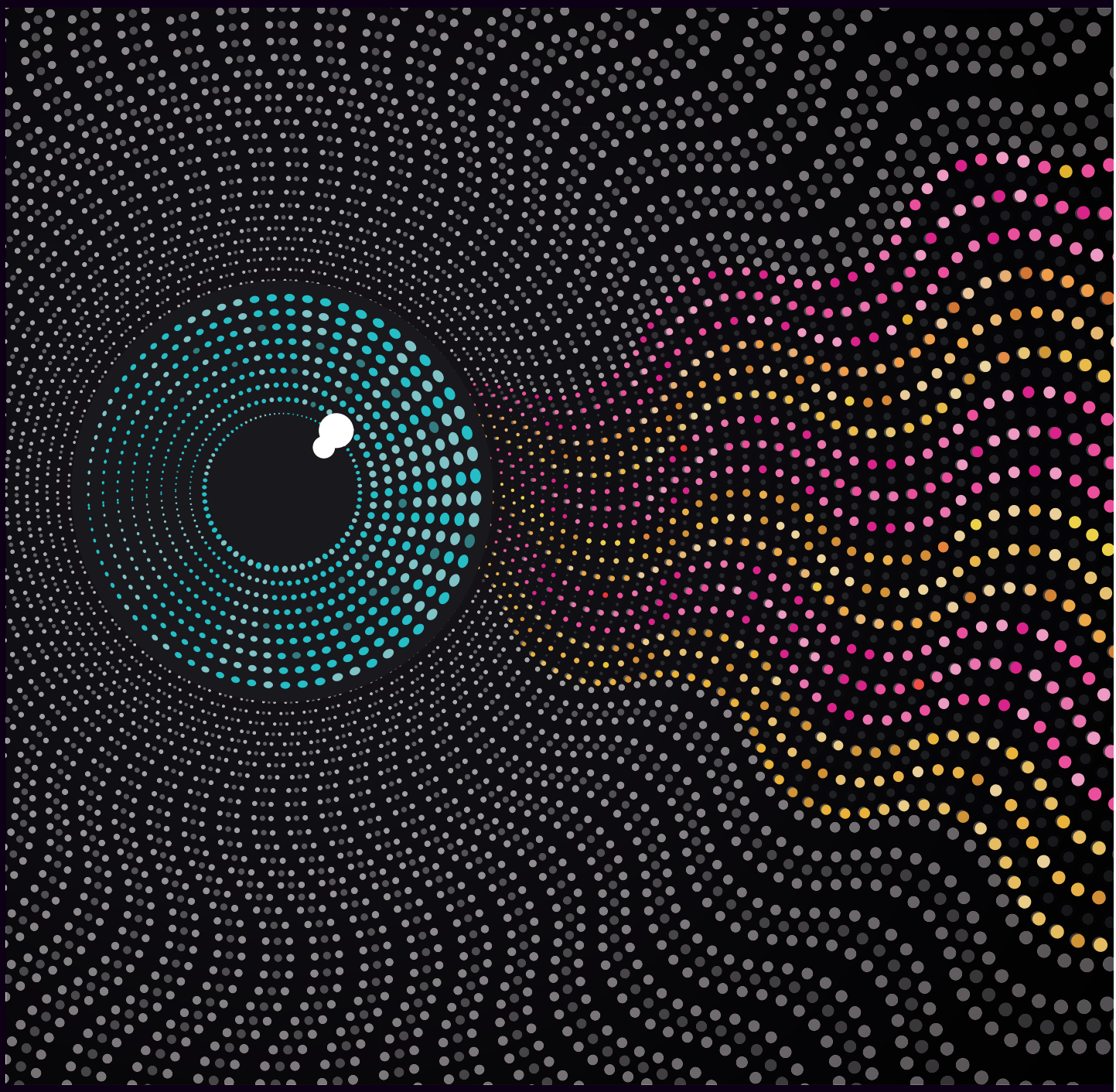
Funding a healthy future

The health and care deficit diagnosed

OCTOBER 2016



CIPFA The Chartered Institute of Public Finance & Accountancy

PF Perspectives

This is the fourth in a series of *PF Perspectives*, produced by CIPFA and *Public Finance*. They are designed to stimulate discussion on key public finance and policy issues. These essays, by leading public sector practitioners and experts, examine the future of health and social care in the face of an ageing population, financial constraints and Brexit

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FOREWORD

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ISSN 2058-1777

Life, as they say, is what happens while you're busy making other plans.

And, two years on from the launch of the NHS Five Year Forward View, life has been throwing plenty of curveballs at the health and social care system.

Some of the financial and demographic challenges were anticipated in NHS England's ambitious five-year plan. Others, such as the post-Brexit economic and fiscal uncertainty, were harder to predict.

But either way, we are witnessing a healthcare system under severe financial stress.

The worrying level of annual trust deficits, the growing rationing of services – and the unrelenting pressures on social care – have set off warning lights up and down the country.

To ensure a healthy future for health and social care, we need to confront these issues and take steps to stabilise both the finances and operational performance.

This is why finance professionals across health and care sectors have such a critical role to play.

It is they who have been charged with implementing the financial "reset", recently announced by NHS England and NHS Improvement.

In practical terms, this means tough new cost controls, performance ratings and incentives, alongside an intense focus on integration and transformation.

In the longer run, as CIPFA detailed in its discussion paper, *More Medicine Needed*, difficult decisions may have to be made about precisely what the future "NHS offer" is going to be.

Should there be more charges, a bespoke tax or a "golden ratio" of GDP for healthcare spending? Is more rationing inevitable?

All these issues and many more are explored in this latest collection of *PF Perspectives*. Leading experts, practitioners and policymakers take stock of the sector's finances and discuss what steps must be taken to bring them back into good health.

A wide-ranging public debate is needed on the tough choices facing our healthcare system – and the different funding options on the table. These essays, and the issues they raise, make an important contribution towards that end.

Underpinning them all, though, is the need for sound public financial management. Without that, we cannot deliver the healthcare system's core objectives – let alone achieve the nice-to-haves.

We may have plans, strategies and diagnoses galore. But, when life intervenes, and the system is creaking under the strain, we must pull together to ensure that hospitals, GP surgeries and adult social care services are up to scratch.

A clean bill of financial health is the essential first step.

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CONDITION CRITICAL

Going the long distance

ESSAY 1

BY ANITA CHARLESWORTH

Funding a sustainable healthcare system was always going to be a marathon, not a sprint

Anita Charlesworth *is director of research and economics at the Health Foundation*

WHEN ASKED WHAT it was that prime ministers most feared, Harold Macmillan famously said: "Events, dear boy, events." Well, the summer of 2016 has certainly been eventful.

The UK referendum decision to leave the EU, the installation of a new prime minister and government, and of course the country's overwhelming success at the Rio Olympics – all these extraordinary developments took place within a matter of months.

For the NHS, 2016 was always going to be a pivotal year – one that defined and shaped its prospects. This is the year of the so-called "front loading" of the spending review settlement. Extra cash has been injected into the system with the explicit goal of restoring financial balance and resetting performance.

The aim is for more of the health service to achieve the standards set out in the NHS Constitution on access and waiting times, areas where performance has been steadily falling in recent years. Front loading is also supposed to provide the investment and impetus for the transformative change required to make NHS England's Five Year Forward View a reality by 2020.

Stark scenarios

This has not been plain sailing. The decision to leave the EU has direct implications for the NHS. Total health spending accounts for nearly 10% of UK GDP, and 80% of that is publicly funded. The consensus of recent economic forecasts published by the Treasury indicates that growth is expected to slow in the aftermath of the referendum result.

In that scenario, health would receive additional funding only if the government was prepared for one of three things to happen: a higher fiscal deficit; higher taxes; or cuts to other areas of public spending. These would be tough decisions – £100 million a week for the NHS is equivalent to a 1p rise in the basic rate of income tax.

The government's Autumn Statement will be critical for the NHS. It will be the first official post-referendum assessment of the prospects for economic growth, and the new chancellor Philip Hammond will set out his approach to tax, spending and deficit reduction.

If 2016 has taught us one thing, it is be wary of predictions. With that caveat in mind, at the time of writing, the most likely outcome of the autumn statement is no change to the 2015 Spending Review settlement for health and social care. However, deficit reduction is likely to go on for longer, meaning prolonged austerity for public services.

If the chancellor does largely confirm the 2015 spending numbers, it is important to understand what this means for the health service.

The negotiations for the 2015 Spending Review were rooted in the Five Year Forward View. The headline figures are familiar to most people in healthcare, but that should not detract from their starkness. Based on past trends, funding pressures will add around £30 billion to the cost of the English health system in real terms by 2020-21, compared to 2014-15. Over the long term, NHS productivity growth has averaged around 1% a year. Without additional money, this will leave the health service with a funding gap of £22 billion.

The last government's commitment to deficit reduction meant the chances of an additional £22 billion in the 2015 spending review looked extremely remote. NHS chief executive Simon Stevens and the other health leaders argued that the vision for health and care set out in the Forward View would allow the NHS to bend its cost curve – and deliver higher levels of efficiency and productivity growth of 2-3% per cent a year. They argued that, if the government provided an additional £8 billion in real terms by 2020-21, the NHS would be able to bridge the gap with £22 billion of efficiency improvements.

At the start of 2016-17, £21.6 billion of efficiency improvements remain to be delivered. These savings are distributed across the NHS in three big blocks. First is the £6.7 billion to be delivered through national initiatives – the bulk of it through national pay restraint. The second area is the £4.3 billion to be saved through demand management. And third, there is £8.6 billion of local provider efficiency improvements. Each of these areas has potential risks.

The government's scope to hold down pay for such a prolonged period will depend on the NHS's ability to recruit and retain staff. This will be shaped by what is happening in the wider labour market and economy – an uncertain factor now given the Brexit vote. If economic growth is lower than forecast, earnings across the economy may grow more slowly, reducing pay pressures in the public sector. However, if the fall in sterling results in higher inflation, this will add to pressures for pay increases that at least match the rising cost of living.

The demand management efficiencies include savings from the commissioning for value programme, which is designed to reduce variations in commissioning between clinical commissioning groups. It also includes financial savings from new models of care, including the Vanguard programmes. Reducing variations has been a goal of healthcare policy for many years but progress has often been limited. Similarly, while the new models of care are undoubtedly important to secure high-quality health services, the evidence for such reforms delivering savings is limited.

Rising to the challenge

Provider efficiency is the largest single component of the £22 billion of aggregate improvements needed to bridge the funding gap. This requires providers to deliver around 2% a year of efficiency improvements, while managing national pay restraint. Over recent years, provider-side productivity and efficiency growth have been much lower than this. Achieving savings at this rate will require major progress in tackling the cost variation – again a policy goal for many years but with little evidence of sustained, systemic progress. And, in 2015-16, providers' financial problems grew enormously with the sector posting a total year-end deficit of £2.5 billion.

The challenge set out in the Five Year Forward View is substantial. NHS England has shown it is possible to produce costings that make the numbers add up. However, if the health system is to manage for the rest of this decade, there is no room for underperformance or delivery failure against this plan. Two years after the publication of the Five Year Forward View, it is clear that delivery of these savings is at high risk – it must be showing up bright red on most of the government's risk registers.

