# NHS funding and efficiency savings

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Executive summary

The Five Year Forward View estimates that the NHS in England is heading for a mismatch between resources and patient needs of nearly £30 billion a year by 2020/21. It suggests that to close the gap, the NHS needs to achieve efficiency gains of 2 per cent to 3 per cent each year combined with staged funding increases close to ‘flat real per person’. This has been interpreted as a funding increase of £8 billion and annual efficiency savings of £22 billion. The Five Year Forward View maintains that this level of efficiency savings is achievable if action is taken on prevention, there is investment in new care models and social care services are sustained.

Since the Comprehensive Spending Review in November 2015 there have been a number of announcements about what healthcare funding will look like over the next five years. This briefing explains these announcements and analyses their implications.

Key points

– The £10 billion increase in NHS spending by 2020/21 initially seemed a very generous settlement for the NHS. However, the Nuffield Trust, The Health Foundation and The King’s Fund have calculated that total health spending in England will rise by only £4.5 billion in real terms between 2015/16 and 2020/21. This puts the NHS half way through the most austere decade in its history, with public spending on health as a proportion of GDP falling to 6.7 per cent by 2020/21.

– The £4.5 billion real increase in health spending is far less than the £8 billion of extra funding called for by the Five Year Forward View. This is further exacerbated by the provider sector deficit and the fact that the funding increase is also expected to cover the transition to a seven-day NHS. The Government has yet to acknowledge this or come up with credible proposals for how the funding gap will be filled.

– Recent funding announcements in technology, mental health and general practice are confusing and, when analysed in more detail, seem to be a case of re-assigning money that had already been announced. We call for greater transparency to accompany future funding announcements, particularly around where funding will be taken from as well as how and when it will be distributed.

– In 2016/17 there is a lack of available funding for transformation. The investment needed to achieve the vision and scale of efficiency savings set out in the Five Year Forward View will be pushed back to 2017/18 onwards, where there are much smaller increases to NHS funding. It is difficult to see how the NHS will be able to make real progress on transformation in the short to medium term.

– As NHS provider deficits continue to increase we remain concerned that even more money will be diverted from transformation to help reach financial balance.

– There is still no credible plan for the majority of the £22 billion efficiency savings that the NHS needs to make by 2020/21. Even if we assume that all the measures the Government has announced so far achieve the savings predicted and generate no additional costs, which seems unlikely, this only results in £6.5 billion of savings for the NHS.

– The measures used by the NHS to achieve efficiency savings over the last Parliament are no longer viable. The NHS needs to come up with an alternative plan to achieve sustainable efficiency savings on this scale, without this taking priority over the need to maintain patient safety, clinical quality and consistently improve performance.

– This Government has funded the increase to NHS funding by making cuts to Department of Health spend outside of NHS England. This includes cuts to budgets for public health, education and training, capital spend and national bodies such as NICE (National Institute for Health and Care Excellence). Spending in these areas is being cut by more than £3 billion over the next five years. There is very little information on how this decrease in spending will be managed.

– The Government’s decision to cut spending outside of NHS England’s budget is incredibly shortsighted. Budget cuts in all of these areas will result in increased costs for the NHS and the taxpayer in the future. Once again, the announcements in this area were not transparent. By referring to what most would consider to be core NHS services, health visiting, drug and alcohol services and sexual health services, as ‘Whitehall budgets’, the Government has not set out the true extent of the funding cuts.

– Another route for the NHS to save money would be to look more widely at the efficiency of care across the system and, in particular, at the scope to moderate pressures on the system as a result of improved population health. However, the Spending Review revealed a cut to public health budgets of 3.9 per cent a year. It is very unclear how this fits with the Five Year Forward View’s call for ‘a radical upgrade in prevention and public health’. 
NHS England has repeatedly made it clear that a lack of investment in social care will have a significant impact on the NHS. Yet the social care funding gap is likely to be somewhere between £2.8 billion and £3.5 billion by the end of the Parliament, with spending on social care as a proportion of GDP at 0.9 per cent. The lack of clarity around recent changes to social care funding means there is still a great deal of uncertainty about what social care funding will look like over the next five years.

The shift towards a social care system based on locally-raised revenue emphasises the growing difference in how health and social care are funded, despite the Government’s commitment to join up health and social care across the country by 2020.

