

HEALTH SELECT COMMITTEE INQUIRY

Submission on public expenditure in the English NHS

23 October 2014

1.0 Executive summary

- 1.1 The Health Foundation is an independent charity working to improve the quality of health care in the UK. We are grateful for the opportunity to submit evidence to this inquiry.
- 1.2 This submission has two parts. Part 1 focuses on the short- and long-term financial prospects for the NHS and the impact this may have on quality and staffing. Part 2 provides data and evidence on income from private patients for NHS and foundation trusts, levels of private and voluntary sector provision, the costs of Private Financial Initiative (PFI), the impact of competition on quality and the potential impact of personal health budgets.
- 1.3 Over the current parliament (2009/10–2013/14), spending on the NHS in England has risen by an average of 0.8% per year in real terms and amounted to £110bn in 2013/14 (TDEL excluding depreciation). But compared to the decade before this (2000/01–2009/10), when the average rate of increase for the UK was 6.7% a year in real terms, the rate of growth has been very low.
- 1.4 In the early years of the parliament, the NHS appeared to be managing well. Pay restraint, administrative cost-cutting and lower spending on prescription drugs prescribed by GPs all helped to bridge the gap between the pressure on the service and available resources.
- 1.5 However, the 2013/14 financial year marked a change. In 2013/14, spending on the English NHS grew by 2.5% in real terms and the Department of Health reported a very small aggregate underspend of £246m, leaving little room for manoeuvre. The problems were greatest among acute hospitals which experienced rising costs (particularly from growing staff numbers) and growing deficits.
- 1.6 Financial support given to NHS providers (both NHS and foundation trusts) by the Department of Health continued to rise – at an average rate of 59% a year in real terms between 2010/11 and 2013/14.
- 1.7 As a result the financial problems shifted from what to do about a relatively small number (around 20) of organisations with deep-seated sustainability problems to how to manage a system of providers whom are struggling to balance their books.

- 1.8 The early indications are that, if anything, this year is even worse. The NHS as a whole is likely to end 2014/15 in deficit. Two-thirds of NHS acute hospitals (NHS and foundation trusts) reported a deficit in the first quarter figures, totalling around £500m.
- 1.9 In the immediate future, the NHS faces significant funding pressures – both NHS England and Monitor have estimated that the NHS faces an affordability gap of 6.6% by 2015/16. Even if the NHS delivers faster productivity growth, there is likely to be a gap of around £2 billion. In the Five Year Forward View (Forward View), NHS England calls for additional £1.5bn for 2015/16.
- 1.10 The financial performance of the NHS matters as it has a significant impact on the overall public finances. But it also poses a risk to quality. The relationship between finances and quality is complex but systems under pressure obviously pose quality risks.
- 1.11 Those hospitals with the deepest financial problems also tend to have quality concerns (measured by Care Quality Commission (CQC) band 5 or 6 ratings or included in the group of hospitals which were reviewed by Sir Bruce Keogh due to being persistent outliers on mortality indicators). In addition, *Cause for concern*, the latest annual statement from QualityWatch (the Health Foundation and Nuffield Trust's joint programme to track quality in the health and care system) and the CQC annual state of care report both found that cracks in quality are beginning to show. For example, *Cause for concern* found that the four-hour A&E waiting times target has not been met by all hospitals for over a year, and patients are waiting on average 48 days for mental health assessments. Signs of stress are also emerging among the workforce, with the proportion of NHS staff reporting stress-related illness rising to 38% in 2013.
- 1.12 The long-term financial projections for the NHS show that questions of productivity and sustainability are not just a feature of the post-recession fiscal challenge but reflect long-term trends which are not unique to England and the UK. Projections of the cost pressures facing the English NHS suggest they will be £30bn higher in real terms by 2020/21. The scale of the finding gap depends of the level of productivity. NHS England's Forward View suggests the NHS will need productivity savings of 2-3 per cent a year, plus additional funding of £8bn over and above inflation, to meet the demand and cost pressures on the service over the next parliament. If productivity tracks past trends, the NHS would need an additional £21bn.
- 1.13 The NHS therefore faces two major challenges. The first is the short-term financial gap. The second challenge is the longer-term financial pressures, coupled with the need to reform services to maximise productivity and ensure that the NHS is able to respond to the changing needs of an aging population with rising levels of long-term physical and mental health conditions.
- 1.14 The Forward View sets out a new vision for the NHS. But, at the moment, the service lacks an effective approach to support sustained financial and service improvement across providers. The prevailing policy direction has been to devolve power to providers and treat them as autonomous units. Through clinically led commissioning, competition and regulatory policy, it has also sought to create a more challenging external environment with the aim of providing sharper incentives to improve.

- 1.15 But the current policy cocktail is not acting to increase productivity fast enough to offset budgetary shortfalls. We believe this reflects fundamental limitations in the current policy approach. Instead, policy should be rebalanced to support front line care and management staff to identify problems and accelerate necessary change. Such an improvement support strategy is almost entirely missing and is a critical next step.
- 1.16 It is clear that more money will be needed in 2015/16, but possibly before. NHS England and Monitor's own assessment is that the NHS faces an affordability gap of 6.6% next year. Even if the NHS delivers faster productivity growth there is likely to be a gap of around £2 billion. The Forward View suggests the NHS needs £1.5bn in 2015/16. We agree that this is essential.
- 1.17 In our recent report, *More than money: closing the NHS quality gap*, we also recommend that a long-term programme of change is needed, so care is provided in a more integrated way, with better co-ordination and more self-management and shared decision making for patients. The changes we envisaged are consistent with the models of care outlined in the Forward View and the NHS needs to be supported to implement these changes at speed.
- 1.18 Such change should be financed by a 'transformation fund'. We are currently working with the King's Fund to quantify how much funding is needed and how such a fund might operate. One option is that the fund could be resourced – at least in part - by releasing surplus assets across the NHS, starting with those held by NHS property services. Monitor's 2013 report, *Closing the NHS funding gap: how to get better value health care for patients*, identified £7.5bn of surplus assets across the NHS. Urgent work should be undertaken to examine the extent to which these assets are still available (as some may have already been sold or be extremely difficult to be realised) and how the value can be unlocked to support transformation across the NHS.
- 1.19 *More than money: closing the NHS quality gap* also recommends developing a proper medium-term strategy for supporting all providers to deliver systematic and sustainable improvement across the NHS. This should include boosting management and leadership skills (among clinicians as well as those in traditional management roles).
- 1.20 Finally, our report called for cross-party acknowledgement that the NHS (and care system) have a long-term funding challenge which can't be filled by efficiency alone. NHS England argues for an additional £8bn by 2020/21. It is the minimum the NHS is likely to need, predicated as it is on very high rates of productivity. Proper engagement with the public after the election, on a non-partisan basis, to decide how we want to pay for our health service so that it can continue to meet patients' expectations for high quality, accessible care, building on the sort of analysis set out in the 2014 Barker Commission on the Future of Health and Social Care in England is needed.

2.0 About the Health Foundation and our submission

- 2.1 The Health Foundation is an independent charity working to improve the quality of health care in the UK. We are here to support people working in health care practice and policy to make lasting improvements to health services. We carry out research and in-depth policy analysis, fund 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 health care system of the highest possible quality – safe, effective, person-centred, timely, efficient and equitable.
- 2.2 The Health Foundation welcomes the opportunity to submit written evidence to this inquiry about public expenditure on health and social care. Our response has been developed by our in-house economics and policy analysts.
- 2.3 Part 1 of the submission explores the impact of finance on health care quality and staffing in the NHS, and the capability and capacity of staff to address the need to improve care.
- 2.4 Part 2 provides some facts and information about income from private patients for the NHS and foundation trusts, levels of private and voluntary sector provision of NHS care, the costs of Private Financial Initiative (PFI), the impact of competition on quality, and the potential impact of personal health budgets.
- 2.5 We would welcome the opportunity to provide oral evidence to the Committee.
- 2.6 Please note that all financial values in this submission are in 2013/14 prices using the June 2014 GDP deflator.¹

¹ HM Treasury, *GDP deflators at market prices, and money GDP: June 2014 (Quarterly National Accounts)*, 30 June 2014. www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-june-2014-quarterly-national-accounts

Part One

3.0 An assessment of quality in the NHS

- 3.1 The NHS in England is four years into what is projected to be the longest period of austerity in the last 50 years. While there is no inexorable relationship between funding and the quality of care, this year's QualityWatch² annual statement, *Cause for concern*,³ and the CQC's annual state of care report,⁴ both provide clear indications that the NHS is under pressure.
- 3.2 The CQC's report found that, although there is much excellent care, the variation in the quality and safety of care in England is too wide and is unacceptable. The report also states safety was the biggest concern for the CQC, with four out of every five safety ratings inadequate or requiring improvement.
- 3.3 *Cause for concern* found that people are waiting longer for care and treatment. The average patient now waits four days longer for planned treatments than they did in 2010, and for over a year major A&E departments have breached the target for 95% of patients to be admitted or discharged within four hours of arrival. There are also problems for people with mental health issues and their ability to get care when they need it. One example is that average waiting times for patients needing a specialist mental health assessment grew by a third between 2010/11 and 2012/13, reversing previous progress.
- 3.4 *Cause for concern* also found that, despite increases in nursing staff numbers, there are signs of stress among the workforce. The proportion of NHS staff reporting stress-related illness rose to 38% in 2013 from a low of 28% in 2008/09.
- 3.5 It therefore appears that, although those working in the NHS have worked hard to maintain quality, cracks are beginning to appear. The ability of the NHS to continue to deliver care at levels of quality expected, and in line with clinical best practice and national standards, is likely to diminish as funding gets tighter.