Part of this is the result of failures at government level. Despite all the claims of additional funding – as the Health Select Committee has recently confirmed – the extra funding provided was closer to £4.5 billion than the £8 billion promised. NHS England has been given increased funding but that has meant less money for key areas including public health, health education and regulation.

The Five Year Forward View recognised that the NHS is not an island. It is hugely dependent on a well-functioning social care system and on good population health. In both these areas, there are grave misgivings. The social care system is not funded to meet the level of need, nor the additional cost pressures from the new living wage. Public health budgets are being cut and the recent government childhood obesity strategy did not meet expectations.

The context for Five Year Forward View delivery has therefore become much more challenging.

But it's not just the context. One of the biggest risks to delivery of the Five Year Forward View savings is the lack of a systematic, strategic approach to the workforce across the health system. For too long, workforce policy has been tangential to healthcare policy. This makes no sense at any time. When a system is trying to transform itself with limited funding, it is impossible to see how change can be effective if the people delivering care are not at the heart of all thinking. ▶

'If 2016 has taught us one thing, it is be wary of predictions'

A second issue is one of focus and approach. This was the summer of the Olympics – most of us were swept away by Team GB's performance. Elite sport has little in common with most of our lives. But, as the post-Olympics analysis has unfolded, certain issues stand out which may have parallels with the efficiency challenge.

In each of the sports in which we excelled, the tale is not one of silver bullets but of long-term effort. Medals were won as the result of persistent, sustained refinement of every aspect of an athlete's preparation – coaching, diet, equipment, psychology and so forth. It is the ruthless focus on incremental gain – day in day out, over years – with more grind than glory. The challenge for efficiency is the same; it means looking at every little bit of the way we deliver care, improving it a bit, then starting again. It's not a one-off project – it has to be part of the health service's DNA and a team effort that involves everyone in the system.

The fear in the sector is that when we come to see all 44 NHS sustainability and transformation plans over the coming months, we will find too much focus on big bang reforms (such as reconfiguration and mergers) and much less on the barriers to ruthless incrementalism – good, real-time performance data, workforce skills and capability development, to name a few.

Many worry that, despite the undoubted worth of the Five Year Forward View, events over the past two years mean that it is now simply not possible to bridge the funding gap purely with improved efficiency. Whatever happens over the next three years, the NHS needs to embed the drive for productivity improvement if the service is to be sustained.

Sustainability – the great prize – is worthy of even more gold medals than team GB cyclists. ●

'Efficiency has to be part of the health service's DNA, and a team effort'

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ESSAY

The care conundrum

BY RICHARD HUMPHRIES

The cash crisis facing social care is now acute, and piecemeal reforms are not enough. An honest debate is needed about the future options

Richard Humphries *is assistant director of policy at the King's Fund*

ANY DOUBTS ABOUT the scale of the financial challenges facing adult social care should have vanished with the recent admission of Simon Stevens, the chief executive of NHS England, that "were extra funding to be available, frankly we should be arguing that it should be going to social care". And this at a time when the NHS itself is facing some of the biggest deficits in its history. So what are the challenges, what is the government doing to address them and where do we go from here?

The most obvious problem is inadequate funding. Since 2010, central government has cut local government grants by 37% in real terms and, despite the best efforts of local authorities to protect social care, spending on services for older people has fallen by 9% in real terms over the same period.

Meanwhile, costs and needs are escalating, especially among the "oldest old", who have complex needs including multiple chronic illnesses, dementia and frailty. Over the past decade, the number of people aged 85 and over has increased by one third and is set to nearly double over the next 20 years. There will be more younger people with complex needs and disabilities too. The acuity of people's needs in all settings is rising. The national living wage is a welcome boost to a notoriously underpaid sector but will add more than £2 billion to payroll costs by 2020.

Projected cost pressures require a real terms spending increase of 4% a year, yet the government's own estimates suggest it will rise by an average of just 0.6% per year over the lifetime of this parliament.

Cuts compounded

The challenge is not just about social care money. Cuts in social care are compounded by underinvestment in other community-based services that support people to live at home and remain as independent as possible, such as district nursing and primary care. This creates a vicious cycle in which older people are more likely to end up in the most expensive parts of the system – long-term care and hospitals – and, in many cases, will experience worse outcomes. The relentless rise in the number of people stuck in hospital (because of "delayed transfers of care") underlines that there are human as well as financial costs. Poor commissioning by the NHS can add to existing pressures on social care budgets.

Making the best use of resources across the NHS and local government is made more difficult by the fragmented organisational responsibilities for commissioning and funding between local authorities, clinical commissioning groups and NHS England. Profound differences remain in professional cultures, funding and payment mechanisms, and governance and accountability arrangements, which frustrate local efforts to join up services.

A third challenge concerns the social care workforce and increasing difficulties in recruiting and retaining enough staff. The Brexit vote has created new uncertainties given that three in five care workers in London were born outside the UK, 28% of them in the EU.

Finally, the profound differences between entitlements to and the funding of healthcare (universal and free at the point of use) and social care (heavily rationed and means ▸

tested) remain poorly understood by most of the public. As a result, public awareness and political priorities focus on the NHS rather than social care, maintaining the inertia that has bedevilled past efforts to reform funding. In this policy and information vacuum, there are no incentives for people to plan ahead and make provision for their care needs, especially for later life.

Finding the funds

Successive governments have failed to rise to these challenges. The coalition government addressed the need for legislative reform through the Care Act 2014 but created rights and expectations without willing the means for local authorities to fulfil them.

The postponement of part 2 of the act (the Dilnot reforms) means that even the very modest protection to families from catastrophic care costs is unlikely to see the light of day. The decision in the 2010 Spending Review to afford relative (though not total) protection to the NHS piled the pressure on unprotected budgets, especially local government, making cuts to adult social care budgets inevitable. The Better Care Fund was an initiative intended to take the wire cutters to the NHS ringfence and allow some money through to alleviate pressures on social care. However, the total of this fund amounts to less than 5% of total NHS and social care spending and, last year, just a third of it was used to protect social care.

The 2015 Spending Review and Autumn Statement offered belated recognition of the deteriorating state of social care finances by allocating an extra £1.5 billion through the Better Care Fund by 2019 and allowing councils to raise more money for social care through a new council tax precept. However, the precept runs the risk of deepening geographical variations in levels of funding and provision – the places with the greatest need for publicly funded social care are likely to raise the least. We estimate that both measures will fail to close the funding gap – set to reach at least £2.8 billion by the end of this parliament.

So the immediate prospects are deeply discouraging and uncertain. Although the precept has enabled many councils to shore up provider fee levels this year, it is not clear whether this will be enough to stave off large-scale provider failures before the new Better Care Fund money comes through in 2019. How many councils will have sufficient political will and electoral capital to use the precept again in each of the next four years?

Changes in local government funding will make care budgets heavily dependent on local levels of property wealth and economic activity. Local authorities have made valiant efforts to achieve savings but are running out of road; directors of adult social services' confidence in their ability to meet statutory requirements over the next few years is plummeting.

Then there are the wider political and economic uncertainties arising from Brexit and the impact of withdrawal from the EU on public finances and on the health and social care workforce.

Three ways forward

The government does not have a clear strategy to address these issues. So what can be done? Our recent research with the Nuffield Trust – *Social Care for Older People: Home Truths* – sets out three strategic challenges for policymakers in shaping how the adult social care

'The Better Care Fund amounts to less than 5% of total NHS and social care spending and, last year, just a third of it was used to protect social care'

system could develop over the next five years.

First, councils could continue to work within the grain of existing policies to **achieve more with less** – for example, through better management of demand, better commissioning, integrated care and other transformation programmes. These have the potential to reduce costs, especially if they make a shift towards place-based planning and single budgets with the NHS. However, many councils have already exhausted these options; any further savings will be tougher and take longer to achieve and will not close the funding gap. To head off the risks of provider failure, there is a strong case for the forthcoming Autumn Statement to bring forward the £1.5 billion extra Better Care Fund money. The need for a new, coherent strategy to improve workforce capacity is now urgent.

Second, if the government is unwilling to provide adequate funding to support the current system, a **different offer** should be developed, based on an explicit acknowledgement that individuals and families have the primary responsibility for paying for care. A fresh policy framework could create financial incentives for people to make provision for care costs through the tax, pension and benefits systems. It might also mean scaling back some of the provisions of the Care Act so that expectations and duties are more realistically aligned with what the government is prepared to fund and local authorities can afford. For many, this will be an unpalatable and unacceptable scenario but it is one that is already upon us.

Finally, a frank and open public debate is needed about how to fund health and social care into the future, recognising that **long-term funding reform** will exceed the lifetime of a single parliament. Much of the ground has been covered by the Barker Commission, especially in terms of options and choices about how additional money could be raised. The need for this debate has never been more necessary or urgent.

‘The postponement of the Dilnot reforms means that even the very modest protection to families from catastrophic care costs is unlikely to see the light of day’

Squaring the funding circle?

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ESSAY

BY SALLY GAINSBURY

Cutting demand – whether through reducing ill health or crude rationing – looks like the only way for the NHS to deal with its soaring deficit

Sally Gainsbury *is senior policy analyst at the Nuffield Trust*

THE NHS, LIKE any household unit, has a choice of two main strategies for dealing with constrained funding: to consume more cheaply or to consume less.

And, just as households across Britain responded to the 2008-09 recession by turning to discount supermarkets, the NHS, from 2011 onwards, embarked on the so-called "Nicholson challenge" to save £20 billion a year by 2015, primarily through cutting the cost of NHS secondary care.

A key tactic for doing that was through the NHS tariff. This lists specific prices that NHS commissioners will pay providers for thousands of common hospital procedures. The tariff's headline annual "uplifts" (something of a misnomer in recent years) are also the reference point for setting payments for acute, mental health and community-based care outside the direct scope of its list.

Each year from 2011-12 to 2015-16, the cash prices in the tariff were deliberately ratcheted down by an average of 1.6% to encourage hospitals to reduce their costs. Factor in inflation (2.4% a year, after the moderating effect of public sector pay restraint) and those cash cuts translated into a real terms reduction in unit payments to NHS providers of 4% a year. That meant that, by 2015, an NHS provider was paid the equivalent of £800 for treating a patient it would have received £1,000 to care for in 2010.

Just like a discount supermarket store, this was the stack 'em high, sell 'em cheap approach to austerity, with England's consumption of NHS care increasing by a fairly steady 3% each year throughout the period – measured in terms of more patients, with more complicated conditions, treated through more complex and advanced healthcare.

This approach worked for a while: the 4% real terms cut in tariff prices became a 4% "efficiency target" – or, more accurately, requirement – and, for a couple of years, providers managed to very nearly match the cuts in their income per activity with equal recurrent cuts to their costs.

A couple of years in, however, the speed of provider cost cutting began to slow, falling to around 2% a year. Yet the real terms cuts to the tariff ploughed on, with prices paid to providers slashed each year by another 4%.

The result was a widening disparity between the cost of providing care borne by hospitals and other providers and the price paid for that care by NHS commissioners. Like any business that sells its goods or services for less than the cost of providing them, NHS providers soon began to fall into deficit.

By 2013-14, NHS accounts revealed an underlying deficit across the trust provider sector of £600 million – somewhat obscured from view through the injection of over £500 million in emergency revenue support or "bailout" that year. The following year – with another 4% real terms cut to tariff prices – the underlying deficit rose to £1.5 billion. The year 2015-16 brought more of the same, and the sector ended the financial year with a reported net deficit of £2.5 billion and a likely underlying deficit of nearer £3.7 billion.

