evidence for
better health care

nuffieldtrust

2015 Comprehensive Spending Review

Representation to HM Treasury

The Nuffield Trust is an independent health think tank. 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.

This is a representation to Her Majesty's Treasury to inform the 2015 Comprehensive Spending Review, in response to the call for views and evidence extended to us on 21 July 2015. It gives a general overview of the funding challenge facing the NHS over the Spending Review period, examines the scope for savings and efficiencies, and assesses the options available to the Treasury.

Key points

- The commitment to increase NHS funding in England by £8 billion in 2020/21 is a generous settlement relative to other departments. But it will be exceeded by the upward pressure on spending driven by an ageing and growing population, the increase in chronic disease and the rising cost of treatments.
- Over the Spending Review period the NHS will therefore increasingly struggle to maintain standards and meet growing demand.
- Additional commitments on seven-day working and increasing numbers of general practitioners will be difficult to achieve within five years under the £8 billion funding scenario.
- There are opportunities to generate savings, including the £5 billion savings identified by the Carter review. These must be seized. However,

Consultation response
September 2015

much of the 'low hanging fruit' is running out, including curbs on pay and staff numbers, crucial to the NHS delivering savings over the 2010 to 2015 period.

- Radical changes to how care is delivered must also contribute to savings over this period. But they will cost before they save and require more engagement from clinicians, managerial time and attention. The £8 billion additional funding provides little if any headroom to do this.
- We are concerned by the lack of commitment to ring-fence other budgets held by the Department of Health. Any attempt to raise the budget of NHS England at the expense of these other budgets, which also provide revenue and vital long-term support to NHS providers, would be counterproductive. Public health and clinical training will be particularly important in minimising the demand for health care and ensuring a supply of professionals that does not push providers into greater reliance on costly agency staff.
- The funding squeeze facing social care is difficult to reconcile with the goals of more prevention and better co-ordinated care outside hospital, and needs to be addressed.
- The growing short-term financial pressures on the NHS is already resulting in an increasingly top-down culture and a greater regulatory burden in order to deliver 'grip' on financial and performance targets. There is a significant risk of a fundamental shift in priorities from quality to finance, a deeply concerning possibility.

1. Overview: the position of the NHS up to 2020

1.1. The scale of the challenge

There is a constant increase across the developed world in the cost of providing health services due to ageing, the rise in long-term conditions, and the discovery of new drugs and technologies.

A series of studies by government bodies and independent bodies like the Nuffield Trust have attempted to estimate the additional funding required to meet these pressures while maintaining the current range of services and standards of care.[1,2] NHS England has provided a figure of £30 billion in cash terms by 2020/21.[3] Estimates like this are always uncertain, as they rely on a constructed counterfactual of zero productivity growth or cost containment, but we believe this to be a credible figure.

In the shorter term, financial pressure on the health service is manifesting itself through provider trusts overspending their budgets at an increasing and unsustainable rate. Planned deficits this year for the foundation trust sector alone exceed last year's deficit of £822 million.[4] NHS Providers has estimated the end-of-year deficit on trends to date at £2 billion.[5] This could be too large to be covered by underspends and reserves elsewhere, raising the serious possibility of the Department of Health breaching its 2015/16 Departmental Expenditure Limit.

1.2. Funding and productivity

NHS England's Five Year Forward View lays out ambitions and ideas for the health service over the next five years. It does not give precise figures for the funding levels which would enable the health service to keep pace with rising demographic demand. However, it has been widely interpreted, including by the current Government's election manifesto, as requiring an £8 billion increase in annual funding from 2015/16 to 2020/21.[6]

This requires meeting a very ambitious target of £22 billion worth of savings by 2020/21, equivalent to around £18 billion over the Spending Review period, or 2 to 3 per cent in real terms. Detailed plans to achieve this have yet to be published. It would require a sustained rate of productivity improvement much faster than has recently been recorded for either the NHS[7] or the wider private economy.[8]

The pressure created by this restriction of funding relative to demand is likely to mean a serious struggle to meet current commitments on waiting times; access to care; quality of care; drug provision; and staffing. Last year our annual statement on quality in the NHS with the Health Foundation found signs of progress stalling in several areas.[9]

