Health Foundation Representation to the 2015 Comprehensive Spending Review

September 2015

About this submission

In July 2015, HM Treasury published '*A country that lives within its means*' – setting out its priorities ahead of the 2015 Comprehensive Spending Review (CSR).

Through the CSR, Departmental Expenditure Limits (DELs) will be set for every government department and all Annually Managed Expenditures (AMEs) will be scrutinised. The Treasury will work with departments to develop options for reforms across DEL and AME to reduce spending and increase efficiency while improving public services. These budgets will be set between 2015/16 and 2019/20.

On health, it states:

The government will protect spending on the NHS in England and backs the NHS 'Five Year Forward View' which outlines a plan for a more sustainable, integrated health service that cares for people closer to home. By committing to increase NHS funding in England by £10bn in real terms by 2020-21, above 2014-15 levels, the government is supporting the NHS in England to deliver its plan and produce a step change in safety, quality and access. In return for the additional investment, the NHS will need to deliver on its commitment to achieve significant efficiency savings by 2020-21, as set out in the Five Year Plan.

It also states that this additional £10bn will ensure that the NHS becomes a 7-day service by 2020-21 and everyone will be able to access GP services 8am-8pm 7 days a week.

The government will be publishing the outcome of the CSR on 25 November 2015 and to inform this it has invited submissions from interested parties by 4 September 2015.

This document contains the submission from the Health Foundation.

All prices are given in 2015/16 prices, using HM Treasury's July 2015 deflator*, unless otherwise stated.

* www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-july-2015-summer-budget-2015

1.0 Key points

- The government has committed to protect the budget for the English NHS over this parliament. The 2015 Conservative Party manifesto committed to 'increasing NHS spending in England in real terms by a minimum of £8bn over the next five years'.
- This was reiterated by HM Treasury (see above), which committed to increasing NHS funding in England by £10bn in real terms by 2020/21, above 2014/15 levels. This includes the real-terms increase of £2bn between 2014/15 and 2015/16, accounting for the difference.
- The government commitment means that the budget for the NHS will rise from £116.6bn in 2015/16 to £137.5bn in 2020/21 in cash terms (after accounting for inflation). This commitment equates to a cash-terms budget of at least £132.4bn in 2019/20 (the period covered by the spending review). This would be an average annual real-terms increase of 1.3% between 2015/16 and 2019/20.
- In the period from 2009/10 to 2015/16 funding for the English NHS rose by 1.1% a year in real terms. If the government increases the NHS budget in England by £8bn by 2020/21 this decade will still see the lowest real-terms growth in health spending since the NHS was founded.
- Over the last five years, while health was protected from the full impact of fiscal austerity, funding grew less than the estimated pressures on the service.
- The result has been a decline in the financial position of English NHS providers that needs immediate attention. NHS trusts and foundation trusts in England reported a combined deficit of £851m in 2014/15. Half of NHS providers could not balance their budget.
- Monitor's planning assumptions estimate that there is a further affordability gap of at least £1.5bn in 2015/16. This is the gap that would arise even if hospitals were able to achieve unprecedented efficiency gains of 2.5% in 2015/16.
- There are efficiency opportunities in the NHS and productivity varies across the service. Lord Carter of Coles' interim report on the operational productivity of NHS providers concluded that there are 'significant efficiencies to be made but there is no magic wand for delivering them'. Unlocking this potential will require a different approach and concerted action across all health care providers. This will take time and the *Five Year Forward View* expected savings to increase towards the end of the parliament. This combined with the scale of the current deficit argues for much of the £8bn to be 'front-loaded'. That is, with higher increases in the early years of the spending review.
- Due to the need to front-load, if the 2019/20 budget is lower than £132.4bn this would not be consistent with the manifesto commitment to support the *Five Year Forward View*.
- The *Five Year Forward View* (published in October 2014) states that the NHS can only continue to improve the quality of health and health care sustainably with an 'upgrade in prevention and public health', patients gaining 'far greater control of their own care' and new models to 'break down the barriers for how care is provided'. Our analysis confirms that the NHS model is not fundamentally unaffordable or unsustainable, but requires substantive reform to the delivery of care and the approach to improving productivity.

- In the *Five Year Forward View* NHS England estimated that, with no action, meeting rising demand and cost pressures would require an extra £30bn above inflation for its budget by 2020/21. It is planning to make substantial efficiency savings of £22bn by 2020/21, but even if it is able to achieve that it will require annual increases to its budget rising to £8bn to bridge the funding gap. This would see the NHS England budget rise from £101.1bn in 2015/16 to £120.5bn in 2020/21, and at least £115.8bn in 2019/20.
- The government has announced that public sector pay will rise by just 1% a year in cash terms. This is below inflation and recent trends in private sector pay. Without careful management there is a major risk of this leading to further increases to the number of agency staff, which in turn increases the cost of providing care.
- Recent years have seen a substantial increase in NHS spending on temporary and agency staff. In 2014/15 NHS spend on these staff groups was £3.8bn, compared to £3.1bn in 2013/14. This is a real-terms increase of 25%. If this continues to rise it would result in a substantial additional cost pressure. Continuing to rise at even half this rate would result in an additional cost to the NHS of £2.5bn in 2019/20. It is therefore essential to increase the supply of qualified non-temporary staff.
- There are financial consequences for the undersupply of nurses, including increased spending on agency staff and money being spent on bringing in staff from overseas. The NHS needs to expand training places but in a time of austerity training cannot be immune to the requirement to become more efficient and reduce costs. One way to do so may be to look again at the financial support offered to nurses and allied health professionals in training to bring this closer into line with the position of other students, and use any savings to expand training places to meet future demands.
- Given the importance of training enough qualified staff there is a strong case for protecting the budget for Health Education England (HEE) in line with that for NHS England. This would mean the HEE budget rising from £4.9bn in 2015/16 to £5.8bn in 2020/21 in cash terms – at least £5.6bn in 2019/20.
- If pay increases are kept to 1% a year, the NHS will still need to achieve efficiency growth of 2% a year in real terms. This is a substantial task given that this is much higher than the long-term historic rate of 1% a year, and substantially higher than the recent rate for the acute sector of 0.4% a year.
- Achieving this efficiency growth is likely to require additional investment in a national transformation programme to improve efficiency across all NHS organisations, overseen by a dedicated transformation fund, as outlined by the Health Foundation and The King's Fund in our recent report *Making Change Possible: a Transformation Fund for the NHS*. Some potential efficiency savings have already been identified in the Carter Review (which estimates £5bn of potential savings by the end of the decade). The NHS will need to implement these proposals and identify other areas of substantial savings to reach the full £22bn required.
- With major reductions in other areas of public spending, it is unlikely that the government will find additional investment above the £8bn already committed to. One option for funding transformation is a one-off, time-limited transfer from the Department of Health capital budget to its resource budget. While a decrease in

capital investment is not without long-term impacts, the need to transform is immediate if we are to realise savings over this parliament and put the service on a sustainable footing.

- Over the longer term, funding for transformation could be generated through development of the NHS estate into a sustainable source of new income. This could replace the funding from the capital budget after a set time period. There is a strong case for a substantial review of the use of the NHS's estate. Sales of surplus assets are unlikely to realise significant sums (c. £700m), but more innovative approaches to estates could offer significant opportunities for both the NHS and wider public service reform.
- Similarly, moving towards multi-year budgets and a reformed workforce planning system will be crucial elements of a more efficient system.
- Given the challenges facing the NHS, tough choices need to be made. It is not clear that the introduction of seven-day services would be cost effective. A recent paper makes clear that the estimated cost of implementing seven-day services exceeds the maximum amount that NICE would recommend the NHS should be prepared to spend on eradicating the observed weekend effect. A comprehensive roll-out of seven-day services across the NHS is therefore unlikely to be a cost-effective use of resources.
- The NHS cannot operate as a silo, and its sustainability relies on the rest of the health and care system being properly financed. Delivering the *Five Year Forward View* relies on the fact that 'we take action on prevention, invest in new care models, sustain social care services, and over time see a bigger share of the efficiency coming from wider system improvements.' It also asks the service to empower patients and communities.
- Public health budgets have recently been reduced by £200m. In addition to the impact on the population's health, any further disinvestment in public health risks harming the health and care system as a whole and may increase cost pressures on the NHS.
- Improving the health and wellbeing of the population relies on an effective public health system, as does delivering the *Five Year Forward View*. If the budget for Public Health England (PHE) rises in line with NHS England's budget, it would increase from £3.7bn in 2015/16 to £4.4bn in 2020/21 in cash terms. For 2019/20 this would be at least £4.2bn in cash terms. The contribution to this from the Department of Health would rise from £0.9bn to £1.0bn in 2019/20.
- A sustainable NHS also depends on a sustainable social care system. However, social care is facing fundamental challenges:
    - Access has reduced significantly, with a 25% reduction in provision between 2009/10 and 2013/14.
    - Funding for adult social care has fallen by £4.6bn in cash terms between 2010/11 to 2015/16, equivalent to almost a third of net real-terms spend.
    - Recent projections from the Personal Social Services Research Unit (PSSRU) estimate that public spending on adult social care would need to rise by £2.9bn between 2015 and 2019 (£3.7bn by 2020) to meet rising need under the current system.

    - The Resolution Foundation estimates that the new national living wage will put additional cost pressures on social care providers of a gross public cost of £2.3bn in 2020 on top of the projections above.

- Given these challenges it is not clear that the social care system will be sustainable if funding continues to fall. Social care is therefore a priority for any resources that can be found in this spending review in addition to the £8bn for health. Disinvestment in social care is likely to be a false economy, and may increase cost pressures in the NHS.
- The task facing the government over this parliament is therefore not just to secure the resources and deliver service change for the coming five years but also to place the health service on a more sustainable footing for the longer term. To do this the service needs to reform and a public and political consensus on the longer-term funding levels and options for the NHS and social care also needs to be established.

