Public Accounts Committee: Sustainability and financial performance of acute hospitals in England

Health Foundation evidence
January 2016

1. Introduction

1.1. Thank you for the opportunity to submit evidence to the Public Accounts Committee's oral evidence session on the sustainability and financial performance of acute hospitals in England. In our evidence we have tried to provide the committee with key facts and analysis to supplement the information contained within the National Audit Office's (NAO) report from December 2015. The information provided includes the latest figures on the financial performance of NHS trusts and foundation trusts from Quarter 2 of 2015/16 as well as our research on health care funding and productivity.

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. Funding

3.1. Following the Spending Review, NHS England's budget will rise by £7.6 billion in real terms between 2015/16 and 2020/2, although other health spending will fall by more than £3 billion - a 20% cut. Overall, the budget for health is set to rise by 0.9% a year in real terms over this parliament; this is pretty much identical to health spending over the last parliament, but the context is very different. In 2010 most providers were in good underlying financial health, there were opportunities for one-off and relatively straightforward efficiencies to be made and earnings across the whole economy were falling alongside health workers' pay.

3.2. The additional £7.6bn will be front-loaded with a significant increase in 2016/17, which is very welcome. However, much of this money will be absorbed by dealing with deficits among NHS providers and by additional pension costs. With much smaller increases in later years, the NHS will struggle to maintain services, let alone

invest in new models of care and implement seven-day services. This places even more emphasis on the huge challenge of finding £22bn in productivity improvements by the end of the parliament.

3.3. In the longer term, the funding available for the NHS and adult social care will be influenced by the rate of economic growth, decisions about tax, the level of overall public spending, and how public spending is allocated. The government has committed to eliminating the deficit in the national budget by 2019/20 and is planning to run a surplus of around £10bn (0.5% of GDP) by 2019/20.

3.4. We have projected public funding for health and social care up to 2030/31 based on the official economic and fiscal forecasts from the Office for Budget Responsibility (OBR). Health and social care budgets are projected to increase by 2.5% a year in real terms between 2020/21 and 2030/31. This assumes that tax receipts increase in line with GDP and that the government continues to run a surplus of 0.5% of GDP. This would see the NHS and care budget increase to £210bn by 2030/31 (2015/16 prices).

3.5. Even with the expected additional funding for the UK health system, there is likely to be a gap between the available health budget and the funding required to maintain the quality and range of services. This gap is estimated to be £2bn by 2020/21, rising to £9bn by 2030/31.

3.6. For adult social care, the pressures are rising faster, yet the budget is expected to fall over the next five years before subsequently increasing at a similar rate to GDP. Our analysis projects a potential funding gap for adult social care of £6bn by 2020/21 and £13bn by 2030/31 unless there is a change in policy. The projected health funding gap of £9bn in 2030/31 is worth 5% of the projected budget that year; for adult social care the funding gap of £13bn is equivalent to 62% of the total expected budget for 2030/31. The estimated funding gap for adult social care does not allow for the additional costs of the new National Minimum Wage or implementation of the cap on lifetime care costs included within the 2014 Care Act. These changes would add a further £2.2bn to the cost of adult social care by 2030/31.

