HOUSE OF LORDS

Library Note

Sustainability of the National Health Service as a Public Service Free at the Point of Need
9 July 2015

Founded in 1948, the NHS in England has always been based on the principle of providing quality healthcare, which is free at the point of need. However, over recent years, there have been increasing pressures on the NHS finances, leading to concerns the organisation may face a growing annual funding gap. As such, the NHS has been encouraged to make efficiency savings, increase productivity and improve value for money. The organisation also intends to tackle its financial pressures by taking measures to improve public health, thus reduce spending on treatments and admissions. This Library Note considers some of these issues, providing analysis on current NHS finances and highlighting recommendations on how the service can meet its demands.

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1. Introduction

The NHS was founded in 1948 with the ambition of providing good healthcare for all, which is free at the point of delivery.[1] Initial spending on the NHS in the UK was around 3.5 percent of GDP;[2] today, estimated spending has risen to around 7 percent of GDP.[3] Despite this increase, however, NHS England and Monitor have projected that the NHS in England may experience an annual £30 billion funding gap by 2020.[4] In light of the current public spending conditions, the organisations warned that it would be unwise to rely on increases in funding to bridge the gap. Therefore, they have emphasised the need to improve productivity and efficiency in the service, and use preventative measures to reduce demand. In addition, in their 2014 report on the NHS's finances, the National Audit Office stated that headline figures of financial sustainability had worsened in the NHS over recent years, and expressed concerns about future sustainability if measures were not taken to improve financial management and efficiency.[5] More recently, the King's Fund have also published projections, in advance of the 8 July 2015 Budget, warning that "financial problems are now endemic among NHS providers, with even the most prestigious and well-run hospitals forecasting deficits [this year]".[6]

This Library Note considers some of the issues and recommendations raised by these bodies. Please note that, as health matters are largely devolved in Northern Ireland, Scotland and Wales, this Note focusses principally on the NHS in England (unless specifically stated). However, many of the challenges facing health services are similar across the regions. In addition, the Note focuses on sustainability in its financial context, rather than its environmental context. Further information on environmental sustainability in the NHS (which often does link to financial sustainability) can be found on the Sustainable Development Unit website.[7]

2. Organisation and Objectives of the NHS

2.1 Organisation

Since the Health and Social Care Act 2012 came into force, the commissioning of NHS healthcare in England is now primarily organised through NHS England and regional Clinical Commissioning Groups (CCGs). As noted in a recent briefing by the House of Commons Library, the Act gave:

> [...] General Practitioners and other health professionals responsibility for commissioning the majority of health services, created an independent NHS Commissioning Board (now known as NHS England), and gave local authorities responsibilities for public health and for coordinating local NHS services, social care and health improvement.[8]

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[1] NHS Choices, 'The History of the NHS in England', 24 June 2013.
[2] House of Commons Library, *NHS Funding and Expenditure*, 3 April 2012, SN/SG/724, p 4.
[3] The King's Fund, *The NHS Productivity Challenge: Experience from the Front Line*, May 2014.
[4] Monitor, *Closing the Funding Gap: How to Get Better Value Health Care for Patients*, October 2013, p 1.
[5] National Audit Office, *The Financial Sustainability of NHS Bodies*, 7 November 2014.
[6] The King's Fund, *The Budget: Health and Social Care Funding*, 3 July 2015.
[7] The Sustainable Development Unit is funded by, and accountable to, NHS England and Public Health England.
[8] House of Commons Library, *Structure of the NHS in England*, 1 June 2015, CBP 07206, p 4.

Much of the statutory responsibility for these extended commissioning powers lies with CCGs.[9] There are currently over 200 CCGs in England, and among their responsibilities is commissioning services, which include:

- Urgent and emergency care (such as Accident and Emergency);
- Elective hospital care (including outpatient services); and
- Community health services (such as health visiting and mental health services).[10]

CCGs were introduced on 1 April 2013, and replaced primary care trusts.[11] Responsibility for overseeing CCGs lies with NHS England, the relationship between which can be described as follows:

> NHS England is the body responsible for ensuring that there is an effective and comprehensive system of CCGs. NHS England also provides national leadership on commissioning and allocates funding. It has a duty to publish commissioning guidance, to which CCGs must have regard[.][12]

NHS England also has responsibility for commissioning primary care services (including GP services), and "provides national leadership for improving outcomes and driving up the quality of care".[13] The body is intended to be independent of the Government, and is tasked with delivering the Department of Health's mandate (see section 2.2 of this Note).

A number of regulatory bodies operate within the structure of the health service in England, providing regulation and support to the NHS in pursuit of its mandate. These include:

- The Care Quality Commission—The independent regulator for quality in health and social care in England; the body inspects and rates core health care services.[14]
- Monitor—Acts as the sector regulator for health services in England. Monitor's responsibilities include ensuring the NHS provides quality and value for money, and maintaining essential healthcare services.[15]
- NHS Trust Development Authority—Oversees the performance of NHS trusts, and supports their structure and transition towards Foundation Trusts.[16]

Further information on NHS Trusts and Foundation Trusts can be found on the NHS Choices website, 'NHS in England' (7 January 2015). For details on the organisation of the NHS in Scotland, Wales and Northern Ireland, see the House of Commons Library Note, *Structure of the NHS in England* (1 June 2015, CBP 07206, pp 6–7).