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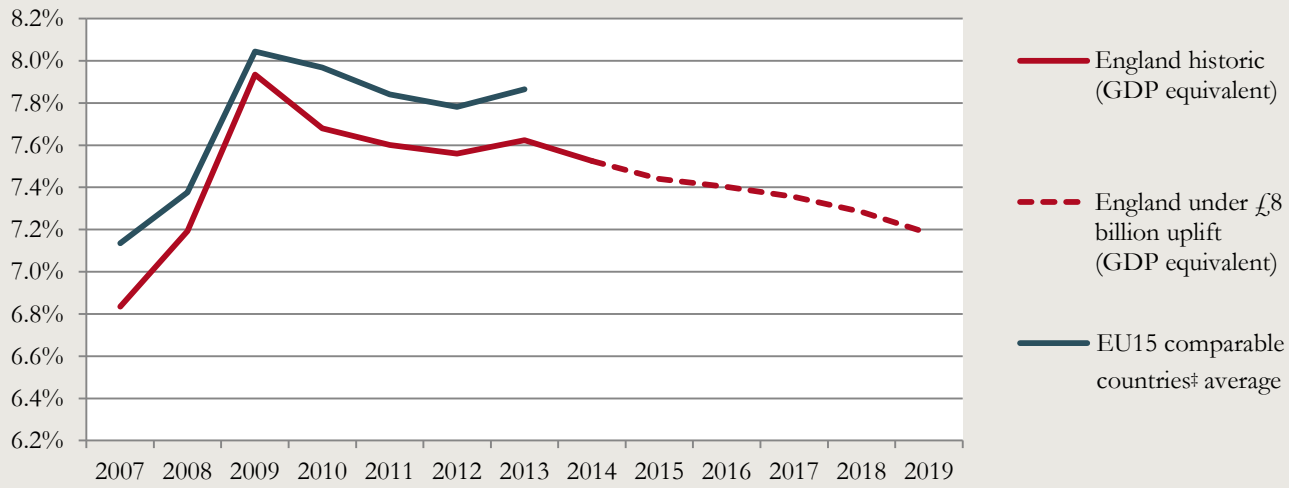
[1] Monitor (2013) Improvement opportunities in the NHS: Quantification and Evidence Collection [linked from document]
[2] Nuffield Trust (2012) A Decade of Austerity
[3] NHS England (2014) Five Year Forward View
[4] Monitor (2015) Bennett lays down billion pound challenge to NHS foundation trusts
[5] NHS Providers (2015) The General Election campaigns are avoiding NHS funding questions that really matter
[6] Conservative Party (2015) Conservative Party Manifesto
[7] University of York (2015) Productivity of the English NHS 2012-13 Update
[8] ONS (2014) Multi-factor Productivity, Indicative Estimates to 2012
[9] Nuffield Trust and Health Foundation (2014) Cause For Concern: QualityWatch Annual Statement 2015

Comparing funding plans internationally further underlines that this will be a very difficult settlement for the NHS. The UK spends an unusually low proportion of GDP on government-funded health care for a developed country, and this has been the case for many decades. A funding increase of £8 billion in England over the Forward View period is generous in the context of continued fiscal tightening, but it is very likely to lower this still further, as shown in the chart below based on OBR forecasts. Lord Wanless wrote in 2002 that this "contributed cumulatively" to the deepest problems that the NHS faced, and this remains an important observation.[10]

Figure 1: Government spending* on health care as a proportion of GDP†
(not including private or social sector)



* English health spending here is based on the departmental expenditure limit of the Department of Health, not including depreciation and taken from the Annual Report and Accounts.

† GDP can only be calculated at UK level: a GDP-equivalent figure for England is reached by adding England's GVA to a proportion of the remaining components of GDP based on the relative size of its economy. Nominal growth forecasts are taken from the OBR March 2015 release, GVA and GDP from latest ONS figures.

‡ EU15 comparable countries consist of members of the EU15 with over 10 million inhabitants, other than the UK. These are Belgium, France, Germany, Greece, Italy, Netherlands, Portugal and Spain. Data is drawn from the World Bank.

2. The outlook for savings in the NHS

2.1. Pay and clinical workforce

2.1.1. Pay policy

Holding pay below inflation was a major factor in the NHS delivering savings during the previous Spending Review period. Exact estimates depend on assumptions about how fast pay would have risen under an alternative scenario, but the Department of Health's intention was that they should account for 40 per cent of total savings, or around £5 billion.[11,12]

The 1 per cent pay cap announced in the 2015 budget would represent a significant real-terms pay cut. Compared to a scenario where pay keeps up with inflation, it implies savings of around £1.8 billion annually in 2019/20. Pay settlements that further restrict

[10] Wanless D (2002) Securing our Future Health: Taking a Long-Term View
[11] The King's Fund (2014) The NHS Productivity Challenge
[12] Nuffield Trust (2012) A Decade of Austerity

annual increments to lower-paid or higher-performing staff could generate even larger reductions in the wage bill.[13]

However, over the Spending Review period real-term wage cuts on this scale would be difficult and perhaps counterproductive. Monitor has stated that pay restraint over the last parliament was "not a sustainable strategy for improving productivity in the NHS. Periods of wage restraint are generally followed by periods of 'catch up' with their trend level in subsequent years".[14]

Given this challenge in even consolidating previous savings, continuing real-terms pay cuts to amount to around 4 per cent of current pay may not be possible. The UK consistently has to attract a significant proportion of doctors and nurses each year from abroad[15,16], and it consistently faces issues with the emigration of qualified professionals. Wages therefore need to be attractive in a global market. The current recovery of private sector wages[17] will also increase the potential for problems with recruitment and retention in the medium term.

