

Health Select Committee: Impact of the Comprehensive Spending Review on health and social care

Health Foundation evidence

January 2016

1. Introduction

1.1. Thank you for the opportunity to submit evidence to the Health Select Committee's inquiry on the *Impact of the Comprehensive Spending Review on health and social care*. This evidence is intended to supplement our joint submission with The King's Fund and the Nuffield Trust by summarising the Health Foundation's own research and analysis that falls within the scope of the committee's inquiry.

2. About the Health Foundation

2.1. The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK.

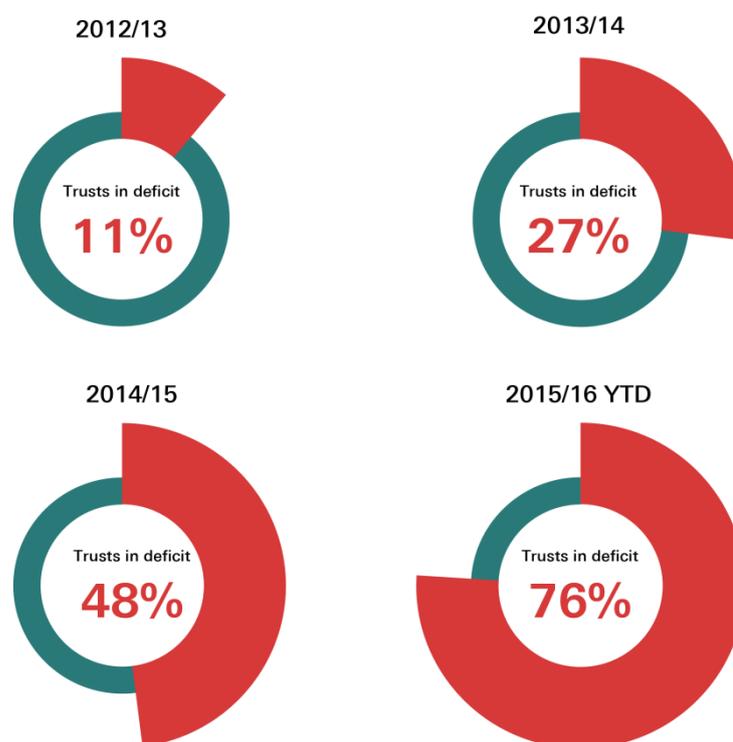
2.2. Our aim is a healthier population, supported by high quality health care that can be equitably accessed. From giving grants to those working at the front line to carrying out research and policy analysis, we shine a light on how to make successful change happen. We use what we know works on the ground to inform effective policymaking and vice versa.

2.3. We believe good health and health care are key to a flourishing society. Through sharing what we learn, collaborating with others and building people's skills and knowledge, we aim to make a difference and contribute to a healthier population.

3. Deficits, achieving efficiency savings and transformation

3.1. The NHS budget in England is under increasing strain. The number of trusts in deficit has increased rapidly since 2012/13, as illustrated by figure 1. The net deficit of NHS providers rose to £1.6bn at the end of the second quarter of 2015/16 and the proportion of providers in deficit continues to rise. For example, 76% of NHS providers (182 trusts) reported a net deficit in Quarter 2 of 2015/16 compared to 48% (115 trusts) at the end of 2014-15.

Figure 1: Percentage of NHS providers in deficit, 2012/13 to Q2 2015/16



3.2. As outlined in the *Five Year Forward View*¹, the NHS in England needs to make 2-3% of efficiency savings each year between 2015/16 and 2020/21 to close the projected £22bn gap between resources and patient need. This is widely recognised as very challenging given the historic performance of health care systems in sustaining efficiency and productivity growth.

3.3. In December 2015 the National Audit Office in its report *Sustainability and Financial Performance of Acute Hospital Trusts*² highlighted that acute trusts in 2014-15 made fewer recurrent cost savings than in previous years. Such a trend will be unsustainable in the long term and NHS providers will need to focus on improving productivity if they are going to achieve necessary efficiency savings. Recognising the scale of the task for the NHS, the government asked Lord Carter of Coles to review the operational performance of NHS hospitals. The interim report was published in June 2015³, with the full report due to publish during the first quarter of 2016. In his interim report, Lord Carter identified the potential for hospitals to make £5bn in efficiency savings by 2020/21. Hospitals are now being asked to identify future savings as part of their sustainability and transformation plans.