4.0 Public expenditure on NHS care

- 4.1 Table 1 sets out how spending on the NHS in England has changed since 2009/10. It shows that spending growth for the NHS in England has averaged 0.8% per year in real terms between 2009/10 and 2013/14 (TDEL excluding depreciation). It also shows that between 2009/10 and 2010/11 health spending fell by 0.6% in real terms. However,

² QualityWatch is a major research programme providing independent scrutiny into how the quality of health and social care is changing. Developed in partnership by the Nuffield Trust and the Health Foundation, the programme provides in-depth analysis of key topics and tracks an extensive range of quality indicators.

³ QualityWatch. *Cause for Concern*. The Health Foundation & Nuffield Trust, 2014. <http://www.qualitywatch.org.uk/annual-statement/2014>

⁴ Care Quality Commission. *The state of health care and adult social care in England 2013/14*. CQC, 2014. <http://www.cqc.org.uk/content/state-care-2013-14>

spending has grown every year since 2011/12 and reached £110bn in 2013/14. These rates of increase contrast sharply with 2000/01 – 2009/10, when annual spending growth in the NHS averaged over 6.7% in real terms%.⁵

4.2 Despite the overall increase in health spending, if we consider how much money is available per head of population, a different picture emerges. The amount of real terms spending per head decreased every year from 2009/10 until 2011/12. It only started to show an increase in 2012/13 and continued to grow in 2013/14 when it returned to similar values to 2009/10 at £2,037 (table 1).

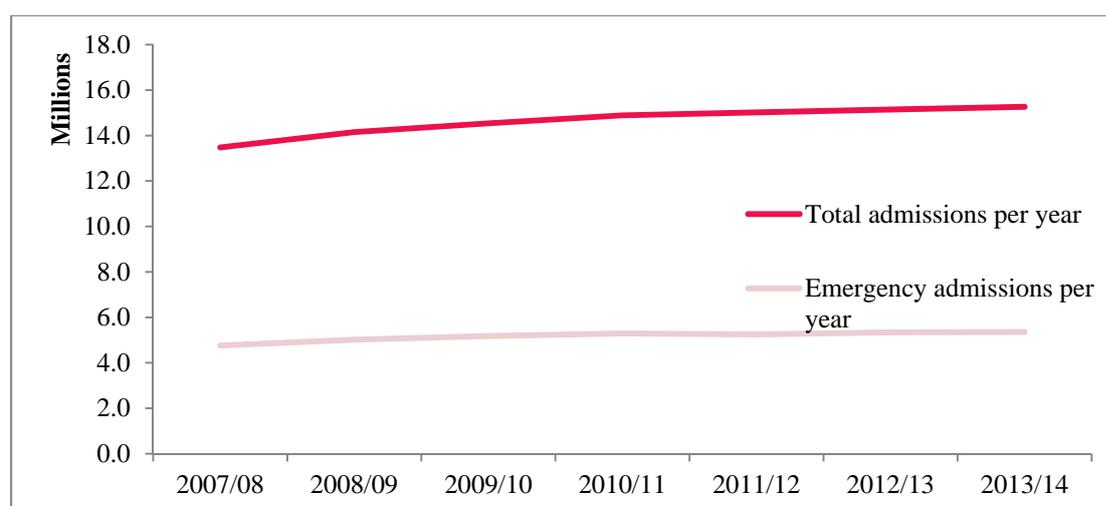
4.3 The constrained funding is against a backdrop of steadily rising activity. For example, figure 1 shows that between 2007/08 -2013/14 there has been an average increase in the number of admissions of 2% a year.

Table 1: Total Department Expenditure Limit (DEL) from 2009/10 to 2013/14, (in 2013/14 prices) (£000s)

	2009/10	2010/11	2011/12	2012/13	2013/14
Resource DEL, excluding depreciation, in real terms	100,598	101,216	101,869	103,189	105,427
Capital budget, in real terms	5,591	4,373	3,877	3,848	4,294
Total DEL, excluding depreciation, in real terms	106,189	105,588	105,747	107,036	109,721
Annual change in Total DEL expenditure, in real terms		-0.6%	0.2%	1.2%	2.5%
Total DEL, excluding depreciation, per capita, in real terms	2,034	2,006	1,991	2,001	2,037
Annual change in Total DEL expenditure per capita, in real terms		-1.4%	-0.7%	0.5%	1.8%

Source: PESA, 2014 & ONS Population estimates, 2014

Figure 1: Activity in the NHS



⁵ Taunt R, Lockwood A, Berry N. *More than money: closing the NHS quality gap*. The Health Foundation, 2014. www.health.org.uk/publications/more-than-money-closing-the-nhs-quality-gap/

Source: Health and Social Care Information Centre

- 4.4 Another way to understand the health of NHS finances is to compare actual and planned spending. Each year the NHS plans to spend a bit less than its full allocation to manage financial risks. If the size of the underspend is small, it is an indicator that NHS finances are likely to be under strain.
- 4.5 In 2013/14 DH underspent the Total Department Expenditure Limit excluding depreciation by £246 million. Looking at the resource element of the NHS budget, the level of the underspend has fallen sharply. In 2013/14, the total resource underspend decreased from £1.1bn in 2010/11 to £0.3bn⁶. During 2013/14, the underspend decreased by 80% compared to 2012/13 (figure 2).

Figure 2: Resource DEL under-spend, 2010/11 to 2013/14 (real terms, £millions)



Source: Department of Health Annual Report and Accounts 2014

5.0 The financial position of NHS and foundation trusts for 2013/14, and forecasts for 2014/15

- 5.1 In 2013/14, the Department of Health reported that NHS providers had ended the year with a net deficit of £108m with 65 trusts (NHS Direct, 24 NHS trusts and 40 foundation trusts) reporting a deficit⁷. This compares to a net surplus in 2012/13 of £602m (in 2013/14 prices) as reported by National Audit Office⁸ when 25 trusts were in deficit.

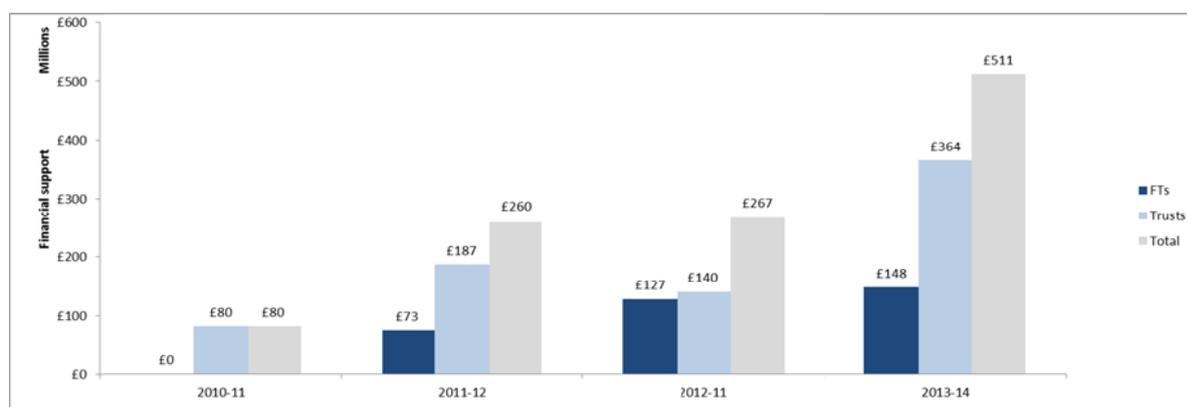
⁶ This includes depreciation.

⁷ Department of Health. *Annual Report and Accounts*,. Department of Health; 2014, <https://www.gov.uk/government/publications/department-of-health-annual-report-and-accounts-2013-to-2014>. www.gov.uk/government/publications/department-of-health-annual-report-and-accounts-2013-to-2014

⁸ http://www.nao.org.uk/wp-content/uploads/2013/07/10220-001_Indicators-of-financial-sustainability-in-the-NHS.pdf⁸ National Audit Office (NAO). *2012-13 update on indicators of financial sustainability in the NHS*. National Audit Office; 2013. www.nao.org.uk/wp-content/uploads/2013/07/10220-001_Indicators-of-financial-sustainability-in-the-NHS.pdf

- 5.2 The breakdown of NHS and foundation trust finances allows us to infer that in 2013/14 the bulk of the provider deficit was amongst NHS trusts, rather than foundation trusts. Foundation trusts reported an overall surplus of £133m in 2013/14, whereas NHS trusts reported an overall deficit of £241m.
- 5.3 Early indications are that in the current financial year foundation trusts are also struggling to balance their books. For the first quarter of 2014/15, Monitor report that foundation trusts were also in net deficit. The net deficit across foundation trusts totalled £167m compared with a planned deficit of £80m. Eighty per cent of the 86 FTs that reported a deficit were acute trusts.⁹ NHS TDA also reported that NHS trusts were in net deficit by July 2014, totalling £300m, compared with a planned deficit of £224m.¹⁰ The total net deficit for both NHS and foundation trusts for the first quarter of 2014/15 was £467m. Once again the problems are concentrated in acute hospitals. Across all NHS providers (NHS and foundation trusts) 97 were in deficit amounting to two-thirds of all acute hospital providers and the net deficit of acute hospitals was just over £500m.
- 5.4 The figures above include financial support given to trusts in financial distress every year by the Department of Health. Financial support to trusts has increased at a rapid average rate of 59% a year in real terms between 2010/11 and 2013/14, rising from £80m to £511m. The rate was particularly high in the most recent year, with the amount of financial support given to trusts nearly doubling in 2013/14 compared to the previous year (figure 3). Despite the increase in support, providers remain under considerable financial pressure.