2.1.2. Workforce planning, use and composition

Workforce planning aims to shape the supply of professions that the NHS needs, and prevent costly or limiting shortages. There is a particular need to reshape the workforce in order to support the important aims of providing more care outside hospital and better co-ordinated care for people with very complex conditions. However, the number of staff in roles which would appear to be central to this, in particular GPs and community nurses, has been growing much more slowly than the number of hospital-based doctors in recent years.[18]

There is also a shortage of nurses more generally, especially as trusts have sought to increase nursing numbers following the Francis Inquiry into failings at Mid Staffordshire NHS Foundation Trust and the development of new guidance on nurse staffing ratios. Experience here demonstrates that when the supply of staff fails to keep up with clinical or regulatory requirements, it leads to very high costs as NHS trusts are forced to hire agency and temporary staff.[19] NHS and foundation trust spending on contract and agency staff increased by £800 million in the last financial year to £3.3 billion, or around 7 per cent of all NHS staff costs. The increase alone was almost equal to the entire deficit among NHS trusts and foundation trusts.[20] [21]

The fundamental driver of these issues is an undersupply of professionals. Credible projections suggest that this will continue.[22] Introducing new staffing targets, or attempting to use the monopoly power of the NHS to drive down agency rates, as NHS bodies are doing, will have limited effects. The Government should look closely at

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[13] Department of Health (2014) Written Evidence to the DDRB
[14] Monitor (2013) Improvement opportunities in the NHS: Quantification and Evidence Collection [linked from document]
[15] GMC (2015) List of Registered Medical Practitioners - statistics
[16] NHS Employers (2014) NHS Qualified Nurse Supply and Demand Survey
[17] Office for National Statistics (2015) Supplementary analysis of average weekly earnings
[18] Nuffield Trust (2015) Equipping the NHS with the staff it needs
[19] Nuffield Trust (2015) NHS agency staff costs: treating the symptom not the cause
[20] Monitor (2015) Quarterly report on the performance of the NHS foundation trust sector: year ended 31 March 2015
[21] NHS Trust Development Authority (2015) NHS Trust Service and Financial Performance Report for the period ending 31 March 2015
[22] Centre for Workforce Intelligence (2013) Future nursing workforce projections – starting the discussion

restrictions on nursing training places, which are heavily oversubscribed. They should also consider whether there is a case for nurses being exempted from the requirement to earn a certain salary in order to remain in the UK on a general skilled worker visa.[23,24]

In the shorter term there is a need to accept these constraints, and to use the existing workforce differently. Some progress has been made in using pharmacists, of whom there is a growing oversupply, to absorb the workload of general practice and out-of-hospital new models of care, especially around minor ailments and urgent care. However, a commission carried out by the Nuffield Trust argues that the profession's full potential in a care-giving role has yet to be realised.[25]

Similar flexibility in use of the workforce is also possible within services. In the UK mid-tier 'physician associates' able to diagnose, treat and refer but without full medical training remain uncommon and are hampered by their inability to prescribe as they have no formal regulation in this country. However, they are widespread in the United States.

Extending the role of nurses to take on tasks usually done by doctors, including prescribing and procedures such as endoscopy, offers similar potential. While this may improve cost-efficiency in some individual roles[26], savings from these new uses of skill mix can easily be over-estimated as less experienced staff can take longer to make decisions and use more resources. However, they do offer a different way to meet rising demand where shortages of doctors raise the risk of having to rely on costly locum staff. Currently, these innovations remain relatively localised. Successful wider uptake may require:

- more nationally agreed definitions, regulations and guidance
- careful evaluation and monitoring
- the granting of regulated prescribing rights to physicians associates.[27,28]

2.2. Other technical efficiencies

2.2.1. Savings from procurement, streamlining and restructuring

A major factor in the health service's response to the £15–£20 billion savings drive over the last Parliament was the realisation of efficiencies at the provider level, centrally driven by cuts in the 'tariff', the price rates for hospital procedures. A detailed breakdown of these savings has not been centrally compiled. Around £1 billion came through cuts to administration, principally non-clinical staff.[29] Reductions in these groups bottomed out around 2013/14, despite continued downward pressure on the tariff price. Nursing numbers were also initially decreased, a trend which has since been reversed since the Francis inquiry.[30] Increasing the rate of vacancies was another response which has limits, probably already reached.[31]

The interim report of Lord Carter's Review of Operational Productivity in NHS Providers suggests the scope for up to £5 billion in NHS savings over the Spending

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[23] House of Commons Library (2015) The £35,000 salary requirement to settle in the UK
[24] Nuffield Trust (2015) Equipping the NHS with the staff it needs
[25] Nuffield Trust (2015) Now More than Ever
[26] British Journal of General Practice (2015) Physician associates and GPs in primary care: a comparison
[27] Primary Care Workforce Commission (2015) The future of primary care: creating teams for tomorrow
[28] Nuffield Trust (2015) Equipping the NHS with the staff it needs
[29] The King's Fund (2014) The NHS Productivity Challenge
[30] Health and Social Care Information Centre (2015) Hospital and Community Health Services Workforce Statistics
[31] The King's Fund (2014) The NHS Productivity Challenge

Review period. They would comprise £2 billion in savings from workflow and workforce; and £1 billion each from better use of medicine; better procurement and management of estates.[32]

These are credible estimates of what is possible, but achieving these savings will be difficult. This is particularly the case for savings which rely on greater standardisation in procurement and operations. This is hard to achieve across large, autonomous organisations, and too much centralisation risks undermining the scope for local experimentation flexibility.