2.0 Introduction and context

In 2012, the UK spent 8.5% of GDP on public and private health.[*1] Of the EU-15 countries only Luxembourg and Ireland dedicated less of their GDP to health. Austria, Belgium, Denmark, France, Germany, the Netherlands, and Sweden all chose to spend over 10% of their GDP on health.

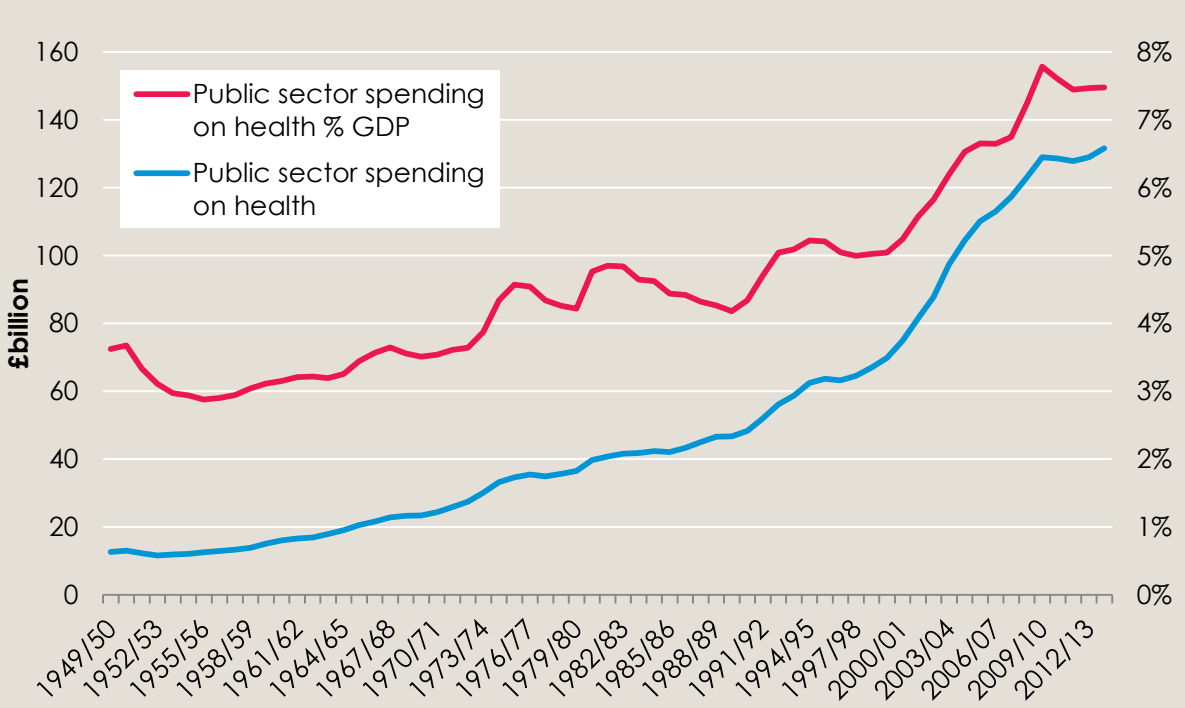
Nonetheless, public satisfaction is the second highest it has ever been, and people are just as likely to think the NHS has improved as they as to think it has deteriorated over the past five years.[2]

Historically, public spending on health care services in the UK has increased at an average rate of 3.7% per year in real terms since 1949/50, although this has slowed in recent years (Figure 1). Health spending has been a growing share of overall public spending and in 2015/16 it will account for almost £1 in every £5 of government spending across the UK.

Health is a devolved function for the UK, and so the precise level of resources allocated outside England depends on decisions made by each of the devolved administrations of Northern Ireland, Scotland and Wales In this spending review the UK government will set the funding envelope for the English NHS and total public services allocations for the devolved administrations.

In this submission we therefore focus exclusively on the spending review decisions for the English NHS, but there will of course be Barnett consequentials for the rest of the UK.

Figure 1: Public spending on health in the UK 1949/50 to 2013/14 in 2014/15 prices, and as a percentage of national income



Source: Health Foundation calculations, using data from: Public Sector Statistical Analyses 2014 (HM Treasury), Fiscal Facts: Spending by function (Institute of Fiscal Studies), OHE Guide to UK Health and Health Care Statistics 2013 (Office of Health Economics, Hawe E and Cockcroft L), UK National Accounts – The Blue Book (Office for National Statistics), GDP deflators at market prices, and money GDP (HM Treasury).
Note: GDP deflators for 1949/50 to 1954/55 are estimated.

[*] Current spending, so not including capital investment.

While the future outlook for NHS funding is unclear, attitudinal research shows that 38% of people would be willing for the government to cut other public services to protect the NHS[3] and 59% of people support increasing taxes as a way of funding the NHS.[4]

3.0 Health spending over the 2010-2015 parliament

England has a growing and ageing population with rising prevalence of certain chronic conditions. This leads to additional pressures on the NHS which, combined with the rising input costs, new technology and increased expectation for health care services, means that health care funding pressures continue to grow beyond the rate of inflation and economic growth. Over the long term funding pressures on the NHS typically increase by around 4% a year above inflation.[5]

Although the NHS was protected from the funding cuts over the last parliament the rate of increase in funding was much lower than the estimated rise in demand for services. Over the last parliament the NHS budget grew by an average of 1.1% a year, from £109.3bn in 2009/10 to £116.6bn in 2015/16 (Table 1). This was the lowest rate of increase in funding since 1955.[6]

Table 1: Health expenditure in England from 2009/10 to 2015/16

	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
health expenditure, cash terms (£)	98,419	100,418	102,844	105,222	109,777	113,300	116,574
annual change, cash terms (%)		2.0	2.4	2.3	4.3	3.2	2.9
health expenditure, 2015/16 prices (£)	109,341	108,558	109,226	109,976	112,419	114,433	116,574
annual change, real terms (%)		-0.7	0.6	0.7	2.2	1.8	1.9

Source: PESA 2015[7]
Note: health expenditure is measured as total department expenditure limit, excluding depreciation

Initially the English NHS managed to meet the rising demand and cost pressures, largely as a result of one-off or temporary savings: pay pressures were reduced due to public sector pay restrictions; administrative budgets decreased from £5.9bn in 2010/11 to £3.1bn in 2015/16;[7] and prescribing costs fell as a number of the most commonly prescribed pharmaceuticals reached the end of their patent resulting in more generic dispensing.

Across the NHS staff numbers fell and many providers implemented recruitment freezes and looked for income generation opportunities.[8] This has not proved to be sustainable and from 2012/13 the financial position of the NHS began to deteriorate, recurrent (on-going) savings became harder to find and as a result the proportion of non-recurrent (one-off) savings started to rise.[9] And in the wake of the Francis Inquiry, staff numbers rose.

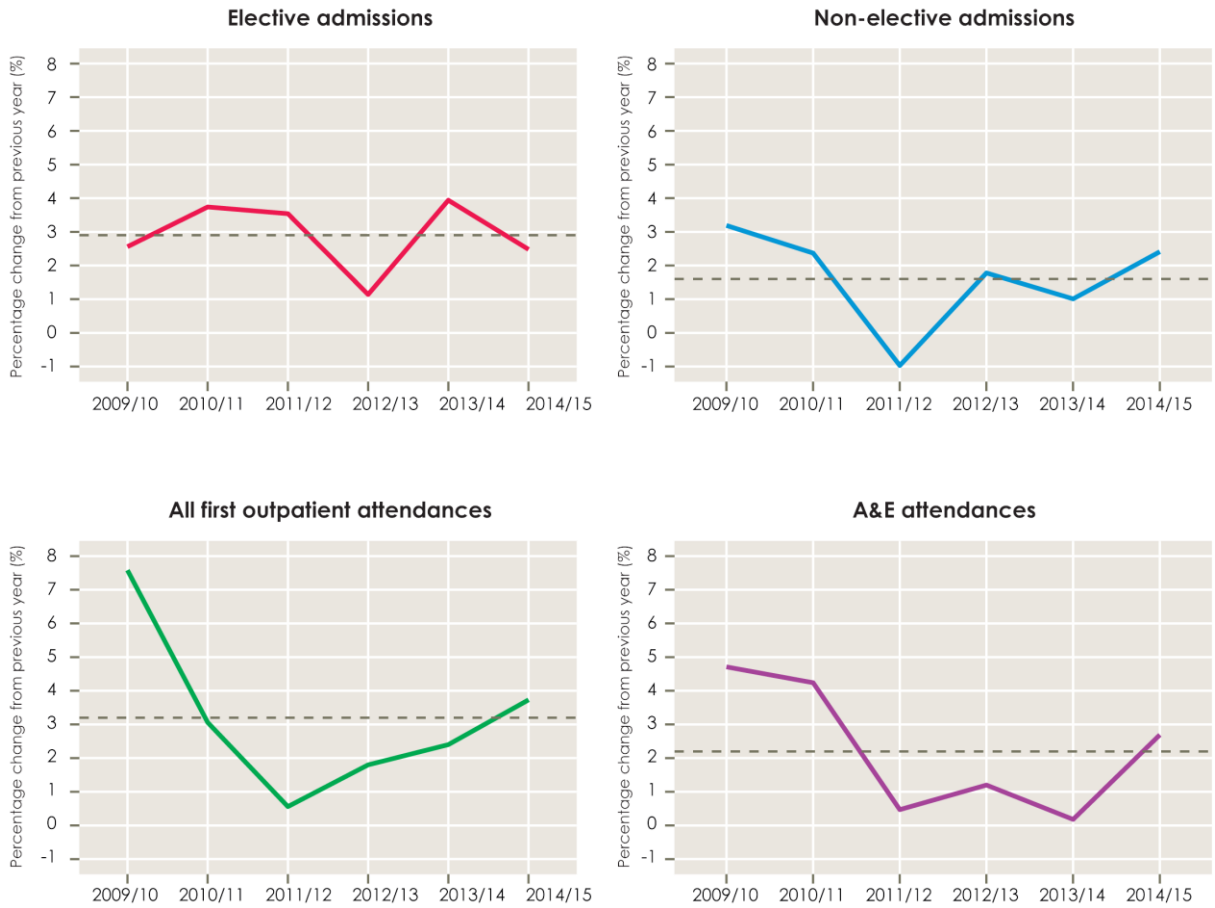
The operating cost of NHS providers between 2012/13 and 2013/14 rose by 2.1%, more rapidly than the income which rose by 1.1%.[10] Similarly, between 2013/14 and 2014/15, NHS providers' operating costs increased further at a rate of 2.3% while income rose by 1.9%[11]

The financial pressures on the acute sector partly reflect increased demand for acute care. Between 2010/11 and 2014/15 outpatient first attendances increased at an average annual rate of 2.1%, total inpatient admissions increased by 2.0% per year and A&E attendances increased by 1.1% per year. Although the demand for hospital services has increased in recent years the growth rate of activity is not unprecedented (Table 2). Recent trends form the same data can be seen in Figure 2.