3.4. Productivity and efficiency are related but different measures of the performance of the health system. Productivity is the ratio of outputs of care (eg the number of hip replacements performed, patients treated in accident and emergency, etc) to inputs used to produce the care (number of staff, number and types of drugs, etc). The key

¹ <https://www.england.nhs.uk/ourwork/futurenhs/nhs-five-year-forward-view-web-version>

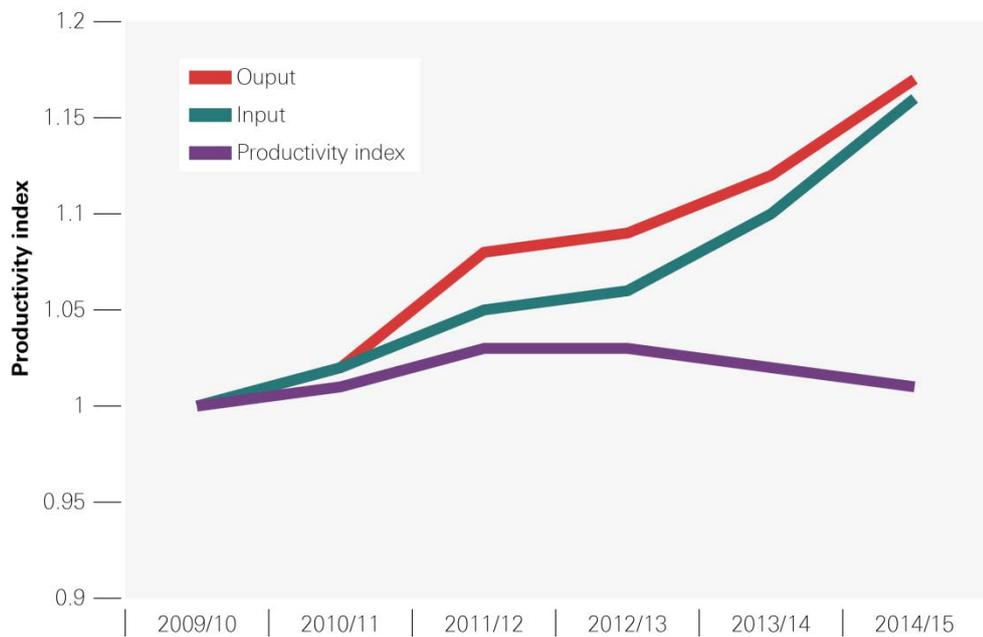
² <https://www.nao.org.uk/report/sustainability-and-financial-performance-of-acute-hospital-trusts/>

³ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/434202/carter-interim-report.pdf

difference between efficiency and productivity is that while productivity focuses on the number and mix of inputs used to deliver care, efficiency also considers the cost of the inputs.

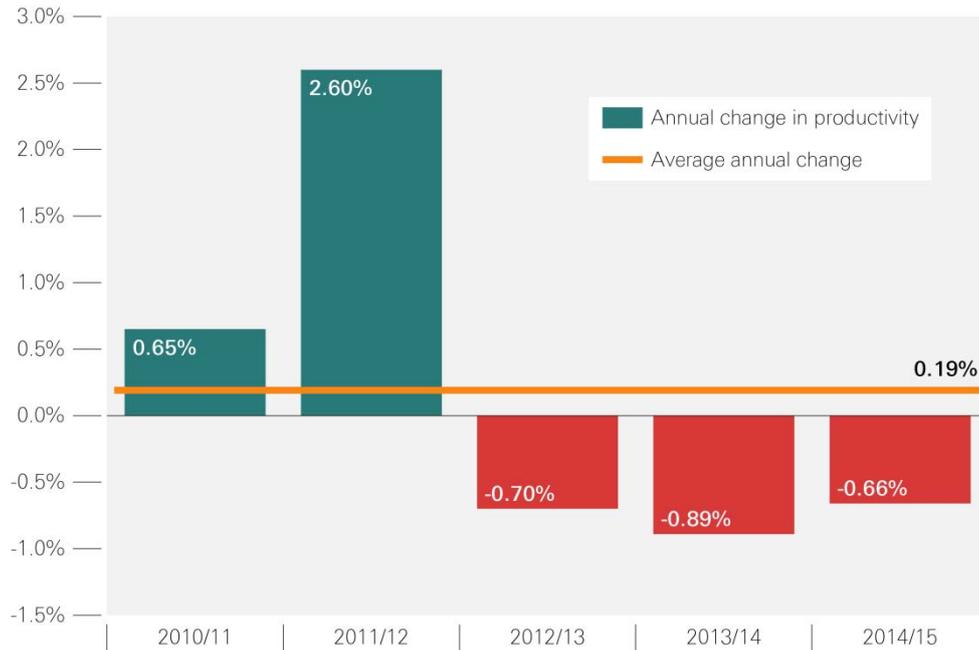
3.5. The productivity of acute hospitals in England has continued to deteriorate. Between 2013/14 and 2014/15 productivity fell by 0.66% - the third consecutive year productivity has fallen. This is the result of inputs in 2014/15 rising faster (5.1%) than outputs (4.45%). Figure 2 (below) shows that inputs have increased at a faster rate than outputs since 2012/13 leading to a falling productivity index.

