About the NHS Confederation

The NHS Confederation is the only body that brings together the full range of organisations that make up the modern NHS. Our membership of almost 500 organisations spans the whole health economy and we speak with authority for the NHS on the issues that matter to all those involved in healthcare.

We bring the whole system together and we have submitted a formal representation to HM Treasury for the 2015 Spending Review. It outlines our main messages to the Government on how it can support the NHS in this parliament. It stands for the views of all our networks and offices, including:

- Mental Health Network
- NHS Clinical Commissioners
- NHS Employers
- NHS European Office
- NHS Partners Network
- Northern Ireland and Welsh NHS Confederation

The messages and proposals outlined in our representation to the 2015 Spending Review are based on detailed analysis and engagement with our members. They have also been developed in partnership with a wide range of organisations in the health and care system, building on the relationships developed as part of the 2015 Challenge. These partnerships will remain as we look to communicate the proposals we want to see implemented in the 2015 Spending Review.

SR15 Supporting Analysis

The moral case for transforming how care is delivered to better suit the needs of people today is strong. There is however an equally compelling economic case for investing in the NHS now, so it can better support our society to live healthier lives with less need for medical care. Put bluntly, a strong economy needs a strong NHS.

It is increasingly apparent that more of the same is unsustainable. Unless we get serious about prevention, health needs will continue to grow putting more pressure on our universal health care system. Unless we develop a truly coordinated approach to care, public funding will continue to grow to fund demand with a diminishing rate of return.

This document is the supporting analysis for the conclusions and recommendations made in our full representation.

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1 NHS Confederation submission to the Spending Review can be found here: [http://www.nhsconfed.org/resources/2015/09/spending-review-2015](http://www.nhsconfed.org/resources/2015/09/spending-review-2015)
2 NHS Clinical Commissioners have submitted a sector representation, which our submission supports
3 The 2015 Challenge brought together 21 influential national organisations
1. Spending on the NHS grew in the last parliament

The Departmental Expenditure Limit (DEL) for the NHS increased by around £5.8 billion in real terms between 2010-11 and 2014-15. An additional £2.1 billion has been planned for 2015-16. The same period has seen total public spending decrease, which has required large cuts in other areas of public spending. The NHS budget has increased by around 5 per cent in real terms in the last parliament, while the budget for the Department of Communities and Local Government, for example, saw a reduction of around 45 per cent.\(^4\) Spending in the last parliament was dramatically different though from the previous parliament, in which the health budget increased by 18 percent and public spending overall by 12 per cent.\(^5\)

![Changes to departmental expenditure limits, 2010-11 to 2014-15](image)

Source: Public Expenditure Statistical Analyses 2015

2. Additional funding in the last parliament funded increased activity

The resources provided in the last parliament realised additional value and helped meet the seemingly relentless increase in demand for health services. This is on top of already unprecedented levels of demand in recent decades. With additional funding between 2010 and 2014, the NHS has delivered:

- 893,219 more finished consultant episodes (5.2 per cent increase)\(^6\)
- 571,213 more admissions (3.8 per cent increase)\(^7\)

\(^4\) HM Treasury (2015a), Public Expenditure Statistical Analyses
\(^5\) HM Treasury (2010), Public Expenditure Statistical Analyses
\(^6\) HSCIC (2014a), Hospital Episode Statistics
\(^7\) HSCIC (2014a)
3. There are three main reasons for the growth in demand on the NHS

The first is the size of the population, which has increased by 2.1 million people in England between 2010 and 2014. The second cause is the ageing population with the number of people over 70 years old, who account for more costs per head\(^\text{15}\), rising by 390,616.\(^\text{16}\) The third reason for growing demand is the prevalence of long term conditions, which estimates suggest 30 per cent of the population have at least one and 70 per cent of the NHS budget is

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8 HSCIC (2014a)
9 NHS England (2015a), A&E Attendances and Emergency Admissions
10 HSCIC (2014b), Hospital Episode Statistics – outpatient attendances
11 HSCIC (2015a), Mental Health and Learning Disabilities Statistics
13 NHS England (2015b)
14 NHS England (2015b)
15 NHS England (2013), The NHS belongs to all of us technical annex
spent on. These factors contribute to putting pressure on the budget for delivering universal healthcare and the Institute for Fiscal Studies (IFS) calculated a 1.1 per cent real terms increase in health spending needed to keep pace with these pressures in the last parliament.