There may also be a need for clinical practice to change before these administrative savings can be fully realised. For example, surgeons train with particular types of equipment, which means there are significant potential training costs if these are changed.

Greater use of collective bargaining by NHS providers, using their dominant market position, has the potential in theory to drive down costs. However, organisations like NHS Supply Chain are not able to use full market power in negotiation, because they cannot bargain with the commitment of a large number of trusts in hand (trusts choose to take part after a deal is reached).

2.2.2. Length of stay in hospital

Our analysis of trends in hospital care suggested rising inpatient demand over the Spending Review period would result in 2.9 million additional days in hospital beds. This represents an acceleration of trends up to 2012/13, with a roughly estimated annual cost increase of £2.6 billion over the spending review period.[33]

Over the period 2006–13, the effect on bed days of a similar rise in demand within different groups was ameliorated by reducing patient length of stay. Because each patient required fewer bed days on average, more could be admitted in total without additional investment.[34] Reduced length of stay has a much better track record as a means of managing demand than reductions in admissions based on community interventions, which have tended to disappoint in the short term (see below).

Reducing length of stay requires both steps towards greater efficiency within hospitals, and preventive care and support for discharge from other health and care services as discussed below. This means that the overall savings from controlling bed days will be offset to some extent by a need for increased spending elsewhere.

A forthcoming paper we have produced with Monitor will provide more details on the scope for reducing length of stay, and evidence about how to achieve this. Key points include a continuous focus on how patients flow through the system, rapid decision making, and getting the basics of planning and processes right.[35]

2.2.3. Increasing private provision and management of clinical services

Although some private companies will have good value propositions, especially in non-clinical 'back office' roles where they specialise, international evidence does not support

[32] Review of Operational Productivity in NHS providers (2015) Interim Report
[33] Nuffield Trust (2014) NHS hospitals under pressure: trends in acute activity up to 2021/22
[34] Nuffield Trust (2014) NHS hospitals under pressure: trends in acute activity up to 2021/22
[35] To be published on 9 September at http://www.nuffieldtrust.org.uk/our-work/projects/exploring-approaches-reducing-length-stay

the idea that for-profit health care governance necessarily creates greater efficiency.[36] There is a need for realism about whether the independent sector can change the scale of productivity growth across the NHS as a whole.

While in theory private companies might be able to find payroll and work-flow savings within clinical services by offering lower pay, or working conditions which give more discretion to employers, in practice clinical regulation and the Transfer of Undertakings (Protection of Employment) regulation will limit the scope for this in the medium term.

2.3. Prevention and allocative efficiencies

2.3.1. Moving treatment to less intensive, lower cost settings

A range of national initiatives are currently in process with the partial aim of making health care more preventive, and reducing reliance on hospitals (and nursing or care homes).

- The 'Vanguard' areas piloting new models of care from the Five Year Forward View.
- Integrated care pioneers in 14 areas, bringing together a range of local alliances.[37]
- The Better Care Fund at a local authority and NHS commissioner level.[38]
- Devolution to Manchester, Cornwall and other areas also aims in part to align local authority and NHS incentives to encourage prevention.[39]

These initiatives may create a more co-ordinated and co-operative environment, in which it is easier to identify people who could be better treated outside hospital and make this happen. They may also create more incentives at organisational level to support this.[40] Some out-of-hospital teams of combined professionals will be well suited to support earlier and safer discharges from hospital. This is vital to continued reductions in the length of stay in hospital.

However, based on over 30 evaluations of community-based interventions, we found that within their intended timescale of one or two years, initiatives almost all failed when they aimed to reduce hospital use in a cost-effective fashion (often the aim was reduction in emergency admissions).

This may be partly due to the timescale itself. The size of the task of building relationships, incorporating ongoing lessons and changing clinical ways of working mean that the effects should not be expected to be visible for at least three years, usually longer.[41]

Redesigning services in ways that deliver more care for the same funding will require substantial time and commitment from clinicians and front-line managers. There is a risk that efforts to exert 'grip' in the short term through reliance on punitive performance

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[36] World Health Organization (2010) The relative efficiency of public and private sector health care delivery
[37] NHS England (2013) Integrated Care Pioneers Announced
[38] Local Government Association (2014) Better Care Fund
[39] Association of Greater Manchester Authorities (2015) Greater Manchester Health and Social Care Devolution Memorandum of Understanding
[40] Nuffield Trust (2015) Nuffield Trust responds to announcement of 29 Vanguard areas to implement the Five Year Forward View
[41] Nuffield Trust (2013) Evaluating integrated and community-based care: how do we know what works?

management and new information requirements will undermine the motivation needed to unlock deeper sources of savings.

Another likely obstacle to cashable savings is that the costs of wards, equipment, and safe clinical teams costs in hospitals cannot be removed in a linear fashion in response to reduced activity. Success in generating savings from new models of care with more emphasis on out-of-hospital treatment is more likely to take the shape of community services absorbing the increase in demand, rather than taking current demand away from hospitals.