Figure 3: Financial support given to NHS and foundation trusts between 2010/11 to 2013/14 (£000s, 2013/14 prices)



Source: Correspondence with DH, 2014

⁹ Monitor. *NHS foundation trusts under pressure from rising demand*. Monitor; 19 September, 2014. www.gov.uk/government/news/nhs-foundation-trusts-under-pressure-from-rising-demand

¹⁰ NHS Trust Development Authority. *Board meeting, 18 September 2014 Paper E*. NHS Trust Development Authority. <http://www.ntda.nhs.uk/wp-content/uploads/2014/07/Paper-E-Service-and-Financial-Performance-Report-for-July-2014.pdf>

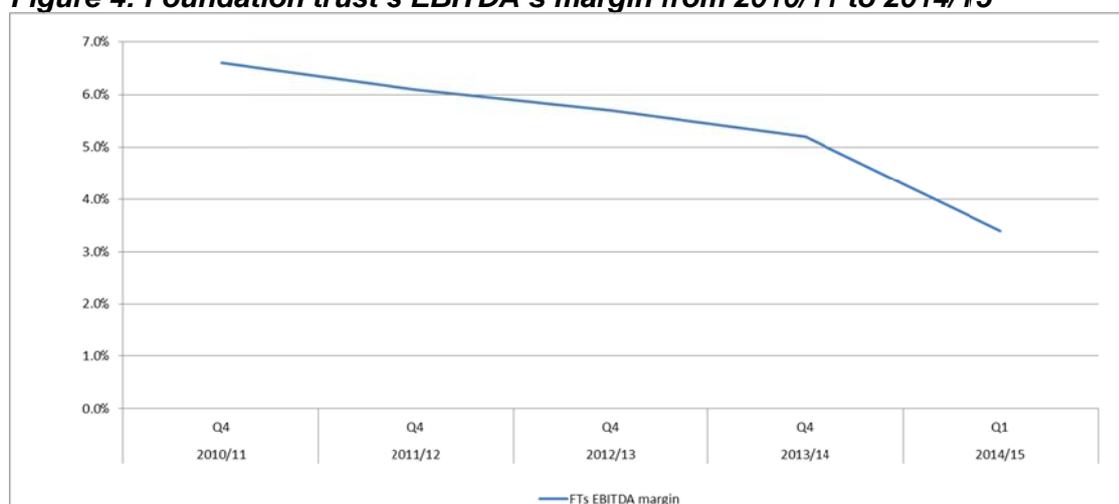
5.5 Foundation trusts' Earnings before Interest, tax, depreciation and amortisation (EBITA) which is an indicator of operating efficiency has decreased steadily from 6.6% in 2010/11 to 5.2% in 2013/14. At the first quarter of 2013/14, EBITDA's margin further declined to 3.4%, which is 0.6% below plan (table 3 & figure 4)

Table 3 Foundation trust's EBITDA's margin from 2010/11 to 2014/15

	2010/11	2011/12	2012/13	2013/14	2014/15
	Q4	Q4	Q4	Q4	Q1
FTs EBITDA margin	6.6%	6.1%	5.7%	5.2%	3.4%

Source: NAO, 2013¹¹, NHS Foundation Trusts: Consolidated Accounts 2013/14¹², Monitor 2014¹³

Figure 4: Foundation trust's EBITDA's margin from 2010/11 to 2014/15



Source: as for table 3.

6.0 The long-term pressures on the NHS

6.1 In this section we explore the outlook for NHS funding in 2015/16 and 2016/17. We then consider the outlook for the next parliament and beyond, using two projections of long term cost pressures and the NHS England Forward View assessment. Finally we provide some international comparisons.

6.2 As table 4 shows, the affordability challenge (the gap between demand and cost pressures on the NHS and resources available without productivity improvements) is

¹¹ National Audit Office. 2012-13 update on indicators of financial sustainability in the NHS. The Stationary Office; 2013. http://www.nao.org.uk/wp-content/uploads/2013/07/10220-001_Indicators-of-financial-sustainability-in-the-NHS.pdf

¹² Monitor. *NHS Foundation Trusts Consolidated Accounts 2013-14*. Monitor; 2014. <https://www.gov.uk/government/publications/nhs-foundation-trusts-consolidated-accounts-201314> data for 2013/14

¹³ Monitor. *Quarterly report on the performance of the NHS foundation trust sector: 3 months ended 30 Jun 2014*. Board Meeting, 24 September 2014, Agenda Item

4. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/356383/BM1492_NHSFT_quarterly_performance.pdf

expected to be greatest in 2015/16 and 2016/17. This is largely due to a combination of the rises in the cost of pensions (0.7% in 2015/16, and 1.4% in 2016/17), and the pressure from the transfer of funding to social care as part of the Better Care Fund. In 2015/16 NHS England and Monitor identify that the total affordability challenge is greater than the level of provider and system efficiency. This would equate to a potential funding gap of around £2 billion in 2015/16.

Table 4: The total affordability challenge

	2014/15	2015/16	2016/17	2018/19
Total affordability challenge	3.10%	6.60%	5.50%	4.70%
Provider Efficiency	2.00%	2.50%	2.00%	2.00%
System Efficiency	1.00%	2.00%	1.00%	1.00%
Remaining Challenge	0.10%	2.10%	2.50%	1.70%

Source: Guidance for the Annual Planning Review 2014/15, Monitor¹⁴

6.3 Looking at the next parliament and beyond, the Nuffield Trust,¹⁵ estimates that longer-term cost pressures on the NHS from rising demands and rising input cost growth, will increase by around 3.9% a year in real terms (assuming no productivity gains). The main factors leading to this additional funding pressure are demography (an increasing and aging population), treatment of long-term conditions and rising pay costs.

6.4 We have made a second projection using data from the Office for Budget Responsibility (OBR).¹⁶ In 2014, the OBR estimated that 7.7% of UK GDP was spent on the NHS in 2013/14. This equates to £130bn. We have used their projection for government health spending and assumed that:

- spending on the NHS per head of population rises in line with earnings by age and gender
- annual productivity savings of 2.2% a year are made, in line with whole economy productivity.

6.5 The current planned spend for the English NHS this year is £111bn in 2013/14 prices.¹⁷ This amounts to 6.6% of UK GDP.

6.6 Using this year as a starting point, we can estimate spending on the English NHS over the next parliament (figure 5). The Nuffield Trust projection, which assumes no productivity gains, shows that spending would need to grow by around £30bn in real terms by 2020/21. This is in line with the NHS England's Forward View assessment.¹⁸

¹⁴ Monitor. *Guidance for Annual Planning Review, 2014/15*. Monitor; 2013. www.gov.uk/government/uploads/system/uploads/attachment_data/file/283273/GuidanceAnnualPlanningReview2014-15Revised.pdf

¹⁵ Nuffield Trust. *A decade of austerity? The funding pressures facing the NHS for 2010/11 to 2021/22*. Nuffield Trust; 2012. <http://www.nuffieldtrust.org.uk/publications/decade-austerity-funding-pressures-facing-nhs>

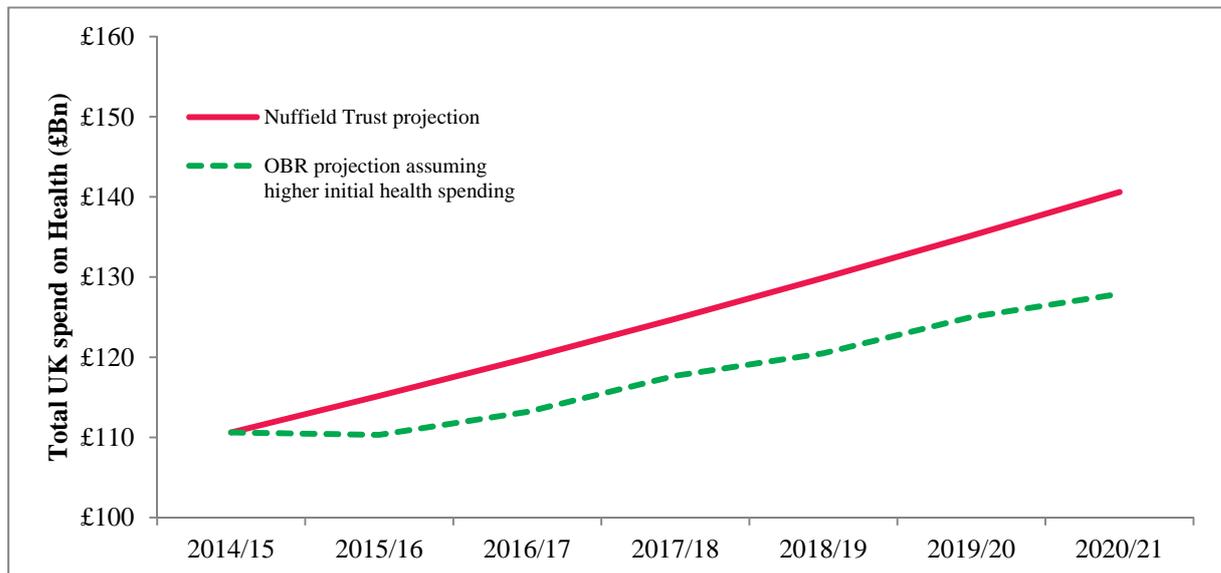
¹⁶ Office for Budget Responsibility. *Fiscal sustainability report*. OBR; 2014. <http://cdn.budgetresponsibility.org.uk/41298-OBR-accessible.pdf>

¹⁷ HM Treasury, *Total Departmental Expenditure Limit excluding depreciation*,. PESA, 2014

¹⁸ NHS England. *Five Year Forward View*. NHS England; 2014.