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[9] ibid, pp 8–9.
[10] The specific functions, duties and governance of CCGs are set out in the Health and Social Care Act 2012.
[11] NHS Choices, 'NHS Structure', 7 January 2015.
[12] House of Commons Library, *Structure of the NHS in England*, 1 June 2015, CBP 07206, p 8.
[13] NHS Choices, 'NHS Structure', 7 January 2015.
[14] Further details can be found on the Care Quality Commission website.
[15] GOV.UK, 'Monitor: About Us', accessed 30 June 2015.
[16] House of Commons Library, *Structure of the NHS in England*, 1 June 2015, CBP 07206, pp 12–13.

2.2 Objectives and Priorities

Published in March 2013, the NHS Constitution sets out the rights and values people can expect under the NHS, including those relating to patients/members of the public, and those relating to staff.[17] The document sets out a general vision for the NHS, stating:

> It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science—bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most.[18]

The Constitution also sets out seven key guiding principles of the NHS.[19] In summary, these are:

- The NHS provides a comprehensive service to all (regardless of gender, ethnicity or sexual orientation).
- The NHS is based on need, not the individual's ability to pay. NHS services should be free of charge, subject to certain exceptions as legislated for by Parliament.
- The NHS aspires to the highest standards of excellence and professionalism (the document notes that this should extend to the quality of care and patient experience).
- The NHS aspires to put patients at the centre of all that it does. This includes the promotion of patient choice and individuals' differing needs.
- The NHS should work across organisational boundaries and in partnership with other services or public sector bodies.
- The NHS is committed to providing value for money, efficiency and sustainability.
- The NHS is accountable to the public, communities and patients (this includes an emphasis on transparency).

The document then sets out some key values (including respect, compassion and dignity), and the rights and responsibilities applicable to patients or staff.[20]

The Department of Health also publishes an annual mandate for the NHS, which sets out the overall aims of the organisation each year, and a number of specific objectives. The most recent mandate—published in December 2014, and covering April 2015 to March 2016—stated:

> This mandate plays a vital role in setting out the strategic direction for NHS England and ensuring it is democratically accountable. It is the main basis of ministerial instruction to the NHS, which must be operationally independent and clinically-led. Other than in

[17] Department of Health, *NHS Constitution for England*, 26 March 2013.
[18] ibid, p 2.
[19] ibid, p 3.
[20] ibid, pp 5–15.

> exceptional circumstances, including a general election, it cannot be changed in the course of the year without the agreement of NHS England. The mandate is therefore intended to provide the NHS with much greater stability to plan ahead.[21]

The mandate outlined the control NHS England has over the NHS budget, and stressed its legal duty to provide a comprehensive health service in line with stated objectives. The mandate also reemphasised the Government's commitment to the NHS remaining "free at the point of delivery", and specifically rules out the introduction of new patient charges.[22] Additional objectives contained in the current mandate included: preventing ill-health and improving early diagnosis of conditions such as cancer and heart disease; better management of ongoing physical and mental health conditions such as dementia, diabetes and depression; helping people recover from episodes of ill health, such as strokes; ensuring patients experience better care and are treated with "compassion, dignity and respect"; and providing care in a safe and clean environment (therefore minimising the chances of patients picking up additional infections).[23]

In addition, the mandate highlighted the importance of NHS England delivering its objectives within its available financial resources, "both in the current spending review period and beyond".[24] As such, the Government set NHS England the objective of ensuring good financial management across the commissioning system and securing "unprecedented improvements in value for money across the NHS".[25] In pursuit of this, the mandate stated that the Government was committed to:

> [E]nsuring the development of a fair and transparent identification and payment system for overseas visitors and migrants accessing the NHS. We will, therefore, continue to work with providers and NHS England to identify cost-effective ways of maximising the recovery of costs incurred through the treatment of chargeable patients (as to be defined by the forthcoming legislation).[26]

Further to the objectives set out in the Department of Health's mandate, on 18 May 2015 the Prime Minister, David Cameron, reemphasised the Government's commitment to seven-day GP services, and set out a number of broader objectives for the NHS (such as an increased focus on mental health and an improved use of technology throughout the health service).[27] In doing so, the Prime Minister also stressed the scale of the challenges facing the NHS, and called for it to "step up" to delivering efficiency savings. Despite this, he asserted that the NHS would always remain "free for everyone under a Conservative government", and restated his party's commitment to increase real terms spending on the NHS to "at least an extra £8 billion a year by 2020".[28]

In response to the Prime Minister's speech, the former Health Minister, Norman Lamb MP (Liberal Democrat) and several medical bodies (such as the Academy of Medical Royal Colleges) reportedly questioned whether the NHS had the resources (both in terms of finances

