The Health Foundation
Inspiring Improvement

Closing the NHS funding gap: Can it be done through greater efficiency?

Summary of a roundtable discussion, 30 January 2014

Event report
February 2014

Contents

Acknowledgements

The 30 January 2014 'Closing the NHS funding gap' event was attended by a senior group of leaders from arms-length bodies, other national bodies, commissioners and providers. Thank you to all who came and contributed, in particular the presenters: Toby Lambert, Anita Charlesworth and Richard Murray.

The views presented in this report are not necessarily the views of the presenters or their employing organisations.

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Introduction

In October 2013, Monitor published *Closing the NHS funding gap: how to get better value healthcare for patients.*[1] The report highlighted the financial challenges facing the NHS in England and the need for the system to close an expected funding gap which could reach £30bn a year by 2021. The report identified four key areas where there were opportunities to make significant productivity gains across the NHS by 2021 and beyond:

- **improving productivity** within existing services (*potential productivity gains of £6.5bn to £12.1bn by 2021*)
- **delivering the right care in the right setting** (*potential productivity gains of £2.4bn to £4bn by 2021)*
- **developing new ways of delivering care** *(potential productivity gains of £1.7bn to £1.9bn by 2021)*
- **allocating spending more rationally** (Monitor did not attempt to quantify productivity gains).

Monitor's report gave a number of examples of good practice and linked to evidence which might help organisations within the system reduce the funding gap.

On 30 January 2014, the Health Foundation convened a roundtable discussion to discuss the issues further, aided by presentations from Toby Lambert (Director of Policy and Strategy, Monitor), Anita Charlesworth (Chief Economist, The Nuffield Trust) and Richard Murray (Director of Policy, The King's Fund).

This report highlights the key points from the presentations and discussion on the day. The roundtable was held under the Chatham House Rule.

Key points from the presentations and discussion

1. The extent of the £30bn financial gap was accepted, but it may be too optimistic

It is important to set likely future spending on the NHS in the context of the wider economy and the financial position of other public services. The Office for Budgetary Responsibility (OBR) was established in 2010 to provide independent analysis of the UK's public finances. The OBR provides economic and fiscal forecasts for the UK and assesses whether the government will meet its medium-term fiscal objectives. In its latest Economic and Fiscal Outlook report (published December 2013),[2] the OBR forecast suggests that, based on current government plans, in the nine years from 2009/10 to 2018/9 the UK's budget deficit should have fallen by 11.1% of Gross Domestic Product (GDP). Figure 1 overleaf shows the sources of deficit reduction. Approximately 80% of the reduction comes from lower public spending. On the graph RDEL (resource departmental expenditure limit) represents day-to-day spending on public services and administration; CDEL (capital departmental expenditure limit) is a measure of public sector investment (ie capital spending).

The forecasts are already predicated on economic growth. It is worth noting that further GDP growth would not necessarily lead to a commensurate rise in tax receipts and therefore will not guarantee the availability of additional funds for public services.

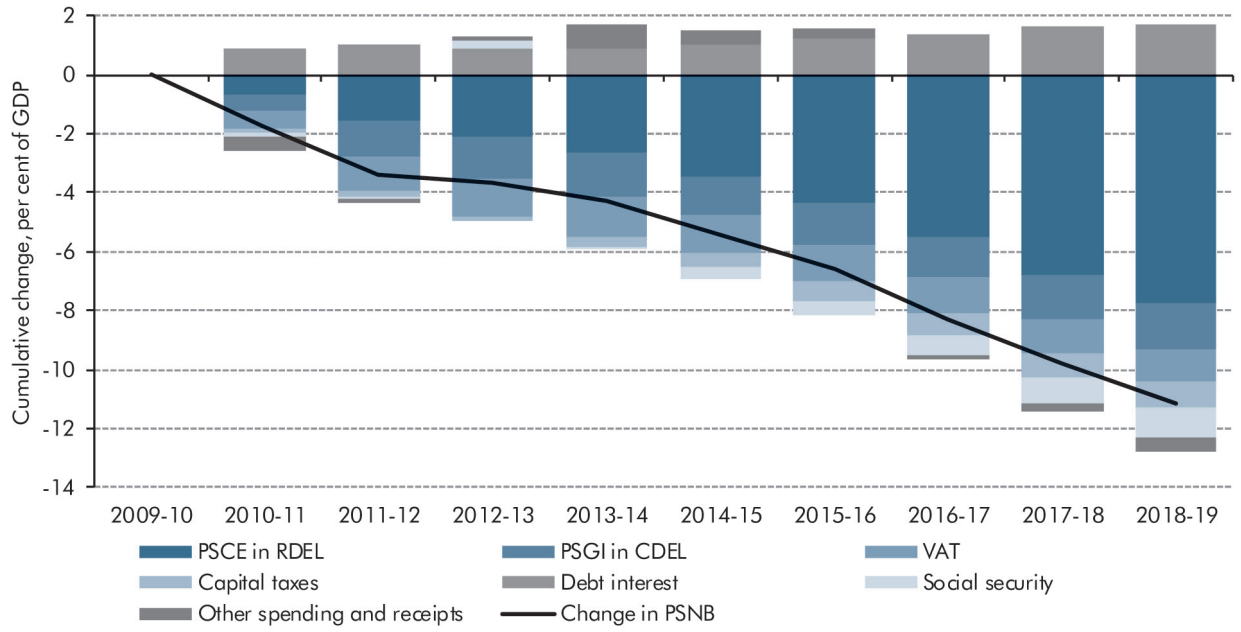
Health spending has thus far avoided severe cuts to its budget from government as other public services have taken the brunt of cuts. If health spending continues to be protected, other departments and public services will see further significant reductions in their spending limits. The Institute for Fiscal Studies has suggested that the cumulative cuts in public spending over five years from 2010/11 to the financial year 2015/16 would average 10.3%, or 18.5% across unprotected areas. Further cuts are likely in 2016/7 and 2017/18 and if spending on the NHS and other protected services remains ring-fenced, other areas would need to be cut by 15%, implying cumulative cuts of 32.9% over seven years.[3]