It is not that the NHS's strategy to consume cheaper failed. Between 2011-12 and 2015-16, NHS providers managed to cut their real terms unit costs by around 10%. The problem is that prices were cut by 15% over the same period.

The new deficit normal

The sheer scale of provider deficits – with over 85% of acute providers reporting deficits in 2015-16 – has now forced a change in tack. This financial year (2016-17), prices in the NHS tariff have been increased in cash terms for the first time this decade as part of a strategy (with strings) to eradicate last year's overspend. The increase is modest – just 1% – so is more than outstripped by expected provider inflation of 3%. But it does bring the annual efficiency requirement down to the 2% level providers have been managing over recent years.

However, this will do nothing to reduce the size of the provider deficit, as it does nothing to reduce the mismatch between the cost of care for providers and the price paid for that care by commissioners. However, it does at least stop both the deficit and mismatch from getting any bigger – as long as providers meet the 2% real terms cut in tariff prices with continued 2% recurrent cuts to their unit costs.

The more significant change is for NHS commissioners, who buy and plan care from providers on behalf of patients. For them, the cash increase in the tariff marks the end of the discount supermarket, buy cheaper approach to austerity. Throughout the 2010-11 to 2020-21 decade, commissioner allocations are relatively steady, averaging around 3% cash growth a year. However, the increase in tariff rates from 2016-17 onwards means that 3% extra cash will suddenly buy significantly less extra care each year, as commissioner buying power against the tariff will be reduced from an average 4.5% growth a year between 2010-11 and 2015-16 to just 2.4% from 2016-17 onwards.

That 2.4% buying power figure is particularly problematic because it is below the 3% annual increase in NHS activity we have seen over the past decade, which NHS England expects to continue to 2020-21. It means that, if nothing else changes, by 2018-19 NHS commissioners will no longer be able to afford to pay the invoices sent to them by providers to cover the tariff price of the ever increasing numbers and complexity of patients they treat. Our modelling at the Nuffield Trust suggests that the current rate of activity growth will result in a net NHS overspend of around £2.5 billion a year by 2020-21, this time shared between both provider and commissioner accounts.

‘Nuffield modelling suggests that the current rate of activity growth will result in an NHS overspend of £2.5bn a year by 2020-21’

Limiting demand

The controversial local NHS rationing schemes emerging over the summer and autumn are a response to this and an indication that the NHS is now shifting from an almost sole focus on consuming cheaper to an attempt to consume less as well, or at least to slow the pace at which it buys more.

But crude rationing measures – such as banning or limiting certain treatments, or halting all elective referrals for a given period – are seen as the last resort by desperate commissioners, teetering on the brink of financial imbalance. The preferred solution to the need to reduce activity rates is to reduce the growth in demand – essentially to reduce the level of population ill health and the need to consume healthcare – rather than to respond to need and demand with arbitrary treatment bans or restrictions. NHS England's ambition, although not yet clearly stated, appears to be to reduce the rate of activity growth by a full percentage point from 3% to 2% growth a year.

However, the sticking point for demand reduction – in the form of either upstream public health interventions or downstream schemes that identify patients most at risk of deterioration to give them earlier treatment and care – is that it requires investment in service transformation before its returns may be reaped.

The £2-£3.4 billion a year Sustainability and Transformation Fund awarded to the NHS as part of last autumn's Spending Review was intended to answer that need.

However, almost all of that money this year will be needed to cover provider deficits. And, because the adjustment to the tariff merely freezes the gap between unit costs and unit payments rather than closes it, there is every prospect the full fund will be needed to finance provider deficits each and every year until 2020-21. That would be the case even if providers managed to cut their unit costs by 2% in real terms every year; this is because as fast as providers cut their unit costs, the tariff will cut their unit income.

So while there is now widespread recognition across the NHS that the policy of answering austerity by attempting to consume cheaper through a 4% recurrent cut to the tariff has more than run its course, that recognition has not been reflected in the funding envelope awarded to the service. To simply free up the funds needed to invest in the alternative tack of reducing the growth rate in service consumption, hospitals and other providers are now, yet again, being asked to find 4% recurrent cuts to their costs.

That 4% efficiency requirement is implicit in the effective maximum tolerated ▶

underlying deficit – control total – set for the provider sector for 2016-17 of £2.4 billion; this is down from the starting point of the £3.7 billion underlying deficit for 2015-16.

Our analysis suggests providers will then need to make another 4% recurrent cut to their costs in 2017-18, and follow that in 2018-19 with a further 3% before they can return to financial balance by the end of that year.

That would then free up growing chunks of the transformation fund money for investment in service transformation and demand reduction.

Simple? Not really. A 4% recurrent cost cut is not only around twice the rate providers have managed in recent years but also far in excess of the level Lord Carter's 2016 report to the Department of Health on hospital productivity found could be expected between now and 2020.

Optimism bias

The 44 regional sustainability and transformation "footprints" – made up of local NHS commissioning and providing organisations, as well as local authorities – are attempting to develop plans that can square this circle. But there is a risk of optimism bias in their assumption of dramatic cost savings from, for example, shifting care out of hospitals to GPs and community health services.

First, such a shift would need to be achieved in a context where individual acute hospital trusts remain primarily accountable for delivering their own income and expenditure balances – which may not coincide with an interest in reducing their activity and therefore income. To overcome that hurdle is simply to face the next: not leaving the acute provider with stranded fixed costs. These typically run to 30% of the total cost, a proportion of which can wind up absorbed into higher unit costs for other retained activities. The remainder can often only be removed altogether by closing physical capacity – beloved NHS bricks and mortar – requiring time and political capital, which may be in short supply.

Even if the optimists are proved right, and NHS providers manage to pull off historic levels of efficiency savings over the next three years, the challenge remains for commissioners to successfully invest the freed-up "transformation" funds in reducing the rate of growth in demand and consumption.

There is little evidence in this field for what works, bringing the risk that even if providers manage to substantially reduce their costs, the NHS could still find itself in 2021 having to reduce its consumption through crude rationing. ●

This essay was produced in association with John Appleby, director of research and chief economist at the Nuffield Trust

'Like any business that sells its goods or services for less than the cost of providing them, NHS providers soon began to fall into deficit'

The Brexit factor

ESSAY 4

BY ELISABETTA ZANON

The prognosis for the NHS in a post-Brexit world is still very uncertain. What are the issues to watch out for as negotiations unfold?

Elisabetta Zanon *is director of the NHS European Office at the NHS Confederation*

SINCE THE UK voted to leave the EU, and Theresa May became Britain's new prime minister, there has been endless unpicking of her oft-quoted but highly ambiguous statement "Brexit means Brexit". What does it mean for the country? What does it mean for the world?

Here we focus on the possible meaning of Brexit for the NHS. It has potential implications for a number of critical areas, expressed by the handy acronym: **B**udget, **R**esearch, **E**mployment, **X**-border healthcare, **I**nnovation and clinical **T**rials.

First and foremost, there could be a budgetary impact on the NHS. Much discussion took place in the run-up to the referendum about possible additional funding for the health service as a result of leaving the EU. However, it has become clear that, if economic growth were to slow, funding no longer being paid to the EU could be more than cancelled out by the negative economic consequences of leaving.

While it is difficult to quantify the possible financial impact of an economic downturn on the NHS and views on the economic outlook vary, some predictions have been made. The Health Foundation has estimated that the NHS budget could be £2.8bn less than the amount currently planned for 2019-20; and the Economist Intelligence Unit has stated that, by 2020, the NHS will spend £135 less per head as a consequence of the UK leaving the EU.

In the case of a prolonged economic fallout, the effect on an already stretched NHS budget could potentially lead to longer waiting times or reduced access to innovative, expensive medicines and health technologies.

Brexit could also affect clinical research and innovation in the NHS. Collaboration with our European counterparts has helped us to develop new treatments, adopt advances more quickly and improve the quality of healthcare. It has also facilitated the enrolment of NHS patients in clinical trials, allowing them to access new and possibly life-saving treatments when no other medical option is available to them.

The NHS's participation in EU collaborative research could be affected in the case of prolonged uncertainty about whether the UK will adhere (or not) to the EU regulatory framework on the authorisation and conduct of future clinical trials. A new EU clinical trials regulation is due to be enacted in 2018, which will streamline the procedures to assess and authorise clinical studies, removing duplication and reducing delays. Importantly, these new EU rules will introduce some flexibility and simplification that will make it easier for NHS trusts to participate in multinational clinical trials. For example, it will become possible to carry out a trial that involves patients in different member states with one application, instead of having to apply to carry out the trial in each country involved. This will speed up the time it takes to start such clinical trials. This is a positive change for studies into treatments for rare diseases which, by their very nature, require the participation of patients from several countries.

It will be crucial for the NHS that these positive changes are not lost because of Brexit and that NHS organisations and, more importantly, our patients, do not miss out on the opportunities offered by collaborative research with European partners. ▶

In a similar vein, uncertainty has emerged about whether it will still be possible for NHS trusts to lead or be members of European reference networks for rare and complex diseases after Brexit. These networks are a new form of EU collaboration between specialised healthcare providers, which aim to pool knowledge in specific clinical areas to increase the speed and scale at which advances in medical science and health technologies are incorporated into care provision.

If the UK's new relationship with the EU were not to allow us to take part in these networks, this would be a blow to our leading role in international medical science. It could have negative implications for patients, by potentially slowing down the take-up of innovations and putting them into NHS medical practice. In turn, this could damage the NHS's ability to attract and retain some of the most renowned clinicians in the world, who often decide to work for the NHS due to its reputation in leading medical research.

Known unknowns

Brexit could also restrict our ability to recruit and retain EU employees. There are around 144,000 EU health and social care professionals currently working in England, equivalent to 10% of our doctors and 5% of our nurses. Some 80,000 work in adult social care, 58,000 work for the NHS and 6,000 work for independent health organisations, A weak currency, coupled with prolonged uncertainty on whether EU freedom of movement rules will continue to apply in the future, could make the UK a potentially less attractive destination for EU migrant care workers and other healthcare staff.

There could also be consequences for NHS patients in terms of their ability to access cross-border healthcare in the event that EU mechanisms and rules in this area no longer applied. This could mean that British citizens on holiday in Europe might no longer be able to use the European Health Insurance Card. The EHIC allows British citizens to receive emergency or immediately necessary healthcare on the same terms as the residents of the country they are in.

EU law also gives Britons who are on the continent for a longer period – such as pensioners and those working in other EU countries – entitlement to healthcare in the country where they live. These rules are extremely complex, but the key principle is that Britons are entitled to healthcare on the same basis as the local population, thanks to a system of reimbursement of costs between the UK and the host country.

In the future, this system might no longer apply, unless bilateral agreements are negotiated between the UK and each individual EU country. This could mean that our citizens might have to purchase private health insurance or come back to the UK when in need of healthcare.

It should be stressed that these EU rules are reciprocal and therefore uncertainty also exists over whether EU citizens will be entitled to NHS care in the UK following Brexit. Selfishly, we may believe that this could potentially help alleviate pressure on our stretched healthcare system, as there are around twice as many EU citizens living in the UK as there are UK nationals living in the EU. However, this is unlikely to happen, as UK nationals living abroad are often older and in greater need of care than the younger and therefore healthier EU citizens who work or study in the UK.