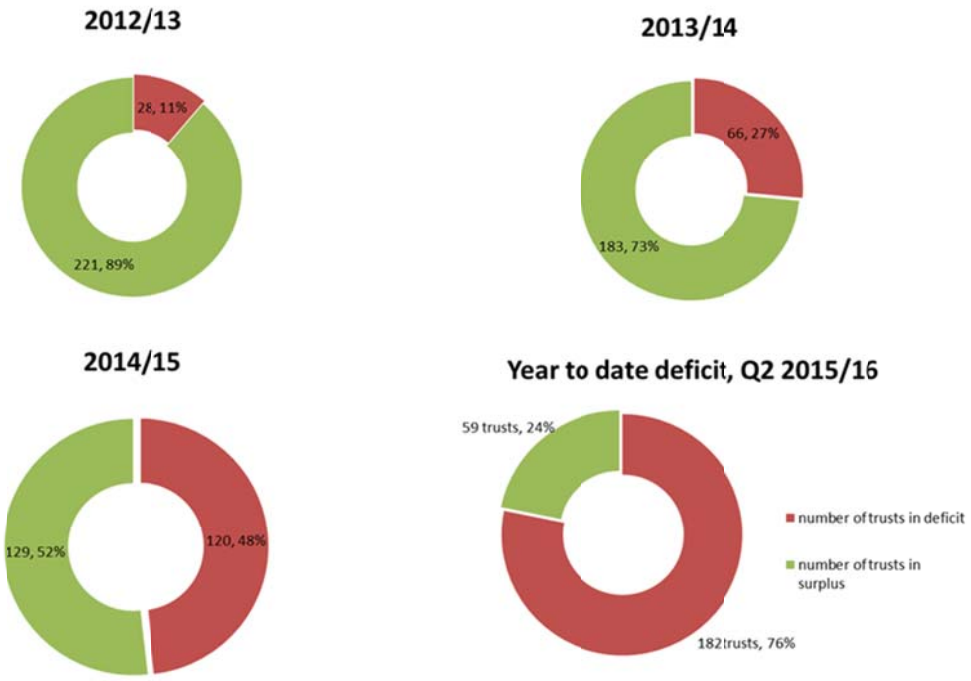
3.7. The scale of the health funding gap in the UK depends on the ability of the NHS to deliver sustained efficiency improvements and to minimise pay pressures. Our estimate of a £2bn funding gap by 2020/21 is predicated on the government being able to hold down pay growth in the NHS for a further four years. This is very challenging given that the NHS is already struggling to recruit and retain staff, particularly in nursing, and is increasingly reliant on expensive agency staff.

3.8. We have assumed that the NHS is able to make savings of 1.5% a year through improved efficiency. If it only achieves efficiency savings of around 1.0% a year, which is closer to the long-run trend for UK health service-wide productivity, the potential NHS funding gap would increase to £5bn by 2020/21 and £23bn by 2030/31.

4. Financial performance

4.1. The NHS budget is under increasing strain. The number of trusts in deficit has increased rapidly since 2012/13, as illustrated by the chart below. 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% (182 trusts) of NHS providers reported a net deficit compared to 48% (115 trusts) at the end of 2014-15.

Percentage of NHS providers in deficit between 2012/13 and Q2 2015/16



4.2. The deterioration in NHS provider finances is the result of their operating costs (staff costs, drugs costs, premises expenses etc.) rising more rapidly than the income they receive from the commissioners of care – clinical commissioning groups and NHS England. These problems are mostly concentrated in acute hospitals. Monitor and the NHS Trust Development Authority highlighted spiralling agency costs and delayed discharges as key factors contributing to the worsening financial position of NHS trusts and foundation trusts in the latest quarterly figures published on 20 November 2015.

4.3. The formation of NHS Improvement presents an opportunity to clarify the current financial accountability regime. The regime needs to be reformed with the goal of ensuring that all providers have challenging but realistic budgets that reflect their specific opportunities for efficiency. This should build on the work of Lord Carter of Coles, which is seeking to identify the efficiency potential in hospitals across England. 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.

4.4. 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.