1 Monitor. *Closing the NHS Funding Gap: how to get better value healthcare for patients.* Monitor. October 2013.

2 Office for Budgetary Responsibility. *Economic and Fiscal Outlook (December 2013).* The Stationery Office. December 2013.

3 Tetlow G. *We shall squeeze… until the pips squeak – Post spending round briefing.* The Institute for Fiscal Studies. 27 June 2013.

Figure 1: Sources of deficit reduction in the UK economy, 2009-10 to 2018-19. Graph reproduced from the Office of Budget Responsibility Economic and Fiscal Outlook (December 2013)



Source: ONS, OBR. Excludes Royal Mail and APF transfers. See paragraph 4.162.

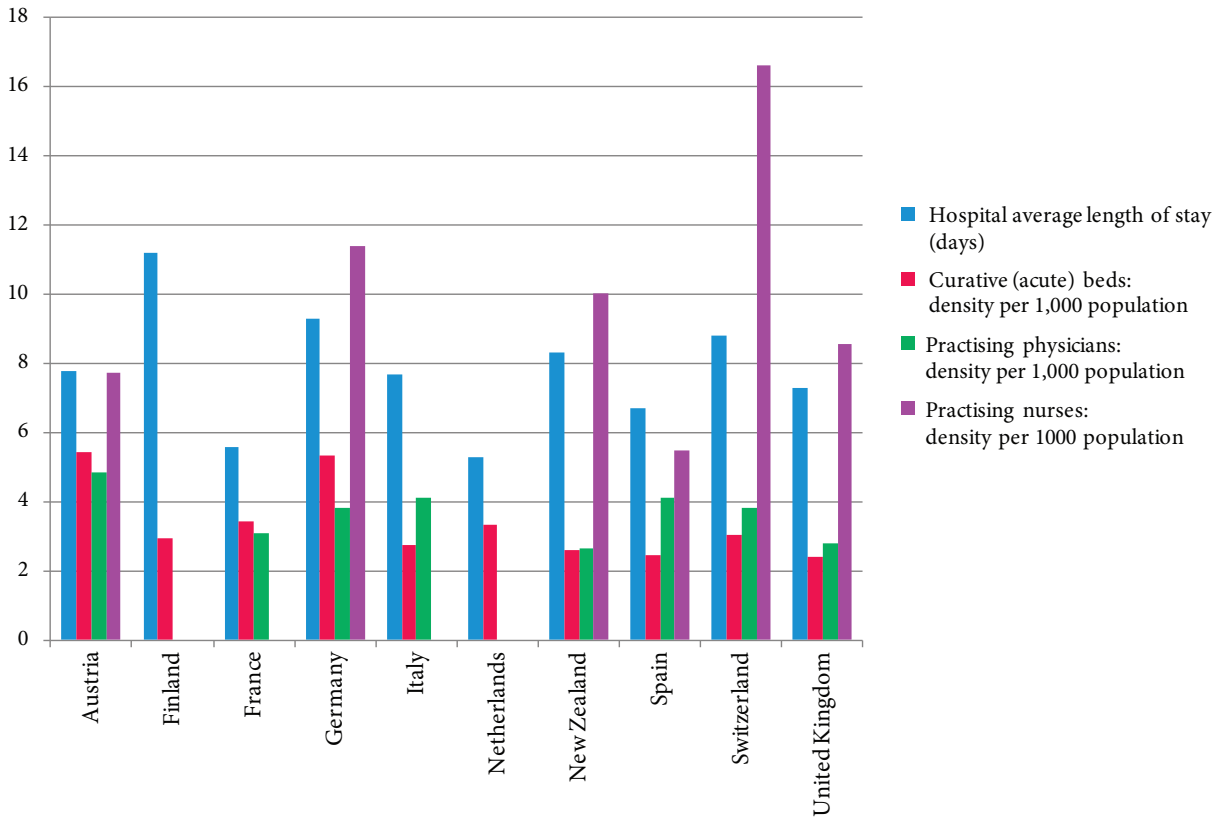
Analysis by NHS England suggests that the estimated £30bn funding gap for the NHS in England by 2021 is based on the assumption that the health budget would remain protected in real terms.[4] The latter is by no means guaranteed given the pressures facing other public services.

2. The NHS in England does not appear particularly 'flabby' next to health systems in other developed countries

At the roundtable it was argued that the NHS was being asked to plan based on spending levels that were not realistic given the demand for care, the comprehensive nature of benefits offered, and the existing supply of staff and facilities. For example, compared to other developed countries, the UK has a relatively low number of beds (although length of stay rates could be improved) and the NHS does not stand out as having far more nurses or doctors compared with peers in other developed counties (see Figure 2). In addition, total health expenditure as a proportion of GDP is not particularly high compared to other developed economies (see Figure 3). All this suggests that the NHS is not excessively 'flabby' and the savings required are potentially optimistic.