At this stage, it is impossible to predict whether these possible implications will materialise and, if so, to what extent, as we do not know what kind of new relationship with the EU the UK government will seek, how long negotiations with the EU will last, and what the outcome will ultimately be. Even with all these variables, it is clear that there are potentially important implications – particularly in relation to staffing issues – that will have to be taken into account.

A critical factor is whether the UK continues to have access to the EU's single market in the future. Continued access to the single market is likely to imply adherence to EU policies and rules in the areas described above and hence a smaller degree of change from an NHS perspective. At the other extreme, a total exit from the single market would leave the UK free to determine its own policies and to seek bilateral agreements with selected countries in these areas, with a bigger potential impact on the NHS.

Over the coming months, as the UK government elaborates its leave strategy and eventually sheds some light on what the implications of "Brexit means Brexit" really are, we shall be conducting further analysis of how the proposed approach could affect the NHS, with the aim of briefing negotiators and, ultimately, securing a good outcome for healthcare services. ●

'There are potentially important implications – particularly in relation to staffing issues – that will have to be taken into account'

DRILLING DOWN

Far better than cure

5

ESSAY

BY DUNCAN SELBIE

Focusing on prevention brings long-term financial as well as health benefits. So how can we make it happen?

Duncan Selbie *is chief executive of Public Health England*

GOOD HEALTH is about more than healthcare. It is also about having a decent job, somewhere safe and warm to live, a good education and access to green space. Health issues cut across all public services, and it is only by working across government and in different sectors and communities that we will be able to address the tide of preventable disease that threatens the current system.

Life expectancy in England continues to rise – but we have yet to see improvements in levels of disability and ill health. Sickness and long-term disability are responsible for an ever-greater proportion of the burden of disease, with people living longer and spending more years in ill health. Yet much of this human and financial cost is potentially preventable.

Failing to address these issues not only endangers the health and wellbeing of people in England but also threatens our economic productivity and the future sustainability of the NHS.

National data on healthy life expectancy shows a significant disparity between local authorities. For example, in 2012-14, Wokingham had the highest healthy life expectancy at 70 years for men and for women – almost 15 years longer than Blackpool, which had the lowest average healthy life expectancy at 55 years. As the pensionable age in England continues to rise, increasing action to prevent and reduce health inequalities is vital to ensure a healthy working population.

The statistics are daunting. Nearly one in five adults smoke. A third drink too much alcohol. Just under two thirds are overweight or obese. Many of these risk factors are enabled – and often encouraged – by the environments in which we live, work and socialise.

Behavioural risk factors such as smoking, hypertension, alcohol, being overweight and a lack of physical activity are responsible for 40% of disability-adjusted life years – years that are lost due to ill health, disability or early death. They are major contributors to premature death, including from cancer, heart disease, stroke, respiratory disease and liver disease.

Long-term conditions now take up 70% of the NHS budget, and the number of people with three or more of these is predicted to rise from 1.9 million in 2008 to 2.9 million in 2018. It is estimated that there will be a mismatch between NHS resources and patient needs of nearly £30 billion a year by 2020-21. The health sector has recognised the extent of the challenge ahead and what must be achieved in its Five Year Forward View, which calls for a radical upgrade in prevention, along with a need to do more to promote and incentivise new models of care.

Local authorities, which lead on public health, are also navigating a tough economic landscape. Public health budgets are shrinking while other services that affect public health, such as housing and transport, must compete with other statutory obligations for funding.

However, within this context of increasing demand and financial pressure, a huge opportunity exists for preventive public health. If health in the worst-performing regions matched that in the best-performing ones, England would have one of the lowest burdens of disease of any advanced country.

Currently, 40% of health services' workloads are caused by potentially preventable issues,

yet the proportion of health expenditure directed at prevention, although hard to estimate reliably, is probably close to just 4%.

Public health reaches right across government, from education to justice and the economy. In order to provide efficient, effective interventions to improve public health, we must change the way we use our resources to achieve greater impact. By gradually redirecting the money we have to where we can make the greatest difference to health, both within public health and across the public sector, we can affect real change.

A joined-up approach

We are already seeing how government policy and investment from other departments can play a big part in improving health and wellbeing. For example, the Department of Transport's cycling and walking investment strategy, published this year, has committed more than £300 million to improve roads and provide cycling proficiency training for children. This helps make walking and cycling the natural choice for shorter journeys, with clear benefits for health outcomes. Long-term unemployment – known to affect mental and physical health as well as economic growth – is being addressed by a number of reforms at the Department of Work & Pensions to support people to get back into work.

Tackling obesity – one of the greatest challenges facing this country – also requires action from across the system. Public Health England is taking the lead, working with the food and drink industry to reduce the amount of sugar in food products popular with children and promoting tools and advice to help children and families eat more healthily and get more exercise. But dismantling the obesogenic environment must involve a broad coalition of partners, including schools and catering services, council planning departments, transport authorities and the Treasury.

Funding is required for all of this work, but success is not just about increasing funding. It must also be about rethinking how we spend what we already have, and pooling budgets across silos and departments to achieve better outcomes across a range of objectives.

Taking action

The NHS Five Year Forward View emphasised that any increase in funding must be matched by increases in efficiency, supported by action on prevention, investment in new care models, sustained social care services and wider system improvements. In order to set new and achievable targets, the health sector must understand what it spends on prevention, and the return on that investment.

Work to deliver this is taking shape. Existing funding is increasingly being used in innovative and cost-effective ways to deliver our promise to get serious about prevention.

For example, the NHS Prevention Board has launched the Healthier You: NHS Diabetes Prevention Programme. A collaboration between Public Health England, NHS England and Diabetes UK, it is the world's first nationwide programme designed to reduce people's risk of developing type 2 diabetes and help to prevent associated conditions including sight loss, kidney failure, cardiovascular disease and stroke. It will support and be supported by the NHS Health Check, so those identified by the NHS Health Check are referred to high-quality, evidence-based behavioural interventions.

The NHS, working in close partnership with local government, is reviewing sustainability and transformation plans across 44 geographical areas. These blueprints set out how areas plan to improve health, quality of care and finances over the coming years, including how they will promote prevention. This is an important step towards a more integrated, place-based approach to public health, with leaders from local government and the NHS working together to get the best possible value from their shared work.

Local authorities are best placed to respond to the needs of their populations, and the Cities and Local Government Devolution Act 2016 will see even greater devolution of powers to them. For example, the devolution of health and social care spending to Greater Manchester will give it more control over spending on hospitals, GP surgeries and drop-in centres, and the ability to fully integrate funding for health and social care, delivering efficiencies and local solutions to local problems. Devolution is also intended to boost local economies, create jobs and improve infrastructure, all of which can improve public health and wellbeing.

Barriers to progress

A lot of work is being done to shift the focus from treatment to prevention, with innovative projects and programmes across the country. There are also significant barriers.

First, we must make better use of case studies and other evidence to show investment ▶

'Prevention is not just about saving money, but also about taking the most cost-effective action to improve health and reduce health inequalities'

is needed in prevention. Some work has been done to assess the cost-effectiveness of prevention: one study summarised evidence relating to around 200 public health interventions and found that 85% were cost effective – below £20,000 per quality-adjusted life year (a year of life in perfect health) set by the National Institute for Health and Care Excellence.

However, this approach is limited as it may fail to take into account the longer time horizons of most public health interventions and the fact that the benefits may be directly or indirectly felt in several parts of the system.

Second, while some interventions produce quick results, such as suicide prevention and hypertension management, others take many years to pay off. A short political cycle and immediate pressures on frontline services can make it hard to secure investment in prevention and public health, particularly when costs and savings go to different parts of the system.

Third, addressing noncommunicable diseases and associated risk factors is complex and requires an integrated, whole system approach. It cannot work without buy-in from other government departments and local and national partners, including local authorities and voluntary organisations.

Moving forward

Overcoming these barriers will require input from across the system, as well as a long-term commitment to change. Public Health England is working with local and national partners in many ways to address the three challenges outlined above.

First, to set achievable and effective targets for national spend on prevention, we must clarify further what the health and social care system already spends on this, and how it compares internationally; we are working with CIPFA on this. We are piecing together evidence from the public health grant, social care prevention expenditure and NHS spend on preventive activity in primary care to build a wider picture of preventive spend across the system.

Alongside this, we must better understand the value that is derived from expenditure on prevention compared to treating disease. We will continue to build on our work for the Treasury to clarify return on investment (ROI) in relation to the public health grant, and will draw upon ongoing work in Scotland and Wales to summarise the ROI in various areas of prevention.

We will also be reporting on how other government departments approach ROI and what we can learn from them. This should support conversations with other departments on how they can promote health and wellbeing and help to address wider social determinants of health.

Second, shifting investment from treatment to prevention requires a whole-system perspective and a long-term view, while recognising the need to identify potential short-term savings. For example, financial incentives, used by the NHS to reward good performance or agreed outcomes, should be used to encourage outcomes linked to disease prevention, rather than just treating avoidable illness. Longer-term planning and budgeting beyond the annual cycle will support this, while budgets must become more integrated to enable joint commissioning and avoid perverse incentives such as cost-shifting between sectors.

Working closely with NHS England and NHS Improvement in key areas like diabetes prevention will help to align incentive mechanisms. We must also ensure that sustainability and transformation plans have a continued focus on preventive activity and that we continue to provide relevant evidence on interventions that work to help local systems make the case for investing in prevention.

Third, we must recognise that prevention is not just about saving money but also about taking the most cost-effective action to improve health and reduce health inequalities. Our mission is to protect and improve the health of the people and, to be effective in this, we need to work with partners on majoring in prevention rather than cure – and on delivering significant benefits not only to the health and social care system but also across our whole society.

‘Sustainability and transformation plans are an important step towards a more integrated, place-based approach to public health’

For the greater good

ESSAY 6 WN

BY PETER SMITH

Greater Manchester doesn't just talk about joining up health and social care budgets – it is doing it, with promising early results

Lord Smith *is chair of Greater Manchester Health and Social Care Strategic Partnership Board, and leader of Wigan Council*

EVERY DAY, THE media is full of horror stories about the failure of the NHS to keep up with rising demand – accident and emergency department closures, clinical commissioning groups no longer paying for routine operations, hospitals in deficit.

We know we are all living longer – which at my age is great news. But we are also living longer with increasingly complex problems. Older people require more frequent and more expensive medications and procedures, and there is often insufficient community support for them to be safely discharged if they end up in hospital. These problems are completely different from the ones the NHS faced when it was founded in 1948.

Hospital trusts do their best, but often act as though they operate in isolation from each other as competing businesses, rather than as a system. There are increasingly serious workforce shortages that will be exacerbated with Brexit reducing recruitment from the EU. We cannot recruit and retain enough GPs but we allow 40% of their valuable time to be taken up with non-medical or social issues, such as loneliness, debt or poor housing.

So what do we do?

The NHS is underfunded but money alone won't solve its problems. We need to work differently and more coherently across health and social care, and focus on reducing demand, particularly where ill-health is self-inflicted by lifestyle.