Combined spending on health and social care is predicted to be 7.6 per cent as a proportion of GDP by 2020/21, far below the proposal in the Barker Report that there is a ringfenced budget for both health and social care that represents 11 per cent to 12 per cent of GDP.
1. ‘NHS funding’

In November 2015, the Spending Review announced a £10 billion real terms increase in ‘NHS funding’ in England between 2014/15 and 2020/21, stating that this ‘fully funds the NHS’s own Five Year Forward View’. This section of the briefing evaluates this claim, as well as some other recent funding announcements where it is somewhat unclear where the money is coming from and how it will be distributed.

£10 billion NHS funding increase

The £10 billion increase initially seemed a very generous settlement for the NHS, and £2 billion more than the £8 billion that NHS England had asked for. However, the settlement is not quite as it seems. Firstly, the £10 billion is measured against an out-of-date baseline: NHS England’s spend for 2014/15. £2 billion of the £10 billion had already been announced in the Autumn Statement 2014 so the Spending Review itself only revealed an £8 billion real terms increase by 2020/21.

Secondly, as shown in an analysis by the Nuffield Trust, The Health Foundation and The King’s Fund, the Spending Review defines NHS funding as just NHS England’s budget, whereas previous governments have defined NHS funding as the whole Department of Health budget. That means that public health, education and training, capital spend and national bodies such as NICE, described by the Chancellor as “Whitehall” budgets, now fall outside of NHS spending.

This allows the Government to fund the increase to NHS funding by making cuts to Department of Health spend outside of NHS England. In fact, more than £3 billion of the extra NHS funding is funded through real terms cuts to the Department of Health budget by 2020/21. Table 1 sets out health spending over the next five years.

Table 1: Department of Health and NHS England funding 2015/16 to 2020/21

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<thead>
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<th>£ billion (2015/16 prices)</th>
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<tr>
<td>NHS England (±change)</td>
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<tr>
<td></td>
<td>101.3</td>
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<td>Other Department of</td>
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<td>Health (±change)</td>
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<td>Health DEL* (±change)</td>
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* Departmental Expenditure Limit – the total budget allocated to the Department of Health

The calculations by the Nuffield Trust, The Health Foundation and The King’s Fund show that when the previous definition of NHS funding is used, total health spending in England will rise by only £4.5 billion in real terms between 2015/16 and 2020/21, with an average annual increase of 0.9 per cent in real terms. This compares to an average annual increase of 3.7 per cent since the NHS was established, which puts the NHS half way through the most austere decade in its history. Public spending on health as a proportion of GDP will fall to 6.7 per cent by 2020/21, leaving us behind many advanced nations on this measure of spending.

All figures are expressed in real terms using 2015/16 prices and using the HM Treasury GDP deflators at market prices, and money GDP: November 2015 (the Autumn Statement). This will be used throughout the paper. The Spending Review used 2020/21 prices to estimate spending which results in higher forecasted spending in future years.
This is far less than the £8 billion that the Five Year Forward View suggests is necessary to close the £30 billion funding gap, which is even more worrying when you take into account that the estimates in the Five Year Forward View are predicated on the NHS starting from a balanced budget. In reality, provider deficits are expected to reach over £2 billion by the end of 2015/16.  

Seven-day services
The Government has been explicit that the NHS funding increase must also be used to transform the NHS into a seven-day service, something that was not factored into the Five Year Forward View calculations. Research by the Healthcare Financial Management Association (HFMA) shows that implementing seven-day services would cost up to 2 per cent of a hospital trust’s total income, up to £1.4 billion extra annually across the NHS. However, this research was based on a sample of only eight NHS trusts that were not necessarily representative. There is a significant likelihood that the 2 per cent figure quoted underestimates the true cost of a seven-day service.

It is unclear how the Government has factored in this additional funding pressure into either their budget or their expectation that the NHS will achieve £22 billion of annual efficiency savings by 2020/21.

Technology
The Spending Review announced that the Government would invest £1 billion in technology over the next five years. Yet three months later, in February 2016, Jeremy Hunt announced that there would be £4.2 billion invested in NHS technology by 2020/21 including £1.8 billion earmarked to create a “paper free NHS”. Of the £1.8 billion, £900 million is expected to come from capital funding and £400 million from the Sustainability and Transformation Fund. We are still awaiting more details about this funding but it certainly appears to be a case of the Government reassigning money already announced.

Mental health
The Spending Review commits to investing an additional £600 million in mental health services. In February 2016, following the publication of the final report by the Mental Health Taskforce, NHS England committed to £1 billion a year additional funding for mental health by 2020/21. We are pleased to see this commitment as we have long been concerned about the underfunding of mental health and have repeatedly called for the funding for mental health services to reflect parity of esteem with physical health services. However, once again it is unclear where this money is coming from and how it will be distributed.