Figure 2: Change in hospital productivity, 2009/10 to 2014/15



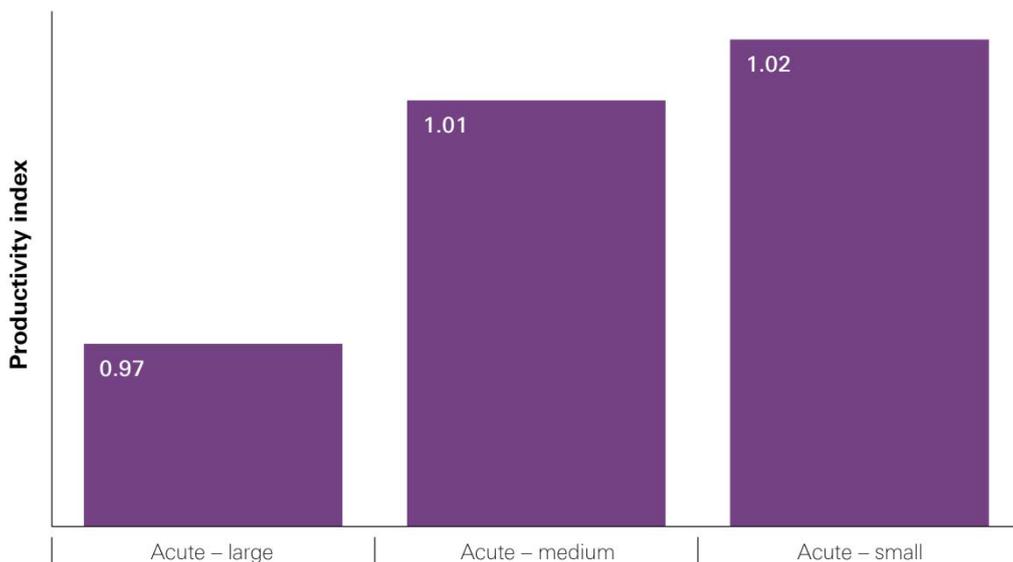
3.6. Overall, the productivity of acute hospitals increased by only 1.0% between 2009/10 and 2014/15 - an average rate of 0.19% per year (as shown in figure 3). Between 2009/10 and 2014/15, hospital input increased by 16.7% (3.1% per year) while the outputs used to deliver that care increased by 15.6% (2.9% per year) leading to the very low level of productivity growth.

Figure 3: Annual change in hospital productivity index from 2009/10 to 2014/15



3.7. Numerous studies show that productivity varies across the country and by type of hospital^{4 5}. For example, when comparing productivity by size of hospitals⁶, we found that in 2014/15 small acute hospitals were still more productive than average by 2%, while larger hospitals were less productive, as shown in figure 4.