The OBR projection, which assumes a 2.2% annual productivity gain, shows spending rising by £17bn in real terms over the same period.

Figure 5: Projections for government spending on health projections



6.7 In reality, if health service productivity grows in line with recent trends, it is likely to grow at a lower rate than for the whole economy, at somewhere between 1.0%¹⁹ and 1.3%.²⁰ So the actual funding pressure is likely to fall between these two projections.

6.8 NHS England’s Forward View confirms that it expects funding pressures to increase by £30 billion by the end of the parliament. It examines 3 options for productivity growth – 0.8% (the very long-run average), 1.5% and a phased step in productivity of 2 per cent initially, then rising to 3 per cent a year over the parliament. This last assumption is predicated on the NHS being supported to deliver the changes to the model of care set out in the Forward View with a transformation fund to support this. These 3 scenarios result in a funding gap after productivity improvements of £21 billion, £16 billion or around £8 billion in 2020/21 compared to flat real resourcing.²¹

6.9 Although the projected increases in spending are substantial, in the period to 2020/12, the UK economy is projected to grow by an average of 2.4% a year in real terms, a total of 16%²². Therefore the share of UK GDP spent on the English NHS will remain at 6.6% under the OBR’s projection (figure 6). Under the Nuffield Trust’s projection, with no additional productivity increases, spending on the English NHS would rise to around to around 7.2% of UK GDP.

6.10 Health spending has grown while the amount spent by other government departments has fallen as the government seeks to reduce the fiscal deficit. In 2015/16 public sector net borrowing is projected to be 3.8 per cent of GDP and public sector net debt to peak

¹⁹ OBR, *Fiscal sustainability report*. OBR; 2014. <http://cdn.budgetresponsibility.org.uk/41298-OBR-accessible.pdf> 2014

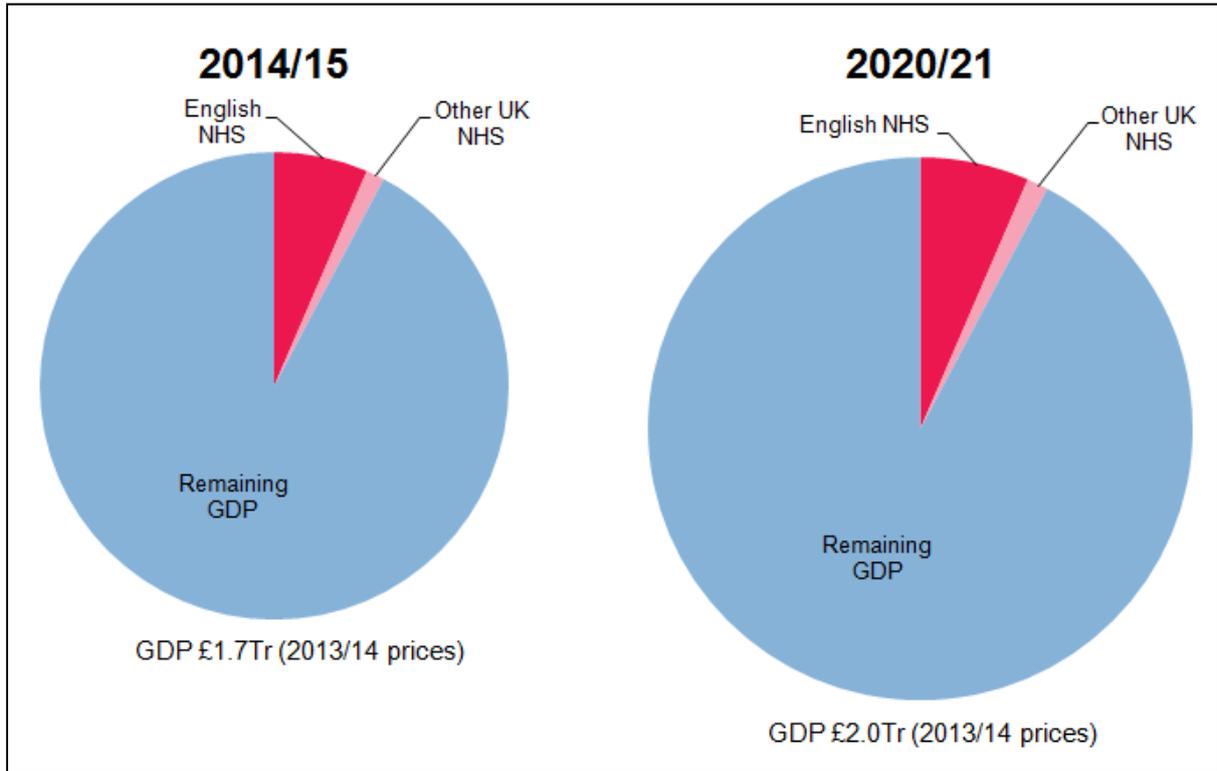
²⁰ Deloitte. *Evidence for the 2015/16 national tariff efficiency factor*, 2014

²¹ NHS England. *Five Year Forward View*. NHS England; 2014.

²² OBR, 2014.

at 78.7 per cent. Net borrowing is forecast to be eliminated by 2018/19 with public sector net debt falling to 74.2 per cent.²³ Further increases in NHS spending as a share of GDP will therefore either have potentially profound effects on other services or require additional government revenue.

Figure 6: Share of GDP spent on health in 2014/15, and OBR projection for 2020/21, scaled relative to real-terms value.



6.11 By 2060/61 the OBR estimate that health spending for the UK will rise to 10.2% of GDP, worth £508bn in current prices²⁴ (figure 7). Assuming England maintains its share of total UK NHS spending, this would be worth £432bn, 8.7% of UK GDP.

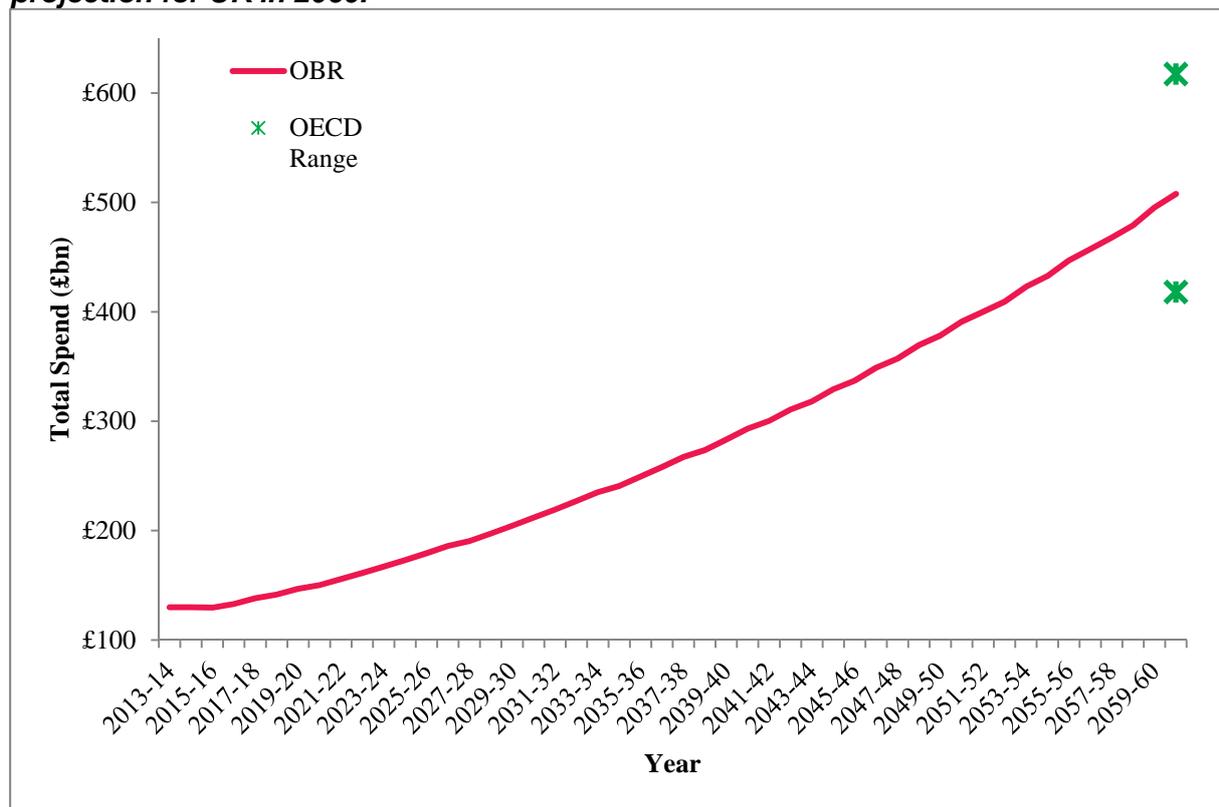
6.12 The OBR's UK projection falls within the range estimated by the OECD, who project that UK spending on health will be between 8.5% and 12.4% of total GDP by 2060 (£418bn to £617bn using the OBR's projection for GDP).

²³ OBR. *Economic and fiscal outlook – March 2014*. OBR; 2014.