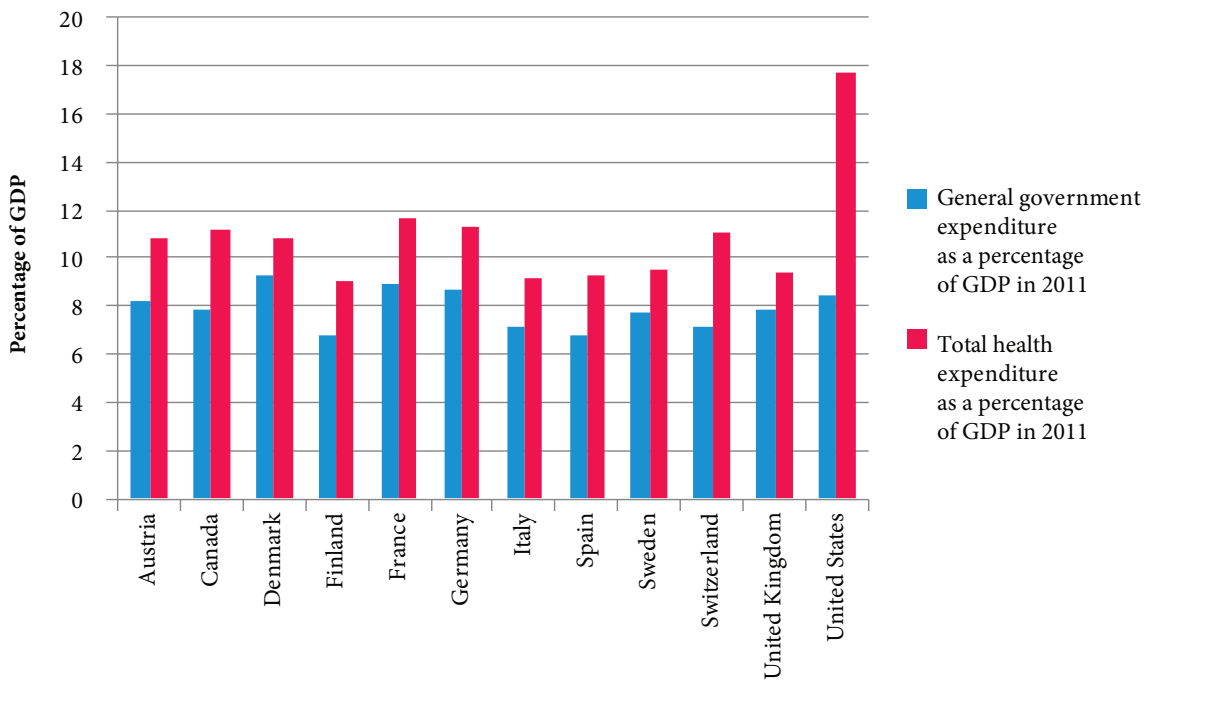
4 NHS England. *The NHS belongs to the people: A call to action*. NHS England. July 2013.

Figure 2: Average hospital length of stay, number of curative beds per 1000 population, number of practising physicians per 1000 population and number of practising nurses in 2011 for some selected developed countries



Source: *OECD Stat, accessed 6 February 2014*

Figure 3: Total health expenditure and general government expenditure as a percentage of GDP in 2011 for some selected developed countries



Source: *OECD Stat, accessed 6 February 2014*

3. The current financial squeeze might affect the system's ability to transform for 2021

While the roundtable's original intention had been to focus the discussion around the challenge of achieving efficiency savings to 2021, it quickly became obvious that there was a more immediate hurdle to clear first – there was no doubt that the 2014/15 and 2015/16 financial years would be extremely difficult.

The NHS has been expected to deliver up to £20bn in efficiency savings by 2014/15 though the Quality, Innovation, Productivity and Prevention (QIPP) programme. While the NHS delivered target savings over the first two years of the QIPP delivery period (2011/12 and 2012/13),[5] it will be difficult to maintain this over the second half of the programme. Since April 2011, The King's Fund has undertaken a quarterly survey of NHS trust finance directors to monitor the challenges faced by the health and care systems. In 2014, 86% (n=79) were fairly or very pessimistic about the 2014/15 financial year, with approximately two-thirds of trust finance directors believing that the risk of failing to meet the QIPP challenge was high or very high.[6] This is reflected in data obtained by the Health Service Journal from NHS England (released under the Freedom of Information Act), which suggest that NHS commissioners (inclusive of clinical commissioning groups and NHS England) were forecasting a £246.6m shortfall against the original QIPP target for 2013/14 after quarter 2.[7]

The pressure of meeting QIPP targets is also set against individual trusts and organisations projecting budget deficits for the year. Monitor's latest report of foundation trust performance for quarters 1-3 (2013/14), ending 31 December 2013, suggests that 39 trusts had reported deficits totalling £180m. This compared to a planned gross deficit of £168m. However, 60% of the deficit was concentrated in just five trusts.[8] The NHS Trust Development Authority's (NHS TDA) Summer Report[9] (published September 2013) reflected on the first four months of the 2013/14 financial year. At month four, the NHS trust sector had a financial deficit of £138m compared to a planned deficit of £77m. The report's figures suggested that, as of 31 July 2013, 30% of trusts (and 48% of acute trusts) were reporting a deficit.