Figure 4: Variation in productivity index of hospitals by size, 2014/15



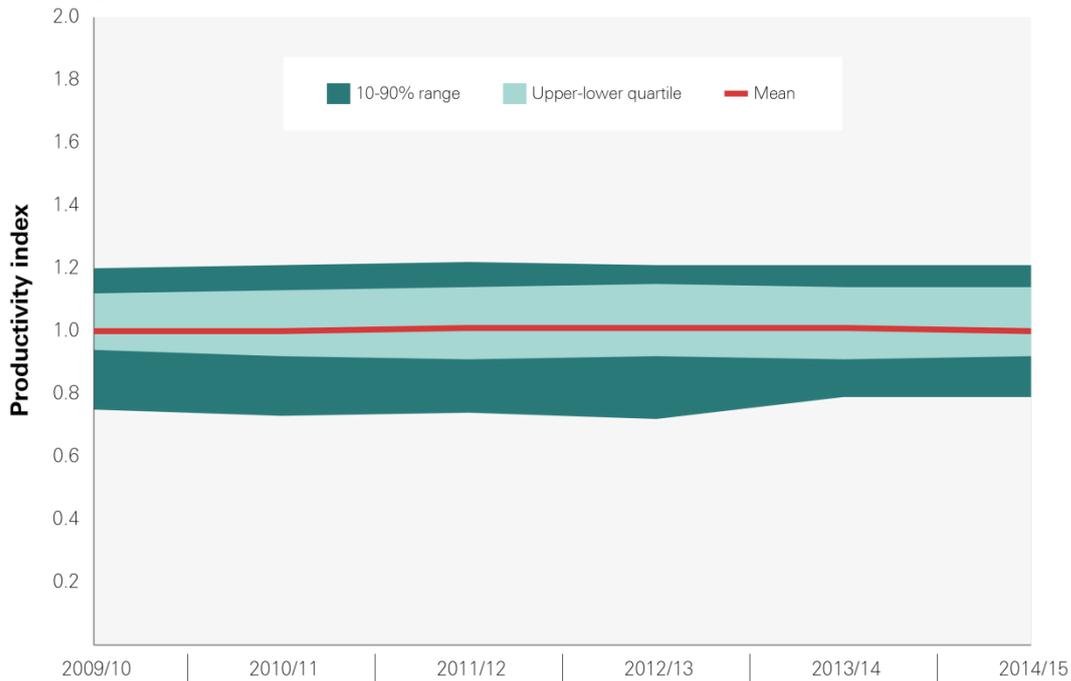
⁴ <http://www.health.org.uk/publication/hospital-finances-and-productivity-critical-condition>

⁵ https://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP110_NHS_productivity_update_2012-13.pdf

⁶ Teaching and Specialist hospitals were excluded from this analysis

3.8. The NHS continues to seek ways to stimulate less efficient organisations to match the efficiency of the best. However, our analysis shows that to date efforts to reduce this efficiency gap have largely failed with little change in the productivity performance of individual hospitals from 2009/10 to 2014/15. For example, 73% of the hospitals that were above or below average in 2009/10 stayed above or below average in 2014/15. The upper quartile of the productivity index range increased from 1.12 to 1.14 in 2014/15 while the lower quartile fell from 0.94 to 0.92, as shown in figure 5. This suggests a slight increase in the range of productivity performance across the NHS last year.

Figure 5: variation in productivity of hospitals from 2009/10 to 2013/14



3.9. It is important to note the limitations of this analysis – we measure crude productivity taking no account of differences in the quality of care provided over time or between organisations. Following the issues raised in the Francis Inquiry into problems at Mid Staffordshire NHS Foundation Trust, improving the quality of care has been a key focus of policy and practice across the NHS and may explain some of the increase in inputs. By focusing on crude productivity we may underestimate NHS performance if quality of care has improved through this period. But other studies suggest some aspects of care quality have deteriorated in recent years,⁷ in which case productivity performance would in fact be lower than we report.

3.10. The need to improve productivity and efficiency is both critical and immediate, but as yet there is no clear national plan for this – Lord Carter’s work identified £5bn of savings but that still leaves a substantial gap to be filled. As mentioned in our joint submission, the NHS is now halfway through the most austere decade in its history. At this mid-point it is clear that the NHS is struggling to find the savings – productivity

⁷http://www.qualitywatch.org.uk/sites/files/qualitywatch/field/field_document/QW_Annual_Statement_2015_WEB.pdf

performance is weak and finances are under extreme pressure. The NHS needs a new approach to change if it is going to reverse the recent deterioration in productivity, make £22bn of efficiency savings and transform the delivery of care for the long term. To achieve these improvements the NHS needs a clear policy framework – including a realistic tariff, a clear accountability framework and multi-year budgets – but also financial and practical support to help realise recurrent efficiency savings and transform the delivery of care.