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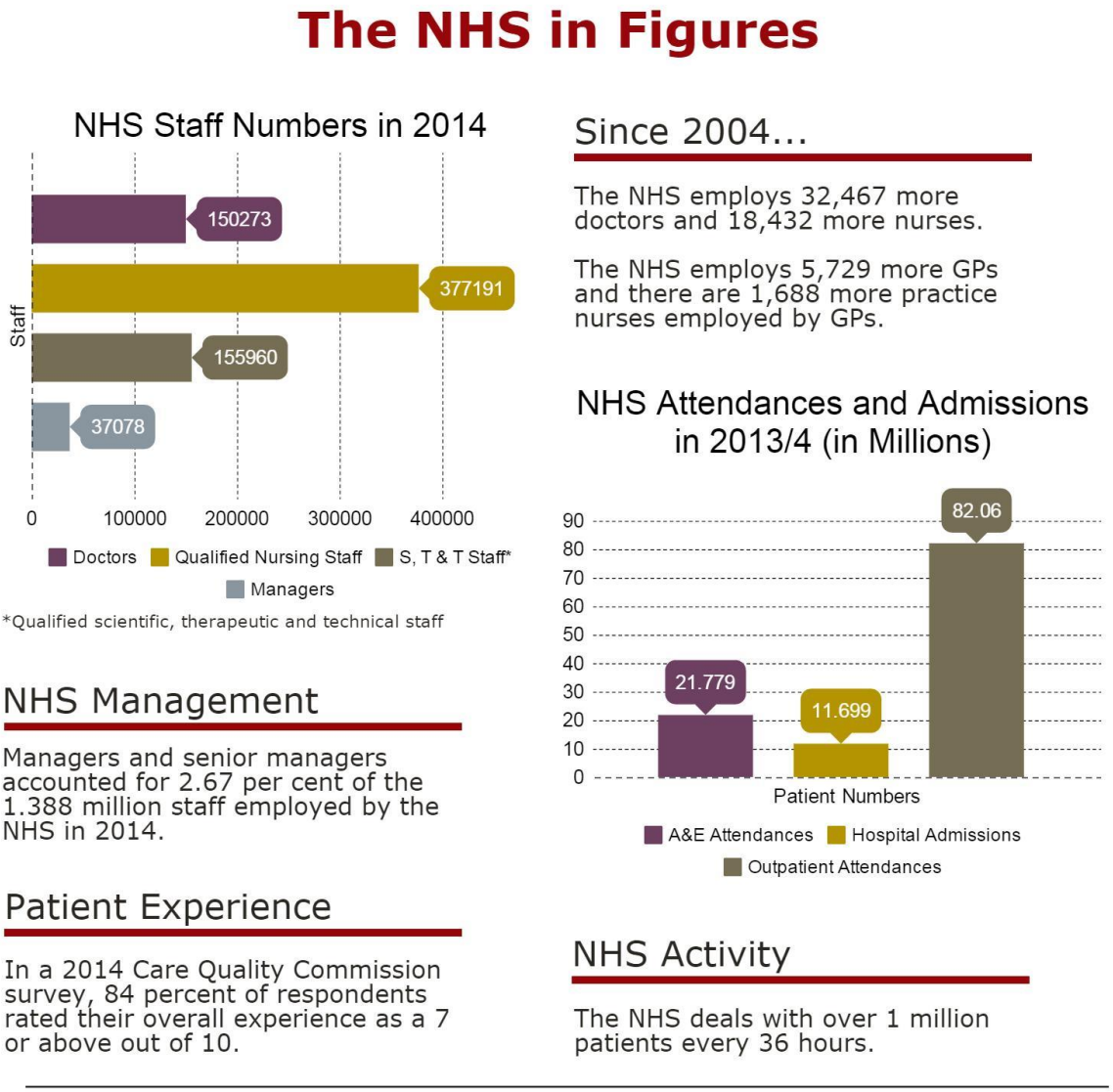
[21] Department of Health, *A Mandate from the Government to NHS England: April 2015 to March 2016*, December 2014, para 7.
[22] ibid, para 4.
[23] ibid, para 11.
[24] ibid, para 8.2.
[25] ibid.
[26] ibid, para 8.3.
[27] GOV.UK, 'Prime Minister on Plans for a Seven-Day NHS', 18 May 2015.
[28] ibid.

and staff) to meet such objectives.[29] Similar concerns have also been raised by the Labour party.[30]



(Source: Statistics taken from the NHS Confederation website)

3. NHS Finances and Pressures

3.1 Current State of NHS Finances

Healthcare think tank, The King's Fund, have estimated the level of the NHS budget in England during recent years as follows:

> Including an additional in-year increase from Treasury reserves of £250 million, the total budget for the NHS in England for 2014–15 was £113.3 billion. In 2015–16 this is planned to rise to £116.4 billion (this includes an additional rise of £1.29 billion

[29] Guardian, 'NHS Lacks Money and Staff for Seven-day Operation, David Cameron Told', 18 May 2015.
[30] Labour, 'Press: Cameron's Plans for a 7 Day NHS Are Not Credible Without the Extra Resources and Staff the NHS Need', 21 June 2015.

announced in the 2014 Autumn Statement and an additional £250 million for mental health services announced in the 2015 Budget).

Allowing for general inflation in the economy, this represents an average real terms increase of 0.9 percent per year from 2010–11 to 2015–16, or 0.8 percent over the current parliament (2010–11 to 2014–15). This is the lowest average annual change of any parliament, contrasting with average annual increases of 5.7 percent under the Labour administrations between 1997–8 and 2009–10 and 3.2 percent under the Conservative administration between 1979–80 and 1996–7.[31]

The Institute for Fiscal Studies estimated that 9.3 percent of UK GDP was used for health expenditure (both public and private) in 2012.[32] According to these estimates, the UK spend on health was the twelfth highest of the countries in the Organisation of Economic Co-operation and Development, behind countries such as France, Germany, the United States and Japan (the United States had the highest level of health expenditure in the list).[33]

Based on the expenditure plans set out by HM Treasury in July 2014, [34] the House of Commons Library estimated that the health budget allocation per head in England would be around £2,137 per person in 2015–16.[35] This is lower than the projected rates for Northern Ireland (£2,569 per head), Scotland (£2,290 per head) and Wales (£2,141 per head). It was estimated that around £100 billion would be managed specifically by NHS England, and would then need to be allocated to CCGs and local health authorities in line with its mandated objectives.[36]

In its November 2014 report on the financial sustainability of NHS bodies, the National Audit Office (NAO) analysed the financial performance of the NHS up to 2013–14, and published projections as to future performance.[37] The report stated that "headline measures of financial sustainability" had worsened between 2012–13 and 2013–14, and highlighted growing financial stress in NHS Trusts and Foundation Trusts.[38] The NAO also highlighted a number of specific areas of concern, including:

- The failure of providers and commissioners in financial difficulty to make appropriate efficiency savings (the report stated that many were instead reliant on increasing their income).