Table 2: Average annual increase in hospital activity based on providers 'time series, 2008/09-2014/15

		2008/09-2009/10	2010/11-2014/15
Outpatient first attendances		7.6%	2.1%
Total inpatient admissions		2.8%	2.0%
of which:			
	non-elective	3.2%	1.0%
	elective	2.6%	2.8%
A&E Attendances		4.7%	1.1%
Source: NHS England A&E attendances[12] and Monthly hospital stats[13]			

Figure 2: Average annual increase in hospital activity based on providers' time series, 2009/10-2014/15

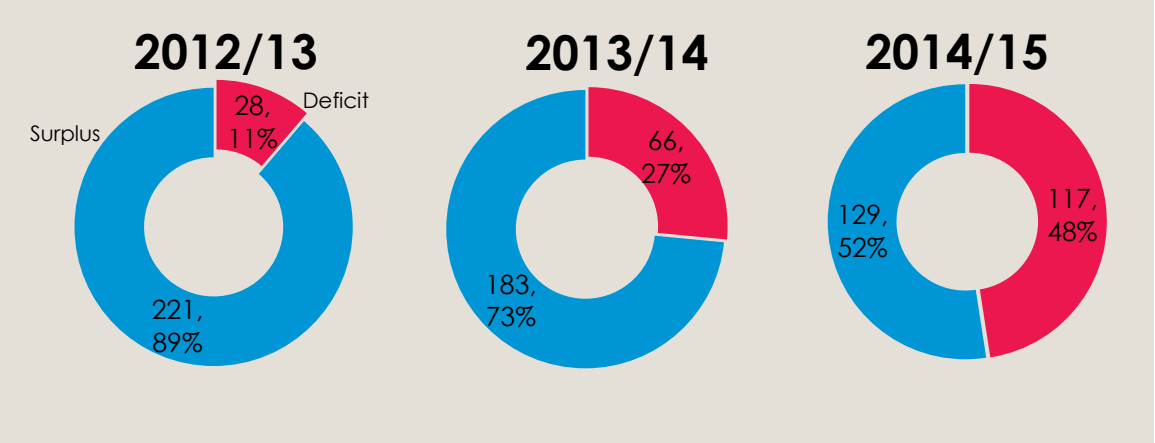


A key driver of higher costs across the NHS has been a rising agency pay bill. In 2014/15 NHS providers spent £47.8bn on staff, up from £46.6bn in 2013/14, a 2.4% annual increase in real terms. This is partly due to a sharp rise in the number of full–time equivalent permanent nurses employed following the Francis Inquiry into poor care standards at Mid Staffordshire NHS Foundation Trust. The number of nurses rose from 307,800 in 2011/12 to 310,200 in 2013/14.[14]

But while permanent staff numbers increased there was a much larger increase in temporary staffing. In 2014/15 the NHS spent £3.8bn on temporary staff, a 25% increase in one year alone from £3.1bn in 2013/14. An increased reliance on agency staff and temporary staff is one of the key underlying causes of the rising operating costs in recent years.[15]

These cost pressures led to the rapid deterioration of the financial performance of NHS trusts with 48% of NHS providers in deficit in 2014/15 (up from 11% in 2012/13) (Figure 3). Overall NHS providers had a net deficit of £851m in 2014/15*. After adjusting for one-off elements the underlying provider deficit was over £1bn at the end of the last financial year. The financial performance of commissioners also deteriorated in 2014/15. NHS England underspent its revenue budget by £0.3bn, just 0.3% of their funding allocation.[16]

Figure 3: Change in number of trusts in deficit from 2012/13 to 2014/15



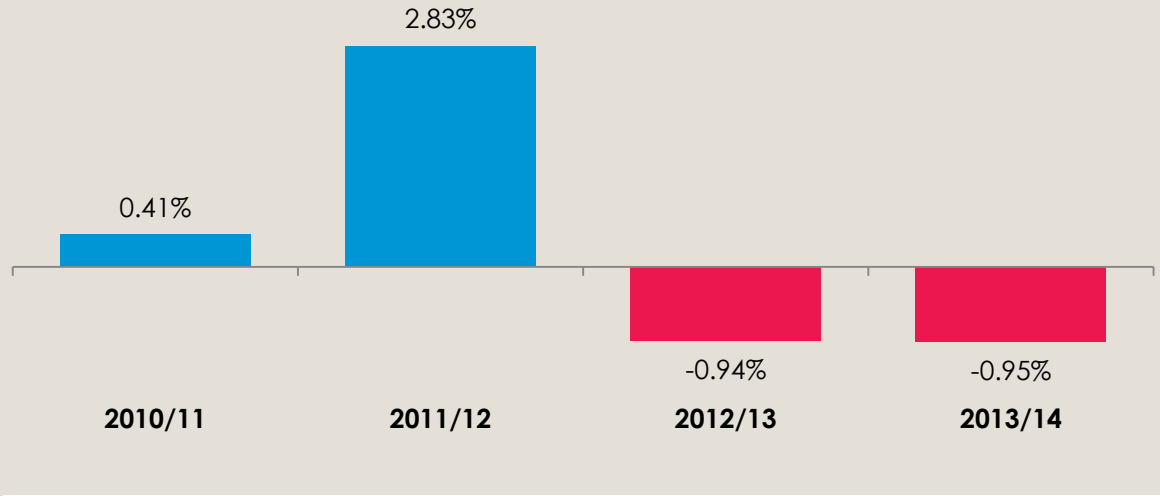
Overall, in 2014/15 the NHS just balanced its budget. The Department of Health underspent its revenue budget of £110bn by just £1.2m in 2014/15.[15] The £1m revenue underspend is a marked deterioration in the departmental level financial performance. It compares to underspends of £314m in 2013/14 and £1.6bn in 2012/13. In order to balance its revenue budget the Department of Health had to receive an additional in-year allocation of £250m, and £640m was transferred from the capital budget to meet day-to-day running costs.[15]

The poor financial position of the NHS is mirrored in disappointing growth in efficiency and productivity. At the start of the last parliament the NHS was tasked with increasing its efficiency by 4% a year.[17] Research by Deloitte for Monitor suggests that between 2008/09 and 2012/13 efficiency increased by 1.2% a year. Updating this analysis to take account of performance in 2013/14, the rate of efficiency growth across NHS acute providers falls to an average of 0.4% a year between 2010/11 and 2013/14.[10]

* Net reported deficit before impairment and gain/loss from transfer by absorption and excluding the consolidation of charitable funds of £94,000.

Crude productivity (the volume of outputs / the volume of inputs) appears to have fallen for the acute sector in the last two years for which data are available.[10]

Figure 4: change in annual productivity for the acute sector from 2009/10 to 2013/14



Source: Lafond, S. Roberts, A. Charlesworth, A. *Hospital finances and productivity: in a critical condition?* The Health Foundation, 2015.

4.0 Social care spending over the 2010-2015 parliament

Adass figures[18] show councils are set to make £500m of service reductions in 2015/16, while facing £600m in extra service demand and price inflation – equivalent to an overall cut in funding of £1.1bn.