NHS England has included a parity of esteem commitment in their commissioning allocations, where commissioners are held to account for ‘allocating growth in funding to mental health at a rate at least in line with general growth in their allocation’. It is unclear whether this is separate or included in the £1 billion annual funding increase.

The Government’s repeated cuts to public health budgets and continued pressures on social care, covered in sections 4 and 5 of this briefing, cast doubts on their commitment to support mental health before it reaches crisis point. As the Mental Health Policy Group put it, ‘We are simply not investing enough in preventing mental health problems in the first place, leaving people to become more unwell and in need of more long-term and costly treatment’.

General practice
The Spending Review announced £750 million of investment in general practice to ‘access GP services in the evenings and at weekends with an extra 5,000 doctors’. It is not clear but it seems likely that this is the remaining money from the £1 billion Primary Care Transformation (formerly Infrastructure) Fund announced in the Autumn Statement 2014 rather than a new commitment.

When the fund was originally announced its purpose was to make improvements in general practice premises and technology. This was welcomed by the BMA following years of underinvestment in GP surgery buildings. A BMA survey found that four out of 10 GP practices said that inadequate facilities stopped them providing even basic care. However, there have been repeated reports of delays in this funding going to practices and over a fifth of the first tranche was diverted to other purposes. This included:

- £10 million for the GP workforce 10-point plan;
- £5 million to pilot clinical pharmacists in general practice;
— £7.5 million for community pharmacy access to summary care records;
— £25.5 million for IT interoperability in the Prime Minister’s Challenge Fund pilots; and
— £10 million targeted support for struggling practices in special measures.17

Whilst some of these are undoubtedly important aims we do not think that the right approach for tackling
the crisis in general practice is to take money previously committed to much-needed improvements in GP
infrastructure to dogmatically pursue increased access in the evenings and weekends.

Similarly, while we support the Government’s effort to recruit extra GPs there is no sign that the
Government will be able to use the funding effectively to fulfil its pledge to recruit 5,000 extra GPs. The
latest figures on applications for 2016 GP training places were 5 per cent lower than last year;18 when one in
10 trainee posts in England were left unfilled. We believe that the right way to increase recruitment figures
would be to begin a sustained programme of investment into general practice that gives GP services the
ability to cope with rising patient demand, making general practice a more attractive career option for
medical graduates.

On what appears to be a more positive note, NHS England has increased primary care commissioning
allocations by 2 per cent or more in real terms each year from 2016/17 to 2020/21. Figure 1 gives an
overview of primary care commissioning spend over the next five years.19

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<td>£ billion</td>
<td>£7.3bn</td>
<td>£7.5bn</td>
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<td>£8.1bn</td>
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In 2016/17, this means a cash increase of £310 million for general practice. In February 2016, revisions
to the GMS contract in England for 2016/17 were announced, with an investment of £220 million. NHS
England has been clear that this is ‘only one small element of a far wider package’20 yet there is only £90
million left within the allocation for 2016/17 to provide the rest of the package, which suggests that even
more money might end up being diverted from the Primary Care Transformation Fund.

Moreover, expenses for GPs working under either a GMS or PMS contract increased by £185 million across
the UK from 2012/13 to 2013/1421 (the last available year of data). In 2016/17 there are known new
expenses for practices to fund, in addition to the usual increase in running costs. Therefore, most of the
additional money will be spent on expenses with little left to relieve the pressures on primary care.

In addition, it should not be forgotten that many GP practices face significant reductions in their baseline
funding through further cuts to core GMS and PMS funding in 2016/17, and the £310 million overall
increase will not cover these major losses for individual practices.
Conclusion
The £4.5 billion real increase in health spending between 2015/16 and 2020/21 is far less than the extra funding called for by the Five Year Forward View. Even if the full £8 billion were made available, this would require an unprecedented level of efficiency savings to be made by the NHS in England over the next five years, and for which no credible plan currently exists. The situation is further exacerbated by the fact that the provider sector deficit is expected to reach over £2 billion by the end of 2015/16 and that the funding increase is also expected to cover the transition to a seven-day NHS. The Government has yet to acknowledge this or come up with credible proposals for how the funding gap will be filled.