Given the short-term funding pressures, 2021 is a long way away. The roundtable participants' general view was that the public had not yet grasped the seriousness of the situation but it was unclear what level of deficit would prompt more attention. Asking the system to deliver radical, transformational change may be unrealistic given the day-to-day pressures to deliver. However, the financial squeeze may be necessary to prompt the action needed.

4. Alignment between quality and efficiency is vital

When QIPP was first envisioned, the £20bn worth of efficiency savings by 2015 was set in the context of improving the quality of care. Yet while it is possible to realise savings from quality improvement, quantifying those savings can be difficult and is dependent on a number of factors including the prevailing financial, regulatory and cultural environment. The impact of efforts may often be improvements in quality of care or productivity rather than cost savings such as reduced expenditure on staff and resources. Additionally, providers often do not save money because they bear the cost of the intervention and the prevailing payment mechanisms do not offer strong enough incentives to make radical improvements.[10,11,12]

5 Department of Health. *Department of Health Annual Report and Accounts 2012-13. For the period ended 31 March 2013*. The Stationery Office. July 2013

6 The King's Fund. *How is the health and social care system performing? Quarterly monitoring report*. The King's Fund. January 2014

7 Williams D. Growing QIPP shortfall predicted. *Health Service Journal*. 21 November 2013.

8 Monitor. *Performance of the foundation trust sector: nine months ended 31 December 2013*. 21 February 2014.

9 NHS Trust Development Authority. *Summer Report for the period 1 April to 31 July 2013*. NHS Trust Development Authority. September 2013.

10 Øvretveit J. *Does improving quality save money?* London: The Health Foundation, 2009.

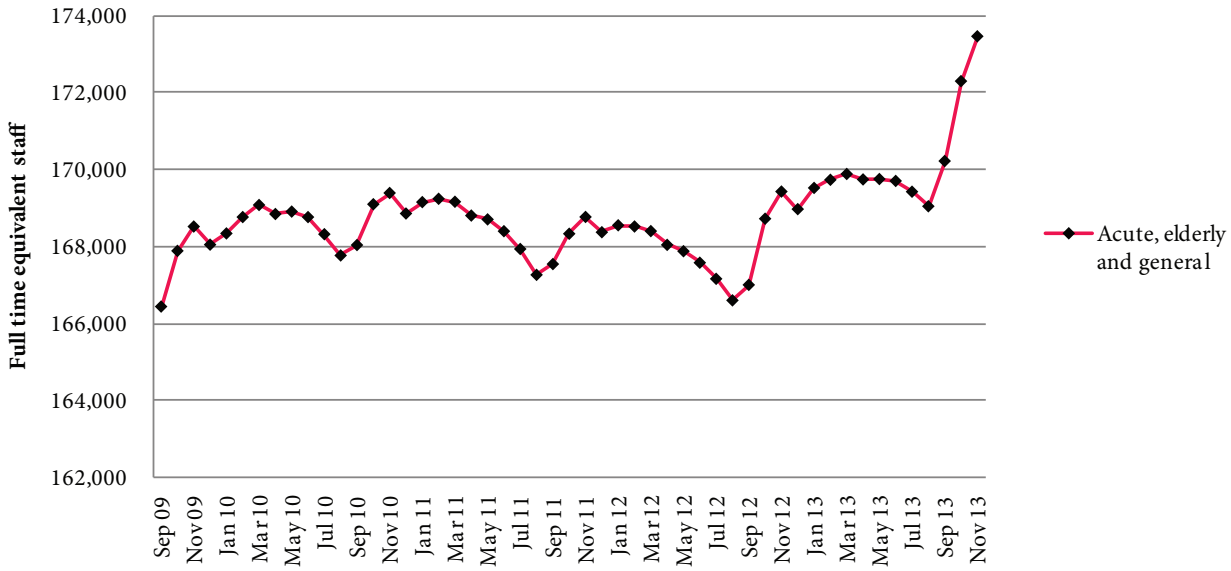
11 Øvretveit J. *Does clinical coordination improve quality and save money?* London: The Health Foundation, 2011.

12 Øvretveit J. *Do changes to patient–provider relationships improve quality and save money?* London: The Health Foundation, 2012.

A priority for the system will be to ensure that goals for improved quality and efficiency are aligned and that short-term interventions to improve quality do not increase the scale of the financial challenge to come. For example, one roundtable participant suggested that in 2006/7 some areas chose to cut back on funding for community services as there were fewer targets associated with the sector. However, this approach was not consistent with the direction of policy in the immediate period afterwards – to support patients in the community to keep well and avoid the need of admission to acute hospital. In recent months, particularly after the publication of the second Francis report,[13] there has been an increase in the acute, elderly and general nursing workforce (see Figure 4) as providers have focused on improving quality and safety of care.

There is a clear interrelationship between the response the system takes to financial and quality pressures today and the impact on the system's ability to close the funding gap by 2021 (see Figure 5 overleaf).