<http://budgetresponsibility.org.uk/fiscal-sustainability-report-july-2014/>

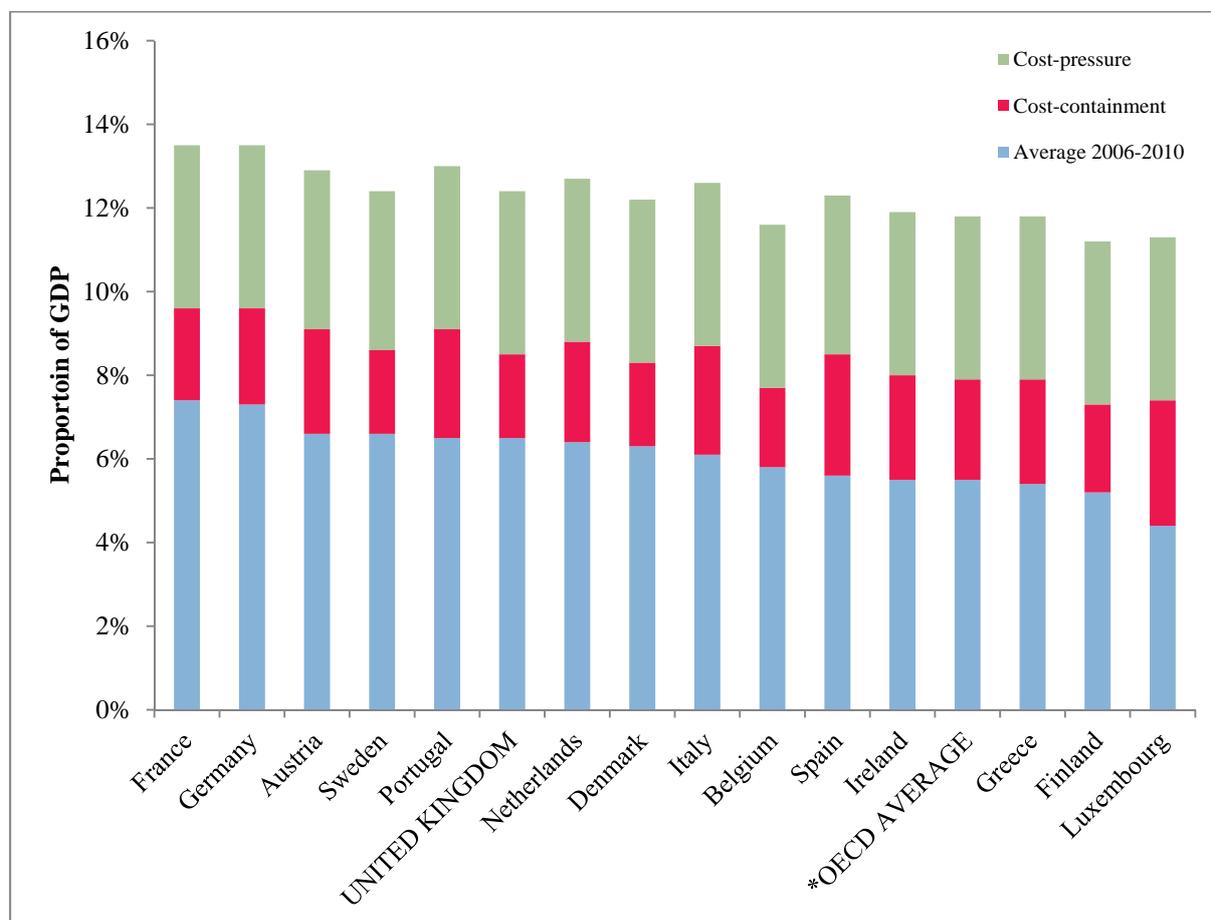
²⁴ Author's calculations based on OBR projections of GDP and proportion of GDP spent on health.

Figure 7: OBR projection of UK health spending to 2060/61, compared to OECD projection for UK in 2060.



6.13 The UK is not alone in facing rising pressures for health. The OECD estimate that by 2060 all countries will have increased their proportion of GDP on health spending by at least 1.9 percentage points, and potentially as much as 7.6. The relative projected pressures for the UK are actually lower than for other countries. Between 2006 and 2010, the UK was the fifth highest public spender among the EU15 countries. Based on the OECD projections, other countries would overtake so the UK would become the eighth (cost-containment scenarios) or seventh (cost-pressure scenario) highest public spender (figure 8).

Figure 8: OECD projection for average public spend on health for EU15 countries, as a proportion of GDP between 2006 and 2010, with projected spend in 2060 under both cost-containment and cost-pressure assumptions.



7.0 Staffing the NHS

7.1 Staffing is a key component of the ability of the NHS to deliver and improve care. In this section we explore the costs of staffing the NHS and whether the NHS has the staff it needs to be able to improve care and address the financial challenge.

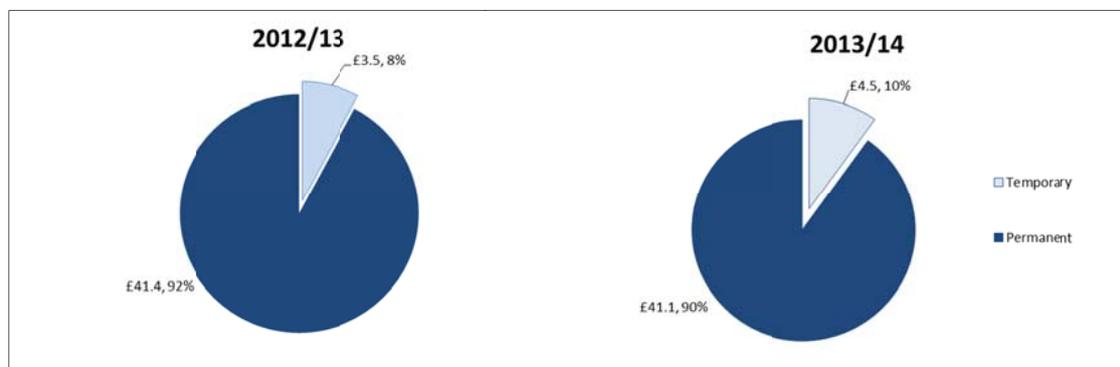
7.2 Staff cost accounts for about two third of NHS providers' total expenditure. Total expenditure on staff for NHS providers increased by 2% in real terms, from £44.8bn in 2012/13 to £45.6bn in 2013/14²⁵. However, the cost of permanent staff has decreased in real terms by 0.6% from £41.4bn in 2012/13 to £41.1bn in 2013/14. The cost of non-permanent staff has increased by £1 billion (28% in real terms) from £3.5bn in 2012/13 to £4.5bn in 2013/14²⁶. Expenditure on temporary staff accounted for 10% of total staff

²⁵ Department of Health. *Annual report and accounts 2013/14*. Department of Health; 2014.

²⁶ Temporary/non-permanent staff includes those on inward secondment or loan from other organisations, agency staff and those engaged on a contract to undertake a project or other temporary task. It does not include amounts payable to contractors for services, that is, where the staff remain under the control of the contractor

cost in 2013/14 compared to 8% in 2012/13 (figure 9, NB figures do not add due to rounding).

Figure 9: Expenditure on temporary and permanent staff in 2012/13 and 2013/14, real terms (£billion)



Source: NHS trust financial accounts (2013/14), Monitor' annual report (2013/14)²⁷, DH Accounts, 2013²⁸

7.3 Data in table 5 and 6 shows that both NHS administration costs and the number of managers in the service have fallen during the course of this parliament. Comparisons with other health care systems²⁹ and other industries³⁰ show that the NHS is spending a relatively low percentage of its total budget on management.

7.4 These data suggests that the service may be under-managed at present. We would argue that an under-managed service will make it more difficult to implement and embed new ways of working and to achieve ongoing productivity savings. At the Health Foundation, we know from the work we have funded that delivering improvement in a complex operational environment requires highly developed management skills.^{31 32} The presence of good managers across the service is essential if change is to be delivered and maintained.

²⁷ Monitor. *NHS foundation trusts: consolidated accounts 2013/14*. Monitor; 2014. www.gov.uk/government/uploads/system/uploads/attachment_data/file/331166/Consolidated_Accounts_2013-14.pdf

²⁸ Department of Health Annual Report and Accounts, 2012/13; 2014.

²⁹ Santry, C. *Lansley's 'over-managed' NHS claim undermined by analysis*. HSJ; 21 July 2011. www.hsj.co.uk/news/finance/lansleys-over-managed-nhs-claim-undermined-by-analysis/5032766.article

³⁰ The King's Fund. *Future of leadership and management in the NHS*. The King's Fund, 2011

³¹ Hardacre J, Cragg R, Shapiro J, Spurgeon P, Flanagan H. *What's leadership got to do with it? Exploring links between quality improvement and leadership in the NHS – An evaluation of the Health Foundation's leadership programmes*. The Health Foundation, 2011.

³² Ling T, Soper B, Buxton M, Hanney S, Oortwijn W, Scoggins A, Steel N. *How do you get clinicians involved in quality improvement? An evaluation of the Health Foundation's Engaging with Quality Initiative – a programme of work to support clinicians to drive forward quality*. The Health Foundation, 2010.

