-funding_0.pdf

of several community-based interventions, designed in part to ease pressure on hospitals, showed no evidence of an impact on admissions.[31] The Nuffield Trust has also evaluated the first year of the integrated health and social care model developed in North West London for over-75s and people with diabetes. We found no significant reduction in emergency hospital admissions in the short term.

These studies suggest Monitor's cautious estimate of the potential savings from integrated care up to 2021/2 may be more realistic. Such caution is supported by evidence from international studies suggesting that any evidence of integration having impact on hospital admissions is typically seen only after a minimum of three to five years.[32]

2.5. Savings through the use of telehealth technologies

"Telehealth" systems send information about a person with a health condition remotely to a professional, who can intervene following indicators of deterioration. It has often been suggested that wider use of these technologies could secure substantial savings in the NHS, primarily by reducing the need for care in hospitals and general practice.[33]

However, the Nuffield Trust's evaluation of the Department of Health's "Whole System Demonstrator" pilot, the ever largest controlled trial of these technologies, showed that while there were some reductions in emergency admissions for patients using telehealth, these did not appear to lead to a significant reduction in the cost of treating these patients.[34] Further analysis also showed that telehealth use did not appear to lead to reduced contact with general practitioners or practice nurses.[35]

3. Measuring changes in output and quality related to funding

3.1. Overview

An understanding of whether the NHS is reacting to financial pressure by developing patterns of decision-making which prioritise or ration care is necessary for our understanding of where savings are coming from, and to ensure that any rationing of care necessary is accountable to patients and taxpayers.

Our QualityWatch programme aims to provide independent scrutiny into how the quality of health and social care in England is changing over time. The programme's first annual assessment of quality found a picture of general improvement over the past decade, with no clear signs of discontinuity at the introduction of spending restraint in 2010.[36] However, we also conclude that there are signs of pressure on urgent care, underlying recent increases in the numbers of people waiting more than four hours for

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[31] http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/evaluation_summary_final.pdf

[32] http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/evaluation_of_the_first_year_of_the_inner_north_west_london_integrated_care_pilot.pdf

[33] https://www.gov.uk/government/speeches/speech-wednesday-7-march-paul-burstow-2nd-international-congress-on-telehealth-and-telecare

[34] http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/120622_impact_of_telehealth_on_use_of_hospital_care_and_mortality.pdf

[35] http://www.biomedcentral.com/1472-6963/13/395

[36] http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/131010_focus-on-hip-fracture.pdf

A&E care.[37] This may in part reflect the combination of an established trend of rising admissions from A&E with the recent levelling off in funding growth.

3.2. Key potential indicators of priority-setting

Several studies have recently examined signs of rationing at particular points in the care pathway and for particular procedures. Changes in activity and triage and restriction policy around elective procedures for conditions which do not typically imply the threat of serious complications are likely to provide relevant indicators for priority-setting. Possible examples include cataract surgery and non-medical caesarean sections.[38]

[37] http://www.qualitywatch.org.uk/annual-statement/2013/detail
[38] http://www.bmj.com/content/347/bmj.f4351

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