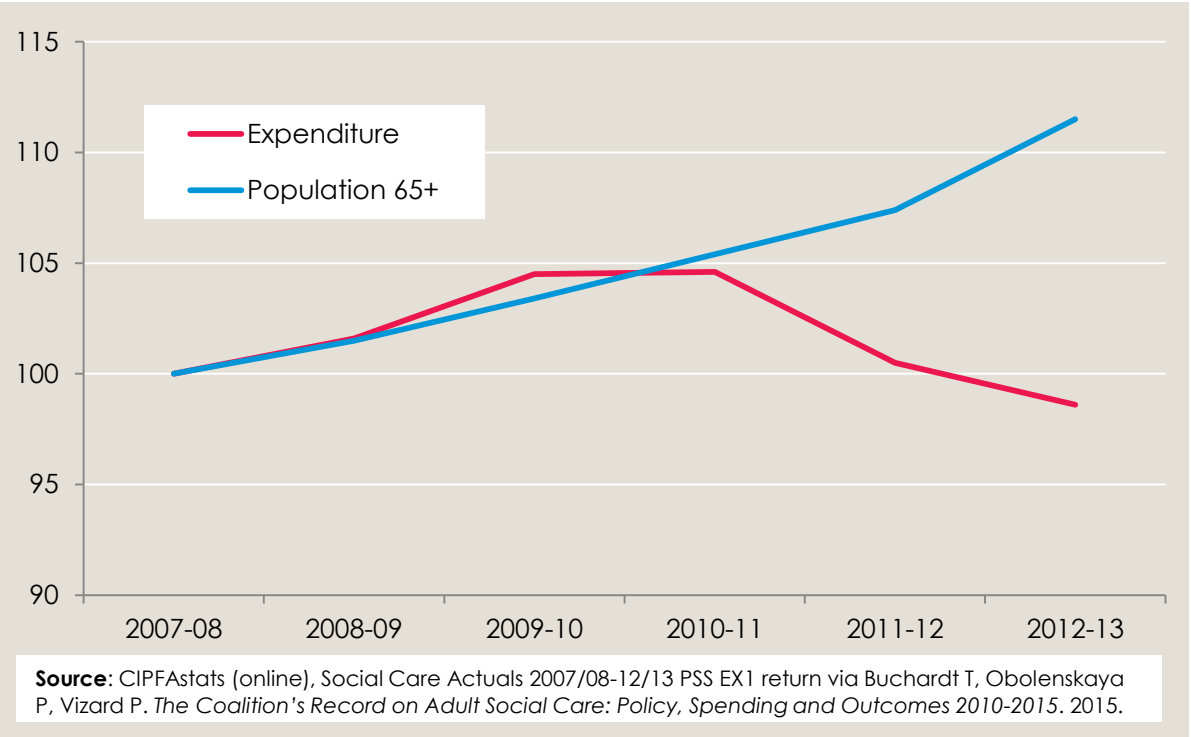
Net current expenditure on adult social care has fallen. Table 3 shows a clear reduction in spending on adult social care since 2009/10, when net current expenditure was £16.1bn. It was 7% lower in 2013/14 in real terms. As Figure 5 shows, spending has fallen, while the size of the elderly population has been growing consistently.

Table 3: Expenditure by Councils with Adult Social Services Responsibilities (CASSRs) by accounting category, 2009/10 to 2013/14, England, £bn in 2015-16 prices

	2009/10	2010/11	2011/12	2012/13	2013/14	Change 2009/10 to 2013/14	Average annual change
Net current expenditure	16.1	15.8	15.7	15.3	15.0	-7%	-2%

Source: NASCIS PSS-EX1 return

Figure 5: Indexed growth in real total gross expenditure on Adult Social Care in England and demographic pressure, 2007-08 to 2012-13



Source: CIPFAstats (online), Social Care Actuals 2007/08-12/13 PSS EX1 return via Buchardt T, Obolenskaya P, Vizard P. *The Coalition's Record on Adult Social Care: Policy, Spending and Outcomes 2010-2015*. 2015.

Adass reports[18] that the funding for adult social care has fallen by £4.6bn in cash terms between 2010/11 to 2015/16, equivalent to 31% of real-terms net budgets. It reports that the percentage of savings secured through efficiency has fallen from 80% in 2014/15 to 75% in 2015/16. Over the same period, savings from income have increased from 4% to 6%, and from service reductions from 16% to 18%. Therefore fewer savings are proportionately being made from efficiencies and more from charges and reducing front-line services.

There have been some efforts to share funding between health and social care. The Better Care Fund (BCF) is a government initiative designed to increase cooperation between the NHS and local authorities by creating a shared budget to provide joined up health and care services to vulnerable and elderly people. The BCF aimed to have a pooled national budget totalling a minimum of £3.8bn. Some local authorities and CCGs have allocated more resources to the fund, meaning that in 2015/16 this pooled budget will be £5.5bn.[19] The BCF aims to improve community health care and has a target of reducing hospital admissions by at least 3.5% from 2014 levels by 2015/16. In their September 2014 plans, local authorities estimated that the BCF would save a total of £532m by 2015/16 across health and social care. Of these savings, it is anticipated that over half will be achieved through reduction in emergency admissions.[19] The National Audit Office (NAO) argues that even if emergency admissions fell by 3.5%, this level of savings may be ambitious since acute trusts have significant fixed costs and large-scale changes would be needed to decommission services.

The sustainability of the care market is reliant on cross-subsidy between different types of funding: NHS residents, local authorities and self-funders. The gap between council fees and provider costs has widened due to pressure on health and social care budgets, threatening the sustainability of the care market. Self-funding older people pay significantly more than councils for places in nursing and care homes (over 40% more on average, for

equivalent care). In contrast, councils have been able to secure discounted rates, so pay less than the cost required for good quality care (17% less for residential, and 19% less for nursing care). This places the market in a precarious position where it is dependent on the right mix of different kinds of funders, a mix which varies significantly across the country.[20]

5.0 What have been the consequences of funding pressures for the quality of NHS care?

Funding constraints do not necessarily translate into shortfalls in quality of NHS care, but make the task of maintaining and improving quality more challenging.[21] Evidence from QualityWatch, our joint research programme with the Nuffield Trust, tracks changes in the quality of health and health care.[22]

During the 2010-2015 parliament the NHS managed to maintain and improve quality across a range of areas. But progress on improving quality stalled in some areas and may even be starting to unravel in the face of growing pressure from increased demand, unit costs and financial constraints. For example:

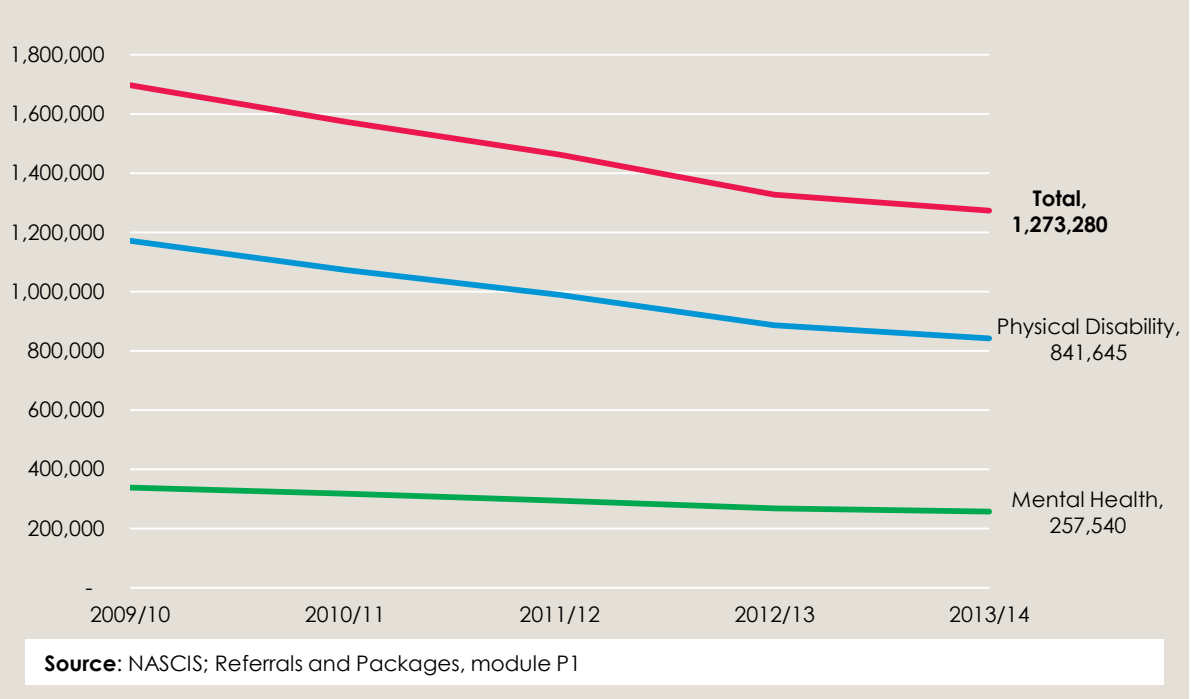
- Continued progress was made in tackling key harms in hospital, but significant increases were observed in *C. difficile* infections and both MSSA and *E. coli* bacteraemia in 2014/15.[23] Warning signs also emerged from the NHS workforce, with work-related stress and perceptions of a blame culture continuing to rise.[24]
- A series of waiting time targets were failed in urgent and emergency care, cancer services and elective care in the latter part of the parliament.[25] Access remains better than 15 years ago, but the provision of targeted extra resource has largely failed to arrest the deterioration in performance.
- Mental health services for children and young people is a key area of concern, with very long waiting times for specialist services, increased treatment thresholds and mixed appropriateness of services.[26] Some other mental health services improved, but many people with severe mental health problems are still not receiving high quality care.
- Since 2000, successive governments have made commitments to person-centred care, but there is a lack of coherent and consistent indicators across all areas of care.[27] There have been improvements in a number of areas but in others there has been little real progress. One in five inpatients still report that they are not always treated with dignity and respect and more than 40% are not involved as much as they want to be in decisions about their care.
- The NHS compares well internationally on some measures of quality, but there is considerable scope for improvement in several important areas.[28] Analysis of the OECD Health Care Quality Indicators highlights that the UK health system performed worse than most comparable countries on 14 of the 27 metrics considered.[29]

There is qualitative evidence that at least some providers of care have opted and would opt to protect quality at the expense of their financial position.[30] This is unlikely to be sustainable in the longer term, but exactly how long providers can continue to maintain quality by absorbing cost pressures is unclear. Some aspects of quality are more sensitive to financial constraints than others but if the gap between spending and demand continues to grow, this may lead to continued deterioration across an expanding range of performance measures. It is difficult to see how the NHS can avoid improvement to the quality of care stalling, or even deteriorating in some areas, following the general trajectory of the last five years.