- 3.11. Beyond this, the NHS cannot bridge the funding gap alone. To unlock the opportunities for system efficiencies, which undoubtedly exist, there needs to be an effective public health strategy and a high performing, sustainable social care system.
- 3.12. Recent trends combined with cuts to public health funding and pressures on social care suggest the 2-3% efficiency target set out in the *Five Year Forward View* is extremely ambitious.
- 3.13. In a joint report with The King's Fund, as described in our joint submission, we made the case for a Transformation Fund of £1.5–2.1bn a year between now and 2020/21, over and above the existing financial settlement described in our joint submission. One opportunity for funding real transformation in the short-term 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 impact, 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 which could replace the funding from the capital budget after a set time period.

4. Impact of the Spending Review on the integration of health and social care

- 4.1. The Spending Review set out an ambitious plan so that by 2020 health and social care is integrated across the country. All areas are expected to have plans for this by 2017.⁸
- 4.2. We have considered two factors in assessing the impact the Spending Review might have on the integration of health and care: the financial context of both health and social care services, and the national and local policy planned to achieve integrated services.
- 4.3. The financial settlement for the NHS is challenging, but the social care settlement is even more so. As we discussed in our joint submission, spending on social care is subject to some uncertainty, but looks set to remain roughly flat. New powers to raise council tax by up to 2% to spend on social care and additional money through the Better Care Fund (BCF), while welcome, will not be enough to close the social care funding gap, which we estimate will be somewhere between £2.8bn and £3.5bn by

⁸https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/479749/52229_Blue_Book_PU1865_Web_Accessible.pdf

the end of the parliament. It is therefore unlikely that the current range and quality of social care services can be maintained. This follows a period of reduced spending in the last parliament, which resulted in 25% fewer people receiving care than had previously been eligible.

- 4.4. The gap between social care funding and need between now and 2020 could result in an ever dwindling service for the NHS to integrate with, covering fewer people and able to provide less support. In addition, national and managerial support for change is reducing in line with financial cuts to arm's length bodies and local management capacity. This is an extremely challenging context in which to try to integrate services.
- 4.5. In policy terms, three main initiatives contribute to aspirations to integrate health and social care: the BCF, devolution deals (where integration is often cited as a goal for health and care⁹), and NHS England's new models of care programme (which mainly focuses on integration within health care). There are also previous efforts to integrate health and social care such as the Integrated Care Pioneers,¹⁰ set up in 2013.
- 4.6. The BCF has not been without problems to date,¹¹ and both it and the vanguards are at a relatively early stage of implementation, meaning their likely impact cannot yet be robustly assessed. That being said, both have generated conversations and action locally – and therefore opportunities to better integrate health and social care.
- 4.7. Devolution deals also represent an opportunity for local organisations to work together and integrate care. Alongside this, conversations between local and national players can, through devolution, be more sensitive of the health and care needs of local populations than perhaps was possible before. Devolution should allow pooling of budgets at a wider geographical scale than has happened previously (which may be more conducive to the planning of some services), and for local leaders to galvanise action (which may allow areas to overcome previously 'sticky issues' on integration).
- 4.8. It is not yet clear how the various initiatives will coordinate effectively. For instance, localities within Greater Manchester are still required to submit separate BCF plans¹². However, there is clear policy intention to integrate care.
- 4.9. Integrating care is a significant change requiring organisations and professionals to work differently. It is also challenging to implement – a recent systematic review found little conclusive evidence of financial or quality benefits for the 38 health and social care programmes examined.¹³ Overcoming cultural differences between services and achieving financial integration were identified as particular challenges.

⁹ <http://www.health.org.uk/blog/english-devo-bids-healthy-or-not>

¹⁰ <https://www.england.nhs.uk/pioneers/>

¹¹ <http://www.parliament.uk/business/committees/committees-a-z/commons-select/public-accounts-committee/news/report-planning-for-the-better-care-fund/>

¹² <https://www.gov.uk/government/publications/better-care-fund-how-it-will-work-in-2016-to-2017>

¹³ Mason A, Goddard M, Weatherly H, Chalkley M. Integrating funds for health and social care: an evidence review. *Journal of Health Services Research & Policy* 2015;20(3):177-188.