- Increased demand for emergency admissions, despite attempts to curb demand by capping the payments tariff available to the trusts when above a certain level of admissions (above a certain base level—taken from 2008–09—trusts only received 30 percent of the payment they would otherwise receive for emergency admissions; the remaining 70 percent is intended to be invested by commissioning bodies on improving patient care outside of hospitals).

- A continuing reliance on cash support from the Department of Health.[39]

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[31] The King's Fund, 'The NHS Budget and How Has it Changed', 24 March 2015.
[32] Institute for Fiscal Studies publication, *The Green Budget*, December 2014, p 180.
[33] ibid.
[34] HM Treasury, *Public Expenditure: Statistical Analyses 2014*, July 2014.
[35] House of Commons Library, *Structure of the NHS in England*, 1 June 2015, CBP 07206, p 8.
[36] ibid, p 7.
[37] National Audit Office, *The Financial Sustainability of NHS Bodies*, 7 November 2014.
[38] ibid, p 10.
[39] ibid, pp 7–9.

The NAO described the financial trends as unsustainable, and stated that it could not be confident that value for money would be achieved over the next five years.[40]

Further, a subsequent report from the House of Commons Public Accounts Committee summarised financial performance in the NHS as follows:

> The NHS must be financially sustainable in the medium to long term for it to provide sustainable services to patients. Key tests of financial sustainability include changes in the surplus or deficit of the NHS as a whole and the number and scale of organisations in financial distress. However, the financial health of NHS bodies has worsened. Between 2012–13 and 2013–14, the net surplus of NHS commissioners, foundation trusts and NHS trusts decreased from £2.1 billion to £722 million. The percentage of NHS trusts and foundation trusts in deficit increased from 10 percent in 2012–13 to 26 percent in 2013–14; and nearly a quarter of clinical commissioning groups ended the 2013–14 financial year with a less favourable financial position than they planned. The Department issued £1.8 billion of cash support to NHS trusts and NHS foundation trusts between 2006–07 and 2013–14 to help them meet their operational cash needs.[41]

The Committee also noted the impact of the emergency admissions tariff, and stressed that it currently hinders the financial sustainability of NHS bodies, rather than helping them.[42] The Committee highlighted statistics suggesting a 48 percent increase in emergency admissions over the last 15 years. In response, Monitor argues that this figure may have been higher had the 30 percent payment cap not been introduced, though it stated that it would work with NHS England to review the policy.[43]

Regarding the need to make efficiency savings, the Committee noted the current four percent target agreed by NHS England and Monitor, and reported that, in practice, the annual efficiency savings had been around one percent to two percent.[44] In addition, the Committee found that these savings were partly achieved through pay freezes, which NHS England and Monitor accepted were unsustainable.[45] Looking to the future, NHS England and Monitor reasoned that further savings could be achieved through advances in technology or medicine, and by "changing the way healthcare was provided".[46] Regarding the latter point, it was suggested that this would require upfront capital investment, which could potentially be achieved by selling off a number of surplus cash assets in the NHS. However, the report also noted the NAO's concerns that cost data was not collected and recorded consistently enough to enable proper systematic analysis.[47] The need to address this issue was accepted by Monitor and by NHS England.[48]

In addition, the report highlighted the need to make better use of "cost saving opportunities" (such as planning recruitment better to minimise reliance on temporary staff, who are often more expensive than permanent staff), and to increase collaboration between local health bodies in pursuit of better value for money.[49] The Secretary of State for Health, Jeremy Hunt,

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[40] ibid, p 10.
[41] House of Commons Committee of Public Accounts, *Financial Sustainability of NHS Bodies*, 3 February 2015, HC 736 of session 2014–15, para 3.
[42] ibid, p 9.
[43] ibid.
[44] ibid, p 11.
[45] ibid.
[46] ibid.
[47] ibid, p 12.
[48] ibid.
[49] ibid, pp 5–6.

has recently announced the introduction of new rules to attempt to curb the use and cost of staffing agencies in the NHS.[50] The Health Secretary has also recently stated that, in future, people who miss GP appointments will be told how much it cost the NHS.[51] It is estimated that missed GP appointments cost the taxpayer £162 million and missed hospital appointments cost £750 million.[52]

The financial issues affecting the delivery of NHS services have also been considered by bodies within the profession, such as the Royal College of Nursing and the Royal College of Physicians. Commenting on the issue in 2014, the Royal College of Nursing (RCN) suggested that, although they fully believed that the NHS should remain free at the point of delivery, there could be an argument for introducing GP charges.[53] The body recognised that this could be a controversial move, but reasoned that it recognised the limited nature of NHS resources. Further to this, the RCN called for better financial planning for the NHS, stating that this was essential to enable staff to plan future healthcare services. The Royal College of Physicians also emphasised their support for an NHS free at the point of delivery, and called for further investment in medical education and to support research.[54]

3.2 Future Pressures on NHS Finances

In its 2013 report, *The NHS Belongs to the People: A Call to Action,* NHS England briefly outlined some of the external issues that could potentially put pressure on England's NHS budget over the next few years:

> Future trends threaten the sustainability of our health and care system: an ageing population, an epidemic of long-term conditions, lifestyle risk factors in the young and greater public expectations. Combined with rising costs and constrained financial resources, these trends pose the greatest challenge in the NHS's 65-year history.[55]

The report went on to stress:

> [W]ithout bold and transformative change to how services are delivered, a high quality yet free at the point of use health service will not be available to future generations. Not only will the NHS become financially unsustainable, the safety and quality of patient care will decline.[56]