4. Forecasts suggest demand pressures will increase further in this parliament

Office for National Statistics (ONS) projections indicate that the population in England will grow by 2.1 million by 2020 with an additional 1.2 million people aged over 70. Rates of long-term conditions, such as diabetes, are also predicted to grow year-on-year throughout the course of the next parliament. This additional demand will require real terms spending increases of around 1.2 per a year or 4.9 per cent across the whole parliament. A budget increase of 5 per cent, as seen in the last parliament, would therefore only just cover the growth in demand for health services over that period.

5. Demand is not however the only cause of increasing pressures on the NHS budget

Analysis shows that the NHS Hospital and Community Health Services (HCHS) index, which is a weighted average of the change in the price of labour and non-labour goods, grew at a higher rate than economic-wide inflation between 1985 and 2010. This was mostly caused by

17 Health Select Committee (2014), Managing the care of people with long-term conditions
18 Institute for Fiscal Studies (2015), IFS Green Budget
20 Health Select Committee (2014)
21 Institute for Fiscal Studies (2015)
the growth in labour costs, which have risen above general inflation by around 3 per cent a year.\textsuperscript{22} This factor is significant when you consider around seventy percent of costs in NHS provision are linked to labour.

6. Pay restraint has helped to contain labour costs in the NHS

In the last parliament, pay inflation grew at a slower rate than in the wider economy. This was mostly due to pay restraint across the public sector from 2010. This started with pay being frozen in 2010 and then maximum pay increases limited to 1 per cent from 2013-14. These measures have stemmed the growth in the pay bill, although even 1 per cent pay growth accounts for a 0.7 per cent cost pressure on the NHS budget each year. Furthermore, the end of the parliament saw pay costs grow due in part to investment in front-line staff as part of the implementation of Francis and Keogh recommendations. This was demonstrated by a rapid rise in unplanned contract and agency staff spending, which in 2014-15 amounted to £1.8 billion for NHS providers.\textsuperscript{23}

7. Non-pay costs have grown above inflation

While pay costs were contained in most of the last parliament, spending on goods and services have increased over and above inflation. This has prompted a zero-inflation policy on non-pay expenditure and the work of Lord Carter to champion how the NHS might keep costs under control.\textsuperscript{24} Lord Carter published his initial findings and identified that while there are significant efficiencies to be made there is no magic wand for delivering them.\textsuperscript{25} The interim report also identified how the NHS was already performing well to improve hospital efficiency and so the challenge is even greater to innovate to improve further.

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{average_annual_change_in_nhs_pay_and_prices_2003_to_2014.png}
\caption{Average annual change in NHS pay and prices, 2003 to 2014}
\end{figure}

\textsuperscript{22} Institute for Fiscal Studies (2015)
\textsuperscript{24} Department of Health (2013), \textit{Better Procurement, Better Value Better Care}
\textsuperscript{25} Lord Carter (2015), \textit{Review of Operational Productivity in NHS providers: Interim report}
8. The NHS is relatively efficient

The NHS is not complacent about the need to be productive. It is determined to get the most out of taxpayer funding, as any resources wasted could be spent on improving patient care. Nonetheless, it is important to recognise that while there is no doubt waste in the NHS, it’s not fair for some to suggest it is wasteful. International evidence reveals that while the UK spends around 9 per cent of its GDP on health, other major health care systems spend more – with Germany, France and the United States spending 11.3, 11.6 and 16.9 per cent respectively in 2014. International studies also rank the UK first among all major health systems for both efficiency and quality of care. Polling suggests the public recognise this, with 70 per cent of people believing the NHS provides good value for money to taxpayers. Nonetheless, those same surveys indicate a good portion of the public who think the NHS could do more to reduce waste and inefficiency, which of course is correct.