In February 2015, 37 Greater Manchester leaders in NHS provider trusts, GP practices, the North West Ambulance Service, Greater Manchester Fire and Rescue, all 10 councils and 12 CCGs signed a historic agreement with NHS England. This enabled the devolution of £6bn of NHS resources to be shaped around the specific needs of the 2.8 million residents of Greater Manchester, effective from 1 April 2016.

By that date, we not only achieved a smooth transition of responsibilities but also had put in place new strategies for Greater Manchester and the areas it covers. Each of the 10 boroughs has locally agreed plans that take into account the differences between populations in places such as Oldham and Trafford, and achieve local ownership while ensuring they are consistent with the regional approach.

For the first time ever to my knowledge, we have a genuinely co-produced, co-owned plan for health and social care in one region. It is no longer about the commissioner/provider annual financial tussle. We have developed new payment and contracting models that close the fiscal gap, as well as improve patient outcomes and prevent our residents from becoming patients in the first place.

We have now reached the harder task of implementation.

This is quite simply the single biggest shake-up of public services that I have witnessed in 25 years of being leader at Wigan Council and during my involvement in the Greater Manchester Combined Authority, and it has been achieved by partnership.

Five core themes

Despite their local variation and unique identity, our local plans are based on five core transformation themes that are consistent across Greater Manchester, and which we have set out in our Health and Social Care Strategic Plan.

First is a fundamental change in the way people and our communities take charge of managing their own health and wellbeing, whether they are well or ill. This will include: exploring the development of new relationships between NHS and social care staff and the public who use services; finding the thousands of people who are living with life-changing health issues and do not even know about them; and investing far more in preventing ill health. We want people to start well, live well and age well.

Second is the development of local care organisations where GPs, hospital doctors, nurses and other health professionals come together with social care, the voluntary sector and others looking after people's physical and mental health, as well as with managers, to plan and deliver care. This is so that when people do need support from public services, it is largely in their community, with hospitals needed only for specialist care.

Third, hospitals across Greater Manchester will work together across a range of clinical services to make sure expertise, experience and efficiencies can be shared widely. This will allow everyone in the region to benefit equally from the same high standards of specialist care.

Other changes will make sure standards are consistent and high across Greater Manchester as well as save money. The sharing of some clinical and non-clinical resources will be looked at.

Finally, support functions will be integrated across all organisations. These mergers will give people greater access and control over their health records and ensure they are available to hospitals, GP practices and social care, so that people need only tell their story once. This also includes investing in workforce development throughout the area, sharing and consolidating public sector buildings, investing in new technology, research and development, innovation and spreading great ideas.

Not just sticking plaster

To help turn our radical ideas into action, we have received £450 million in transformation funding from the NHS. As it says on the tin, this is to change the way health and social care work across the region. It is not a sticking plaster to patch over current cracks.

We have identified future funding deficits and are working to eliminate this fiscal gap over five years. However, we are not engaged merely in a savings exercise.

If we succeed, we will improve health outcomes across Greater Manchester. We have set a range of ambitious targets: 1,300 fewer people dying from cancer; 600 fewer people dying from cardiovascular disease; 270 more babies weighing more than 2,500g at birth, which makes a significant difference to their long-term health; and 2,750 fewer people experiencing serious falls, which will be achieved by supporting people to stay well and live at home for as long as possible.

We also want to raise the level of achievement of children, for example by ensuring that more of them reach a good level of social and emotional development with 3,250 more children ready for the start of school aged five. This will have both short and long-term beneficial effects.

In addition, we want to tackle the health issues that are a barrier to the almost 200,000 citizens in Greater Manchester who are long-term unemployed. This would make our city region both healthier and wealthier and, hopefully, happier too.

The consultation after the publication of our plans showed that the people of Greater Manchester and our workforce largely back our ideas, which are focused on them, not on organisational or sectional interests.

It is exciting, it is time consuming and it is exhausting, but it is definitely creating the robust future health and social care system that will improve the lives of the people of Greater Manchester.

'We have a genuinely co-produced, co-owned plan for health and social care in one region. It is no longer about the commissioner/provider annual financial tussle'

Up close and personal

ESSAY 7

BY MIKE ADAMSON

A focus on individual healthcare needs is vital to avoid unnecessary crises and wasted resources. Voluntary organisations are well placed to provide this

Mike Adamson *is chief executive of the British Red Cross*

MANY SERIOUS CHALLENGES face health and social care. But, based on our experiences at the British Red Cross, there are two in particular that resonate.

First, too many people are not consistently supported in the community to live as well as they possibly could. And second, too many people have to reach the point of crisis before they receive support.

Many voluntary and third sector organisations are well equipped to tackle these issues. There is a growing awareness that this is not just desirable in itself, given such organisations' ability to engage with people and their communities. It can also often be the most cost-effective approach in the long run.

The Red Cross has operated in the critically important space between hospital and home ever since the NHS was established in 1948. We now reach more than 80,000 people a year through our 160 hospital and community services across the UK.

This experience has shaped our thinking on health and social care policy and practice, and given us many insights into the ways voluntary and community services can make a significant difference to outcomes.

We have seen first hand how, when people are unable to access the right services at the right time, it threatens their independence, pushing them into crisis and causing unnecessary suffering. There is clearly a strong humanitarian imperative for change.

While a plethora of initiatives have been created to respond to these challenges, they tend to overcomplicate matters in the short term – and ignore the longer term altogether. Instead, we need to look at what can be achieved within the current economic climate while simultaneously planning beyond the immediate parliamentary cycle.

If we are to support people to live well and avert the point of crisis, our solutions need to focus on people, place and policy. It's worth examining all these aspects briefly. But first, some context.

The longer view

We have an ageing population. While this is a human success story that should be celebrated, living longer does not necessarily mean living well. Some 48% of women and 36% of men aged 80 and over have at least one limitation when it comes to daily living activities such as walking across the room, bathing or showering, eating, getting in and out of bed or using the toilet.

This ageing population means demand is increasing on our severely overstretched health and social care systems, services and resources. NHS activity is growing by an estimated 3.1% per year; but average NHS spending on retired households is nearly twice that on non-retired households. The Department of Health estimates the average cost of providing hospital and community health services for a person aged 85 or over is around three times greater than for a person aged 65-74 years.

Meanwhile, the Five Year Forward View requires the NHS to find savings of around £22 billion by 2020 to balance its books. Analysis by the Nuffield Trust has concluded that, ▶

even if hospitals and other NHS providers make cost savings of 2% per annum, the funding gap will still stand at around £6 billion by 2020.

Health and social care are, of course, interdependent. The latest figures show that not only are delayed transfers of care increasing but also that the proportion of delays attributable to adult social care rose over the past year to 32.2% in June 2016, compared with 31.3% in June 2015.

Fewer people are receiving social care and those who are having care delivered are getting less of it. It is now estimated that the funding gap in social care will reach between £2.8 billion and £3.5 billion by the end of 2020. As the National Audit Office recently put it, "national and local government do not know whether the care and health systems can continue to absorb these cumulative pressures, and how long they can carry on doing so".

In the face of these daunting pressures, the voluntary sector has proved itself able to add significant value to the work of health and social care professionals, often bridging gaps between the two sectors. According to the King's Fund, three million people across England volunteer in health and social care. Through the expertise they have gained, we are able to identify key areas for improving and transforming services.

The people solution

Focusing on individual needs is central to health service transformation. This should happen at every contact point in the system. Health and social care professionals need to help people identify personal goals that are integral to living well. These goals must be incorporated into all handovers between services, and regularly reviewed by professionals, services, departments and voluntary organisations.

This person-centred approach focuses resources on where they are most useful, improving efficiency and potentially saving costs. It is an area where input from voluntary organisations can be particularly useful. In many instances, it is simply a case of identifying what the barriers are to someone receiving appropriate treatment.

For example, in the case of one woman the Red Cross was supporting, our volunteers discovered she was refusing to engage with her local physiotherapy service because she didn't want to leave the house without first having her hair done. Once this very reasonable personal "goal" was identified, they arranged for a mobile hairdresser to visit – and she subsequently had the treatment and regained her mobility. All it took was some sensitive and effective personal engagement.

There are countless other examples, from arranging pet care, to making arrangements for a neighbour to tend to a loved one's grave, to organising and providing transportation and mobility aids, where a person-focused intervention makes the difference between a vulnerable, often isolated member of the community accessing the services they need or not.

An agreement between services that embeds this goal-setting approach can, in our experience, help to deal with these obstacles. If this small step were to be applied across the country, people would be much more consistently supported, saving valuable healthcare resources in the long run.

The place solution

Similar issues arise with our multiple, overly complicated health and social care organisations. At the moment, we have separate national NHS, adult social care and public health outcome frameworks. While there is some oversight across the frameworks, they are far from integrated and hard to navigate.

This can all too easily result in siloed local planning and commissioning. Developing shared, place-based outcomes can help overcome this, bringing together expertise from local government, community pharmacies, the voluntary, community and social enterprise sectors, housing providers and other local services to efficiently pool resources and work towards a common purpose.

Health and wellbeing boards are a natural place for this work to happen, though their effectiveness varies across the country. The Place-Based Health Commission's *Get Well Soon* report offers guidance on how to progress this approach, such as supporting the role of "system translators". Health and social care professionals admit they often speak different languages to the point where they sometimes struggle to understand one another. System translators, attached to no specific organisation and who can talk the language of both "sides", have the potential to lead change and help a cooperative culture to emerge.

At a time of great pressure on resources across health and social care, a place-based focus on service transformation makes sense, whether through the NHS Vanguards,

'The voluntary sector has proved itself able to add significant value to the work of health and social care professionals, often bridging the gaps between the two sectors'

sustainability and transformation plans, or other initiatives. The voluntary sector has much to offer, operationally and strategically, in this regard – particularly when it comes to helping to join up and integrate local services on behalf of patients and service users.

The policy solution

However, in common with many other organisations, we believe there also needs to be political will at a national level to overcome the difficulties of dealing with completely different eligibility criteria and approaches to charging within health and social care.

While we welcome the many efforts to bring health and social care closer together – notably the Greater Manchester devolution exercise – there are lessons from our experiences on the ground in Scotland, Wales and Northern Ireland that point to the need for new legislation in this area.

This is the only mechanism through which true health and social care integration can be achieved. Devolution within England looks likely to be a stepping stone in this direction, but is insufficient to secure it fully. In Wales, meanwhile, despite local goodwill, devolution of health and social care powers has made only limited progress. Agencies still have just a few duties to pool health and social care budgets.

In Scotland, on the other hand, legislative steps have been taken to introduce single integrated budgets and shared outcomes, incentivising investment in prevention – and offering us a potential blueprint to learn from. Without such policy solutions, it is hard to avoid cost shunting between health and local authorities, or reduce the gaps between services into which people fall.

Shifting health and social care from being reactive to preventive is, without doubt, the only way to ensure a sustainable, cost-effective response to the pressures of a growing and ageing population. It is also the only way to ensure that people are not only living longer but also living well.

And it is an area where the voluntary sector has a unique and valuable role to play in the challenging period ahead.