Table 5: Senior Managers/ Managers FTE as percentage of total FTE staff in the English NHS

Year	Senior Managers/Managers FTE	Total FTE staff (All contracted positions in English NHS organisations)	Senior Managers/Managers as percentage of total FTE
2010/11	39,746	1,055,638	3.8%
2011/12	36,487	1,039,110	3.5%
2012/13	35,354	1,037,312	3.4%
2013/14	34,658	1,046,048	3.3%

Source: NHS Hospital & Community Health Service (HCHS) monthly workforce statistics - Provisional Statistics, June 2014³³

Table 6: NHS Administration costs as a percentage of total spend

Year	NHS administration costs £m (outturn: admin costs of DH, ALBs, CCGs etc (ie all commissioning and strategic functions). Does not include costs associated with front-line providers)	Total spend £m (outturn: Total DEL)	Admin costs as a percentage of total spend
2010/11	5,704	105,588	5.4%
2011/12	3,641	105,747	3.4%
2012/13	3,733	107,036	3.5%
2013/14	3,051	109,721	2.8%

Source: PESA 2014³⁴

7.5 However, it is important to recognise the vital contribution of front-line clinical staff and other staff groups to the effective management and leadership of the service. Front-line clinical staff, as well as managers, should possess a grasp of core management processes such as project planning, budgeting, staffing, measuring performance and problem solving.

³³ Health and Social Care Information Centre. *NHS Workforce Statistics - July 2014, Provisional statistics*. HSCI; 2014. www.hscic.gov.uk/searchcatalogue?productid=16025&q=monthly+nhs+hospital+and+community+service+workforce+statistics&sort=Most+recent&size=10&page=1#top

³⁴ HM Treasury. *Public Expenditure Statistical Analyses 2014*. HM Treasury; 2014. <https://www.gov.uk/government/statistics/public-expenditure-statistical-analyses-2014>

7.6 Moreover, from a quality improvement perspective, we know that ‘distributed leadership’ (whereby the responsibility for driving and embedding change is shared across a *whole* team or organisation), as well as strong clinical leadership, have an important bearing on improvement programmes’ long-term success.^{35 36 37 38 39 40 41 42} Ensuring that clinicians in particular are introduced to leadership and management skills and concepts at an early stage in their training, would help ensure that the NHS has the skills needed to improve care while addressing the financial challenge.

8.0 The implications of the NHS financial position

8.1 The key message from this submission is that NHS finances are currently extremely tight and there will be no let up. The deficits reported by Monitor and NHS TDA for the first quarter of 2014/15 are a sign of how difficult it is for the NHS to live within its current funding allocation and to meet the health care needs of our population. Spending pressures are expected to increase by £30bn by the end of the decade, with most estimates suggesting that, on past trends, productivity savings will be able to meet just a third of this. NHS England very challenging agenda is to aim for just over two-thirds through productivity, requiring significant additional funding for the NHS above inflation.

8.2 The root causes of the spending pressure are a growing and aging population, rising incidence of chronic conditions and increasing input costs. These causes are not going to go away, nor will the spending pressure be solved by changes around the edges, such as reducing PFI costs, or increasing the number of overseas patients who pay for their care.

8.3 Instead, the NHS needs to change significantly how it delivers care and there is a growing consensus about what needs to change. For example, care should be co-ordinated across different settings and more care should be provided outside of hospitals. There should also be a greater role for patients through self-management and shared decision making. However, despite the consensus on what needs to change, at the moment, the NHS does not have the skills or capability to make these changes happen in a sustainable way, particularly in management and quality improvement at the front line.

³⁵ Ahmad N, Ellins J, Krelle H, Lawrie M. *Person-centred care: from ideas to action*. The Health Foundation; 2014.

³⁶ Health Foundation. *Final report on the independent evaluation of Safer Clinical Systems Phase 2*, awaiting publication

³⁷ Health Foundation. [Shine: Improving the value of local health care services](#),. Health Foundation; February 2014

³⁸ Health Foundation, [Improving Patient Flow](#),. Health Foundation; April 2013

³⁹ Health Foundation. [Leading for better health care: A Learning Report](#),. Health Foundation; 2005.

⁴⁰ Health Foundation. [Team Spirit: How the Health Foundation's Shared Leadership for Change teams are working together to improve diabetes services for patients](#) ,. Health Foundation; 2007

⁴¹ Health Foundation. [Evaluation of the Shared Leadership for Change Award Scheme](#),. Health Foundation; 2009.

⁴² Health Foundation. *Final report on the independent evaluation of Safer Clinical Systems Phase 2*,. awaiting publication.

9.0 Recommendations

- 9.1 To meet the financial challenge and to enable the NHS to deliver comprehensive world class care, we need:
- 9.2 More money in 2015/16 – and possibly before – NHS England and Monitor’s own assessment is that the NHS faces an affordability gap of 6.6% next year. Even if the NHS delivers faster productivity growth there is likely to be a gap of around £2 billion. The Forward View suggests the NHS needs £1.5bn in 2015/16. We agree that this is essential.
- 9.3 More money is also needed in the longer term – the cost pressures will continue to grow and cannot be closed by productivity alone. This means that ongoing additional funding is required to enable the NHS to continue to deliver high quality comprehensive care.
- 9.4 However, to ensure that care is delivered in a way which does achieve productivity gains and is of the highest quality possible, a long-term programme of genuine change is needed. This should be financed by a ‘transformation fund’. We are currently working with the King’s Fund to quantify how much funding is needed and how such a fund might operate. Part of the finance for such a fund could come from releasing surplus assets rather than new calls on the public purse. Monitor identified £7.5bn of surplus assets across the NHS⁴³ and urgent work should be undertaken to examine how the value of these assets could be unlocked to support transformation across the NHS. It is however important to note that some of these assets will already have been sold and some of it will be difficult to realise.
- 9.5 The programme of change should also be supported by a strategy for providers to deliver systematic and sustainable improvement across the NHS. This should include boosting management and leadership skills (amongst clinicians as well as those in traditional management roles).
- 9.6 There should be cross-party acknowledgement that the NHS (and care system) have a long-term funding challenge which can’t be filled by efficiency alone, if we want a service that continues to improve and is able to respond positively to medical advance. NHS England argues for an additional £8bn by 2020/21. It is the minimum the NHS is likely to need, predicated as it is on very high rates of productivity. Proper engagement with the public after the election, on a non-partisan basis, to decide how we want to pay for our health service so that it can continue to meet patients’ expectations for high quality, accessible care, building on the sort of analysis set out in the 2014 Barker Commission on the Future of Health and Social Care in England is needed.

⁴³Monitor. *Closing the NHS funding gap: how to get better value healthcare for patients*. Monitor; 2013. www.gov.uk/government/publications/closing-the-nhs-funding-gap-how-to-get-better-value-healthcare-for-patients

Part 2

10.0 Data and evidence on key NHS policies

10.1 As requested by the committee, this section provides data and evidence on:

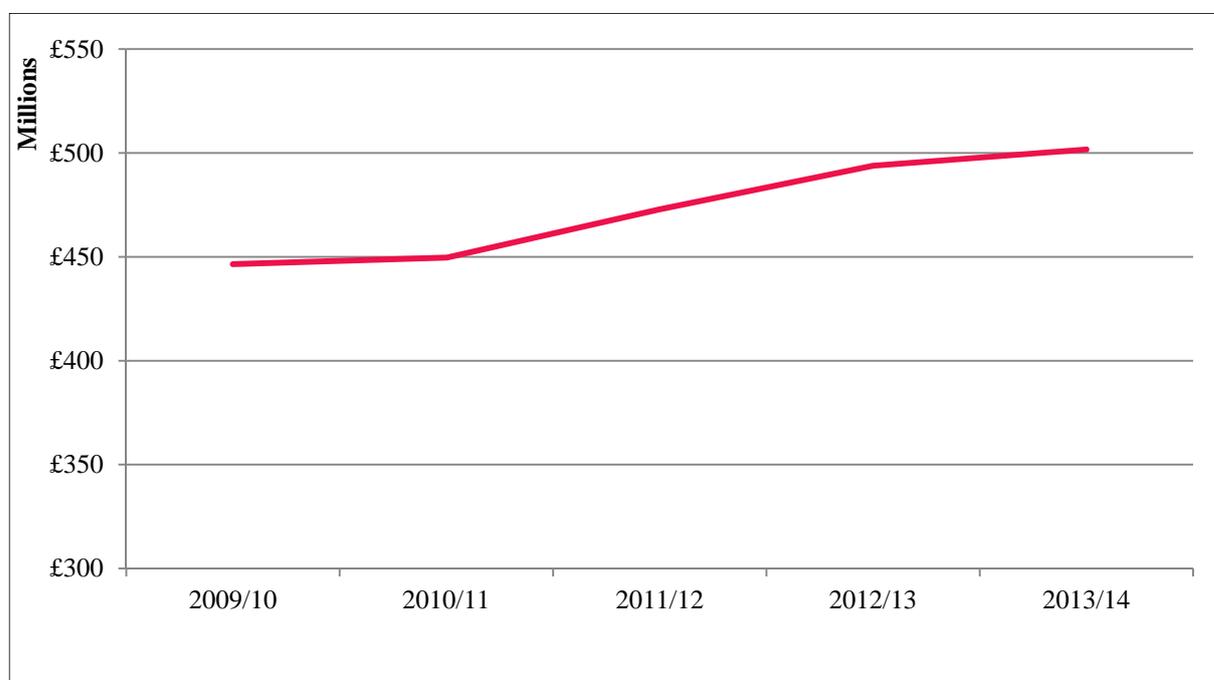
- income from private patients for the NHS and foundation trusts,
- levels of private and voluntary sector provision,
- the costs of PFI,
- the impact of competition on quality,
- the potential impact of personal health budgets.

11.0 Income from private patients for NHS and foundation trusts

11.1 The income NHS providers (NHS and foundation trusts) earned from private patients has increased by 12.4% in real terms from £446m in 2009/10 to £502m in 2013/14 (figure 8). But this is still a very small portion of total operating income, remaining at around 0.7% in 2009/10 and 2013/14.