Figure 4: Qualified nursing, midwifery and health visiting staff in England by area of work and level, published January 2014



Source: *Health and Social Care Information Centre, Provisional NHS Hospital & Community Health Service (HCHS) monthly workforce statistics (published February 2014)*

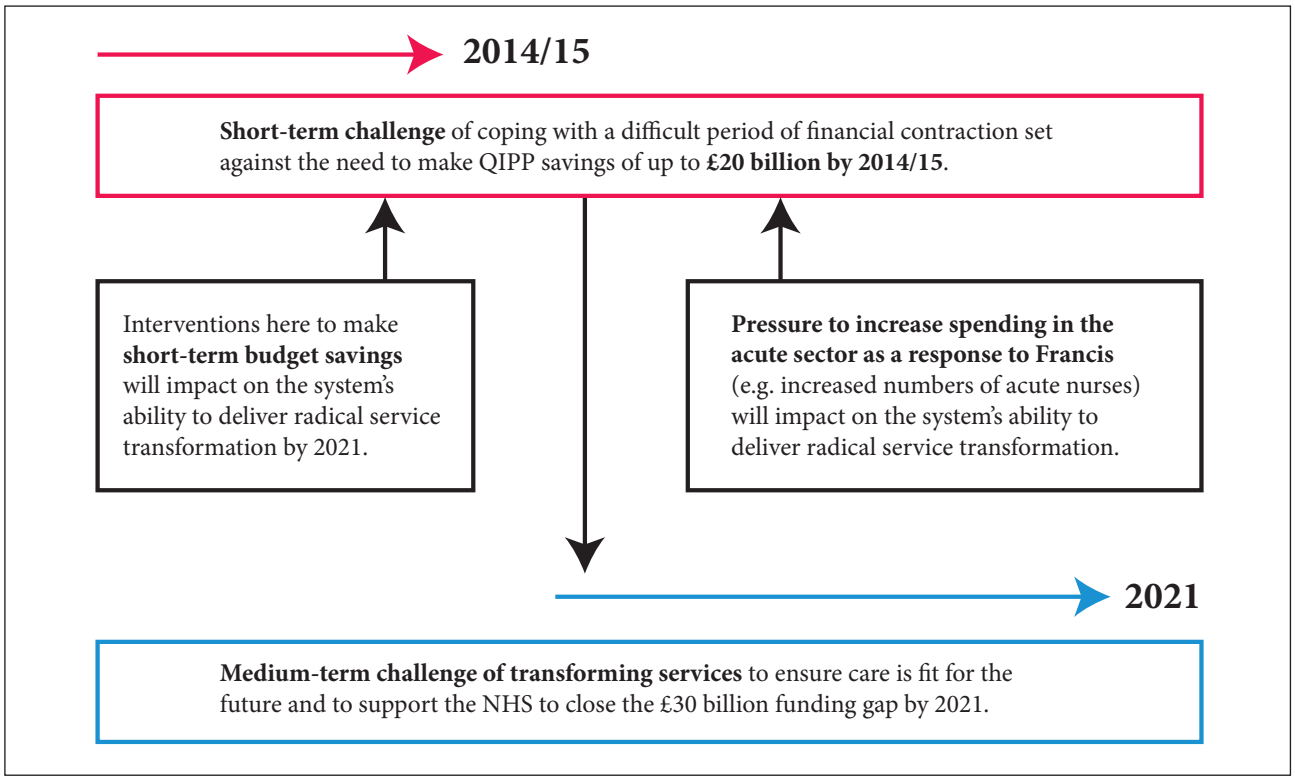
In the past, in times of financial challenge, providers have been 'bailed out' or given marginal extra funds to meet very specific objectives (for example the recent additional funds to support A&E units over the winter months). While in some cases this subsidy may have been entirely appropriate, there may have been a lost opportunity during the period of funding growth to 2009/10 to future-proof the system and we should not make the same mistake during this current period of austerity.

4.1 Alternative income sources

The group also noted the potential scope to pursue additional funding options for the health service. The temptation is to view NHS spending as being the sole responsibility of the taxpayer but other options could be considered further, for example better partnerships with the life science sector, private equity firms and social investors.

13 Francis R. *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. The Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013.

Figure 5: The twin-track challenge facing the NHS: The approach to dealing with financial challenge and quality concerns in 2014/2015 will have an impact on the system's ability to deal with longer-term transformation



5. There are a number of cultural barriers which make innovation more challenging

The group frequently discussed cultural barriers to innovation. The discussion can be divided into two separate themes: a) attitude towards success and failure; and b) willingness to use the right tools, models and evidence.

a. System culture towards failure and success

On culture, a number of participants referred to a general ambivalence towards both success and failure, as well as a fear of risk taking. For example, in the past, there has been very little action taken in response to 'failure' except to remove the chief executive and very little recognition or reward for success.

Context is vital and, while it can be useful to consider successful examples of care delivery from abroad (such as India's Aravind Eye Care), it is important to understand the differing regulatory and cultural contexts relative to the UK.

Some participants felt that there was still a conflict between the perception of a national, unified NHS and the drive to introduce change at a local level. To be truly radical, the system would need to operate ahead of the evidence base and be given licence to 'break rules' in a manner consistent with good judgement. The general view was that the current service offer had been 'hardwired' to suit the current system. While there might be a will to make system changes, a range of issues such as payment mechanisms, contracts (both with staff and for services), professional interests, regulatory interventions, etc, had evolved within the NHS and could be barriers to effective change.

Anecdotally, it was felt that staff appraisal systems were not being used effectively and that there was a clear expectation of staff for incremental rises in wages as an automatic entitlement. There could be scope to link pay progression more to performance rather than length of service, thereby ensuring that the organisation's workforce is better incentivised in line with its board's objectives.