Moreover, the recent funding announcements in technology, mental health and general practice are confusing and when analysed in more detail, seem to be a case of the Government re-assigning money that had already been announced. We call for greater transparency to accompany future funding announcements, particularly around where funding will be taken from as well as how and when it will be distributed.
2. Transformation

Of the £10 billion annual increase to NHS England’s budget by 2020/21, as announced in the Spending Review, £6 billion will have been delivered by 2016/17 (£2 billion in 2015/16, £3.8 billion in 2016/17). This frontloaded funding is intended to ‘give the NHS the platform to begin delivering the vision set out in the Five Year Forward View’. This section of the briefing explores whether the structure of the funding and the conditions for access allow it to do this.

2015/16

Of the £2 billion additional investment in 2015/16, £480 million was committed to supporting transformation in primary care, mental health and local health economies. This included £200 million for the new care model ‘vanguards’, £250 million for the Primary Care Infrastructure Fund and £30 million to increase investment in mental health. However, NHS England has so far only published details of how £61 million of the £200 million allocated to the new care model vanguards has been spent. Similarly, there have been repeated reports of delays in the Primary Care Infrastructure Fund going to practices and we know that over a fifth of the tranche was diverted to other purposes.

Sustainability and Transformation Fund

From 2016/17 onwards, funding for transformation will come through a Sustainability and Transformation Fund: £2.1 billion of the £3.8 billion announced for 2016/17 is committed to this fund. The sustainability element, intended to bring the provider trust sector back to financial balance, has been allocated £1.8 billion; whereas the transformation element, intended to support new models of care and implement policy commitments like seven-day services, GP access, mental health and prevention, has only been allocated £339 million.

Over the next five years the amount allocated to the fund will increase, reaching £3.4 billion by 2020/21. We do not yet know the details of how this will be split in future years but NHS England has said that the ratio between sustainability and transformation will change as the provider sector comes out of deficit. Therefore, in theory, there should be a greater amount available in future years for transformation and new policy commitments. Figure 2 shows how the Sustainability and Transformation Fund develops over the next five years.

Figure 2: Sustainability and Transformation Fund 2015/16 to 2020/21
The Government and NHS England have made it clear that the focus for 2016/17 is to return the system to financial balance. However, this means that there is a real risk that there will be a lack of available funding for transformation in 2016/17. Returning to financial balance is undoubtedly an important goal but it means that the activity needed to achieve the vision set out in the Five Year Forward View will be pushed back to 2017/18 onwards, where there are much smaller increases to NHS funding. In addition, we assume that any delay in providers reaching financial balance will mean reduced resources to support transformation.

In ‘Health and social care priorities for the Government: 2015-2020’ the Nuffield Trust argues that, rather than forcing trusts to resort to drastic measures to achieve financial balance, it would support a more managed transition to achieving financial balance over the next two to three financial years. This would allow for faster progress on transformation than is currently possible.

The £1.8 billion ringfenced for sustainability in 2016/17 will be allocated depending on hospitals meeting a series of strict conditions. All allocations must be agreed in advance with both HM Treasury and the Department of Health. As The King’s Fund put it, the front-loaded funding comes with strings attached. The need for approval from HM Treasury shows both an increase in central control and a deliberate move away from the financial independence promoted in the Health and Social Care Act 2012.

In addition, the way that the fund is set up for 2016/17 favours providers of acute emergency care. The acute sector has the largest deficits so this makes sense within the context of reaching financial balance but it seems to go against the ultimate strategy of investing in out-of-hospital services.

Looking further forward, the way that the fund is set up from 2017/18 onwards does seem more compatible with transforming services towards the vision set out in the Five Year Forward View. From 2017, access to transformation funding is dependent on new sustainability and transformation plans: place-based, five-year plans that should encompass all CCG and NHS England commissioned activity, as well as ‘better integration with local authority services, including, but not limited to, prevention and social care’.

**Conclusion**

The tight regulations surrounding the increased funding and the strong focus on sustainability, for the first year (2016/17) at least, make it difficult to see how the NHS will be able to make real progress on transformation in the short to medium term. It is certainly not clear how the front-loaded funding can help the NHS to begin delivering the vision set out in the Five Year Forward View. Moreover, as NHS provider deficits continue to increase we remain concerned that even more money will be diverted from transformation to help reach financial balance.

The King’s Fund has put it simply: ‘The Government’s commitment is the bare minimum needed to continue to meet patients’ needs and maintain standards of care. It will not pay for new staff, the upfront costs of essential changes to services or new initiatives such as the Government’s pledge to implement 7-day working across the NHS.’
3. Efficiency savings

The NHS has been tasked with achieving £22 billion annual efficiency savings by 2020/21. Achieving savings on this scale would be unprecedented and, whilst there is no doubt that there are further efficiencies to be found within the NHS, it is important that they are achieved in a safe and sustainable way. This section of the briefing explores and evaluates the various initiatives that the Government and NHS England are pursuing to increase NHS efficiency.