9. Technical efficiencies were relied on mostly to fill the funding gap in the last parliament

The NHS was set the challenge at the beginning of the last parliament of delivering around £19 billion in savings, as part of the Quality, Innovation, Productivity and Prevention (QIPP) programme. The NHS has performed excellently in meeting this challenge and many savings have been driven by reducing the unit costs of services through the National Tariff.

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26 OECD (2014), Health Statistics
27 Commonwealth Fund (2014), Mirror, mirror on the wall
28 Department of Health (2014), Public perceptions of the NHS and Social Care
29 Health Select Committee (2013), Public expenditure on health and care services
research indicates that acute and specialist provider productivity has dipped in the final years of the last parliament, particularly with pressures on hospitals to increase staffing numbers.\textsuperscript{30}

![Source of efficiency, 2011 to 2013](image)

Source: The King’s Fund 2014

10. A funding gap was still apparent in the last parliament

The current financial position of NHS providers indicates a diminished position with many more ending the parliament in deficit. A little under half of the NHS provider sector ended 2014-15 with a budget deficit and the total deficit across the provider sector was £822 million.\textsuperscript{31} Other indicators suggest a similar decline in NHS finances over the course of the parliament. For example, the average FT earnings before interest, taxes, depreciation and amortisation (EBITDA) margin, which is a good measure of profitability, has fallen to 3.8 per cent.\textsuperscript{32} In 2009-10, this stood at 7.1 per cent.\textsuperscript{33} Commissioning budgets are also showing signs of strain. While CCGs ended 2014-15 with a small underspend, they relied on a number of one-off items and drew down from a historical surplus pot that is fast diminishing.\textsuperscript{34} The commissioning budget for specialised services, held by NHS England, has overspent by almost £600 million in the last two years alone.\textsuperscript{35}

\textsuperscript{30} Health Foundation (2015), Hospital finances and productivity: In a critical condition?
\textsuperscript{31} Monitor (2015), and NHS TDA (2015)
\textsuperscript{32} Monitor (2015)
\textsuperscript{33} Monitor (2010), NHS Foundation Trusts: Consolidated Accounts 2009-10
\textsuperscript{34} NHS England (2015c), Consolidated 2014/15 Year-end Financial Report
\textsuperscript{35} NHS England (2015c)
11. Pressures on the NHS budget indicate a funding gap for this parliament

The *Five year forward view* estimates the combination of pressures, i.e. growing demand, no productivity and flat funding, at around 3.5 per cent a year. This will produce a mismatch between resources and need by 2020-21 of around £30 billion a year. This gap is significant and could only be met through a combination of managing demand, increasing productivity and additional funding.

12. We need to start with a genuine attempt to improve public health

It’s important to recognise that most of the £30 billion funding gap is created by growing demand pressures. Managing demand could then slow this growth and reduce the overall funding gap that emerges by 2020-21. There is a tendency in public services to focus on supply-side reform because often there is more control over this than demand, which in theory can be limitless. The *Five year forward view* describes how our economic prosperity depends on “a radical upgrade in prevention and public health”. There is a potential for public health strategies to keep people healthy and prevent them from primary or secondary illness. It would seem counter intuitive then to cut resources for public health, as the recently announced £200 million cut in non-NHS spending would result.

13. Meeting the funding gap is a shared aim of both the Government and the NHS

It is a priority of both Government and NHS leaders to ensure there is not a funding gap in the NHS of £30 billion by 2020-21. A settlement is needed then on how to meet this gap through

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36 NHS England (2014), *Five year forward view*
37 HM Treasury (2015b), “Chancellor announces £4½ billion of measures to bring down debt”
the NHS improving productivity and the Government providing additional funding. The 5YFV secured a political commitment of at least £8 billion additional funding a year by 2020-21. In turn, this sets an ambitious target for the NHS in delivering productivity gains of at least 2 per cent a year, which would be worth the remaining £22 billion. This is more than double the long run rate achieved by the NHS, according to the IFS.  