The group also discussed the absence of a 'success' regime. Success has to matter but there are very few incentives for successful providers to take risks. Often, success for one provider is at the expense of another NHS organisation. There are too few incentives for joint ventures and collaborations across whole health economies, or between providers in different areas. The Department of Health has since announced that Sir David Dalton will lead a review which will investigate how the system could better support high achieving NHS organisations to establish national groups of hospitals.[14]

b. The system's willingness to support effective innovation tools and methodology for innovation

The terms innovation and improvement are often interlinked but there are major differences in approach between the two. The concept of improvement (ie doing things better) is generally incremental. Innovation (ie doing things differently) requires a more radical approach. In other sectors, investment and effort is focused where success is likely. Language suggesting that everyone 'is an innovator' is not always helpful. The UK is as innovative as any other county but pockets of innovation in the NHS tend to remain localised.

As a sector, it has long been known that the health system could be much better at 'spread' of good and innovative practice. The evidence suggests that large conferences, best practice guidance, websites, case studies, etc, have limited impact on the diffusion of innovation. Similarly, the number of staff in the NHS trained in, and using, formal improvement methods such as 'lean' or theory of constraints, is still too small to make much difference, despite their impact in some areas.[15] If the same approaches continue to be used, the system will be having the same conversations in 2021. In contrast, there are tools such as modelling or simulations which could be used more effectively to support planners to minimise the risks of specific system interventions.

As an extension of the 'success regime', there was a rich discussion on how to incentivise expansion of successful institutions. There are very few incentives for successful providers to run or acquire other organisations. In addition, acquisitions would fall under the remit of the competition authorities (assuming they met the turnover test) and if trusts were in similar geographic localities, the case for relevant customer benefits would need to be compelling. The system in England is unusual compared to many other health systems which often feature greater use of provider chains or federations.

There was some discussion about the capacity of the system to translate a successful management or clinical approach from one organisation to another and there was some scepticism as to how this might work in practice without considerable support. It was noted that the evidence on the effectiveness of mergers in healthcare was mixed and incomplete. For example, Gaynor *et al* looked at the impact of the 112 NHS hospital mergers which occurred between 1997 and 2006 but found little evidence that mergers achieved gains other than a reduction in activity. While admissions and staff numbers fell relative to the pre-merger position, labour productivity did not rise and financial deficits increased. While most measures of quality were unchanged, the team couldn't demonstrate quality improvements that would offset the poorer financial performance.[16]

A focus on partnerships or cooperative ventures across specific services might be more effective. Such partnerships might allow for common service frameworks and joint rotas. This approach might be more economically viable and offer spare capacity to dedicate to service transformation. However, in some circumstances it might still fall under the remit of the competition authorities as services might be consolidated across a geographical area.

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14 The Department of Health. "Super-heads' review on how best NHS CEOs could take-on failing hospital'. 14 February 2014. Accessed on 26 February 2014 via https://www.gov.uk/government/news/sir-stuart-rose-to-advise-on-nhs-leadership

15 See, for example: The Health Foundation. *Improving patient flow: how two trusts focused on flow to improve the quality of care and use available capacity effectively*. London: Health Foundation, 2013.

16 Gaynor M, Laudicella M and Propper C. *Can Governments do it better? Merger mania and hospital outcomes in the English NHS*. The Centre for Market and Public Organisation, 2012.

6. Radical transformation of services is required

During the discussion, one participant referred to the Wanless review in the context of the potential impact varying degrees of citizen engagement might have on future funding pressures. Wanless noted that greater patient and citizen engagement in health would mean costs rising less steeply in the future. He said that the system needed to do more to encourage greater public engagement in order to increase the levels of health awareness, and to establish more effective relationships between the public and the health system. It is interesting to note that the vision for 2022 a decade ago was very similar to the vision for 2021/22 today. In his review, Wanless highlighted the following objectives:

- Patients would be at the heart of the health service and the service would move beyond 'informed consent' to 'informed choice'.
- Modern and integrated IT systems would be used to join up all levels of health and social care.
- Patients would receive high-quality care in the right setting with different types of care effectively integrated into a smooth service.
- The majority of general and less specialised medical and surgical care would have been moved out of large hospitals and into the community.
- Social care would not be a bottleneck preventing the NHS from working well.[17]

Clearly that vision is still work in progress. In particular, the group considered why progress in moving care into the community had been slow. Tariff and system incentives were common discussion points. The payment by results (PBR) system should have reduced variation in activity within the acute sector but it has not proved to be a strong enough incentive to reduce growth in activity. Similarly, there is still widespread variation in metrics such as procedure cost and length of stay. In parallel, spending on the acute sector has grown rapidly. There was recognition amongst the group that very few acute providers had seen a real saving on their fixed costs. Balance sheet adjustments (such as suspending capital spend) had given organisations some marginal space but this did not necessarily represent a real contraction in spending.

Analysis by the Nuffield Trust suggests that spending on acute care had grown by at least £8bn in real terms (an average of 3.4% each year) between 2003/4 and 2011/12, with a squeeze occurring from 2009/10.[18] The analysis also demonstrated that funding growth had been disproportionate across sectors. For example, between 2010/11 and 2011/12 spending on community care grew at 6% compared to a 1.2% growth in hospital care, a 0.5% growth in mental health spending and a 1.2% real-terms reduction in GP services. During the discussion, one participant referred to the challenge of recruiting GPs and suggested that the policy push to increase access to primary care might reduce the capacity of staff to engage with service transformation.