NHS payment system

In 2016/17, the financial priority for the NHS is to bring the provider sector back to financial balance. Based on current financial performance, providers are forecasting a 2015/16 year-end net deficit of £2.4 billion to £2.8 billion.

In very simplistic terms, the deterioration in NHS provider finances is the result of their operating costs rising more rapidly than the income they receive. In 2014/15, total operating costs rose by 2.2 per cent while total income rose by 2.0 per cent. NHS hospital income is largely determined by the NHS national tariff. In recent years, a contributor to the limit on hospital income has been the inclusion of an ‘efficiency factor’ in the tariff. This required trusts to make cost savings of 4 per cent (2011/12 to 2014/15) and 3.5 per cent (2015/16), which they have struggled to keep up with. Figures from Monitor show that in 2013/14 NHS foundation trusts managed 3 per cent and in 2014/15 only 2.7 per cent. Given this, it is not surprising that significant deficits have been building up.

We have consistently warned that setting efficiency factors at this level was unsustainable. In the most recent NHS Providers financial sustainability survey, an unrealistic efficiency factor was judged the biggest challenge to achieving financial balance. NHS England and Monitor seem to have recognised that this policy has not been entirely successful and, in the 2016/17 tariff proposal, they have reduced the efficiency factor to 2 per cent and included a 3.1 per cent inflation uplift. It will be the first time that tariff prices have risen in real terms since 2011.

However, this is predicated on the provider sector having a deficit of no more than £1.8 billion by the end of 2015/16. If any provider falls short of their expected position they will be expected to deliver additional efficiencies. Given the current state of provider finances it seems increasingly unlikely that this target will be met, which suggests that at least some providers will be required to continue to meet efficiency savings of over 2 per cent. Therefore, we remain concerned that providers will need to make blanket efficiency savings beyond those they can afford.

In addition, it remains unclear whether the £5 billion of savings outlined in Lord Carter’s report, discussed in the next section, are in addition to the savings that trusts will have to make through their normal course of business — i.e. the efficiency factor. It is important for trusts’ financial planning that these details are made clear as early as possible.

Carter report

One of the most publicised initiatives to achieve efficiency savings is Lord Carter’s report into operational productivity and performance in English NHS acute hospitals. It was published in February 2016 and includes 15 recommendations to save the NHS £5 billion per year by 2020 through reducing unwarranted variation in acute hospitals. The recommendations focus on optimising the use of clinical staff and medicines, as well as improving procurement and estate management. One way that it suggests doing this is through creating a model hospital, which will help trusts understand ‘what good looks like’. Lord Carter makes it clear that a significant proportion of these savings ‘cannot be unlocked unless delays in transfer are managed more effectively’.

In general, the recommendations in the report seem to focus on areas where there is potential for greater productivity but a number of them require a great deal of further work and it is hard to measure at this time how successfully they will be implemented. There is little evidence that the method of reducing variation by making everybody as good as the top performers has ever been successful. For example, this has underpinned the approach to setting prices for care over recent years, but variation in productivity among acute trusts has changed little from 2009/10 to 2014/15.
Charges for overseas visitors and migrants

The Department of Health has introduced some regulatory changes aimed at making further efficiency savings. These include the option of further extending charges for overseas visitors and migrants who use the NHS, which is expected to save £500 million per year by 2017/18.\(^{40}\) The BMA is concerned that these changes could end up generating more costs than savings. Not only is it likely to cause confusion among patients, it will also require GPs and hospital doctors to spend more time on the paperwork and bureaucracy needed to regulate charges. Most importantly, no patient with a serious health need should be deterred from seeing a doctor, especially if their condition poses a public health risk.

Agency staff spending

There has been a clampdown on the money spent on agency staff, which NHS Improvement has predicted will save £1 billion by 2018.\(^{41}\) However, 55 per cent of trusts have expressed concern that they will not be able to meet new nationally-imposed caps on agency staff spending and 22 per cent of NHS trust finance directors have said that the controls would affect their ability to ensure safe staffing levels, with a further 35 per cent unsure of the impact.\(^{42}\) We agree that the over-reliance on agency staff strains trusts’ resources and is not an effective way to manage the workforce but we are concerned that these measures will have a detrimental impact on quality.