2.3.2. Devolution

The pooling of budgets and strategic responsibilities planned for areas like Greater Manchester and Cornwall makes sense in principle. It may unlock opportunities for better co-ordinated care and services in the long run, and it is a viable way to address the weaknesses in accountability which might be thrown up as new models of care become more powerful.[42] However, as with less radical models of local integration, it is unlikely to deliver savings in the short term.

2.3.3. Preventing the need for health care

The Five Year Forward View assumes substantial progress in ameliorating the rise in long-term conditions. This must be a Government priority. Diabetes, alcohol harm and (increasingly) dementia are all major sources of NHS demand amenable to public health interventions.[43] The Nuffield Trust's Decade of Austerity modelling project suggested that savings of around £4 billion could be achieved over the Spending Review period if rates of hospital admission due to these and similar conditions could be held flat[44].

The Five Year Forward View is also predicated on a social care system continuing to uphold its current level of support, especially for frail older people with complex needs. Otherwise, there will be additional upward pressure on both numbers of hospital admissions and length of hospital stay. We note with concern that the Local Government Association predicts 29 per cent of need for social care at current eligibility levels will not be funded by the end of the decade, even before an extra £1 billion of net cost pressure potentially generated by the new Living Wage is factored in.[45]

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[42] Nuffield Trust (2015) Reconsidering accountability in an age of integrated care

[43] Public Health England (2014) From evidence into action: opportunities to protect and improve the nation's health

[44] Nuffield Trust (2012) A Decade of Austerity

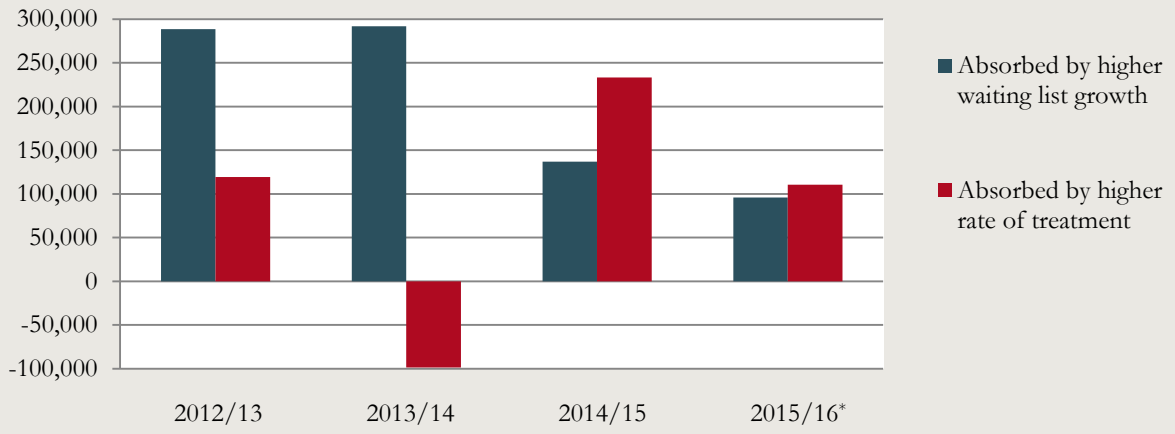
[45] Local Government Association (2015) National living wage to cost councils £1 billion a year by 2020/21

2.4. Rationing care

2.4.1. Waiting lists

Lengthening waiting lists for elective care represent rationing of care in several ways. Much of the increase in the number of patients referred by GPs for elective care since 2012 has been absorbed by increasing the length of the waiting list, which was previously shrinking, rather than by increasing the volume of care provided.

Figure 2: Absorption of the increased number of patients referred above 2011/12 baseline number of patients treated or remaining on list



* Only one quarter of data available for 2015/16

Source: NHS England (2015) RTT Overview Timeseries

Less directly, longer waiting lists may mean patients deterred from continuing to seek NHS treatment altogether, and GPs may be less likely to refer.

We have shown that challenges with major waiting times have already become systemic.[46] Growing waiting lists are likely to continue to play a growing role in rationing care in a scenario in which the NHS cannot fully deliver £22 billion in efficiency savings.

2.4.2. Limiting access to treatments

Rationing of treatments by local commissioners currently mostly affects 'procedures of limited value', like tonsillectomies, or groups who gain less from procedures, such as smokers or women who want but do not medically need a caesarean section. Under a scenario in which the NHS cannot entirely keep up with demand through savings, this is likely to become more widespread.[47]

The difficulties faced by the NHS in funding successful new drugs, such as Sofosbuvir,[48] suggest that the National Institute of Health and Care Excellence's (NICE) typical cut-off area for cost-effectiveness may be too low to reflect the current balance between emerging treatments and health service funding. Consideration of NICE's mandate and the wider treatment approval system should examine whether an explicit remit to consider NHS finances may be necessary.