The potential impact of an ageing population on the NHS was considered by the House of Lords Select Committee on Public Service and Demographic Change in its 2013 report, *Ready for Ageing?*.[57] The Committee stated that "a rapidly ageing society means many more older people living for more years, often with one or more chronic long-term health conditions; a consequence of this and other pressures is a large increase in health and social care costs".[58] In

[50] Department of Health press release, 'Clampdown on Staffing Agencies Charging NHS Extortionate Rates', 2 June 2015.
[51] BBC News, 'NHS to Reveal Cost of Missed Appointments to Patients', 3 July 2014.
[52] ibid.
[53] Royal College of Nursing, 'Clarity Needed on Future NHS Funding Says RCN', 18 June 2014.
[54] Royal College of Physicians, 'Stop Reorganising, Increase Funding, and Commit to Free NHS', 15 September 2015.
[55] NHS England, *The NHS Belongs to the People: A Call to Action*, July 2013, p 5.
[56] ibid, pp 5–6.
[57] House of Lords Select Committee on Public Service and Demographic Change, *Ready for Ageing?*, 14 March 2013, HL Paper 140 of session 2012–13.
[58] ibid, p 11.

particular, the Committee quoted estimates that the number of people with diabetes is projected to rise by over 45 percent, that cases of arthritis, coronary heart disease or stroke could each rise by over 50 percent, and that the numbers of people with dementia may rise by over 80 percent.[59] It also argued that:

> [T]he current healthcare system is not delivering good enough healthcare for older people and is inefficient; there is an urgent need to change the current system to provide better healthcare more efficiently and this should help with the predicted funding shortfall.[60]

Many of these concerns regarding future pressures on NHS services were shared by Monitor, which referred to estimates that (without appropriate action) the funding gap for NHS England could grow to £30 billion a year by 2020.[61] (It should be noted that these estimates were made before the Prime Minister announced an increase in real term spending on the NHS of at least £8 billion a year by 2020.[62]) To address the potential funding gap, Monitor emphasised the importance of providing better value healthcare for patients and improving productivity in the NHS.[63] It envisaged that this could be done by altering how the NHS provides its services, and re-investing any money saved into further improving them. However, Monitor also stated that:

> Taking this approach to improving productivity could close the funding gap but it won't be easy. Historically, productivity growth in the NHS has lagged productivity growth in the economy as whole. That has two important implications for NHS decision makers. First, to have a chance of closing the expected £30 billion a year gap by 2021, the NHS will need to achieve "more for less" at a higher rate than it ever has done before. Second, "one huge heave" will not be enough. To prevent the gap from simply re-opening after 2021, the NHS will need to continue improving productivity by at least the same rate as the rest of the economy, year on year. Only by keeping up a higher rate of productivity improvement can the NHS remain financially sustainable in the long term.[64]

The issue of the £30 billion funding gap was also considered by the NHS in its report, *Five Year Forward View*.[65] This suggested that, traditionally, the NHS has achieved 0.8 percent of efficiency savings annually, but that the figure has been nearer 1.5–2 percent in recent years.[66] However, the NHS believed this could be increased to 3 percent per year if action was taken to sustain social care services, invest in new care models, improve prevention measures and work towards wider improvements in service provision.[67] However, in addition to working towards efficiency savings to close the funding gap, the paper reasoned that the gap could also be reduced through increased funding or by decreasing demand for NHS services (for example, by taking action on national health risks such as obesity, smoking or alcohol misuse).[68] It suggested that any attempt to "muddle through" the next few years (eg by relying on short term solutions) would not be sustainable and may widen gaps in health and wellbeing, care and

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[59] ibid.
[60] ibid, p 12.
[61] Monitor, *Closing the Funding Gap: How to Get Better Value Health Care for Patients*, October 2013, p 1.
[62] GOV.UK, 'Prime Minister on Plans for a Seven-Day NHS', 18 May 2015.
[63] Monitor, *Closing the Funding Gap: How to Get Better Value Health Care for Patients*, October 2013, p 1.
[64] ibid, pp 1–2.
[65] NHS, *Five Year Forward View*, October 2014.
[66] ibid.
[67] ibid, p 5.
[68] ibid, p 5.

quality, and funding and efficiency. The Five Year Forward View has been backed by the Government in their mandate for the NHS.[69]

Further reading on health expenditure:

- Institute for Fiscal Studies, *The Green Budget*, December 2014, Chapter 8 (This includes details information on past and current health expenditure, and discusses some of the pressures faced by the health service.)

- Nuffield Trust, 'NHS in Numbers: Key Charts' website, accessed 30 June 2015 (This contains a range of charts relating to health spending.)

- House of Commons Library, *Health Expenditure*, 8 June 2015, SN/SG/2640; and *NHS Funding and Expenditure*, 3 April 2012, SN/SG/724 (This contains figures on health expenditure dating back to the 1950s.)

- King's Fund, *Financial Failure in the NHS: What Causes It and How Best to Manage It*, 9 October 2014

4. Meeting Efficiency and Value for Money Challenges

NHS Five Year Forward View

The NHS's *Five Year Forward View* describes the "traditional divide" between primary care, community services, and hospitals as an increasing "barrier" to the type of care people need.[70] As such, the report called for greater integration of these services. It stressed that this could help the organisation deal with the increasing pressure of long term health conditions, and would also provide better value for money.