It is of crucial importance that financial objectives do not take priority over the need to maintain patient safety, clinical quality and consistently improve performance. This year, for the first time, a majority (53 per cent) of trust finance directors reported that the quality of care in their local area had worsened.\(^{43}\) Given that staff costs are by far the biggest area of spending for NHS providers, it seems unlikely that trusts will be able to balance budgets without reducing headcounts to some extent. The events in Mid Staffordshire should serve as a constant reminder of what can happen when financial considerations take precedence.\(^{44}\)

We believe that the safest and most effective way to reduce reliance on high-cost agency staff is through long-term workforce planning that improves and promotes substantive employment in the NHS. A recent report by the National Audit Office found that local workforce plans often underestimate the workforce needed, as they are driven by financial constraints rather than staffing needs.\(^{45}\)

Quality, Innovation, Productivity and Prevention (QIPP) initiative

The majority of the £20 billion efficiency savings delivered during the 2010-15 Parliament were through a combination of pay restraint, cuts to central budgets, cuts to the payment tariff and removing regional and local tiers of management following the Health and Social Care Act 2012.\(^{46}\) In its first two years — 2011/12 and 2012/13 — the biggest area of savings came from tariff efficiency, which amounted to savings of £4.8 billion over the two years. The second largest element of savings was from a staff pay freeze, and totalled £1.7 billion from the NHS budget over both years.\(^{47}\)

The implications of repeated unsustainable tariff costs is discussed earlier in this briefing but it is equally important that going forward there are not continuing limits on staff pay. The NHS Staff Survey shows that NHS staff morale is falling and stress is increasing, with 38 per cent of staff suffering from work-related stress in 2014.\(^{48}\) The Five Year Forward View is explicit that NHS pay needs to increase in line with private sector wages in order to recruit and retain staff.

It is also important to note that the savings made through QIPP decreased each year. In 2014/15, savings were only £1.8 billion, less than half the savings in each of the previous three years. This indicates that the amount of savings that can be extracted from these approaches is coming to an end and the NHS needs to come up with an alternative plan to achieve sustainable efficiency savings on this scale.
Conclusion
Even if we assume that all the measures described above achieve the savings predicted and generate no additional costs, which seems unlikely, this would only result in £6.5 billion of annual efficiency savings for the NHS. There is still no credible plan for the remaining £15.5 billion of efficiency savings that the NHS needs to make by 2020/21.

In their analysis of hospital finances and productivity, the Nuffield Trust argue that if the NHS is to come close to achieving the efficiency savings required in a safe manner then it needs to make rapid progress on new models of care. Therefore, it seems that another potential effect of delaying transformation is that the NHS will be prevented from making radical new inroads into productivity and, ultimately, from meeting the aim of achieving £22 billion of efficiency savings a year by 2020/21.

Another route for the NHS to save money would be to look more widely at the efficiency of care across the system and, in particular, at the scope to moderate pressures on the system from improved population health. Given this, we would expect there to be increased funding for public health and yet, as the next section sets out, the reality is quite the opposite.

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ii This is calculated by adding up the savings that the Government predicts will be made through the initiatives described in this briefing: £5 million annual savings from the recommendations in the Carter report, £1 billion from the clampdown of agency spending and £500 million from extending NHS charges for overseas visitors and migrants.
4. ‘Non-NHS funding’

For the purpose of this briefing any funding that falls outside of NHS England’s budget is referred to as ‘non-NHS funding’. This is in order to be consistent with the Government’s use of ‘NHS funding’ in the Spending Review to refer to just NHS England’s budget. The areas discussed in this section still come under the Department of Health and we would consider them part of the NHS. Funding that comes under this category includes public health, education and training, capital and national bodies such as NICE.

Non-NHS spending is being cut by more than £3 billion over the next five years. The cuts begin immediately, with a £1.7 billion decrease in the Department of Health’s budget outside of NHS England for 2016/17. There seems to be very little information at the moment for how this decrease in spending will be managed and we have a number of serious concerns.

Public health

The Spending Review revealed a cut to public health budgets of 3.9 per cent a year. This is in addition to the 2015/16 in-year cut of 6.2 per cent to local authorities’ public health grant, which has been described as ‘the falsest of false economies’. Public health funding is already stretched to the limit and these further cuts mean that local authorities will struggle to fulfil even their statutory responsibilities, let alone provide additional services that will improve population health.