[46] Nuffield Trust (2015) Access to hospital care – is the NHS on target?
[47] Nuffield Trust (2015) Rationing in the NHS
[48] NICE (2015) TA330 Sofosbuvir for treating Hepatitis C, Implementation

The Cancer Drugs Fund has weak intellectual foundations: it sets aside NHS money specifically to spend on treatments that are found not to be cost-effective. A system of interim drug approval may help to replace it, but there is a strong case for most responsibilities simply being handed back to NICE.[49]

2.5. Charging or shift to an insurance system

The economic case for shifting towards a health care system funded by private premiums or charges has not been proven. This would destroy a key principle of the NHS, while having mixed results for the financial sustainability of health care in the UK.

Many insurance-based systems in comparable European countries are considerably more expensive than the NHS on a per capita basis. In 2012, the total cost of health care in Germany across the public, private and social sectors was around 11.3 per cent of GDP as compared to 9.3 per cent in the UK, a difference which would be the equivalent of spending an additional £34 billion each year on the NHS.[50] With tax subsidies and risk pooling, the separation of social insurance from public finances is often limited or illusory.[51,52,53]

A £5 charge per GP appointment would raise £2.3 billion each year given current usage.[54,55] However, this would be largely a one-off increase, with no fundamental change to the dynamic of pressure on the NHS. Charging creates a substantial administrative burden and the problem that either use of charges will cause poorer or more ill patients to avoid services they need; or, broad exemptions are applied for older people, people in poverty, children and those with long-term conditions, greatly reducing effectiveness as a revenue source.

2.6. Controlling spending in the short term

Regulatory organisations are currently leading a concerted drive to control provider deficits in the current financial year, asking trusts to modify their plans, and to optimise staffing and waiting times with financial considerations in mind.[56]

While it is vital that the Department of Health controls spending, it is also important to recognise that short-term measures like this can damage medium and long-term capacity to innovate. A culture of seeing cost control as the fundamental goal of health service management, rather than quality of care, was a major theme of the Francis Inquiry into failings of care at Mid Staffordshire Foundation Trust, encouraging staff and managers to conceal rather than confront problems.[57]

A high proportion of time is spent by NHS managers dealing with regulators, commissioners and central bodies. This does little to directly solve underlying problems, which are often about co-ordinating local health systems.[58]

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[49] Nuffield Trust (2015) Rationing in the NHS
[50] World Bank (2015) Health expenditure, total (% of GDP)
[51] OECD (2015) Health Expenditure Statistics
[52] European Health Observatory (2010) Health Systems in Transition: France
[53] European Health Observatory (2014) Health Systems in Transition: Germany
[54] Office for National Statistics (2015) Overview of the UK Population
[55] Nuffield Trust (2015) Fact or fiction? Demand for GP appointments is driving the 'crisis' in general practice
[56] Health Service Journal (2015) Providers ordered to take tough new measures to cut deficits. The Nuffield Trust has seen a similar letter given to NHS Trusts by the NHS Trust Development Authority.
[57] Mid Staffordshire NHS Foundation Trust Public Inquiry (2013) Final report
[58] Nuffield Trust (2015) The way the NHS manages A&E problems is not fit for purpose

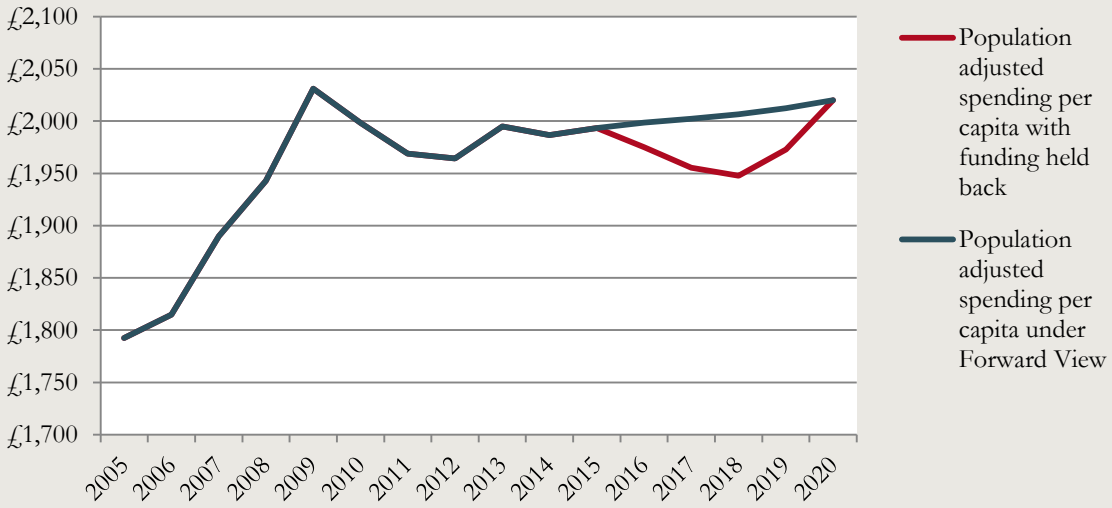
Rather than forcing some provider trusts to resort to drastic measures to achieve financial balance by the end of the 2015/16 financial year, at the cost of attention to more fundamental issues, there needs to be a process identifying where a more managed transition to achieving financial balance would be more productive.