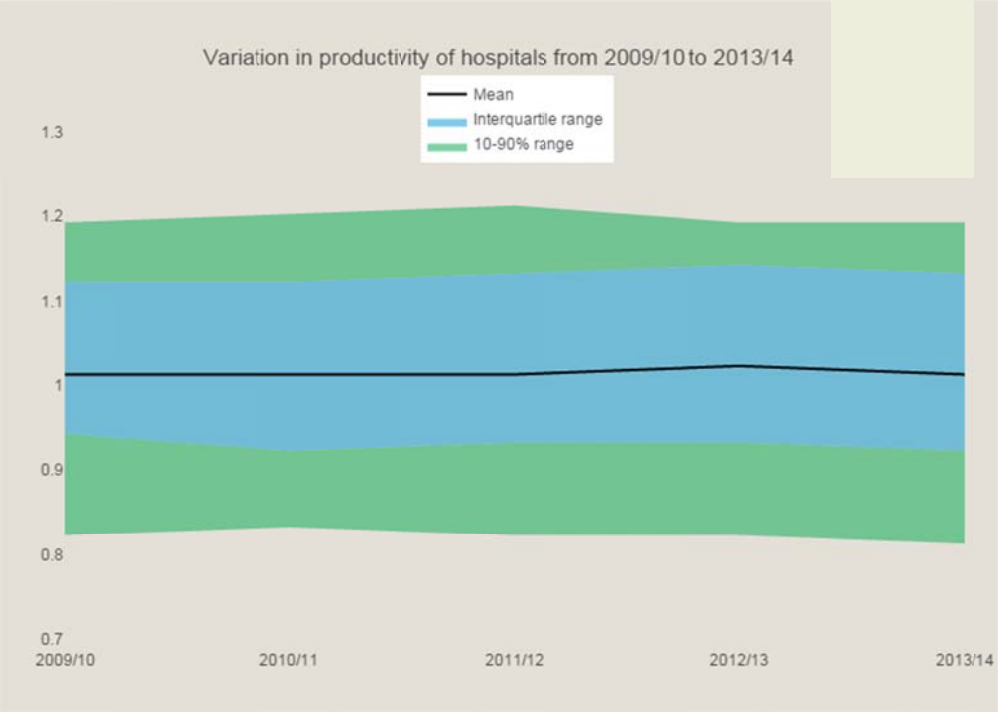
5. Productivity

5.1. The NHS in England, as shown in NHS England's *Five Year Forward View*, needs to make 2-3% of efficiency savings per year by 2020/21 to close the £22bn gap between resources and patient need. The NAO in December 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.

5.2. The deterioration in hospitals' finances is mirrored by declining productivity for acute and specialist hospital care. NHS hospitals did improve their efficiency over the last parliament but our analysis shows that the rate of efficiency improvement averaged just 0.4% a year; productivity increased by 0.4% and 2.8% in 2010/11 and 2012 respectively, but fell by nearly 1% in 2012/13 and in 2013/14. The 0.4% average per year is substantially below previous estimates of efficiency improvement, which did not take into account the additional cost pressures in 2013/14.

5.3. The NHS has been seeking to stimulate less efficient organisations to match the efficiency of the best. Our analysis shows that the relative efficiency and productivity performance of individual hospitals has changed very little over the last five years. Eighty-one per cent of the hospitals that were above or below average in 2009/10 stayed above or below average in 2013/14. For example, in the chart below hospitals in the 90th percentile of the productivity index range remained around 1.2 and the 10th percentile remained around 0.8. Similarly, the upper quartile of the productivity index range increased from 1.12 in 2009/10 to 1.13 in 2013/14, while the lower quartile fell from 0.94 in 2009/10 to 0.92 in 2013/14. Significant variations of productivity between trusts suggest that potential savings could be achieved if the poorer performers caught up with the best performing trusts.