The swingeing cuts to the public health budget are at odds with the Government’s expressed commitment to protect and invest in public health services. Cuts to the public health grant will inevitably lead to service reduction and will, in the longer term, result in greater costs for both the NHS and the taxpayer. Coupled with the reduction in Public Health England’s budget by £65 million in 2015/16, it seems clear that the Government is not serious about investing in public health.

It is very unclear how this fits with the claim that the Spending Review fully funds the Five Year Forward View, which explicitly calls for ‘a radical upgrade in prevention and public health’. In a recent board paper, NHS England is clear that moderating demand growth is ‘dependent on effective government action on prevention and sustained availability of social care relative to rising need. If either of these preconditions to fulfilling the Forward View is not met, it will place additional unfunded pressures on the NHS over the period to 2020/21’.

The Department of Health has since released the Local Authority Circular detailing the public health grant for 2016/17 and 2017/18. Table 2 gives an overview of public health spending over the next five years.

### Table 2: Public health spending 2015/16 to 2020/21

<table>
<thead>
<tr>
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<th>£ million (2015/16 prices)</th>
<th>£ million (2015/16 prices)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public health grant allocation</strong></td>
<td>3,465</td>
<td>3,331</td>
</tr>
<tr>
<td>% change</td>
<td>-3.9%</td>
<td>-4.2%</td>
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The Circular confirms that the Government has only committed to the ring-fenced public health grant continuing for two more years. Following this, the Government is planning to consult on options for fully funding local authorities’ public health spending from their retained business rates receipts. This would leave it up to local authorities to decide the appropriate amount to spend. Given the pressures local authorities currently face we are concerned that there will be a strong temptation to cut even further. We believe that it is essential for the ring-fence on public health spending to be maintained beyond 2017/18 and that the grant grows adequately year on year rather than facing repeated cuts.
Section 5 sets out potential consequences of linking funding to locally based revenue as well as describing the pressures social care is facing in more detail.

**Education and training**

Another consequence of the cuts to non-NHS budgets is that HEE (Health Education England) is expecting their budget to remain static in real terms from now until 2020/21.54 70 per cent of HEE’s budget currently goes on subsidising the salaries of doctors in training. This decision will only increase the pressure on hospitals, which would presumably have to cover any decrease in funding themselves.

HEE are also responsible for training allied health care professionals and healthcare support workers. Skills within these groups are integral to the vision of new models of care and new ways of working. The NHS has a history of basing their workforce plans on existing staffing models and roles rather than what is needed to respond to the changing way services are being delivered.55 This seems another example of the Government ‘plundering a budget that could be used to facilitate but is not, because, unfortunately, the NHS’s history on workforce planning and the imaginative thinking required to do that sort of thing is very poor’.56

Returner schemes are also paid for by HEE and, given the serious recruitment and retention problems in the NHS at present, the decision to not prioritise this may have serious implications.

**Capital spending**

The Spending Review maintains capital spending at £4.8 billion until 2020/21, which represents a significant real-terms reduction over the period. The NHS Planning Guidance is explicit about what this will mean – it explains that there are limited levels of financing available and so the repayment of existing and new borrowing will need to be funded from within trusts’ own internally generated capital resources in most cases.57 This position is likely to continue to exacerbate affordability problems within the NHS in both the short- and the long-term.

In the short-term, private finance initiatives (PFI) will continue to be relied on, putting increasing financial pressure on already stretched providers. The Treasury Select Committee has judged that it does ‘not believe that PFI can be relied upon to provide good value for money without substantial reform’.58 In the long-term, reducing capital investment will mean less money is spent on developing buildings and equipment to make them appropriate for modern health care. This is likely to have an impact on quality and will not be a sustainable strategy when maintained over a number of years.

**Conclusion**

The Government’s decision to cut spending outside of NHS England’s budget is incredibly shortsighted. Budget cuts in all of these areas will result in increased costs for the NHS and the taxpayer in the future, which will undermine any successful efficiency savings in other areas. The decision also seems to directly contradict the strategy of investing in out-of-hospital services. In particular, reducing public health spending goes against both the vision set out in the Five Year Forward View and the Government’s commitment to preventative health.

Once again, the announcements on non-NHS spending were not transparent. By referring to what most would consider to be core NHS services, health visiting, drug and alcohol services and sexual health services, as “Whitehall budgets”, we believe the Government has not set out the true extent of the funding cuts.
5. Social care funding

Between 2009/10 and 2014/15, funding for the provision of adult social care has fallen in real terms by an average of 2.2 per cent a year, leading to a 25 per cent reduction in the number of people receiving publicly funded social care. NHS England has repeatedly made it clear that a lack of investment in social care will have a significant impact on the NHS.