‘From arranging pet care to providing transportation and mobility aids, people-focused interventions can make the difference between a vulnerable person accessing services they need or not’

Shifting the focus upstream

8

ESSAY

BY JOHN MATHESON

Scotland faces economic and fiscal uncertainty, and tough new challenges to its healthcare services. As Yogi Berra said: 'The future ain't what it used to be'

John Matheson *is a former director of finance at NHS Scotland and CIPFA past president*

THE CHALLENGES FACING the health sector in Scotland are well documented. They range from the ongoing fiscal challenge and a changing demographic profile – with an 82% increase in over 75s over the next 30 years – to rightly rising public expectations about the quantity and quality of care.

There are wholly unacceptable variations in healthy life expectancy across Scotland, with more people living with several health conditions. A further factor that often escapes attention is increasing isolation and loneliness; there has been a rise in single-person households from 14% to 35% over the past 50 years.

It is expected that fiscal tightness will continue until at least 2020 and that Scotland will not return to 2009-10 funding levels until 2025-26, representing a cumulative budget reduction in excess of £40 billion. Further macroeconomic uncertainty will inevitably arise as the UK and possibly Scotland negotiate a new relationship with Europe.

As director of finance for the NHS in Scotland, I was made forcibly aware of comparative health service investment levels between acute services on the one hand and the upstream, proactive areas of health promotion and health improvement on the other.

The NHS Scotland budget for 2016-17 is in excess of £13 billion – over 40% of the total Scottish government budget. Perversely, at least 90% of that budget will be spent not on health but on illness. And, of course, the determinants of health stretch way beyond the health service into housing, education, transport, employment, community strength and family support.

All of the above reinforce the need for upstream transformation of how services are provided. This involves a much more coordinated approach across the public sector, including more open engagement with the public around options for change.

In approaching this, Scotland already has a significant advantage in terms of integrated service provision. Health boards have been fully integrated since 2000, providing the full range of acute, primary care and public health services. Since April 2016, adult health and social care provision, with a total budget of over £8 billion, has also been brought together. This is normally managed through an integrated joint board, and there are early signs of success.

The challenge, though, is how we avoid wasting the opportunities offered by the tight financial climate – and use the lack of resources to drive forward innovation and transformation, not just within the health service but also across wider public services. I believe there are immediate opportunities in the following areas.

Innovation and risk

The public sector in Scotland needs to examine its risk appetite thresholds – individually, organisationally and at government level. Failure needs to be recognised as an inevitable risk of pushing boundaries and an opportunity for lessons to be learned rather than a career limiting event.

Critically, this conversation needs also to include our audit colleagues on two fronts. First, with regard to proportionate corporate governance in its various forms. Too often,

governance becomes an impediment and a straitjacket that restricts and prevents innovation and is used as a front for inactivity. Second, auditors need to be looked on as individuals and organisations whose expertise enables them to take a helicopter view of organisations and share best practice across the organisations they audit.

Third sector matters

Scotland's third sector encompasses 43,000 voluntary organisations, including 163 housing associations and 20,000 grassroots community groups.

However, too often, the third and voluntary sectors are an afterthought and an add-on to core service delivery. This approach needs to change quickly, and they must become not just an integral part of service delivery but also fully engaged in strategy development

Quality to the fore

The transformational approach needs to be driven by improving quality and not primarily to reduce cost; if cost reduction becomes the prime driver, the required pace and depth of change will not be achieved. There is unequivocal evidence that a quality-driven approach will have the secondary impact of reducing cost. There are numerous examples where this has been done in the acute sector around infection and readmission rates.

A community-based example is the No Delays initiative developed by NHS Grampian. This gives health professionals, following a consultation, the ability to prescribe and send a personalised digital postcard to a patient with a video clip and information customised to their needs. The digital postcard introduces the care team and helps patients to understand their diagnosis so that they can understand their treatment better and make changes to their lifestyle. There has been a major uptake of this in the areas of sexual health, pregnancy (planned and unplanned) and diabetes.

A second community example is United4Health, a Scottish government and European funded partnership across the West of Scotland. Using smartphones and tablets, patients and their healthcare providers are able to exchange information without the need and hassle of time-consuming appointments and travel. This has also increased the quality of service experience through better coordinated and more person-centred care.

Despite these initiatives, the public sector in Scotland still has a propensity to measure performance using a quantity currency based on inputs such as numbers of teachers, nurses, police officers and so forth, rather than a quality measure based around outcomes and outputs. But there are promising new ways to address this.

Valuing the elderly

One of the key determinants of health and wellbeing in someone over 75 is how society values them. Do they feel they are an asset with a useful contribution to make to their local community and beyond, or do they feel that they are a liability and a burden on their families and society?

One of our key societal challenges involves how we engage with the elderly to use their undoubted expertise and experience in myriad areas.

To support old people in achieving their potential, initiatives such as Living it Up (LitU) have been developed in Scotland. LitU was set up by a range of partners, including the Scottish government and Innovate UK, to increase the use of digital technology to support people living with long-term conditions and their carers by increasing their capacity for prevention and self-care. Designed by more than 3,500 people, it now has over 24,000 subscribers and it is active in 11 geographical areas in Scotland, providing advice and local contacts on issues such as cooking, keeping fit, digital upskilling and volunteering.

Initial impact assessment shows both a significant reduction in contact with care professionals and an increase in volunteering.

Focus on child health

At the other end of the age spectrum, having a positive, supportive experience during a child's early years is a key determinant of maintaining both physical and mental wellbeing into and throughout adulthood.

Scotland's children and young people's improvement strategy aims to make the country the best place in the world to grow up in by ensuring children have the best start in life and are ready to succeed. To this end, the Scottish government's learning strategy – Curriculum for Excellence – incorporates health and wellbeing as one of its three core areas.

Another example is the family nurse partnership, which was developed by Professor David Olds at the University of Colorado. It is a voluntary home visiting programme ▶

'Auditors need to be looked on as individuals and organisations whose expertise enables them to take a helicopter view of organisations'

aimed at first-time mums aged 19 years and under. It aims to support them to have a healthy pregnancy, maximise their child's health and development, and plan their own futures and achieve their aspirations. The programme is now offered to all eligible mothers in Edinburgh and is being rolled out across Scotland.

Often a simple initiative is the most powerful. At St Ninian's Primary School in Stirling, all the children walk or run a mile during the school day. This Daily Mile initiative has had the outcomes of no obese children at the school plus an increase in academic achievement.

Thinking strategically

The current financial tightness can lead to an excessive focus on short-term issues. It is essential that, while dealing with immediate difficulties, we retain our commitment to investment in delivering our long-term vision. Short-term decisions should be at least neutral in respect of and at worst not counter to the long-term strategic direction.

This is especially important when it comes to progressing health promotion and health improvement, where overnight change will not occur – and where tenacity is required well beyond the political electoral cycle.

In summary, Scotland needs to make a significant step change in the upstream health of its population. Tinkering with organisational structures and funding mechanisms and models will be a distraction and will not achieve the desired pace of change.

This requires stronger and more open relationships with the public, significant demolition of traditional public sector boundaries and much stronger relationships with the voluntary sector in both strategic and delivery contexts.

It is important to acknowledge that the journey within Scotland has already started, with the direction clearly set by the Christie Commission, which examined options for the future delivery of public services in 2011. The recommendations of the Christie Commission are already being implemented by policies such as health and social care integration and early intervention.

Beyond Christie

This is welcome but much greater pace and impetus are required to develop and deliver this transformation. Scotland remains reluctant to learn from as well as share best practice. Yes, there are some nuggets of exception, but sharing and implementing best practice within Scotland, across the UK and, indeed, the world need to become routine.

The focus still remains too much on acute services and, where a broader view is taken, it is reactive rather than proactive, such as being targeted on getting patients from hospital back into the community. The current and future challenge is to become much more focused on supporting people to remain out of hospital in the first place.

Barriers potentially impeding transformational change include defensive reinforcement of a silo mentality by organisations due to financial constraints – there are fears of both failure itself and the organisational response to failure. Annuality of the fiscal cycle, which drives short-term decision making, and performance assessment that is focused too much on quantity rather than quality measures are also problems.

All of these barriers can be overcome with support, guidance and encouragement from the government, together with a joined-up approach across the public sector. The key to delivering a step change in the transformation journey is to develop a much less risk averse public sector ethos together with a more open and honest two-way engagement with the citizens of Scotland.

'There is unequivocal evidence that a quality-driven approach will have the secondary impact of reducing cost.'

FIXING THE FINANCES

Do the right things right

9

ESSAY

BY MATTHEW CRIPPS

Reducing variation in what healthcare spending achieves will mean resources are used more effectively, providing better value to providers, commissioners and patients alike

Professor Matthew Cripps *is national director of NHS RightCare*

NHS CHIEF EXECUTIVE Simon Stevens told a conference of health sector leaders back in June that the NHS RightCare programme was "not any longer a special project or a hobby" but "absolutely mission critical for the sustainability of what the next three or four years look like".

To understand what this means – and how value improvement in the NHS went from being seen as a cottage industry to the rapid industrialisation of this approach – we need to look at where value fits within the context of improving performance management in the NHS and how it contributes towards financial sustainability.

"Doing the right things right" is a long-standing management maxim – and one that underpins the NHS RightCare approach. Arguably, it has been adopted in the field of healthcare only in the past 20 years, during which time there has been a focus on quality, safety and value. Key reports on these areas from the Institute of Medicine and the Department of Health have stimulated healthcare providers and clinicians to improve the quality of the care.

This focus on research – and, from 1996 onwards, on evidence-based decision making – raised the question of whether we were indeed "doing the right things right". Decisions about what healthcare services should or should not be provided were increasingly to be based on evidence of both clinical and cost effectiveness.

This in itself, however, was not enough. Research from the US shone a light on the importance of unwarranted variation in the impact of spending. One landmark study found health outcomes for people in Boston, Massachusetts, to be no better than those for people in New Haven, Connecticut, despite having 50% more healthcare resource invested in them.

The upshot was the publication of the influential Dartmouth Atlas of Healthcare in 1999, which documents large, unexplained variations in the effectiveness of treatments and the distribution of resources. Examples include the over- or underuse of interventions such as hip and knee replacements resulting in little value for the individual or population treated. Subsequent evidence from deprived populations in England has shown that a differential impact is also influenced by inequity.

The cumulative effect of all this research was to prompt the Department of Health, in 2006, to produce reports on variation and value. This work was coming to the fore when along came a hugely significant event for healthcare finances – the global financial collapse of 2007.

A new paradigm

The financial crisis led to a profound shift away from an era in which increasing investment in healthcare was regarded as an obvious measure for developed societies to one in which healthcare – like all areas of public spending – had to justify a return on investment.

This concerned both financial costs to taxpayers and the opportunity cost of spending that could be invested elsewhere, for example in primary schools, battleships or pensions.

Growing concern about the overuse of technology for diagnostic and treatment purposes was also beginning to change the health spending culture.

These developments prompted the NHS in England to introduce the QIPP system (quality, innovation, productivity, and prevention), which was followed by the NHS RightCare programme.

The first phase of RightCare focused on some key success areas. It put value – allocative, technical and personal – on the agenda. It also focused on changing culture through the identification and publication of unwarranted variation in NHS atlases of variation and, subsequently, commissioning for value packs.

Allocative value is determined by measuring and assessing optimal outcomes in different programmes and sub-programmes of care. These could be, for example, between respiratory and cancer care, and then, within respiratory, between asthma and chronic obstructive pulmonary disease (COPD). Technical value is defined by the use of resources, in relation to not only quality and individual patient safety but also the outcomes for all the people in need in a population. Personalised value concerns the degree to which an intervention achieves an outcome that relieves what a patient defines as their principal concern.