In summary, some of the challenges and options presented by the paper included:

- **'Emerging models' of healthcare**

  This relates to changes in the way healthcare is organised in certain areas. The paper refers to a number of projects across the country which appear to demonstrate the benefits of increased integration and innovation when supplying a particular NHS service. For example, the paper lists a project in London where:

  > [I]ntegrated care pioneers that combine NHS, GP and social care services have improved services for patients, with fewer people moving permanently into nursing care homes. They have also shown early promise in reducing emergency admissions. Greenwich has saved nearly £1m for the local authority and over 5 percent of community health expenditure.[71]

  The NHS claimed that these approaches can improve care quality and provide better value for money.

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[69] Department of Health, *A Mandate from the Government to NHS England: April 2015 to March 2016*, December 2014, p 3.
[70] NHS, *Five Year Forward View*, October 2014, p 16.
[71] ibid, p 17.

- **A 'new deal' for primary care**

  Noting the increasing pressure on GP services—such as higher demand from the public and lower numbers of new GPs—the paper stressed the need to provide more investment in primary care, and claimed that it had been "under-resourced compared to hospitals".[72] In particular, the report said that the NHS would focus on giving GP-led CCGs more influence over the NHS budget, increase investment in training of new GPs and other primary care staff, and work to build public understanding of how pharmacies and online resources could help them deal with "minor ailments" (ie negating the need for them to visit a doctor or hospital).

  The paper added that the NHS would also look to introduce a new care model centred around primary care, classed as Multispecialty Community Providers (MCPs).[73] These would become the focal point for certain registered patients (particularly those who were elderly or who had complex health needs), and would allow more involvement in the management of the care by nurses, therapists and other community-based professionals. The report argued that this would enable the majority of the patients' outpatient appointments to be moved out of hospitals and into community settings, and would allow for greater flexibility in how their care was funded and organised.

- **Urgent and emergency care networks**

  The report stated that:

  > The care that people receive in England's Emergency Departments is, and will remain, one of the yardsticks by which the NHS as a whole will be judged. [...] More and more people are using A&E—with 22 million visits a year. Compared to five years ago, the NHS in England handles around 3,500 extra attendances every single day, and in many places, A&E is running at full stretch. However, the 185 hospital emergency departments in England are only a part of the urgent and emergency care system. The NHS responds to more than 100 million urgent calls or visits every year.[74]

  Based on these pressures, the paper made a number of recommendations to improve the organisation of emergency services, including: making more use of community care (including the promotion of evening and weekend GP access); new funding arrangements for urgent and emergency services; and the better funding of mental health crisis services.

- **Increasing focus on 'specialised care'**

  The report stated that the concentration of specialist care services often appears to increase the efficiency of care and treatment. For example, it notes an example in London whereby "consolidating 32 stroke units to 8 specialist ones in London achieved a 17 percent reduction in 30-day mortality and a 7 percent reduction in patient length of stay".[75] Therefore, the paper believed there should be more integration of specialist

[72] ibid p 18.
[73] ibid, p 19.
[74] ibid, p 21.
[75] ibid, p 23.

services around patients. It also highlighted the potential benefits this could bring with certain conditions, such as cancer: "this would enable patients to have chemotherapy, support and follow up care in their local community hospital or primary care facility, whilst having access to world-leading facilities for their surgery and radiotherapy".[76]

- **Enhanced health in care homes**

  The report stated that one in six people aged 85 or over permanently resides in a care home. It also stated that many people within care homes (particularly those with dementia) are not having their health needs regularly assessed, and that this results in avoidable admissions to hospital. As such, the paper emphasised a commitment to "in-reach support", whereby investment will be provided to enable local health and care services to provide medical reviews and rehab services within care homes.[77]

In addition to the services listed above, the report also stressed the need to improve and modernise maternity services and the use of smaller hospitals. Further to this, the paper made recommendations regarding the management of NHS services more generally, calling for greater steps forward in terms of innovation, integration, local leadership and national leadership.[78] In addition, the report noted the need to better embrace new technologies when delivering patient services, and to improve the use and recruitment of the NHS workforce. Regarding the latter point, the paper outlined the large increases in the workforce over the last few years, but questioned its balance:

> Since 2000, the workforce has grown by 160,000 more whole-time equivalent clinicians. In the past year alone staff numbers at Foundation Trusts are up by 24,000—a 4 percent increase. However, these increases have not fully reflected changing patterns of demand. Hospital consultants have increased around three times faster than GPs and there has been an increasing trend towards a more specialised workforce, even though patients with multiple conditions would benefit from a more holistic clinical approach. And we have yet to see a significant shift from acute to community sector based working—just a 0.6 percent increase in the numbers of nurses working in the community over the past ten years.[79]

The report stressed the importance of working with Health Education England to improve the recruitment and retention of NHS staff. In addition, the NHS raised the importance of employers and staff reconsidering how best to ensure working patterns and pay evolve to reward high performance, and to encourage recruitment and retention in areas where need is highest.

The King's Fund broadly welcomed the proposals set out in the *Five Year Forward View*, but expressed concerns that it proposals would not achieve what they are intended to unless "serious attention is given" to the policy changes needed to support local leaders in ensuring the new care models become a reality.[80] As such, the King's Fund published a number of their own recommendations in response to the report.[81]

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[76] ibid, p 23.
[77] ibid, p 24.
[78] ibid, pp 28–29.
[79] ibid, p 30.
[80] The King's Fund, *Implementing the NHS Five Year Forward View: Aligning Policies With the Plan*, February 2015, p 2.
[81] ibid.