6.0 What have been the consequences for the quality of social care?

In social care, quality appears to have been affected through increased unmet need. The number of people receiving local authority-funded care has fallen by 25% between 2009/10 and 2013/14 (-6.9% on average a year). Within this the reduction in access has been particularly great for those with a physical disability, falling by 7.9% a year since 2009/10 compared to 3.4% for those with mental health issues. This does not reflect reduced demand[31], but reduced supply due to inability to provide services within current budgets.

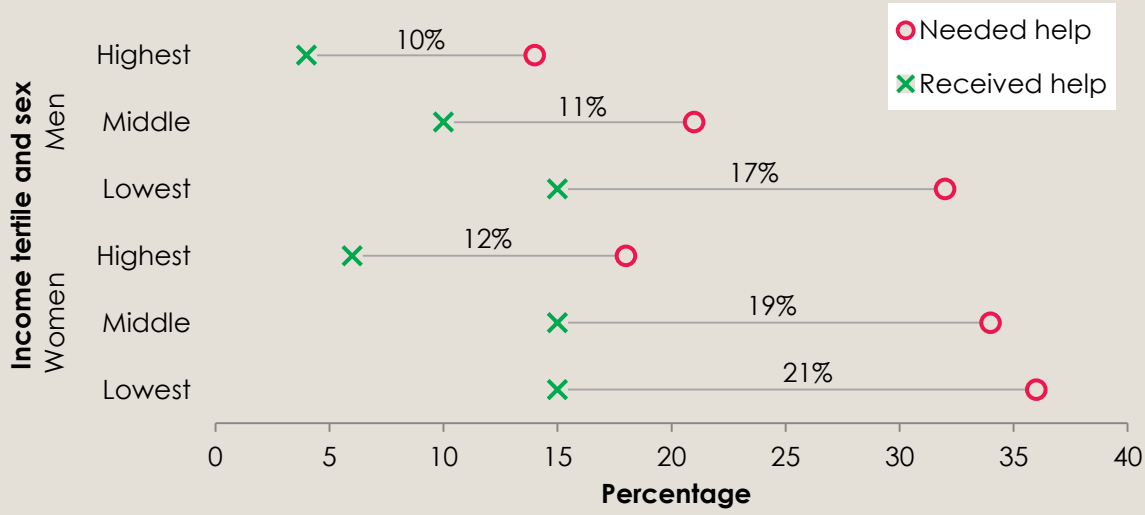
Figure 6: Number of clients receiving services (community-based services, residential care or nursing care) provided or commissioned by local authorities with social services responsibilities, by client type, 2009/10 to 2013/14, England



Source: NASCIS; Referrals and Packages, module P1

Just over half of public funding for adult social care is spent on meeting the needs of those aged 65 and over. Among those 65 and over the difference between need and receipt of help is most significant for those in the poorest third of the population. Just 15% of those over 65 in the poorest third of the population received help (public or private), while over 30% needed help.

Figure 7: Need for and receipt of help with Activities of Daily Living (ADLs) in the last month, by equivalised household income and sex, those 65 and over[32]



Source: Health Survey for England, 2013

It is not clear how the delay of the Care Cap (which would limit costs to £72,000 for over-65s and younger adults) until 2020 – with no clear indication about where money saved from delaying the reforms will go – will impact these distributional concerns.

Likewise, a December 2013 London School of Economics report[33] commissioned by the Care and Support Alliance showed that 500,000 older and disabled people who were not receiving social care in 2012 would have done so five years earlier as a result of tightening eligibility criteria during this period.

7.0 Future spending

NHS

The spending review sets a total budget for the NHS which includes both day-to-day running costs (resource spending) and capital. This is the total department expenditure excluding depreciation (TDEL). In 2015/16 the NHS TDEL budget in England was £116.6bn.[7] In its 2015 manifesto, the Conservative Party committed to increase 'NHS spending in England in real terms by a minimum of £8bn over the next five years'.[34] This was reiterated by HM Treasury in *A country that lives within its means*, which committed to increase NHS funding in England by £10bn in real terms by 2020/21, above 2014/15 levels. This includes the fact that the NHS TDEL increased by £2bn in real terms between 2014/15 and 2015/16.

The addition of £8bn in real terms means that the NHS TDEL will rise from £116.6bn in 2015/16 to £124.6bn in 2020/21, in 2015/16 prices. In cash terms this is £137.5bn in 2020/21, using current projections for inflation – a cash increase of £21bn in headline funding between 2015/16 and 2020/21. This is an average cash increase of 3.4% a year, or 1.3% in real terms.

The spending review will set departmental budgets up to 2019/20 – a year before the government's manifesto commitment. Table 4 shows the corresponding figures for 2019/20

on the assumption of a steady annual real-terms percentage increase in the budget across the period. However, both the *Five year forward view* and *Making change possible: A Transformation Fund for the NHS* highlight the need to invest in order to deliver efficiency savings, requiring the increased investment to be front-loaded (ie rising by more than 1.3% in real terms in the earlier years). Due to this, the budget may be slightly higher than minimum of £132.4bn in 2019/20, but any lower than this will not be consistent with the manifesto commitment to support the *Five Year Forward View*.

Table 4: Estimated budget for English NHS in 2019/20 and 2020/21 according to the manifesto commitment, assuming inflation rises as assumed for GDP Deflator, July 2015

	2015/16	**2019/20**	**2020/21**
TDEL plus real terms £8bn increase by 2020/21 (2015/16 prices)	£116.6bn	£122.9bn	£124.6bn
TDEL plus real terms £8bn increase by 2020/21 (cash terms)	£116.6bn	£132.4bn	£137.5bn

The additional £8bn reflects the government's commitment to support the vision for the NHS set out in the NHS system leaders' *Five Year Forward View.*

The *Five Year Forward View* sets out an analysis of future funding pressures and the options to meet them through combinations of improved efficiency and additional resources. It includes an estimate that pressures on NHS England's budget specifically (£101.1bn in 2015/16[35]) will rise by around £30bn above inflation by 2020/21. NHS England is aiming to make efficiency savings of £22bn by 2020/21, therefore in the same year it will need annual increases rising to £8bn above inflation in 2020/21 to meet the additional pressures. External projections from the Health Foundation show that the scale of the challenge is broadly in line with the *Five Year Forward View* calculations.[36]

Finding these £22bn savings requires efficiency savings of at least 2% a year, much higher than recent trends. At the very least this will require:

- national initiatives on pay and the agreement on pharmaceutical prices which sees the industry provide rebates to the health service if spending exceeds an agreed baseline
- ensuring that all providers 'catch up' with the efficiency performance of the best
- more fundamentally, unlocking system-wide efficiency improvements through better population health and shifting care to more appropriate settings.

How the additional money is allocated among the arm's length bodies will be a decision for the Department of Health in the planning round following the spending review. Table 5 provides our estimates of what some of these allocations might be in order to fully support the *Five Year Forward View*.

As described above, if a greater rate of efficiency growth can be achieved, NHS England's budget would need to see annual increases rising to £8bn above inflation by 2020/21. In cash terms this would see it rise from £101.1bn in 2015/16 to £120.5bn in 2020/21. Assuming a constant real-terms rate of increase, this would be at least £115.8bn in 2019/20.

Delivering the *Five Year Forward View* also relies heavily on strong public health, for example it calls for 'a more activist prevention and public health agenda'. This is unlikely to happen without protection of the budget for Public Health England (PHE). If this grows at the same rate as the budget for NHS England, it will rise from £3.7bn in 2015/16[37] to at least £4.2bn in 2019/20 (cash terms). Of PHE's total budget in 2015/16, £880m is provided from the NHS TDEL. This would therefore rise to at least £1.0bn in 2019/20. The remainder would form part of the settlement for local authorities.

Achieving a higher rate of efficiency growth will require strong investment in staff, and so there is a strong case for Health Education England's (HEE) budget to grow at the same rate. The HEE budget would therefore rise from £4.9bn in 2015/16[38] to £5.6bn in 2019/20.

The remaining TDEL of £9.7bn in 2015/16, which covers capital (specifically included in Table 5 for reference), Department of Health administration and other arm's length bodies, could therefore rise by no more than around 1.0% a year in cash terms to balance the budget, a real-terms decrease of 1.0% a year.

Table 5: Meeting the manifesto commitment – implied increases in the NHS England, Public Health England and Health Education England – all financial figures in billion, stated in cash terms

	2015/16	**2019/20**	**2020/21**	**Average annual change in cash terms**	**Average annual change in real terms**
TDEL plus £8bn real-terms increase by 2020/21 (cash terms)	£116.6	£132.4	£137.5	3.4%	1.3%
NHS England receives £8bn (cash terms)	£101.1	£115.8	£120.5	3.6%	1.5%
PHE budget rises at same rate as NHS England (cash terms)	£3.7	£4.2	£4.4	3.6%	1.5%
PHE budget received from Department of Health rises at same rate as NHS England (cash terms)	£0.9	£1.0	£1.0	3.6%	1.5%
HEE budget rises at same rate as NHS England (cash terms)	£4.9	£5.6	£5.8	3.6%	1.5%
Remainder (cash terms)	£9.7	£10.0	£10.2	1.0%	-1.0%
Amount of remainder for Capital	£4.6	£4.8	£4.8	1.0%	-1.0%

Social care

Recent projections from the Personal Social Services Research Unit (PSSRU) show that public spending on adult social care would need to rise by £2.9bn between 2015 and 2019 (£3.7bn by 2020) to meet rising need under the current system (2015/16 prices).[39] In 2014 the Local Government Association forecast a £4.3bn funding gap in adult social care by 2019/20.[40]

These projections of additional spending pressures in social care do not take account of the impact of the government's decision on the minimum wage announced in the 2015 budget. The new National Living Wage will see the minimum wage for people aged 25 and over increase from £6.50 to £9.35 in 2020 starting with an increase to £7.20 an hour in April 2016.