4.10. The Health Foundation's analysis found four barriers to successful change in the NHS:

- recognition of the need to change,
- having the motivation to change (being empowered to make changes and believing successful change is possible)
- the headspace to make change happen, and
- the right skills and capability.¹⁴

4.11. Headspace is scarce in the current context, as there are multiple and sometimes conflicting central priorities for health, little management capacity in the system, no extra funding for key integration initiatives such as the BCF, and perhaps overly ambitious central expectations for change (for instance for areas to move from a plan for integration to fully integrated care in three years). These factors combine to limit headspace to plan and implement change. While the policy intention for the integration of care is clear, the success of the implementation of integration is much less so.

5. Progress on achieving parity of esteem through funding for mental health services

5.1. Parity of esteem – in essence valuing mental health and physical health equally - has been government policy for some time, and there have been a number of recent financial and service commitments from the Department of Health and NHS England to this effect. More information on NHS England's strategy for improving mental health, and making progress towards parity of esteem, is expected in the NHS England mental health taskforce report, which is due to be published in early 2016.¹⁵

5.2. Funding for mental health services is split across three main areas with mental health services commissioned by:

- clinical commissioning groups (CCGs) (the majority of non-specialist mental health services),
- local government (social care for people with mental health problems, public mental health services, and some services for children and young people with mental health problems), and
- NHS England (specialised mental health services, including forensic services).¹⁶

5.3. Data on the funding for mental health is categorised in two different ways – funding for mental health disorders (depression, anxiety, schizophrenia etc) and funding for dedicated mental health services. There are differences as not all mental health care is provided by dedicated mental health services. For example GPs provide a large amount of mental health care.

5.4. Spending on mental health disorders is available from the national programme budget data. Prior to the NHS reforms of the Health and Social Care Act 2012, programme budget data were collected for all commissioned services. This shows that spending on mental health disorders was relatively stable between 2009/10 and 2012/13, falling at an average rate of 0.1% in real terms from £11.88bn to £11.85bn while the total

¹⁴ <http://www.health.org.uk/publication/constructive-comfort-accelerating-change-nhs>

¹⁵ <https://www.england.nhs.uk/mentalhealth/taskforce/>

¹⁶ <http://researchbriefings.parliament.uk/ResearchBriefing/Summary/CDP-2015-0119>

commissioning programme budget rose by 0.6%. The programme budgeting information shows that in 2013/14 CCGs' budget for mental health was £8.4bn.¹⁷

- 5.5. Since 2013/14, both NHS England and CCGs have been responsible for commissioning mental health services. Whereas programme budgeting information for CCGs is available, NHS England does not publish any programme budget information and so the analysis is partial. Therefore, since 2012/13 total spending on mental health disorders is unknown. This means the parity of funding between physical and mental health cannot be monitored.