NHS England *Call to Action* Report

Recognising the need to improve productivity and work within greater financial restraints, the NHS England '*Call to Action*' report, published in 2013, listed a number of ways that future opportunities could be utilised to improve the efficiency of the service.[82] These included:

- Increasing patient control over their health—the report suggested that greater patient control improves health outcomes, avoids over-treatment and reduces the risks of hospitalisation. NHS England reported that early trials of Personal Health Budgets had indicated improved quality of life and cost-effectiveness. [83]

- Harnessing new technology—the paper stressed that moves to improve the use of digital technology (in line with similar moves in online banking, for example) could improve patient access to their records, whilst also allowing certain patients to have their health monitored at home. NHS England reasoned that both measures would improve overall efficiency. [84]

- Improved data transparency for patients, clinicians and commissioners—this paper argued that this would improve patient knowledge and choice, and could also allow NHS commissioners to better understand how effectively money was being invested.[85]

- Increased focused on individuals' characteristics—the paper states that "a relatively small minority of patients accounts for a high proportion of health service utilisation and expenditure".[86] The report reasons that this provides an opportunity to "manage patients, and help them manage themselves, more intelligently, based on an understanding of individual risk".[87] Noting recent medical advances that may allow clinicians to tailor treatment to individuals' specific characteristics, NHS England reasoned that this could be used to identify problems earlier and to apply targeted interventions.[88]

Backing up its recommendations, NHS England also sought to highlight the economic benefits an effective health service can bring. For example, it stated that:

> [I]llness costs the UK economy dearly: in 2011, 131 million work days were lost due to sickness. This translates into an annual economic cost estimated to be over £100 billion whilst the cost to the taxpayer, including benefits, additional health costs and forgone taxes, is estimated to be over £60 billion.[89]

In addition to the economic advantages of improving health and wellbeing, the report noted the important role the NHS plays in the UK health and life sciences industries.[90]

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[82] NHS England, *The NHS Belongs to the People: A Call to Action*, July 2013.
[83] ibid, p 18. Information on Personal Health Budgets can be found on at: NHS Choices, 'Personal Health Budgets', 26 January 2015.
[84] NHS England, *The NHS Belongs to the People: A Call to Action*, July 2013, p 8.
[85] ibid, p 19.
[86] ibid, p 20.
[87] ibid.
[88] ibid.
[89] ibid.
[90] ibid.

Monitor: *Closing the NHS Funding Gap* Report

Monitor published a report in 2013 costing out how specific productivity and efficiency savings could help reduce the potential £30 billion a year funding gap.[91] Monitor split its recommendations into four categories:

- Improving productivity within existing services;
- Delivering the right care in the right setting;
- Developing new ways of delivering care; and
- Allocating spending more rationally. [92]

For example, the report estimated that improved processes and procurement strategies could annually save between £2.7 billion and £4.7 billion in the hospital sector, and could generate between £1.2 billion and £2.5 billion worth of efficiency savings per year in the primary care sector.[93] More specific recommendations made by the Monitor report included:

- Managing and integrating services for "high risk" groups to prevent hospitalisation or the need for emergency admissions (estimated savings of between £1.2 billion and £2 billion a year).[94]
- Shifting outpatient care to primary settings and emergency care to ambulatory settings (estimated savings of between £1 billion and £1.6 billion a year).[95]
- Teaching patients to manage their own care, particularly those with long-term health conditions (estimated savings of between £0.2 billion and £0.4 billion a year).[96]

The report highlighted the varying allocation of NHS resources to different illnesses and conditions, and suggested that the current approach has been largely shaped by past decisions. Monitor analysed relative spend on different conditions against the relative "burden" of that condition, and found that some "mismatches" appeared to exist.[97] For example, they found that certain long-term conditions (such as coronary heart disease) did not receive as much funding as other conditions which represented a lesser "burden".[98]

Health Foundation

In June 2015, the Health Foundation (which describes itself as an independent charity working to improve health and care in the UK) published a report on improving the quality of care in

[91] Monitor, *Closing the Funding Gap: How to Get Better Value Health Care for Patients*, October 2013.
[92] ibid, pp 2–3.
[93] ibid, pp 5–7.
[94] ibid, p 12.
[95] ibid, pp 13–14.
[96] ibid, p 15.
[97] ibid, p 19.
[98] ibid, p 19.

the UK, alongside generating improvements in efficiency.[99] The report, *Shaping the Future: A Strategic Framework for the NHS*, outlined a number of key areas to focus on:

- Active Cost Management—this included calls to balance short-term efficiency improvements with longer-term targets. For example, the organisation suggested that focus should shift from the NHS's annual finances to multi-year settlements, so as to allow longer-term strategic planning.[100]

- Process Improvement for Quality and Productivity—this would involve the redesign of clinical pathways and services. However, the organisation also stressed the need to better analyse the performance and efficiency of its services, such as primary care. It called for better data collection and an improved emphasis on how the data is used. In addition, the Health Foundation believed that more practical and technical support should be provided for health care commissioners and providers.[101]

- New Ways of Delivering Care—the organisation raised "rapid cycle evaluation" (where ongoing and real-time evaluation is combined with quality improvement support), and the formation of provider networks as promising models to accelerate change.[102]

- Scientific Discovery, Technology and Skills—although welcoming the NHS Innovation Accelerator Programme (which invites ideas for innovation from around the world, and then selects some for development within the NHS), the Health Foundation believed there was still the need to develop the NHS into a more hospitable environment to innovate. The organisation emphasised the need for an increased focus on leadership, analytical and technological skills in the NHS workforce.[103]

Further reading

Information on the subject of improving value for money, productivity and efficiency in the NHS can be found through the following resources:

- Nuffield Trust website, '*Efficiency and Productivity*', accessed 1 July 2015 (This includes links to reports on subjects such as pharmacy services, general practices and the cost of care at the end of life.)