It is worth noting that, in financial management terms, the concept of value is captured by the principles of value for money. Most commonly, these are viewed from the perspective of allocating funding that delivers activities which, in turn, produce an output. All three areas of value are traditionally judged in terms of their economic (allocative), efficient (technical) and effective (personal) value.

So if, for example, we include ensuring that the outcomes are what the individual, informed, patient actually wants and values within "effective" value, we can see how the NHS RightCare concept of value aligns closely with the financial management concept of value for money.

Culture change

A key finding of the NHS RightCare team was that, although structural change per se was not required, there were some disincentives in the structures that needed to be addressed. For instance, if a hospital's income depends largely on the referral of patients to its clinics, this leads to the separation of generalist and specialist care and the growth of hospital services as opposed to primary care.

These and other issues are addressed by the various models put in place by NHS RightCare. Atlases of variation were introduced to change the culture of clinical professionals who, by and large, had assumed they were doing evidence-based practice and/or following guidelines, and were very surprised to learn about the degree of variation that could not be explained. The design and language of the atlases was intended to spark a change in culture. The commissioning for value programme and its products evolved from the atlases and built on this intention.

Programme budgeting is another vital means of changing culture. Instead of ▶

'Clinicians had assumed they were doing evidence-based practice and were very surprised by the degree of variation that could not be explained'

'There is a variation of between £6m and £12m per population being spent on people with musculoskeletal problems'

healthcare being seen as consisting of large, horizontal chunks of primary, secondary and tertiary care, the health service needs to be viewed as a matrix or hybrid organisation. It is vital to ensure health centres and hospitals are well run – but the core business of the health service should focus on, for example, women with pelvic pain, people with back pain or asthma, people in the last year of life, people with several health conditions and so on.

Using the principles of programme budgeting, a new approach has been taken. Expenditure of programme budgets varies between 1.5 fold and twofold; this is small in comparison with the variation in clinical practice, but still immense in its implications. It means, for example, there is a variation of between £6m and £12m per population being spent on people with musculoskeletal problems. The aim was to draw in clinicians to take responsibility, along with finance managers, for making the best use of resources – a move greatly supported by a report from the Academy of Medical Royal Colleges, *Protecting Resources and Promoting Value*, that introduced the concept of "the culture of stewardship" among clinicians.

Significant progress has been made in recent years, but the NHS in England still has to develop programme budgeting far more before it can realise its full potential for supporting population healthcare improvement and achieve financial sustainability across the system.

Another important area of culture change has been systems thinking, involving the development of systems such as those for people with atrial fibrillation, or people at risk of falls and fragility fractures. This was created in partnership with Public Health England, and has helped to introduce a collaborative culture.

Finally, investment in shared decision-making resources – drawing on the experience of the US-based Informed Medical Decisions Foundation – has been made to change the culture of patients as well as clinicians. This is to help patients recognise that healthcare can do harm as well as good, and that they need to think carefully about accepting an offer of a diagnostic test or procedural intervention. As with programme budgeting, significant further benefits remain to be gained for populations from shared decision making – benefits that the second phase of the NHS RightCare programme intends to help the NHS in England realise.

Industrialising the value approach

Early testing of the RightCare approach with local health economies has produced encouraging results – in terms of both patient outcomes and freeing up funds for further innovation. Examples include Hardwick Clinical Commissioning Group, where a 30% decrease in COPD urgent care activity was achieved in seven months, and Vale of York, where a 17% decrease in targeted outpatient activity was achieved through the local design of 136 new optimal clinical protocols.

Successes such as these generated enthusiasm within NHS England for rolling out the NHS RightCare programme nationally in 2016, with tailored support provided for every local health economy to adopt the programme as a "way of implementing change and

contributing towards the sustainability of the NHS". This is being achieved via the wide-scale adoption of a proven methodology.

Alongside the development and dissemination of the value concepts, the RightCare approach has evolved to deliver them within the healthcare system. These efforts are designed to increase value in population healthcare and deliver financial sustainability. They have been supported by many institutions and experts, including the universities of Oxford and Salford, Manchester Metropolitan Business School and the London School of Economics, building on knowledge transfer collaborations with Pfizer, Manchester Airport and McLaren Formula 1 among others.

This industrialisation of the value approach continues to be based on intelligence and the use of data and evidence that shine a light on variation and performance to support quality improvement, coupled with supporting local health economies to implement sustainable change.

The NHS RightCare programme for 2016 and beyond is committed to reducing unwarranted variation and thereby improve people's health and outcomes. It is working with local health economies to achieve this through focusing all stakeholders on four key areas:

- **Making the best use of resources** – to give patients, the population and the taxpayer better value;
- **Understanding how they are doing** – by identifying variation between demographic peers;
- **Focusing on optimal designs** – by identifying priority programmes with the best potential;
- **Using the RightCare approach** – a tried and tested process for sustainable change.

By these means, our approach to achieving optimal healthcare value is being industrialised, so the benefits will be received by all. Our aim is to ensure that the right person has the right care, in the right place, at the right time – making the best possible use of resources available. ●

This essay is co-authored with Professor Sir Muir Gray, director of Better Value Healthcare and former chief knowledge officer to the NHS

'If a hospital's income depends on the referral of patients to clinics, this leads to the growth of hospital services as opposed to primary care'

ESSAY 10

Proving the only way is Essex

BY CAROLINE RASSELL

How does it feel to build a sustainable healthcare finance system from the ground up? One 'success regime' has been finding out

Caroline Rassell *is accountable officer at Mid Essex Clinical Commissioning Group*

IN CASE YOU are still unaware, there has been a quiet and subtle reorganisation of health and care in recent times. The whole country has been split into 44 areas and asked to produce sustainability and transformation plans (STPs). These need to show, over a five-year period, how the whole system can become clinically and financially sustainable.

You may well ask how these are different from previous volumes of plans that have been required of health and care organisations over the past ... well, decades in fact. Could this finally be the "burning platform", the "right time, right place" or any of those other phrases we like to invent to create a sense that this time change will actually happen?

What I do sense is very different this time round is the drive to develop a system-wide plan – one that says what commissioners want to buy should match how providers are sizing up their business. If successful, this could provide a unique opportunity to be in a position where at least the health system players are all aligned.

Of course, this is easier said than done. It doesn't necessarily extend to the care system, where providers are in the main individual or private providers. And it does assume that everyone in health has a similar view of the world, and that all this will provide the answer everybody wants – a health and care system that is clinically and financially sustainable.

Selection process

In Mid and South Essex, we have had the unusual advantage of being one of three areas specially selected by NHS England last year as a "success regime". Sadly, this was not a cause for basking in glory, as the title did not imply anything positive. Instead, it reflected the view that there had not been much, if any, success in terms of tackling the financial and/or clinical problems in our area.

So would the gift of this positive label provide the silver bullet for the improvement that we clearly needed? It certainly has resulted in a number of positive and exciting changes, as well as challenges.

Mid and South Essex is fortunate in that its success regime's geographical area has the same footprint as its STP area. It covers a population of around 1.2 million with an annual health and care budget of around £1.8 billion. There are five clinical commissioning groups, three acute trusts, two mental health trusts, three community providers (one a social enterprise), three upper-tier local authorities (one county and two unitaries) plus another seven district councils.

The area is largely urban and is surrounded by London, the Thames Estuary and some leafy parts of Essex. I am sure that many STP areas have felt the same sense of loss as Mid and South Essex did when parts of the county – West and North Essex – were "left out" of the success regime. In health, we have largely got over this, as there were (and still are) good working relationships with CCGs and hospitals not covered by the success regime. However, it remains particularly challenging in local government, especially for our county, which has been effectively split into three STP areas.

What then have we achieved? Well, there is a sense across all organisations that we are now in the spotlight, and want to rid ourselves of any negative comments about our failure

– and prove instead that "the only way is Essex". Providers and commissioners are now talking a common language, and accept that the problem we have is a system problem rather than an organisational one – one successful organisation won't change the fact the system is in trouble. At our briefings, we have used the image of David Beckham playing for Manchester United wearing an England shirt to illustrate the point. We need all staff to think about the England shirt to start to solve the problems. While they play for their local team, they are also part of something bigger.

As well as creating a culture of system, we spent our initial time diagnosing the problems we faced – staffing, money, demand; the same issues, no doubt, occur in every area. We were also encouraged to start to build bridges – financial bridges.

First, we showed what would happen if we did nothing (depressingly, this would mean moving from a debt of £100 million now to one of £600m in five years' time across health and care). Then we moved on to how we could address this.

The problem now diagnosed, we explored some high-level planning assumptions. Accountants tend to think mathematically: most problems can be solved by cutting this or that, reducing assumptions, hoping for miracles etc. But the size of our debt has meant that, while high-level planning assumptions might deliver an acceptable answer in the short term, they need to be made sustainable. This is where, probably, former plans have come unstuck.

In Mid and South Essex, we have spent a considerable amount of time and resources working with the people who will ultimately be responsible for sustainable delivery – the staff and principally the clinicians. Significant investment has gone into working first with hospital clinicians to look at how sustainable care can be delivered in hospital. This has been led by a senior responsible officer for the "in hospital" work, one of the CEOs within the acute setting, working closely with the three medical directors and a CCG medical director.

Clinically led teams are looking at all the national guidance and best practice for emergency care, elective surgery, women's services and paediatric care to determine the answer to: how do we make the services in our hospitals clinically sustainable and affordable?

The "not in hospital" part of this equation, called "local health and care", is far more challenging to coordinate and develop deliverable solutions for. As the senior responsible officer for this, I know it will require some leaps of faith and some real challenges to the status quo. So far, we have been overwhelmed by the enthusiasm for the work that we have moved forward on already.

'The problem is a system problem rather than an organisational one – one successful organisation won't change the fact the system is in trouble'

Blueprints

We decided to start by developing a blueprint for health and care to cover frailty (defined for these purposes as being aged over 75) and patients at the end of life. This covers care in and out of hospital. The production of the blueprints (or pathways) was led by clinicians from health and social care and the voluntary sector. The idea was that, across the whole of the footprint, every provider should deliver the same outcome from services for over 75s and end of life patients. Recognising that work had already started in different areas, how the care was delivered was not mandated – but the outcomes expected were. The blueprints were launched in July and now the challenge is mobilising them across the patch.

The two areas of the "not in hospital" part of the plan that are the most complicated and, perhaps, controversial are primary care and demand. In Mid and South Essex, the growth in demand for all services is significant. Our hospitals are concerned that, if nothing is done in three years, another 150 beds will be needed to serve frail people and those at the end of life; the demand that a hospital sees is sometimes only one tenth of the demand primary care experiences.

The real crisis is the need to address the increasing demands on primary care and the lack of a sustainable workforce to deliver demand today, let alone demand in five years' time. We have over 180 GP practices in the footprint, and a mixture of large practices, single-handed practitioners and private providers. Quality in some areas is excellent but in others is very poor, with some practices in special measures. Some practices have closed their lists as they are too full to take patients, while others have simply given back their contract as they cannot provide services to a quality they believe is right.