The increased policy attention on supporting better integration of care – for example through the development of the integrated care pioneer programme[19] – was welcomed. There are very real opportunities to improve outcomes and patient experience, but in the short term it will be difficult to realise demonstrable financial gains. For example, the evaluation of the Integrated Care Pilots programme, launched on the back of the Next Stage Review, found no overall significant changes in the costs of secondary care utilisation despite many of the pilots aiming to reduce hospital admissions in a short space of time.[20]

During the roundtable, there was some discussion about the implementation of the Better Care Fund, the £3.8bn pooled budget designed to support improved integration for elderly and vulnerable people.[21] It was noted that this funding was not new money. From 2015/16, the Better Care Fund would include a £1.9bn contribution from core CCG funding,[22] a policy which is not without risk.

17 Wanless D. *Securing our Future Health: Taking a Long-Term View*. HM Treasury. April 2002.

18 Jones N and Charlesworth A. *The Anatomy of Health Spending 2011/12*. The Nuffield Trust. March 2013.

19 Department of Health. *Integration pioneers leading the way for health and care reform*. Department of Health. 1 November 2013.

20 Ernst and Young and RAND Europe. *National Evaluation of the Department of Health's Integrated Care Pilots*. March 2012.

21 Hansard. 2013. H.C. Vol 565, col 313 (26 June)

22 NHS England. *Everyone Counts: Planning for Patients 2014/15 to 2018/19*. NHS England. December 2013.

As a general observation, there was limited discussion during the roundtable about the role of commissioners and the commissioning infrastructure. There still appeared to be an expectation that it would be the responsibility of acute providers to manage down their own capacity and to lead innovative initiatives across the health economy. Is it realistic for acute providers to do this while actively competing with their neighbours for services?

6.1 The impact of reform on the workforce

While there had been an understandable focus on finances, some participants emphasised the need to look beyond the numbers. For example, it was noted that behind the struggle to make economic savings, cuts had an impact on the workforce and on staff motivation. This is set against a media blitz of negativity about NHS care in the wake of the Francis Inquiry. It will be important to consider retention rates, staff survey results and other indicators of morale as well as absolute numbers of staff. Not enough attention is paid to staff and their development.

It was also noted that the NHS has experienced massive growth in staffing numbers over the last decade. It takes time for new starters to become accustomed to their role, responsibilities and environment. This will have an impact on productivity and efficiency. Reform has been a constant feature of the NHS and its effect on productivity and efficiency is largely unknown. This should be an area for future research.

It was noted that there had been a high turnover of leadership teams and chief executives in many provider and commissioning organisations, which would hamper their ability to build good local relationships.

7. The centre should play a supportive and facilitative role and avoid the perception of micro-management

While *Liberating the NHS*[23] was a central pillar of the Coalition Government's reform programme, facets of the previous 'command and control' system are still in place, such as the recent central management of winter pressures and A&E waiting times. There was much discussion about the most appropriate role of the centre both in dealing with the immediate funding crisis and in supporting transformation over the next decade.

There was some debate as to whether there needed to be more 'central grip' over the short-term. While a degree of direction was thought to be helpful, it would need to be carefully managed. Such direction would need to be bold, supportive and facilitative and avoid the perception of micro-management. For example, NHS England's planning guidance[24] could be streamlined to focus on a smaller set of priorities for the system. Other potential actions the centre could take would be to streamline regulatory requirements and to consider whether some functions (such as procurement) might benefit from more consolidation nationally.

8. The time has come for an honest conversation with the public

There has been much debate about the potential implications of a statutory duty of candour for NHS staff but less has been said about the responsibility of politicians and others at national level to be open with the public about the challenges facing the NHS and care system in the future. There is still a public perception that there is one unified NHS and a general lack of awareness of the impact rising demand will have on the health service's ability to deliver in accordance with public expectations, given the funding likely to be available.

The general view of the group was that more needed to be done to inform and engage the public. This might be on two levels:

1. **What should services look like in 2021?** How do people want to access services? What services should be delivered? What interactions are unnecessary, etc.
2. **How should the NHS (and care system) be funded in 2021?** Can we afford to provide the health and care system that the public want? If not, how should the system be funded?

23 Department of Health. *Equity and Excellence: Liberating the NHS.* Department of Health. July 2010.

24 NHS England. *Everyone counts: planning for patients 2014/15 to 2018/19*. NHS England. December 2013.

There was an argument that the current tax rates may be set too low to fund the health service appropriately in the future. It might take a financial crisis to force a more candid debate with the public. There are alternatives to austerity and ultimately there are a range of options to be considered. It was noted however that the term '*closing the funding gap*' was unlikely to win hearts and minds and engage the public. It was suggested that *'better value for patients'* might be more appropriate terminology.