The Spending Review revealed several changes to social care funding that initially looked quite positive. It increased funding for the Better Care Fund and introduced a new social care precept to fund adult social care. It reduced the local government grant by £6.1 billion by 2019/20 but suggested that this will be compensated for by councils retaining all income from business rates.

However, when looked at in more detail it seems that the Spending Review still leaves social care severely underfunded, particularly in the short-term. This section of the briefing shows how this is the case and also evaluates how these changes are likely to impact healthcare.

Better Care Fund

The Better Care Fund creates a single pooled budget across the NHS and local government to incentivise them to work more closely together in local areas. In 2015/16, the Government committed £3.8 billion to the Better Care Fund. This was not new money but money transferred from NHS allocations and other health funding sources. Many local areas made the decision to pool extra money, which took the total spend to £5.3 billion. In 2016/17, the Better Care Fund will be a minimum of £3.9 billion, again, with the money mainly coming from allocations to CCGs, and the local flexibility to pool more remains.

The Spending Review announced additional funding for the Better Care Fund from 2017/18. We are pleased to see that this appears to be genuinely new money rather than money transferred from the NHS. However, the money only starts to come through from 2017/18 whereas there is an urgent crisis in social care funding now. In addition, there is very little information about when this money will be available. The only detail we have seen is that the additional funding will reach £1.5 billion by 2019/20.

The delay is likely to have significant effects on the NHS. Nine in 10 NHS trust finance directors have said that cuts in local authority social care budgets are adversely affecting NHS services. Lord Carter has been explicit that a significant proportion of the £5 billion efficiency savings he believes can be achieved will not be unlocked if delays in the transfer of care are not managed more effectively.

It is also important to note that there is still little evidence that the Better Care Fund has been successful. It is proposed as a mechanism to encourage health and social care to work more closely together planning and delivering services in local areas but in reality it is primarily used to prop up depleted social care budgets. It has helped lessen the impact of social care cuts but at the expense of placing further pressure on already stretched NHS budgets.

Social care precept

The Spending Review announced a new social care precept that enables local authorities to increase Council Tax by up to 2 per cent a year to help fund adult social care. This is being presented as a flexible way for local councils to raise resources to meet the increasing demands on social care. However, the IFS (Institute for Fiscal Studies) has estimated that this mechanism would raise £1.7 billion if used in full and would also need to cover the cost of the new national living wage, which is estimated to be £1.4 billion by 2020. In addition, the impact will vary significantly between councils and is likely to disadvantage deprived areas who will be able to raise less income.

The House of Commons Treasury Committee has asked the Government to ‘explain how it intends to ensure that all English local authorities have the resources and flexibility to respond to their statutory obligations in social care’. It has also suggested that, ‘unless there is a compelling reason why funding needs should grow in line with the council tax base in each local authority, the social care precept is not a sustainable or equitable way of financing social care in the long term’.
Local government funding
The Spending Review announced a cut to central funding for local government grants of £6.1 billion by 2019/20. This is intended to be replaced by an increase in locally-raised revenue, through councils retaining all income from business rates by the end of this Parliament. However, there is very little information at this point about how this will work and the Government has indicated it will consult on how these changes are implemented.

The shift towards a social care system based on locally-raised revenue emphasises the growing difference in how health and social care are funded. As the NHS seems to move back towards centralised control, social care is becoming increasingly reliant on locally based revenue. Despite the rhetoric around integration and the Government’s commitment to join up health and social care across the country by 2020, the extent of the cuts outside of the NHS ring-fence create a powerful disincentive to the NHS to share its resources.67

Conclusion
The lack of clarity around the changes to social care funding means there is still uncertainty about their impact. The full picture will not become clear until local authorities allocate their budgets for 2016/17 but it has been estimated that the social care funding gap is likely to be somewhere between £2.8 billion and £3.5 billion by the end of the Parliament, with spending on social care as a proportion of GDP at 0.9 per cent.68 This will undoubtedly only create further pressure on already stretched NHS resources.

Combined spending on health and social care is predicted to be 7.6 per cent as a proportion of GDP by 2020/21, far below the suggestion in the Barker Report that there is a ring-fenced budget for both health and social care that represents 11 per cent to 12 per cent of GDP.69 Moreover, instead of working towards a more integrated health and care system, the increasing separation in the way that health and social care are funded may continue to deepen the divisions between them.
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