11.2 The average annual growth rate between 2009/10 and 2012/13 was 2.4% in real terms with the annual increase peaking in 2011/12 at 5.2% (figure 10).

Figure 10: Income from private patients from 2009/10 to 2013/14, (2013/14 prices)



Source: NHS and Foundation trusts financial accounts 2009/10 to 2013/14

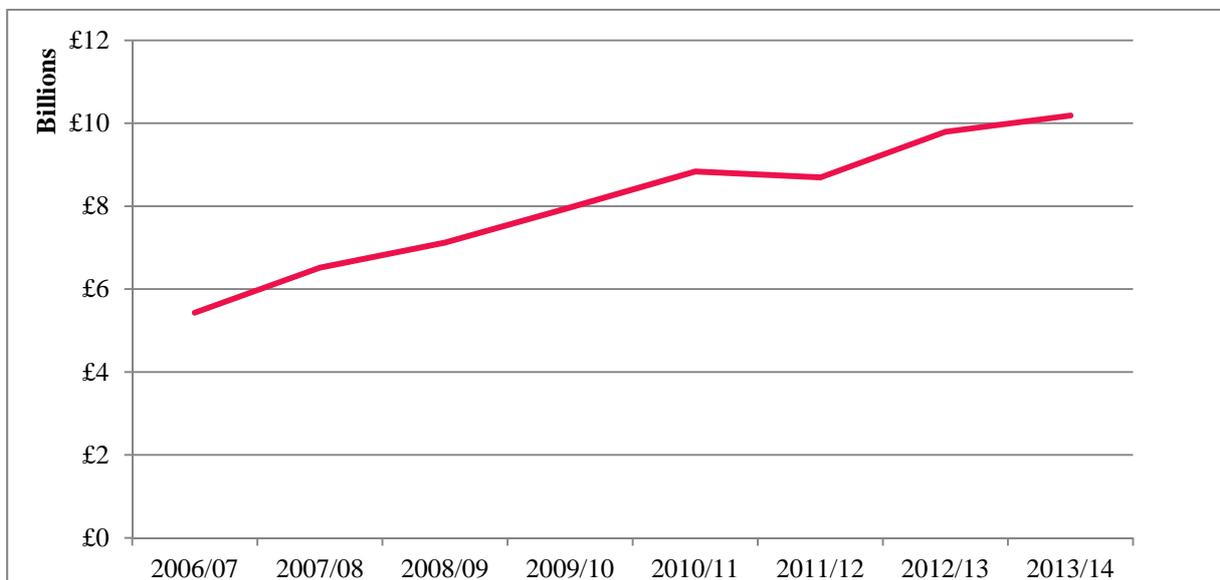
11.3 Of the total revenue from private patient care for NHS and foundation trusts, 8.6% came from overseas patients in 2012/13, an increase of 17% in real terms from the previous year, 2011/12, rising from £41m to £47m.⁴⁴

12.0 The levels of private and voluntary sector provision of NHS care.

Commissioners purchasing health care from non- NHS bodies

12.1 Over the last eight years, there has been an increase in commissioners (Primary Care Trusts (PCTs), NHS England and Clinical Commissioning Groups (CCGs)) purchasing health care from non-NHS providers. Between 2006/07 and 2013/14, spending on NHS funded care provided by non-NHS bodies increased at an annual average of 9% in real terms, from £5.4bn in 2006/07 to £10.2bn in 2013/14 (figure 11).

Figure 11: Purchase of health care from non-NHS bodies from 2006/07 to 2013/14, (2013/14 prices)



Source: Primary Care Trusts' financial accounts from 2006/07 to 2012/13 and NHS England annual report & accounts 2013/14

12.2 Looking at the last two financial years, the purchase of health care from non-NHS providers has continued to increase. In 2012/13, 10% of total commissioner expenditure was spent on non-NHS providers. This increased to 11% in 2013/14 (figure 10).

12.3 NHS England reported that it commissioned £10.2bn of health care services from non-NHS bodies in 2013/14. This represents an annual increase of 4% in real terms compared to PCTs' expenditure of £9.8bn in 2012/13 (figure 12).⁴⁵

⁴⁴ Data for earlier years was not available for foundation trusts

⁴⁵ NHS England. *Annual Accounts and Report*. NHS England; 2014. <http://www.england.nhs.uk/2014/07/22/ann-rep/>

Figure 12: Purchase of health care from non-NHS providers as a proportion of total expenditure.



Source: Primary Care Trusts' financial accounts from 2006/07 to 2012/13 and NHS England annual report & accounts 2013/14

12.4 In 2012/13, the most rapid increase in spending on non-NHS providers was for the provision of community health services (table 7).

12.5 From 2010/11 to 2012/13, total spending on community health services increased at an average rate of 5% annually from £8.9bn to £9.9bn. During this period spending on independent sector provision of NHS community health services increased from £1bn to £1.8bn in real terms and accounted for 18% of the total expenditure on community health services. At the same time, spending on NHS providers fell from £7.1bn in 2010/11 to 6.8bn in 2012/13 in real terms.

Table 7: Primary Care Trust (PCT) spending on community health services provided by the NHS and non-NHS providers from 2010/11 to 2012/13 (values are in billions, in 2013/14 prices)

	<i>PCT spending on NHS bodies (%total share)</i>	<i>PCT spending on independent service providers (ISP) (% total share)</i>	<i>PCT spending on voluntary and other (%total share)</i>	<i>Total PCT Spending for community health services</i>
2010/11	£7.10 (80%)	£1.02 (11%)	£0.73 (8%)	£8.85
2011/12	£6.94 (74%)	£1.35 (14%)	£1.09 (12%)	£9.38
2012/13	£6.84 (69%)	£1.79 (18%)	£1.28 (13%)	£9.91

Source: Into the Red, 2014, figures adjusted to 2013/14 prices

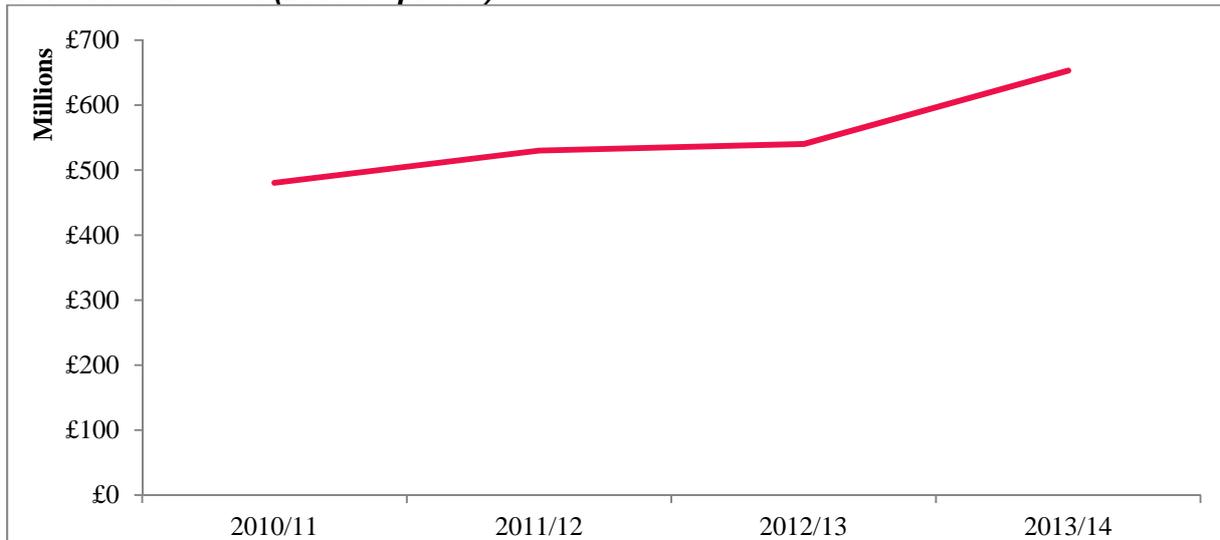
Providers purchasing health care from non-NHS bodies

12.6 As well as commissioners purchasing health care from non-NHS bodies, NHS providers also purchase care for their patients from non-NHS providers. They may do this for a range of reasons, including to help manage waiting times, or to provide different services that the Trust is not in a position to provide.

12.7 The amount of care NHS providers purchased from non-NHS bodies increased by 36% in real terms between 2010/11 and 2013/14, from £480m to £653m, an average of 11% a year. The most rapid growth was between 2012/13 and 2013/14 when it rose by 21% (figure 13)

12.8 However, as a proportion of operating costs, the total spending on non-NHS providers remains low. Between 2009/10 and 2012/13 purchase of health care from non-NHS bodies accounted for 0.9% of the total operating cost.