The new minimum wage affects less than 2% of the NHS workforce, and will increase employee compensation across the economy by just 0.1%. However, it will have a considerable impact on 50-60% of front-line social care workers (700,000 to 1m workers). This is not just a significant number of people, but also has a significant estimated gross public cost of £2.3bn in 2020 (and a gross total cost of £3.8bn), in 2015/16 prices.[4142] This cost largely falls on providers. There are considerable concerns about the extent to which the provider sector can absorb these additional wage costs. In response to budgetary pressures local authorities have been reducing the rates they pay both domiciliary and residential care providers for social care. Between 2010/11 and 2013/14 the rate per week for residential and nursing care fell from £673 to £611 in 2015/16 prices.[43]

There is evidence that, even at the current minimum wage, the care sector has minimum wage non-compliance problems, with around 160,000 care workers (out of 1.4m) being paid less than the minimum wage when all working time is considered.[44] Pay is also falling behind low-skilled jobs in other sectors.[42] The workforce is projected to increase by up to 1m additional jobs by 2025, based solely on expected changes in demand.[45] Alternative projections by Skills for Care, based on a range of funding and provision scenarios, forecast increases in the number of social care jobs in England of 15-55% (up to 825,000 additional jobs) between 2013 and 2025.[46]

8.0 Policy Reforms

While the NHS will be protected from the full impact of the government's fiscal consolidation, this protection is premised on the NHS delivering a level of efficiency savings which it has not hitherto been able to achieve on a sustained basis and when many of the 'quick wins' have already been realised. This will require a fundamentally different approach to that of the last five years.

It is also important to note that at the start of the spending review NHS providers are not able to balance their budgets. NHS providers started the current year with an underlying deficit of over £1bn and Monitor planning assumptions estimated a further affordability gap of around £1.5bn in 2015/16. This is the gap that would arise even if hospitals were able to achieve efficiency gains of 2.5% in 2015/16.[47]

Table 6: The affordability challenge as set out in Monitor planning guidance

	2014/15	2015/16	2016/17	2017/18	2018/19
Total affordability challenge	3.1%	6.6%	5.5%	4.7%	4.6%
Provider efficiency	2.0%	2.5%	2.0%	2.0%	2.0%
System efficiency	1.0%	2.0%	0.1%	1.0%	1.0%
Remaining challenge	0.1%	2.1%	2.5%	1.7%	1.6%
Remaining Challenge (£)		£1.46bn	£1.7bn	£1.26bn	£1.26bn

Supporting the *Five Year Forward View* involves not just a funding commitment but also a commitment to a properly resourced, reformed way of delivering care across health care, public health and social care systems. There is some evidence to suggest that a focus purely on health care to the detriment of wider public services negatively affects population health[48], and that disinvesting in public health and social care is cost-increasing in the long term.[49]

The *Five Year Forward View* states that the ambitious productivity assumption which closes £22bn of the £30bn gap 'is possible…provided we take action on prevention, invest in new care models, sustain social care services, and over time see a bigger share of the efficiency coming from wider system improvements.' This reiterates the need to protect public health spending, as described above. Similarly, it states that 'just as GPs and hospitals tend to be rigidly demarcated, so too are social care and mental health services even though people increasingly need all three'. The need to properly resource all areas of health, including mental health and social care, and empower patients and communities runs throughout it.

To ensure that the NHS is able to deliver the vision in the *Five Year Forward View* and that the annual real-terms funding increases rising to £8bn are able to sustain quality of care and access to services, investment needs to be accompanied by reform.[50]

In our report *Constructive comfort: accelerating change in the NHS*[51], we argue that national bodies' efforts to effect change follow three broad types of approach:

- 'Prod organisations.' This approach aims to direct, prod or nudge providers of care from the outside. Familiar tools here include: legislation; targets; command and performance management; payment (currency and price) incentives; regulation; and competition.
- 'Proactive support.' This approach focuses on enabling organisations more directly to make the changes needed. In the past, prods have been described as offering 'constructive discomfort' for change. By contrast, proactive support efforts offer 'constructive comfort'.
- 'People-focused.' This approach includes both prods and proactive support, targeting NHS staff rather than organisations, as well as actions to inspire, engage and involve staff.

We will focus on the first two types in this report, although a combination of all three will be required by national policy makers in order to achieve real change.

‘Prod’ approaches

Financial accountability regime

The soon to be merged TDA/Monitor NHS Improvement has an opportunity to clarify the current financial accountability regime. The depth of financial difficulty in the NHS provider sector and range of organisations unable to balance their books is a fundamental challenge for the NHS. There is a real risk that financial discipline is lost as providers see being in deficit as normal and unavoidable and the scale of the challenge is too great. The financial accountability regime needs to be reformed with the goal of ensuring that all providers have challenging but realistic budgets which reflect their specific opportunities for efficiency. There are substantial variations in the efficiency and productivity of NHS providers. Narrowing this gap and spreading best practice is essential and at the heart of Lord Carter of Coles’ operational productivity programme.[52] The current financial regime was designed to provide incentives for efficiency improvement as providers were paid according to results and autonomous foundation trusts could retain surpluses to reinvest. This framework has struggled in a climate of austerity. With 77 of 150 foundation trusts and 43 of 99 NHS trusts in deficit at the end of 2014/15, providers are increasingly unable to break even.

It is three years since The NHS Future Forum recommended that ‘NHS England should, as far as possible, build on the principle of certainty around under- and over-spends (including multi-year settlements) in order to allow clinical commissioning groups the ability to plan across multiple years to design, commission and invest in longer-term, sustainable solutions with their local partners – for example, local authorities who already receive multi-year settlements from central government.’[53]

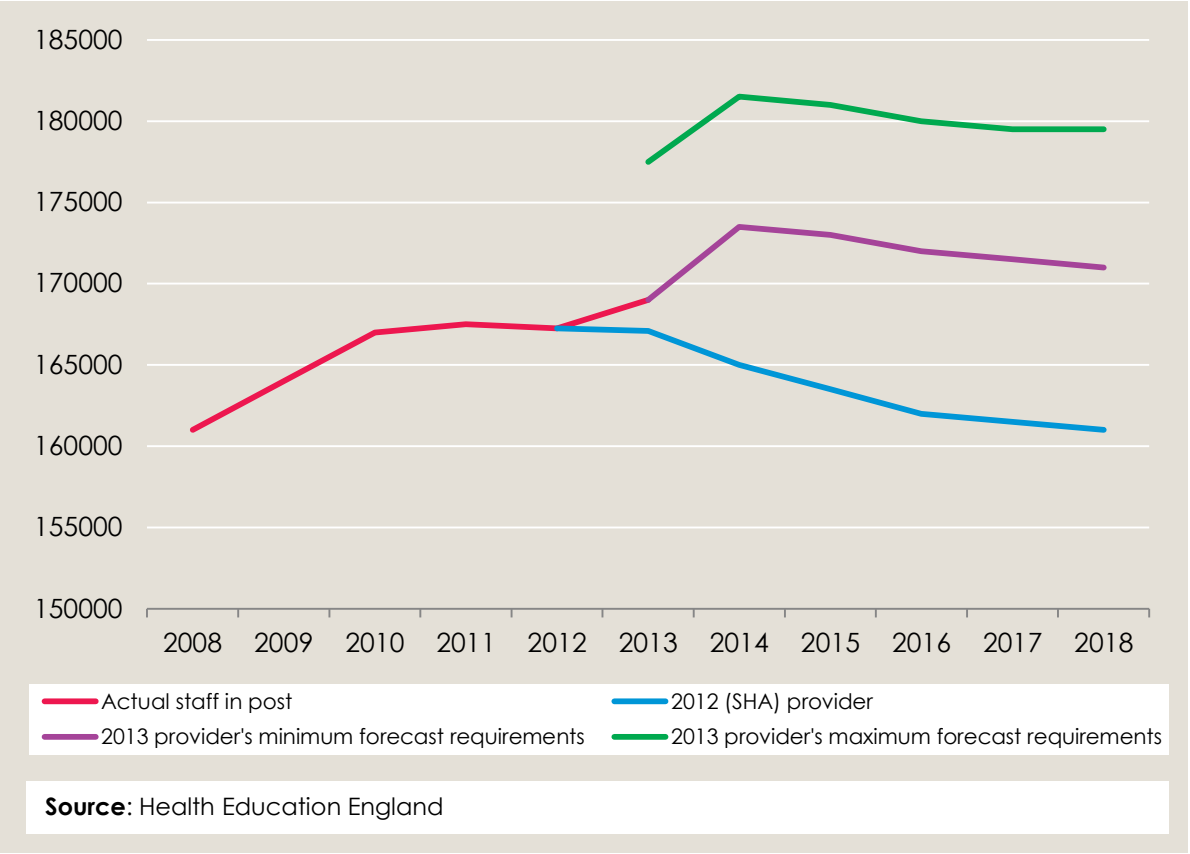
This principle is as true for providers as it is for commissioners. It is clear that the current system of annularity in budgets constricts NHS organisations’ abilities to plan long-term, invest in transformational change, and have certainty about their funding. Alongside additional investment the NHS needs to be enabled to implement multi-year budgets for both commissioners and providers as part of a new system of financial accountability.

Workforce planning and pay

If the NHS is to deliver £22bn of efficiency savings over the next five years it will need to maintain tight control of the growth in pay pressures and improve staff engagement in the process of change. Maintaining control of pay costs means being able to recruit and retain staff and in particular skilled staff.