3. Options on Department of Health funding for the next five years

3.1. Staging of funding

NHS England's Five Year Forward View requires "staged funding increases close to 'flat real per person'" to close its funding gap. NHS England understands this to mean a funding increase that adjusts for the size and age of the population. A delayed or even partially implemented spending uplift would result in the NHS being unable to keep pace: the chart below contrasts the Forward View scenario with one in which spending increases are introduced more gradually up to the 2020/21 financial year itself.[59]

Figure 3: Population adjusted spending per capita: different scenarios, 2005-2020



Furthermore, the Five Year Forward View is right to suggest that even under the most optimistic scenario of success in new models of care, the financial benefits will take at least three years to realise.[60] In the short term, initial sources of cost for these changes will include double running, capital spend, staff retraining and planning time. Given this, and assuming 2015/16 as a starting point, the greatest financial pressure in the Spending Round period will fall between 2016/17 and 2018/19. At the very least, the £8 billion increase in funding must be introduced in even stages.

3.2. Funding additional commitments

3.2.1. Seven day working

There are clear arguments for a vision of seven-day working to regulate workflow and standards of emergency care, reducing variation in mortality. However, it would carry significant costs. A study by the Healthcare Financial Management Association looking at eight trusts found that, in typical cases, hospitals had to spend 1.5 to 2 per cent of total

[59] HM Treasury (2015) Public Expenditure Statistical Analysis Chart (also draws on age-related cost curves provided by NHS England).
[60] Nuffield Trust (2013) Evaluating integrated and community-based care: how do we know what works?

income to implement seven-day care. Across the NHS, this would imply additional annual costs of up to £1 billion by the end of the Spending Review period. A proportion of this might be offset due to some costs being non-recurrent, or through savings from making more use of equipment and sites. The latter in many cases may only be realistic with significant centralisation.[61]

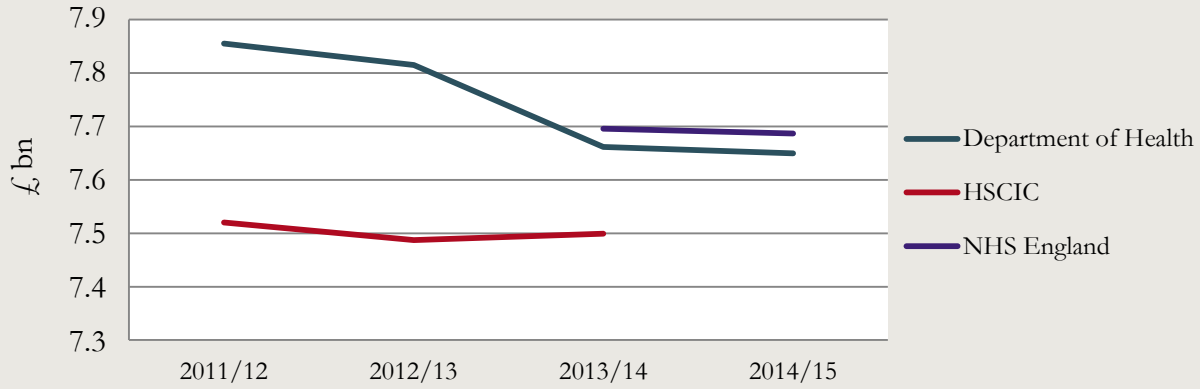
Waiting times and other indicators from the GP Patient Survey show that general practice is already struggling to maintain current levels of access.[62] It is unclear whether seven-day working in general practice work will solve real problems unless it represents an overall increase in the number of appointments available. Where trade-offs exist, the latter might be a priority.

The evidence on demand for seven-day services is patchy. A recent evaluation of weekend GP services in Manchester suggested demand was weaker than during the week.[63] Similar considerations apply to outpatient and other planned hospital treatment.

3.2.2 Increasing the numbers of GPs

The Government's commitment to increase the number of GPs by 5,000 is in line with where priority should lie following years in which the hospital doctor workforce has outpaced other professions.[64] While multiple and only partly overlapping data sources exist, it is clear that despite rhetoric, funding for general practice has stagnated or fallen in recent years. This is almost certainly linked to evidence of worse access for patients, and is difficult to reconcile with a growing role for primary care.[65,66]

Figure 4: Real-terms funding for general practice 2011/12 to 2014/15



Various sources

[61] NHS Services Seven Days a Week Forum (2013) Costing Seven Day Services
[62] NHS England (2015) GP Patient Survey
[63] NIHR Greater Manchester (2015) NHS Greater Manchester Primary Care Demonstrator Evaluation
[64] Health and Social Care Information Centre (2015) Hospital and Community Health Services Workforce Statistics
[65] Nuffield Trust (2014) Is General Practice In Crisis?
[66] Health and Social Care Information Centre (2014) Investment in General Practice; Department of Health (2015) Annual Report and Accounts and earlier documents: NHS England (2015) Annual Report and Accounts

However, previous experience of failure to meet targets[67] suggests that a target specifically attached to GPs as a medical professional group will be difficult. The most cost-effective solution may be more imaginative use of the existing wider workforce.