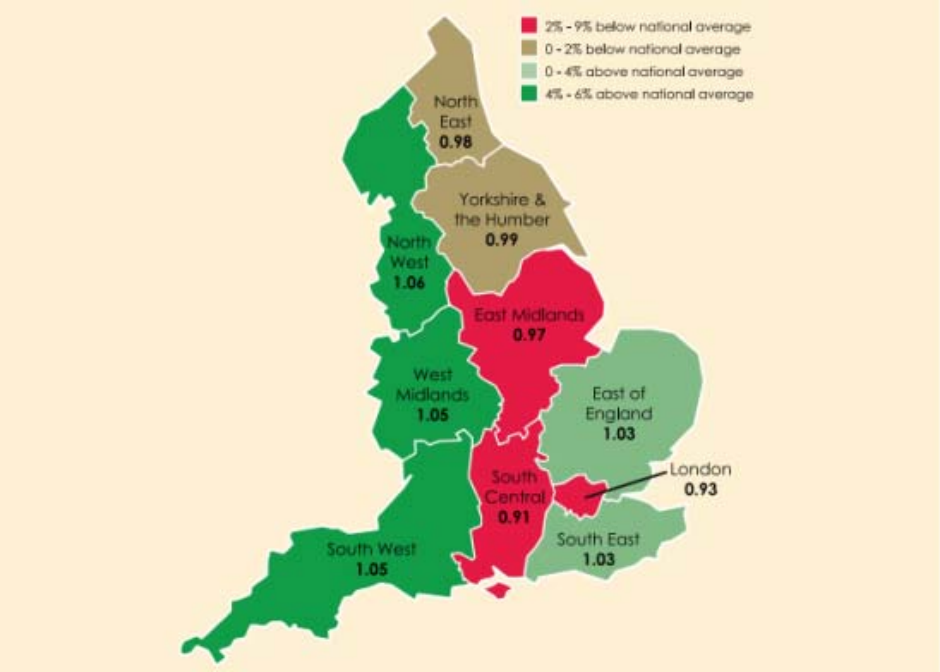
Variation in productivity of hospitals from 2009/10 to 2013/14



5.4. When comparing productivity by size of hospital, we found that small acute trusts were more productive than large and medium acute trusts. In fact, small trusts were 3% more productive than the average, while medium and large trusts were less productive.

5.5. The chart below shows the average hospital productivity by region in England. The results show that London was relatively less productive compared to the national average, and that London, the North East, South Central and the East Midlands were the least productive regions; the most productive regions were the West Midlands, the South West and the North West. The two areas with the largest deficit, the East Midlands and the North East, are both less productive than the national average (3% and 2% below average respectively).

Average hospital productivity by region in England, 2013/14



5.6. 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.

5.7. In a joint report with The King's Fund in July last year, *Making change possible: a Transformation Fund for the NHS*, we argued that the NHS needs a new approach to change if it is to achieve efficiency savings of 2% per year to bridge the funding gap. New models of care in the NHS present opportunities to achieve greater value for money by integrating parts of the health and social care system, but as the NAO suggest these models are untested and it is not clear when the savings can be realised.

5.8. Our joint report with The King's Fund made the case pooling existing disparate strands of funding set aside for transformation into one pooled fund – a Transformation Fund. We argued that a dedicated Transformation Fund of £1.5–2.1bn a year - over and above the existing financial settlement - between now and 2020/21 could be used in two phases. The first phase would focus on achieving

higher rates of efficiency growth across all services, which would then be followed by investment to test new models of care. The second phase would then focus on the 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.

5.9. The government in December announced a £1.8bn Sustainability and Transformation Fund. To be access the fund NHS organisations – including both providers and commissioners – will need to meet strict conditions, which include jointly produced sustainability and transformation plans for October 2015 to March 2021. The need for each NHS organisation within a local area to jointly produce these plans is a positive sign and potentially a shift away from the accountability regime described above. However, as our evidence describes there are significant variations in productivity across the country and there is a concern that the funding announced will simply be used to bailout providers without providing the practical support and expertise needed to make service changes that have the potential to translate into recurrent efficiencies.

5.10. In our view, transformative change in the NHS – including a drive for efficiencies – requires strong, expert leadership which is credible to clinicians and managers. A Transformation Fund, properly resourced, would support investment in four key areas essential for successful transformation, these are: staff time, programme infrastructure, physical infrastructure and double-running costs.

6. Conclusion

6.1. In conclusion, the NHS faces five more years of austerity; the challenge is, if anything, greater for the coming five years than it was for the last. Improving productivity and efficiency is critical, but as yet there is no national plan for this. 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 for transformation. However, the NHS cannot do this all on its own. To unlock system efficiencies requires strong public health and social care too.

Sources

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