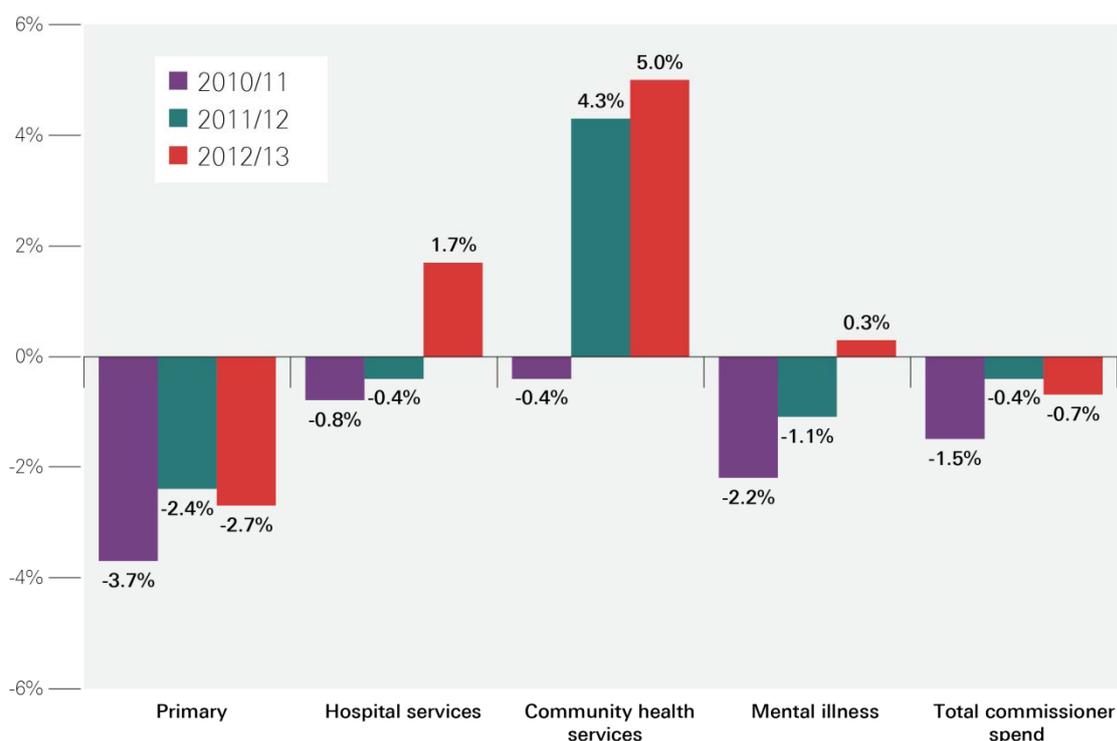
Figure 6: Programme budgeting data 2009/10 – 2012/13. Department of Health, 2012

	2009/10	2010/11	2011/12	2012/13
Mental health disorders (£bn)	10.61	10.96	11.16	11.28
Mental health disorders (£bn) (2015/16 prices)	11.88	11.91	11.94	11.85
Annual change in real terms		0.3%	0.3%	-0.7%
Total commissioner programme budgeting spend	87.36	91.69	92.38	94.78
Total commissioner programme budgeting spend (£bn) (2015/16 prices)	97.79	99.64	98.86	99.60
Mental health as a proportion of the commissioner budget	12%	12%	12%	12%

- 5.6. Another way to measure mental health funding is by measuring expenditure on mental health services. Figure 7 shows how annual changes in commissioner (PCT) spending on mental health compare with other services. It shows that spending on mental health services fell faster than for hospital services in 2010/11 and 2011/12 and then rose at a slower rate (0.3%) than for hospital services (1.7%). This data is not available for the period after 2013.

Figure 7: Annual change in Commissioner (PCT) spending by service type

¹⁷ <https://www.england.nhs.uk/resources/resources-for-ccgs/prog-budgeting/>



5.7. The Spending Review and other government announcements have included money earmarked for mental health initiatives; a breakdown of funding for each year of this parliament is set out in the table below.

Figure 8: Annual government commitments to mental health funding for 2015/16 to 2016/17

Announcement	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
Autumn statement 2014 ¹⁸	£30m	£30m	£30m	£30m	£30m	£30m	£150m
Budget 2015 ¹⁹ (phasing unknown, assume even)	£250m	£250m	£250m	£250m	£250m	£250m	£1.25bn
Spending Review ²⁰ (phasing unknown, assume even)	-	£120m	£120m	£120m	£120m	£120m	£600m
Total	£280m	£400m	£400m	£400m	£400m	£400m	£2bn

¹⁸https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/416330/47881_Budget_2015_Web_Accessible.pdf

¹⁹https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/416330/47881_Budget_2015_Web_Accessible.pdf

²⁰https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/479749/52229_Blue_Book_PU1865_Web_Accessible.pdf