3.2.3. Social care

While it is necessary to maintain a certain level of social care provision for the NHS to meet commitments under the Five Year Forward View, any further funds redirected outside the health sector need to be additional to the flat real settlement plus £8 billion.

3.3. Funding outside the NHS England budget

3.3.1. Overview

The Conservative Party manifesto pledge to increase NHS spending by £8 billion can be read to apply specifically to NHS England, with no guarantee for the services which largely account for the remaining 13 per cent of the Department of Health budget.

However, NHS England's responsibilities are supported by and linked to other health bodies. Substantially reducing other Department of Health budgets to increase NHS England's would not be a sustainable way to meet the health service's funding needs.

The minimum required over the Spending Round is a steady trajectory towards an £8 billion increase (at today's prices) by 2020/21, without unsustainable cuts to other areas of the health budget. Reaching this at a constant percentage increase year on year would imply a 2019/20 Total Departmental Expenditure Limit for the Department of Health of at least £132.4 billion.[68]

3.3.2. Capital spend

Last year, the Department of Health transferred over £600 million in spending from its capital in order to fill the deficits run up by NHS providers to its revenue budget, announced at the supplementary estimate stage in February 2015. This year, documents at an earlier date show £185 million has already been transferred in a similar fashion.[69] As in previous years, public dividend capital, money supposed to be issued as an investment in trusts, was also used by the Department to provide interim revenue support to trusts running at a loss or behind plans.[70]

In short, funding under the capital departmental expenditure limit and the revenue departmental expenditure limit is treated to a considerable extent as being interchangeable. The factors driving this will continue. Given this, substantial cuts to the capital expenditure limit would mean:

- A cut in resourcing for bodies for which NHS England is responsible, if cuts fall primarily or partly on the section which would otherwise be used as a reserve or support for revenue spending.
- Steep reductions in actual capital spending if they in effect fall on the section used for actual NHS provider investment. This is unlikely to be indefinitely sustainable, especially in the context of new models of care requiring new community facilities and possible acute centralisation in some areas.

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[67] GP Taskforce (2014) Securing the Future GP Workforce Delivering the Mandate on GP Expansion
[68] Calculations based on HM Treasury (2015) Public Expenditure Statistical Analysis Chart
[69] House of Commons (2015) Estimates Memorandum for the 2015-16 Main Estimate for the Department of Health
[70] Department of Health (2015) Annual Report and Accounts

3.3.3. Education and training

Some 67 per cent of Health Education England's budget is spent elsewhere in the NHS, funding the work-based training of post-graduate medical and non-medical staff. Cuts would mean a large proportion of this cost falling back on NHS trusts, in particular for postgraduate medical trainees.

As discussed above, workforce planning and training has a delayed impact on NHS financial pressure. It influences the supply of staff and therefore wage pressures, and determines whether trusts are forced to rely on agencies at the margins of their requirements.[71]

However, there may be scope to find some savings by limiting universality of grants, especially for postgraduate training where they could be made conditional on a set period of NHS employment.

3.3.4. Research

Clinical trials funded by the Department of Health again provide a small proportion of the current level of funding for direct patient care. In the longer term, NHS and private industry will rely on continued new discoveries and innovations. New ways of organising care need careful evaluation to show whether or not they really work.

3.3.5. Social care

Although social care does not fall within the health budget, Nuffield Trust research has suggested that under some circumstances it serves effectively as a substitute for care in hospital.[72] As discussed above, there are severe funding pressures facing social care. Our work with the Health Foundation shows that the number of people receiving local authority funded support has fallen, with no data available to understand what has happened to those no longer receiving care.[73] The Government must ensure that the settlement on social care over the Spending Review period does not create greater difficulty discharging patients, or additional demand for the NHS.

3.3.6. Public health

As with other areas, a significant proportion of public health spending funds the delivery of NHS-delivered services like vaccination delivered by GPs. Cuts here would increase NHS England's funding requirements to compensate.[74]

Beyond this, improved prevention has been highlighted repeatedly as crucial to a sustainable NHS over the medium to long term. There is a need to reconsider how future benefits from public health are assessed relative to those from health care.[75] At the commonly used 3.5 per cent 'discount rate' used to weigh up the value of future benefits, NICE evaluation of areas such as diabetes reduction has shown core interventions to be highly cost-effective or net cost saving. There is a danger that decisions taken based on a one-to-two-year timescale will generate considerably higher costs later on.

The £200 million cuts to the public health budget in the 2015/16 financial year should not be repeated.

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[71] Nuffield Trust (2015) NHS agency staff costs: treating the symptom not the cause
[72] Nuffield Trust (2010) Social care and hospital use at the end of life
[73] Nuffield Trust and Health Foundation (2015) Focus on: social care for older people
[74] Department of Health (2015) Annual Report and Accounts

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The Nuffield Trust is an independent health think tank. 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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