Figure 13: NHS and foundation trusts' purchase of health care from non-NHS bodies, 2010/11 to 2013/14 (2013/14 prices)



Source: NHS and foundation trusts financial accounts 2010/11 to 2013/14

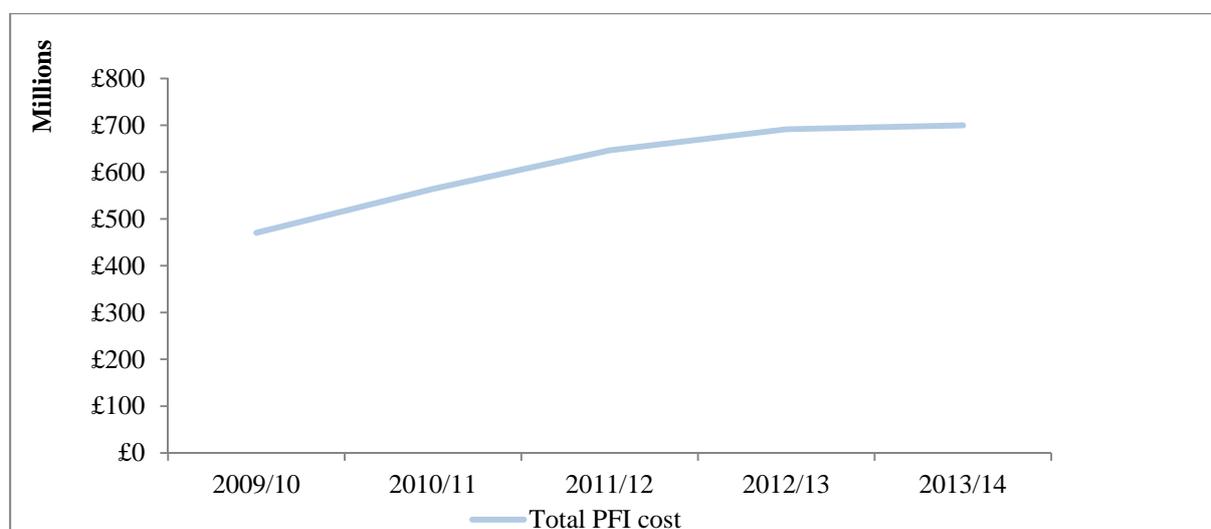
13.0 Private Financial Initiative (PFI) costs

13.1 PFI is a way to finance and provide public sector infrastructure and capital equipment. Under a PFI contract, a public sector authority pays a private contractor an annual fee for the provision and maintenance of a building or other asset, typically over a period of 25 to 30 years. At the end of the contract the public sector authority generally owns the asset.⁴⁶ The intention is to achieve agreed expected savings, however in the case of NHS PFIs, the savings were estimated to be just at £61m across the life of the contracts, far below the current costs.

13.2 The financing cost of PFI contracts accounted for 1% of NHS providers' total expenditure in 2013/14 and has increased by an average of 10% a year in real terms between 2009/10 and 2013/14. This amounts to a 49% increase, in real terms, from £470m in 2009/10 to £700m in 2013/14 (figure 14).

⁴⁶ NAO *Savings from operational PFI contracts*. NAO; 2013. www.nao.org.uk/wp-content/uploads/2013/11/Savings-from-operational-PFI-contracts_final.pdf

Figure 14: Total cost in real terms form 2009/10 to 2013/14 (2013/14 prices)



Source: NHS and Foundation trusts financial accounts 2009/10 to 2013/14

13.3 However, the annual rate of growth of PFI costs has slowed in the latest two financial years. It has fallen from a 20% annual increase in 2010/11 to just a 1% increase in 2013/14.⁴⁷

14.0 Impact of competition on the NHS

14.1 Analysis of the published literature shows that despite some innovative work by research teams at York, the London School of Economics, Bristol and Imperial universities, there is still relatively little evidence about the impact of competition on quality^{48 49}. Bevan and Skellern reviewed the available evidence in 2011 and concluded 'There are strong grounds for introducing patient choice into the NHS as an end in itself, given its potential to empower patients and give them greater control over the conditions of their care..... Nevertheless, how patient choice has affected outcomes in elective surgery remains an open question: the exact role it should play in the policy mix is therefore unclear'.

14.2 Much of the available research examines the impact of choice-based competition in the mid 2000. This work predates the big growth in the use of non-NHS providers following the choice reforms of 2008. It is focused on choice of first outpatient attendance and its impact on hospital care but much of the recent growth in non-NHS provision is in non-hospital settings and will involve a mixture of competition for the market as well as competition in the market. There are also methodological challenges with research in

⁴⁷ NAO, November 2013 http://www.nao.org.uk/wp-content/uploads/2013/11/Savings-from-operational-PFI-contracts_final.pdf⁴⁷ NAO, November 2013

⁴⁸ Bevan G, Skellern M. *Does competition between hospitals improve clinical quality? A review of evidence from two eras of competition in the English NHS*. *BMJ (Clinical Research Ed.)*, 343(oct07_2), d6470. doi:10.1136/bmj.d6470; 2011.

⁴⁹ De Silva D. *Evidence scan: Competition in health care*. The Health Foundation,; 2011.

this area. Studies using just one indicator of quality (often mortality) may not give a complete picture as quality measures can correlate poorly with each other,⁵⁰ and research shows the importance of considering a 'basket' of quality measures rather than just one.⁵¹ Secondly, often these studies necessarily use market concentration as a proxy for competition, as it is difficult to observe competition directly. There are a number of hypotheses for why there may be a link between concentration and quality, of which competition is just one. Thirdly, we may be observing only the first round effects of competition, rather than its effects over time.

14.3 Since 2011 relatively few studies on competition have been published, making it difficult to come to any definitive conclusions on the impact of competition on quality. One recently published paper⁵² concluded that hospital market concentration (as a proxy for competition) appears to have no significant influence on the outcome of elective primary hip replacement, measured by Patient Reported Outcomes Measures (PROMs).⁵³ In healthier patients there was a (small) negative association between hospital market concentration and health gain after treatment. This might suggest that lower market concentration does improve quality. However, this association ($p=0.09$) was not statistically significant at the 5% level, so does not justify rejection of the null hypothesis of no effect of hospital market concentration.

14.4 In addition to choice policy and the role of tendering and procurement policy, competition policy also has an influence on the decisions regarding the configuration of providers in the market and most specifically mergers between hospitals. We explore the impact of this in our forthcoming report on the decision to prohibit the proposed merger between Poole Hospital NHS Foundation Trust and the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trusts. We will share this with the Committee on publication.

14.5 In terms of public perception of choice and competition in the NHS, a patient survey by Monitor⁵⁴ showed that awareness of choice and the offer of choice has been stuck at around half of NHS patients. In 2014, 51% of people were aware of their right to choose a hospital or clinic for an outpatient appointment and 53% had a discussion with their GP about where to receive treatment before being referred for an outpatient appointment. However, fewer than two-fifths of patients said they were offered a choice of hospital by their GP when being referred for an outpatient appointment.

⁵⁰ Gravelle H, Santos R, Siciliani L, Goudie R. (n.d.). *Hospital Quality Competition Under Fixed Prices*. Retrieved October 10, 2014, from http://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP80_hospital_quality_competition_fixedprices.pdf

⁵¹ Vincent C, Burnett S and Carthey J. *The measurement and monitoring of safety*. The Health Foundation,; 2011.

⁵² Feng Y, Pistollato M, Charlesworth A, Devlin N, Propper C, Sussex J. (2014). Association between market concentration of hospitals and patient health gain following hip replacement surgery. *Journal of Health Services Research & Policy*, 1355819614546032. doi:10.1177/1355819614546032; 2014.

⁵³ See <http://www.health.org.uk/blog/how-useful-is-competition-in-improving-hospital-performance/>

⁵⁴ <https://www.gov.uk/government/news/patient-choice-survey-reveals-more-needs-to-be-done>

14.6 Research shows people care strongly about their choice of treatment⁵⁵ when it comes to important aspects of care, arguably more than their choice of provider.⁵⁶ However, currently in England, the NHS performs poorly in involving people in these decisions⁵⁷.

15.0 The potential impact of the extensive use of personal budgets on the funding and planning of health and social care services

15.1 The potential impact of a wider roll-out of personal budgets is difficult to predict. While there are data about the use of personal budgets in social care,⁵⁸ the main evidence about the impact of personal health budgets in England comes from the evaluation of the pilot programme which involved smaller numbers (just over 1,000 recipients of a personal health budget).⁵⁹

15.2 The available evidence indicates that personal health budgets can have a significant positive effect on care-related quality of life and psychological wellbeing. The evidence on cost is less definitive, although the evaluation of the pilot found that they were generally cost effective, particularly when they were of higher value (over £1,000). Personal health budgets also appear to be most effective when people are given more control over the services they choose to meet their needs.⁶⁰ This creates particular challenges for the funding and planning of health and social care services and raises issues in relation to commissioning and decommissioning decisions.

15.3 It has also been suggested that personal health budgets could support better integration of health and social care, for example through the combining of personal budgets for health and social care.

15.4 It will be important to use the opportunity of the wider roll out of personal health budgets to ensure the right information is collected to enable the evidence base to be developed. In addition, more work is needed to understand who personal budgets are most valuable for and in what circumstances they work for them, ensuring that the too often overlooked context, infrastructure, training and support are in place so that the policy has its intended effect.

⁵⁵ Department of Health. *Protecting and promoting patients' interests: the Role of sector regulation*,. Department of Health; 2011, p. 26

⁵⁶ Coulter, A. *Do patients want a choice and does it work?* BMJ; 2010, 341.

⁵⁷ QualityWatch: <http://www.qualitywatch.org.uk/indicator/do-people-feel-involved-decisions-about-their-care>

⁵⁸ For example the second National Personal Budget Survey commissioned by the Think Local, Act Personal Partnership (TLAP) involved 22 councils and included the experiences of 3,300 personal budget holders and carers - <http://www.in-control.org.uk/what-we-do/poet-%C2%A9-personal-outcomes-evaluation-tool.aspx>.

⁵⁹ White C. *The personal touch: The Dutch experience of personal health budgets*. The Health Foundation; 2011

⁶⁰ *Personal health budgets: Challenges for commissioners and policy-makers*, Nuffield Trust, August 2013,

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