Solving this problem, I would argue, is the key that could or will unlock everything, but it's hard. These are independent businesses that, by and large, after seeing underinvestment in recent years, have been asked to do ever more – and are often the front line for all patient and population problems. So what are we doing? ▶

Changing the GP tradition

The publication of the Five Year Forward View for General Practice has been a helpful prompt for signalling that change and investment is needed. As an accountant, I still struggle to see where the investment will come from but, that aside, there is some really interesting information in this document. A review of patients seen in general practice reveals that around 25% of them don't actually need to be seen by a GP but could be seen by another professional, such as a pharmacist, nurse, physiotherapist, mental health practitioner or social prescriber.

We are starting now to work with a few of our practices to map out whether this is true for our footprint so that we can begin to look to shift care away from GPs to other practitioners. As well as this, we are looking to challenge how care is provided. We still have a very traditional model that focuses on face to face consultations; we can neither afford nor have the capacity to continue in this way.

We are working with national innovators and looking at how this has been tackled in other countries. If in England we are happy to use internet banking and scan our own shopping, can we build on this and look for more use of technology to reduce the demand on our medical practitioners? This will take investment, a leap of faith, some flexibility in terms of our love of information governance, support from our regulators and, most of all, a bold and honest conversation with our population.

The second piece of our challenge in the local health and care part of the success regime is demand. We need to start a conversation with the public about what health and care must look like in the 21st century so that it is sustainable, safe and affordable. One of our local authorities suggests that all interaction with the public needs to consist of three questions:

- **What can you do for yourself?**
- **What can we do together?**
- **What do you need from the health and care system?**

While this might not be the Holy Grail, a big conversation is needed, because this could safeguard the health and care system for the future.

It is still early days and, while our plans may be credible, ultimately everything depends on how we deliver. We do now have some good foundations to build success on, and we are hoping that in Essex – by donning an England shirt and playing for the "system" – we can make our health and care system sustainable. ●

'If we are happy to use internet banking and scan our shopping, can we use technology to reduce the demand on medical practitioners?'

ESSAY 11

‘Doing nothing is not a realistic option’

BY JANE PAYLING

Urgent intervention is needed to guarantee the UK population a healthy future. Should there be a “golden” GDP ratio for healthcare spending?

Jane Payling *is head of health and integration at CIPFA*

IT HAS BEEN a turbulent period for health and social care in the UK. Changes in demand due to a growing and ageing population, combined with advances in treatments, are placing increased pressure on public sector budgets.

The early part of this century saw a significant leap in the proportion of GDP spent on healthcare – an increase from 7% to 10% in the first decade. However, changes brought about by austerity will see this fall back closer to 8% by 2020, a figure that can be contrasted with over 11% in Germany, France and the Netherlands.

In 2015, CIPFA concluded, in its *The Health of Health Finances* briefing, that the medium-term financial position was not viable. The government acknowledged this in its November 2015 Spending Review, when the NHS was given additional financial support. There have since been promising policy developments, notably around integration and devolution.

Nevertheless, CIPFA’s follow-up paper in May this year, *More Medicine Needed*, predicted a £10 billion shortfall in the NHS budget by 2020, implying that the funding assumptions behind the NHS Five Year Forward View are not achievable. This is due to difficulties in achieving £22 billion of efficiency savings by 2020, combined with additional spending pressures – including the commitment to provide a “seven-day NHS”, which was added later.

These estimates were also made before the Brexit vote so take no account of its potential impact on the economy, the predicted contraction of public finances and the increased strain on the healthcare workforce (see The Brexit factor, page 15).

Best-laid plans

The NHS Five Year Forward View, issued in October 2014, was widely welcomed for setting a new tone for health and social care management. It took a much broader view of the determinants of health and put an emphasis on longer-term planning and investment in prevention as key to ensuring the sustainable delivery of effective services. Rightly, as well as increased resources, it incorporated expectations of significant efficiency and transformation. Unfortunately, severe financial pressures across the public sector including the NHS – specifically in 2015-16 – signalled a retrenchment to shorter-term responses, intended to resolve immediate issues. Coupled with this has been a failure by all governments, despite the welcome precept flexibility and the Better Care Fund, to fund social care and public health in line with the demographic demands that fall on the NHS. Inevitably, this has limited the scope for preventive spending.

Overall, there has been no significant move to break out of traditional short-term thinking. Healthcare funding remains something of a political football, with the players far more focused on the results of the latest match than the prospects for the following seasons.

The leadership challenge

Against this background, achieving a healthy future for the NHS and social care is a leadership challenge as much as a financial one. CIPFA proposes that the government considers the following: ▶

- **The Five Year Forward View** is based on predicted service pressures of £30 billion. CIPFA feels that more analysis and honest assessment is needed to update this figure, including taking account of the Brexit decision, and assessing the timing of planned savings. We believe the £30 billion figure is an underestimate, and that the NHS will be unable to react quickly enough to make the productivity gains required to achieve the £22 billion savings called for in the Forward View, leaving a severe shortfall in the medium term.
- **To prepare for the larger, older population** of the future, the government should return to the Five Year Forward View, review its assumptions and set aside more funds to encourage long-term preventive investments that will generate future savings. If this could deliver productivity gains, there would be a case to fund this investment through borrowing or even via bespoke taxation.
- **The additional resources** provided to the NHS from 2015 have not changed the underlying position and, as there have also been cuts in areas outside the NHS ringfence (social care, public health, staff education and training), it will be necessary to add to the health and social care budget, charge users or reduce services. To do nothing is not a realistic option.
- **New methods of prioritisation** will be needed if the necessary savings are to be made without affecting services unacceptably. That might, for example, include reviewing the level and range of services provided free at the point of care by the NHS, sometimes referred to as the "NHS offer". Pressures on local government finances have led to overall reductions in the numbers receiving social care (from 1.7 million in 2009 to 1.3 million now) and changes to how care is delivered. Is there an appetite for something similar in the NHS?

It is vital that the coming financial shortfall is addressed as part of realistic long-term planning for health and social care. CIPFA is calling on the government to take a serious look at the balance of demand and supply within health and social care to ensure that the needs of current and future populations are acknowledged and provided for.

This could be achieved in several ways. Building on the conclusions in *More Medicine Needed*, CIPFA proposes that an independent commission is set up to seriously examine the options available to balance demand and supply for health and social care into the future:

- **The commission** would consider the type and levels of services provided, look at the balance between the short term and longer-term trends, and plan expenditure to match. This would be the first stage in a realistic public debate on the funding available versus expectations of the services provided. The commission would need to recommend the best means, however radical, of achieving this new balance of funding and expenditure.
- **To help remove questions** about the level of resources available from the short-term political cycle, it would be helpful to link the expenditure requirements in a formal way to GDP. We suggest that a "golden ratio", which commits the government to a minimum investment in health and social care, would be the best way to increase the certainty with which the NHS and local government can plan.
- **A "golden ratio"** would reduce the unpredictability of politically driven annual settlements, while aligning spending with what the country can afford. International comparisons suggest a ratio of 10% would be achievable yet impactful and similar in magnitude to the findings of the Barker Commission. More work is needed on the exact percentage, in terms of what is needed and the political prioritisation it implies. The figure need not represent a "cap" and it could be subject to regular review by the independent commission.
- **To ensure adequate funding** is available, the government may need to consider increasing the range of funding sources used. In addition to current funding – almost entirely from general taxation - there might be increased charging and co-payments for NHS services, bespoke taxes and greater freedoms for health and social care bodies to raise additional funds for capital investment.

The predicted surge in demand for health and social care cannot be avoided. Difficult choices need to be made and, as a society, we must face up to decisions regarding the extent to which we are willing and able to provide publicly funded health and social care.

Decisions of this magnitude need the serious consideration afforded by an independent commission. Its findings and recommendations should be implemented in a way that reduces the uncertainties caused by the vagaries of short-term politics. ●

This essay was written in collaboration with Sean Nolan, director of local government at CIPFA

'An independent commission should be set up to seriously examine the options available to balance future demand and supply'

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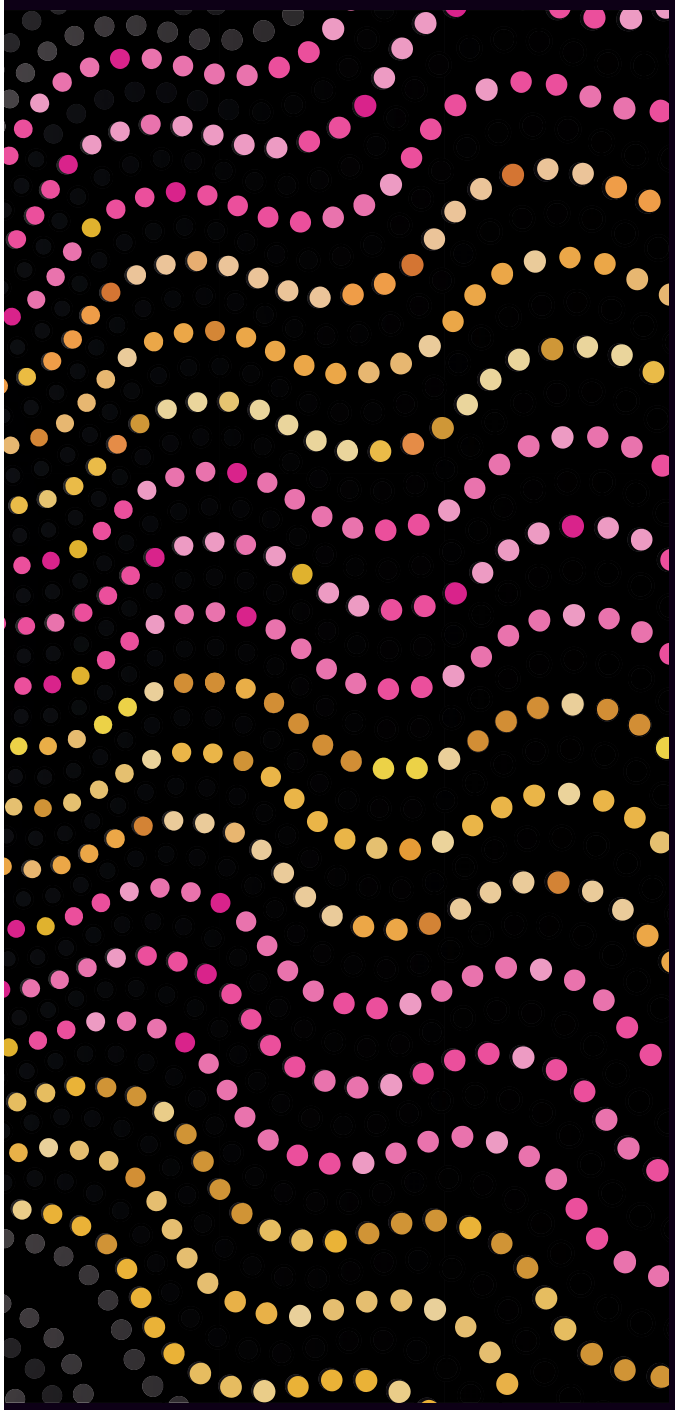

Funding a healthy future

This is the fourth in a series of *PF Perspectives*, produced by CIPFA and *Public Finance*. They are designed to stimulate discussion on key public finance and policy issues. These essays, by leading public sector practitioners and experts, examine the future of health and social care in the face of an ageing population, financial constraints and Brexit

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