- 5.8. There is a central expectation that CCGs increase the proportion of their funding they spend on mental health, although much of the funding earmarked for mental health has not been ring-fenced.²¹ Because of the lack of information on the total funding for mental health it is not possible to assess whether new money promised will improve the overall funding position for mental health over time.²²
- 5.9. Achieving parity of esteem is not merely reaching or exceeding previous levels of funding for mental health – progress requires improvement in a number of dimensions including: access to services, the quality of services, and the availability of information on mental health services.²³
- 5.10. The average number of nurses working in community psychiatry or other psychiatric sectors fell by an average rate of -1.4% per year from 40,200 nurses in 2010/11 to 38,000 in 2014/15 while the number of nurses in the acute sector rose at an average rate of 1.1% per year, from 168,800 nurses in 2010/11 to 176,000 in 2014/15. This doesn't include nurses working in the independent sector, for whom there is no data.
- 5.11. There is generally insufficient information available to assess the quality of mental health services outside of psychological therapies for common mental health problems.²⁴ Information from children and adolescent mental health services (CAMHS) is now being collected,²⁵ but will not be published until later this year.
- 5.12. Policy initiatives have been implemented to address areas where there have been concerns about the quality of care, particularly CAMHS, perinatal mental health and crisis care. However, their newness and a lack of information mean their impact on quality cannot be assessed yet.
- 5.13. There has been some progress on improving access to services. Some waiting times standards are being introduced, but there are currently no firm plans for waiting times standards across the majority of mental health services.²⁶ While singling out a few services for standards helpfully signals priority, it may not address the disparity of priority between mental health and physical health.²⁷
- 5.14. Levels of unmet need (people needing mental health treatment but not accessing it) for mental health services are high.²⁸ Access to psychological therapies for people with common mental health problems has improved, with 15% of the estimated number of people with anxiety and depression now accessing treatment each year.²⁹ This is still some distance short of need.

²¹ <https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf>

²² <https://www.gov.uk/government/publications/2011-12-programme-budgeting-guidance>

²³ <http://www.rcpsych.ac.uk/policyandparliamentary/whatsnew/parityofesteem.aspx>

²⁴ <http://www.health.org.uk/sites/default/files/IsMentalHealthCareImproving.pdf>

²⁵ <http://www.hscic.gov.uk/CAMHS>

²⁶ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/361648/mental-health-access.pdf

²⁷ <http://www.health.org.uk/blog/mental-health-targets-making-best-opportunity>

²⁸ <http://www.kingsfund.org.uk/time-to-think-differently/trends/disease-and-disability/mental-and-physical-health>

²⁹ <http://www.hscic.gov.uk/catalogue/PUB19098/psyc-ther-ann-rep-2014-15.pdf>

- 5.15. Access to secondary mental health services does not seem to have improved, with less people receiving coordinated care.³⁰ Some initiatives such as including Early Intervention in Psychosis services in waiting times standards and expanding the provision of implementing liaison and diversion services (ensuring people can access support rather than sanction from the criminal justice system) should improve some people's access to care. However, 25% fewer people with mental health problems accessed social care between 2010/11 and 2013/14.³¹

6. Appendix

- 6.1. This appendix sets out the methodology used to estimate acute hospital productivity, as described in section 3.
- 6.2. This analysis is an update to our *Hospital finances and productivity: in critical condition?* report (Lafond et al, April 2015)³².
- 6.3. The updated analysis of hospital productivity uses the most recent data on NHS reference costs³³.
- 6.4. For this analysis, we measured the productivity of 152 hospitals in England where data was available from 2009/10 to 2014/15.
- 6.5. We define productivity increases as a ratio of hospital output (acute care activity) to hospital input.
- 6.6. Acute care activity includes: elective inpatient care; non-elective inpatient care; A&E attendances; and day case procedures.
- 6.7. To measure the change in inputs between years, we have used the real terms³⁴ total cost of providing acute care adjusted by the market force factor (MFF). Through this measure we indirectly measure the change in the volume and mix of inputs by removing price changes.
- 6.8. More details on the methodology can be found in the technical appendix published with *Hospital finances and productivity: in critical condition?*³⁵.

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³⁰ <http://www.health.org.uk/sites/default/files/IsMentalHealthCareImproving.pdf>

³¹ HSCIC Community Care Statistics (2009/10-2013/14), Social Services Activity, England

³² <http://www.health.org.uk/publication/hospital-finances-and-productivity-critical-condition>

³³ <https://www.gov.uk/government/publications/nhs-reference-costs-2014-to-2015>

³⁴ Cost in 2014/15 prices using HM treasury deflator December 2015 published on January 8th

³⁵ http://www.health.org.uk/sites/default/files/HospitalFinancesAndProductivity_TechnicalAppendix.pdf