More accurately projecting the staffing requirements for the NHS and then training staff in enough numbers at an efficient cost is crucial for the efficiency and sustainability of the service. Figure 8 shows how employer forecasts for their staffing requirements have shifted over 12 months. The original (2012) forecasts showed a reduction of 1.4% between 2012 and 2014, whereas the workforce actually grew by 1%. In 2013, employers forecast increased employment intentions of 2.1% staff. The 2013 forecast shows additional 3,700 full time equivalent nurses being employed. The difference between the 2012 forecast for March 2014 and the 2013 forecast represents a 4.7% change in the workforce required.[54]

Figure 8: Provider forecasts of future demand – 2012 and 2013 forecasts

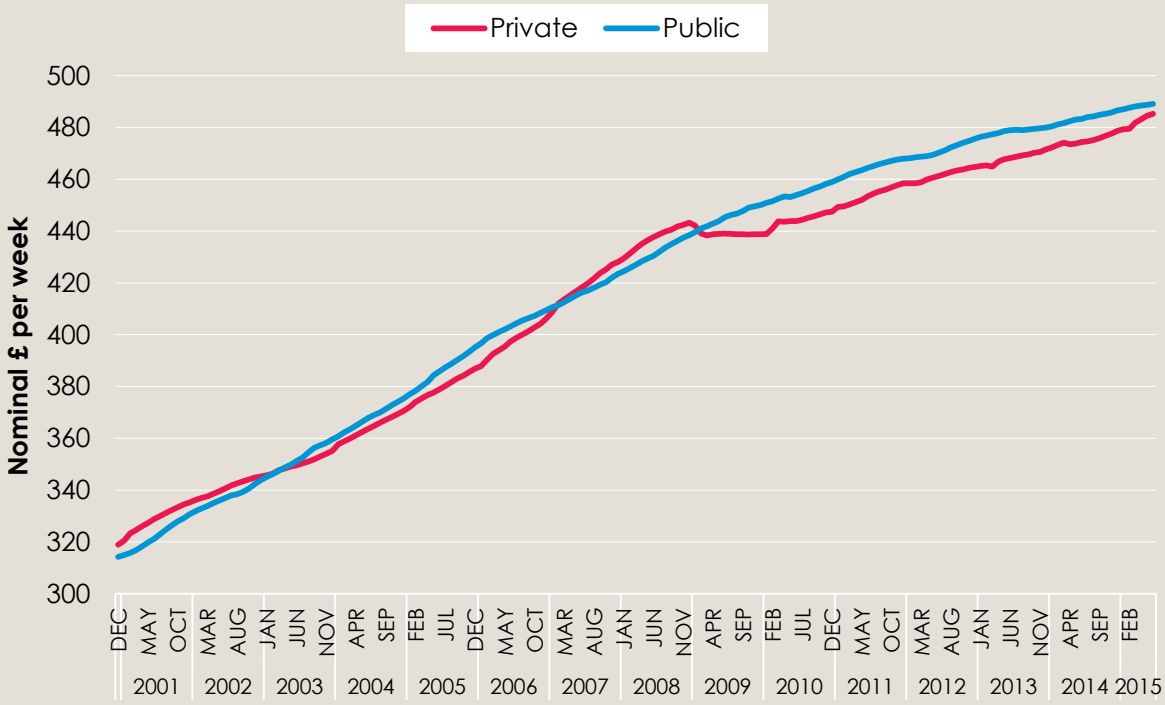


Source: Health Education England

There are financial consequences of the undersupply of nurses. These include increased spending on agency staff, money being spent on bringing in staff from overseas, and schemes such as 'Come back to nursing'. Supply of nursing degrees is controlled with Health Education England funding a certain number of degree places a year. Demand far exceeds supply, with five applicants for every nurse training place. Nurse education is expensive but not training enough staff also costs. In an environment of constrained funding, it is important that the government avoids the temptation to cut training budgets as this is likely to result in additional cost in the medium term. Health Education England is responsible for training doctors, nurses and allied health professionals. Its budget was £4.9bn in 2015/16.[38] If this rises in line with an £8bn increase in NHS England's budget, it would reach £5.6bn in 2019/20 in cash terms (see Table 5 on page 16). But in a time of austerity, just as the NHS is looking at ways to improve efficiency and reduce cost, training cannot be immune to the same requirement. One way to reduce the cost of educating skilled staff may be to look again at the financial support offered to nurses and allied health professionals in training to bring this closer into line with the position of other students and use any savings to expand training places to meet demand.

Pay restraint was crucial to meeting the funding challenge over the last five years. The government has set out its public sector pay policy for the next five years of 1% a year increase in cash terms. Adjusting for pay drift and increase to pension costs in 2015/16, this will be a slight increase in costs of 0.1% a year in real terms (Health Foundation calculations).

Figure 9: Average weekly earnings in the public and private sectors December 2000 – June 2015 (rolling 12-month averages)[55]

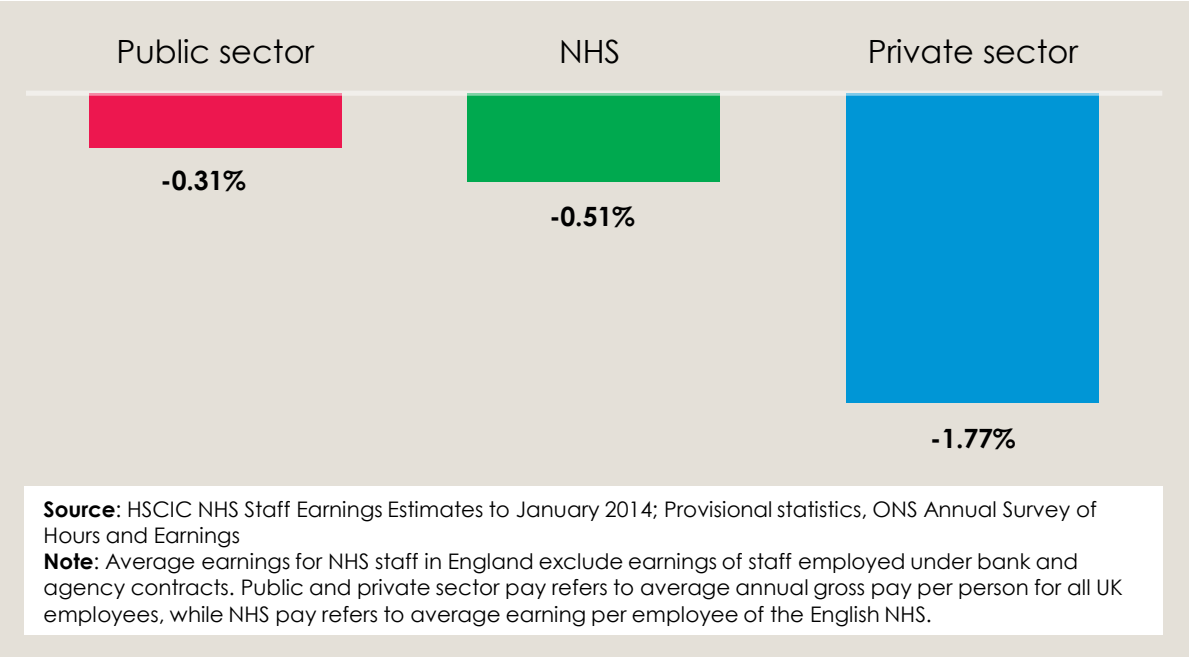


Source: Health Foundation calculations using Office for National Statistics series KA4U for the public sector (excluding financial services) and series KA4O for the private sector, derived from the Monthly Wages and Salaries Survey. Updated from: Cribb, J. Emmerson, C. Sibieta, L. *Public sector pay in the UK*. IFS. 2015.

Controlling spend on workforce in the NHS will be critical over the next five years and failing to be able to do this is arguably the greatest single risk to the ability of the NHS to achieve £22bn of savings. Public and private pay have historically tracked each other quite closely. This can be seen in Figure 9.

Between 2009/10 and 2013/14, average earnings of NHS and UK public sector staff fell in real terms, with an annual average fall of 0.51% (NHS) and 0.31% (UK public sector) during that period. Although the pay growth was constrained in the NHS, pay in the private sector experienced a sharper fall over this period, with average annual pay per person falling by 1.77% in real terms (Figure 10).

Figure 10: Annual average real-terms change in average earning per person from 2009/10 to 2013/14

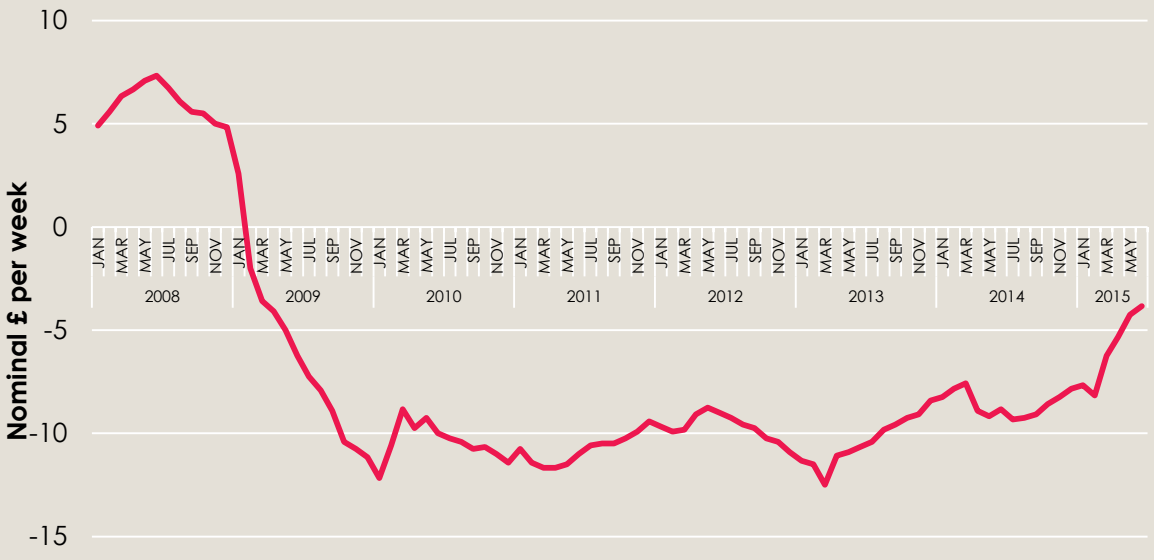


Source: HSCIC NHS Staff Earnings Estimates to January 2014; Provisional statistics, ONS Annual Survey of Hours and Earnings
Note: Average earnings for NHS staff in England exclude earnings of staff employed under bank and agency contracts. Public and private sector pay refers to average annual gross pay per person for all UK employees, while NHS pay refers to average earning per employee of the English NHS.