It would be difficult to have a tenable discussion about increasing NHS funding through additional taxation without the system having first demonstrated that it had done everything possible to maximise efficiency. This view is consistent with the findings of two deliberative events on NHS funding that King's Fund conducted in 2013, in collaboration with Ipsos MORI. While most participants at the events accepted that the NHS was under pressure, there was a lack of awareness as to the scale of the financial challenge facing it. The report concluded that people would need to be convinced that the system was working as efficiently as possible before more radical funding options could be considered.[25]

9. There are signs of optimism despite the financial challenges

While the general tone of the discussion was pessimistic about the financial situation the NHS faces, there were notes of optimism. In the wake of the Francis Inquiry, the repercussions of poor quality care will be central to those planning and delivering care in the immediate future. Many participants gave examples of service transformation and engaged clinical leadership. NHS England's *Everyone Counts: planning for patients 2014/15 to 2018/19* has already made progress in identifying and planning for the models of care that were thought optimal for the future. It identifies six main objectives:

- full citizen engagement and empowerment
- a wider range of primary care provision provided at scale
- a modern model of integrated care
- access to high quality urgent and emergency care
- productivity improvements in elective care
- specialised services concentrated in centres of excellence.[26]

A number of roundtable participants also suggested that, given the pressures the system is under, the NHS has coped remarkably well. The rhetoric of a system in trouble does not necessary tally with the considerable gains that have been made in clinical outcomes for many patient groups and health gains across populations, as well as consistently high levels of patient satisfaction with care.

Some participants thought that there might be additional potential to make efficiency savings if the system could engage better with patients and the public. The rollout of personal health budgets was identified as an area of possible efficiency gain by 2021. A reference was also made to Carers UK's estimate of the economic impact of carers. They estimated that in 2011, the economic value of the contribution carers made across the UK was approximately £119bn.[27] This figure was based on census data and assumed that replacement care would cost £18 per hour. Carers have a significant impact on the health and care sector and without their contribution, the potential efficiency gap might be considerably larger. Small changes in the way carers engage with the system might also have potential to make significant productivity gains. Similarly, there might be a greater role that neighbours, volunteers, health champions and patients/users themselves could assume as part of the health and care 'workforce'.

Another area where efficiency gains might potentially be realised included the role of the pharmacy sector in the management of individuals with long-term conditions. If pharmacists could appropriately access more data about patients, there could be scope for them to provide additional services.

25 Galea A, Dixon A, Knox A and Wellings D. *How should we pay for health care in future? Results of deliberative events with the public*. The King's Fund. 2013

26 NHS England. *Everyone Counts: planning for patients 2014/15 to 2018/19*. NHS England. December 2013.

27 Carers UK. *Valuing Carers 2011: Calculating the value of carers' support*. Carers UK, 2011.

Procurement of services and supplies was also seen as an area that could be further developed, as could the management (or sell off) of unwanted capital estate.

In short, responses to the funding gap were thought to group into two areas: those that could be effective in the short term (2014/15 and 2015/16); and those that could be effective in the medium term (to 2021/2). There are a limited number of effective responses in the short term, but in the medium term, there are many more initiatives which are currently being tried but are in the very early stages and will take time to show full results. Table A summarises some of these. The issue is in part how best to make swift bold change in the short term, while significantly accelerating emergent changes in a broader number of areas for the medium term.

Roundtable participants felt that, to help facilitate the rapid changes needed, an honest discussion with the public was needed about the scale of the challenge faced by the NHS, plus options for the future.

Table A: Potential areas of focus to support the NHS to meet the required efficiency gaps.

Programmes of work which could support the NHS through the short-term funding crisis

- Better procurement.
- Pay: reviewing links between increments and pay progression.
- Reconfiguration: speeding up needed change.
- Cutting the regulatory burden for front-line services.
- Reducing central priorities for front-line commissioners and providers.
- Selling off unnecessary estates.

Interventions which could support the NHS to deliver further efficiency gains by 2021

- A review of system incentives such as the tariff, Quality and Outcomes Framework (QOF), different types of contracts with risk sharing – allow permissive testing of innovations locally.
- Supporting integrated care to develop rapidly.
- A review of workforce development. How can the workforce be best supported to innovate?
- Better central surveillance to spot the impact of innovations on quality and costs of care using routine data.
- The development of a 'success' regime for providers (in time this might facilitate/incentivise new provider models such as federations or acquisitions).
- The development at scale of supportive self-management, underpinned by shared decision making between clinicians and patients.

Conclusion

So, can the £30bn a year gap be closed through efficiency savings by 2021? The general consensus at the roundtable was probably not, given the current pressures on the health system and the impact of funding cuts on other public services. However, participants did recognise that significant improvements in efficiency could be made, and Table A gives some suggestions for the short and medium term. However, until the NHS is safely though 2015/16 it was thought unrealistic to expect its full attention to focus on medium-term transformation and reconfiguration.

The roundtable discussion took a high-level view of the NHS in England. There is clearly scope to build on the points outlined here, and to develop analysis and appraise options on:

– **Part 1: shorter-term action.** What can be done to support the system to meet the immediate financial challenge without limiting its ability to meet the 2021/2 funding challenge?

– **Part 2: system transformation 2021/2**. Building on the work of NHS England, Monitor and others, what can be done to support and nurture more radical innovation and change towards the vision of care that has been well articulated by many over several years?

The Health Foundation is an independent charity working to improve the quality of healthcare in the UK.

We are here to support people working in healthcare practice and policy to make lasting improvements to health services.

We carry out research and in-depth policy analysis, run improvement programmes to put ideas into practice in the NHS, support and develop leaders and share evidence to encourage wider change.

We want the UK to have a healthcare system of the highest possible quality – safe, effective, person-centred, timely, efficient and equitable.

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