- King's Fund website, '*Productivity and Finance*', accessed 1 July 2015 (This includes reports on workforce planning and front line experiences of productivity challenges.)

- National Audit Office, *The Financial Sustainability of NHS Bodies*, 7 November 2014

[99] The Health Foundation, *Shaping the Future: A Strategic Framework for the NHS*, June 2015.
[100] ibid, pp 10–11.
[101] ibid, pp 14–15.
[102] ibid, pp 16–17.
[103] ibid, p 19.

5. Reducing the Demand for Healthcare

In NHS England's 2013 report, *A Call to Action*, the organisation emphasised the importance of the NHS being "a health service, not just an illness service".[104] The report stated that the NHS in England:

> [M]ust get better at preventing disease. In the future this means working increasingly closely with partners such as Public Health England, health and wellbeing boards and local authorities to identify effective ways of influencing people's behaviours and encouraging healthier lifestyles. The NHS has helped many people quit smoking (although there are still about 8 million smokers in England), but has yet to develop similarly sophisticated methods for assisting people to improve their diet, take more exercise or drink less alcohol.[105]

The report stated that four percent of the health budget in England is spent on prevention and public health.[106] Although this is higher than the OECD average, NHS England questioned whether this was enough, and stressed the need for further co-ordination on preventative strategies between Public Health England, health and wellbeing boards and local authorities. It highlighted the need to improve the increasing prevalence of risk factors (such as smoking, drinking, diet and low exercise) among young people, and quoted predictions that around 46 percent of men and 40 percent of women could be obese by 2035.[107] NHS England stated that this could result in an additional 550,000 cases of diabetes, and 400,000 additional cases of stroke and heart disease. The report also highlighted the need to manage the demands of an ageing population and those with long-term health conditions.[108] NHS England suggested that older people tend to rely more on hospital care, and estimated that older people and those with long-term conditions account for the majority of NHS expenditure.[109]

In a further report on the subject of prevention, NHS England set out a five-step framework aimed at helping CCGs commission develop effective prevention strategies.[110] In summary, this covered:

- Better analysis of key health problems at a local level;
- Working together with partners and local community on common goals or priorities;
- Identifying high-impact programmes to tackle local health problems (such as primary prevention programmes and early detection measures);
- Planning out any reallocation of resources; and
- Measuring the impact and experimenting as the programme is ongoing.[111]

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[104] NHS England, *The NHS Belongs to the People: A Call to Action*, July 2013, p 17.
[105] ibid.
[106] ibid.
[107] ibid, p 14.
[108] ibid, pp 12–13.
[109] ibid.
[110] NHS England, *A Call to Action: Commissioning for Prevention*, November 2013.
[111] ibid, pp 14–24.

The idea of prevention, in partnership with efficiency and productivity measures, was also discussed in the NHS *Five Year Forward View*.[112] The report identified a number of avoidable risks, including additional health issues seemingly influenced by health inequalities:

> [O]ne in five adults still smoke. A third of people drink too much alcohol. A third of men and half of women don't get enough exercise. Almost two thirds of adults are overweight or obese. These patterns are influenced by, and in turn reinforce, deep health inequalities which can cascade down the generations. For example, smoking rates during pregnancy range from two percent in west London to 28 percent in Blackpool.[113]

NHS England has previously published estimates that "health inequality costs the NHS well in excess of £5.5 billion per year and between £20 and £32 million in terms of lost taxes and higher welfare payments".[114] Their report stated that—theoretically—the country is moving towards paying billions of pounds of extra taxes in the future, just to pay for preventable diseases.[115] The report emphasised the need to prevent the rising burden of lifestyle-driven ill health, and set out a number of priorities for action:

- Incentivising and supporting healthy behaviour—including support for national campaigns aimed at clearer information and labelling, targeted personal support and changes to how certain products are priced, distributed or marketed.
- Enhanced localised powers and leadership on public health issues.
- Targeted prevention—such as proactive primary care interventions and the shifting of investment to preventative measures to tackle certain illnesses (such as diabetes).
- Workplace health programmes.
- Supporting patients to manage their own health—through the increased availability of information on patients' conditions and community-led help to stay healthy.
- Community engagement—this includes increased support for carers (eg by building on partnerships with voluntary organisations and GP practices), taking measures to support community volunteering, and building stronger partnerships with charitable and voluntary sector organisations (and making it easier for them to obtain NHS grant funding).[116]

The need for a prevention strategy in order to maintain the financial sustainability of the NHS is also an idea backed by the King's Fund, which quoted estimates "that 80 percent of cases of heart disease, stroke and type 2 diabetes, and 40 percent of cases of cancer could be avoided if common lifestyle risk factors were eliminated".[117] The think tank emphasised the cost-effectiveness of preventative measures, particularly highlighting some of the benefits brought about by initiatives to curb smoking. In addition to the measures mentioned above, the King's Fund highlighted the importance of evidence-based interventions, such as specific advice given in

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[112] NHS, *Five Year Forward View*, October 2014.
[113] ibid, p 9.
[114] NHS England, 'Prevention and Health Promotion', accessed 1 July 2015.
[115] ibid, pp 9–10.
[116] ibid, pp 9–15.
[117] The King's Fund, 'Primary Prevention', accessed 1 July 2015.

consultations, community interventions in schools (eg those targeted at tackling childhood obesity) and regulatory actions (for example, government interventions to restrict alcohol or tobacco use).[118]

Further information on preventative measures can be found in the guidance published by the National Institute for Health and Care Excellence and in the 2010 King's Fund report, *A Proactive Approach: Health Promotion and Ill-health Prevention*.

[118] ibid.