Looking more closely at what happened during and after the recession (2008-2015), two trends are clear. First, in the period marked 2008 through 2009 below (referring to the 12 months previous) private sector pay fell sharply in contrast to public sector pay. Then in the recovery period (2013 onwards), private sector pay increased faster than public sector pay, with a particularly sharp recent increase in relative private sector pay. With four more years of public sector pay increases capped at 1%, and no evidence that private sector pay will slow its increase[*], private sector pay is likely to be higher than public sector pay over this spending review period. There is a clear risk that this will make it harder for the NHS to recruit and retain staff, undermining efforts to reduce spending on temporary and agency staffing. The problems are likely to be exacerbated if the NHS does not train enough skilled workers and is unable to access international staff as they are if staff engagement and morale are low.

[*] Not least with the new National Living Wage decreasing levels of low pay in the private sector.

Figure 11: Difference between public and private pay, January 2008 to June 2015



Source: Health Foundation calculations using Office for National Statistics series KA4U for the public sector (excluding financial services) and series KA4O for the private sector, derived from the Monthly Wages and Salaries Survey. Updated from: Cribb, J. Emmerson, C. Sibieta, L. *Public sector pay in the UK*. IFS. 2015.

Temporary and agency staff

Although national pay restraint can help to reduce cost pressures, this is negated if it leads to a greater reliance on temporary and agency staff. There has been a substantial increase in NHS spending on these staff groups. In 2014/15 NHS spend was £3.8bn[15], compared to £3.0bn in 2013/14. This is a cash-terms increase of 26%, or 25% in real terms. If this continues to rise it would result in a substantial additional cost pressure. Continuing to rise at even half this rate would result in an additional cost to the NHS of £2.7bn in 2019/20 (cash terms, £2.5bn in 2015/16 prices).

Seven-day services

Recent research[56] makes clear that the estimated cost of implementing seven-day services exceeds the maximum amount that NICE would recommend the NHS should be prepared to spend on eradication the observed weekend effect. Meacock et al. conclude 'A comprehensive roll-out of seven-day services across the NHS is therefore unlikely to be a cost-effective use of resources, particularly as our estimates of potential health benefit represent the upper limit of what is achievable. Given the lack of evidence supporting the impact of service extension on patient outcomes, the benefits realised would be likely to be much lower. Furthermore, the consequences for patients admitted during the week also need to be considered, as care for these patients may deteriorate if resources are redistributed.'

'Proactive support' approaches

Delivering £22bn of efficiency savings cannot be achieved by central initiatives alone. The bulk of these savings will come from organisations across the NHS changing the way they provide care. Lord Carter of Coles in his interim report on operational productivity[52] set out how the NHS might realise up to £5bn of savings by the end of the decade. While some of these came from improving procurement the bulk of the savings were from improvements in provider operations.

In our joint report with The King's Fund, *Making change possible: a Transformation Fund for the NHS*[57], we argued that to improve the efficiency performance of NHS providers from the trend 1.2% to the 2% a year required to bridge the funding gap, the NHS needs a new approach to change. As part of this it would require dedicated transformation funding. The report recommended:

- A Transformation Fund of £1.5–2.1bn a year in dedicated funding between now and 2020/21. While bringing together existing strands will go some way towards this, more resources will be needed above the £8bn increase in NHS funding already announced by the government.

Table 7: Transformation Fund costs, 2016/17 to 2020/21 (2015/16 prices)

	2016/17	**2017/18**	**2081/19**	**2019/20**	**2020/21**
Efficiency Strand	£1.1bn	£1.1bn	£1.1bn	£1.1bn	£1.1bn
Development Strand	£0.4bn	£0.8bn	£1.0bn	£1.0bn	£0.7bn
Total Transformation Fund	£1.5bn	£1.9bn	£2.1bn	£2.1bn	£1.8bn

- A single body to oversee the investment for transformative change in the NHS, with strong, expert leadership which is credible to clinicians and managers.
- Existing disparate strands of transformative funding should be pooled into one Transformation Fund.
- The introduction of the Fund would involve two phases: 2016/17-2020/21 and 2021/22 and beyond. The first phase would be split into two strands: an Efficiency Strand, which would look to achieve higher rates of efficiency growth across all services, and a Development Strand to invest in new models of care. The second phase would focus on widespread roll-out of the successful new models of care. This would include double-running costs associated with introducing these new models and phasing out old ones.
- The Fund must be properly resourced to support investment in four key areas, which are essential for successful transformation: staff time, programme infrastructure, physical infrastructure and double-running costs.
- The Fund should ensure proper accountability for public money, ensuring its investments are properly linked to, and measured against, core objectives.
- Ongoing evaluation should be a core activity of the Fund. This evaluation would need to include both summative (what works) and formative (how it works) components.
- Further consideration should be given to generating funding through the development of the NHS estate into a long-term sustainable source of new income.

The potential of estates: from *Making change possible: a Transformation Fund for the NHS*

With financial pressures on the NHS continually rising, the government will need to explore additional, long-term sources of funding. We have examined the scope for releasing value from the NHS estate as a means of raising additional resources for a Transformation Fund. Our analysis suggests that selling current surplus estate might yield approximately £700m of one-off funding, but would not meet the costs of the Transformation Fund programme over the next five years. However, it is clear from other analysis that the NHS is not using its estate as well as it could do. Therefore, we recommend work to explore the degree of, and reasons for, variations in efficiency. This would enable the NHS to identify opportunities for sharing best practice and raising the overall efficiency of its estate.

We also recommend that work is carried out to explore the potentially significant opportunity to generate value in a more sustainable way, through the development of the estate. Rather than generating one-off capital receipts, this approach – which could be applied to both surplus estate and that still in use – has the potential to provide the NHS with a substantial and sustainable source of new income, and would not require the sale of NHS land and buildings.

This would fit with efforts to increase the efficiency of the estate, and over the long term could significantly increase its overall value. Of course, the practical and other implications of this approach would need to be worked through, but a possible model might involve the Department of Health partnering with a private sector developer. Under this model (similar to that applied successfully by some Crown Estate sites), the Department could offer a partner an equity stake in the NHS estate and a proportion of the income generated, but would not need to give up its ownership or management responsibility for the assets involved. This estate (or part of it) might be used for commercial purposes, or for the development of social housing in line with the government's broader policy agenda.

Although it represents a new approach to the NHS estate, this model may well have the potential to make a major, long-term contribution to funding the later phases of transformation, as well as providing benefits for the wider economy.

The possibility of funding transformation through development of NHS estates is promising for the medium term. For example, Burton Hospitals Foundation Trust has signed a 10-year deal with a private sector consortium to form a joint venture partnership. The trust will retain a 50% stake in the assets, providing an ongoing revenue return.[58] The trust estimates that asset sales could generate £12.6m over four years (based on their 2013 net value).

It is clear that developing estates will not provide substantial income in the short term. The transformation funding required by the NHS is predominately to support staff to have time to learn new ways of working – an investment in the skills and capabilities of the NHS to implement change. But it would not count as capital investment.

In 2015/16, the NHS capital budget is £4.6bn. In 2014/15 the Department of Health was forced to transfer part of the capital budget to resource budget to meet the costs of provider overspends as efficiency savings failed to be delivered on the scale required. There are signs that a similar or larger transfer will be required in this financial year. One option for

the spending review would be to plan in advance for a capital to resource transfer and use this money in a planned way to resource the Transformation Fund – investing in improved efficiency rather than meeting the costs of under-delivery. This would have consequences for capital investment in the NHS – both new build and maintenance but the urgency of the need for transformation may be greater than the urgency for traditional capital investment. Moreover, this would be a temporary measure and would need to be accompanied by a radical examination of the way the NHS utilises and manages its estate.

9.0 Conclusions

The NHS has historically had funding growth of 3.7% a year. Likewise quality has improved consistently throughout the history of the NHS. With the advent of austerity, the NHS avoided significant deficit through the use of one-off measures such as pay restraint, capital-to-resource transfers, and income generation. These measures are not sustainable. The last spending review period has seen stalling – or even deteriorating – performance on some quality measures. At the same time, half of all hospitals cannot balance their budget.

The *Five Year Forward View* suggests that, while £22bn of efficiency savings could be found, increasing demands mean that the budget for NHS England will still require annual funding increases rising to £8bn by 2020/21. The *Five Year Forward View* explains that these figures are contingent on a properly resourced and properly performing public health system, as well as major transformation within the NHS.

The task facing the current government is therefore not just to secure the resources and deliver service change for the coming five years but also place the health service on a more sustainable footing for the longer term. To do this, a public and political consensus on the longer-term funding levels for the NHS needs to be established. Developments in social care, including the delay of the Care Cap, mean that a similar conversation is even more important in social care. It is hard to see how social care is sustainable with the current funding settlement.

Beyond the current spending review period, our analysis shows health funding pressures will continue to grow beyond the rate of inflation and economic growth. Over recent decades this has been possible as spending on other public services has reduced as a share of GDP, creating headroom for the health service without the need to increase taxes. It is difficult to see how this can continue indefinitely.

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