14. NHS productivity can continue to improve by technical means in the next parliament

The last parliament focused on making technical savings with national levers to reduce the unit costs of delivering current services. More can be done in this area, specifically by enabling supply-side ‘catch-up’ in areas such as procurement and staffing. The Carter Report is an extension of this agenda and it has identified up to £5 billion a year that might be deliverable by 2020-21. This would represent around 23 per cent of the savings needed.

15. The scope for technical efficiency is limited though

The last parliament relied on technical efficiency and this approach was successful in delivering around £19 billion of savings. The nature of these savings are such that they generate diminishing returns as services are cut further. It is noticeable that many NHS services have reached this point and thus this approach is unlikely to deliver the level of savings in this parliament, as it did in the last. This is particularly the case with regards to pay costs. While public sector pay will remain limited to 1 per cent, this will put a stress on retention and recruitment due to the growth of private sector pay above inflation. Furthermore, there will

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38 Institute for Fiscal Studies (2015)
be a growing incentive for staff to undertake agency work if salaried pay is kept below inflation, which is a major cause of increase staffing costs.

16. Allocative efficiencies need to play a bigger part to fill the funding gap

Most of the evidence shows that for the NHS to deliver unprecedented levels of productivity, there will need to be a refocus in this parliament. The scope for reducing unit costs is inevitably limited while the NHS continues to deliver care in the same units. A better strategy will be to put more attention on changing care models and empowering local systems to drive change to deliver sustainability. This would align with the momentum behind the 5YFV and highlight the importance of commissioning to drive changes, while creating the agency locally to make savings.

17. A sector-led plan for delivering £22 billion of savings needs to emerge

The 5YFV outlines scenarios in which the NHS continues to improve productivity to help close the funding gap. It establishes a goal for the NHS in delivering productivity improvements of 2.4 per cent each year. This is far above the long-run average of 1 per cent or even the rate of 1.5 per cent realised in the second half of the last decade. Recent analysis suggests there has been a sharp fall in hospital productivity in the last two years, bringing the average across the last parliament down to around 0.4 per cent a year. Making unprecedented savings in the next parliament will entail a sector-led approach and a clear plan on what can practically be delivered. The NHS Confederation has been working with national bodies to engage its members on this and use them to support a plan for efficiencies in the next parliament.

<table>
<thead>
<tr>
<th>Increased NHS funding by 2020/21</th>
<th>Annual efficiency required from the NHS by 2020/21</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>£30 billion</td>
<td>None – 0 per cent</td>
<td>NHS delivers no productivity improvement</td>
</tr>
<tr>
<td>£21 billion</td>
<td>Standard – 0.8 per cent</td>
<td>NHS delivers long-run productivity average</td>
</tr>
<tr>
<td>£16 billion</td>
<td>Enhanced – 1.5 per cent</td>
<td>NHS delivers productivity average in last five years</td>
</tr>
<tr>
<td>£8 billion</td>
<td>Ambitious – 2.4 per cent</td>
<td>NHS delivers unprecedented productivity</td>
</tr>
</tbody>
</table>

Source: NHS England 2014

18. The NHS will need certainty on funding to deliver savings

What NHS leaders tell us is the importance of having a supportive environment to help them plan and deliver savings. Changing how care is delivered will need certainty and stability on

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40 Health Foundation (2015)
41 This is in partnership with NHS Clinical Commissioners, NHS Providers, Local Government Association, National Voices and royal colleges
funding. Our members are clear on what they need from the Government, with 87 per cent of NHS leaders supporting a binding agreement on absolute NHS and social care spending over the course of the next five years.\textsuperscript{42} Such a deal would provide the scope to move beyond annual cycles and focus on longer perspective. Multi-year funding would enable the NHS to extend other mechanisms over a similar timeframe, such as commissioner allocations, contracts, tariff prices and pay settlements.

\textbf{NHS leaders support for “A binding agreement on absolute NHS and social care spending over the course of the next five year”}

<table>
<thead>
<tr>
<th>Response</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly support</td>
<td>53%</td>
</tr>
<tr>
<td>Tend to support</td>
<td>33%</td>
</tr>
<tr>
<td>Neither support nor oppose</td>
<td>8%</td>
</tr>
<tr>
<td>Strongly oppose</td>
<td>3%</td>
</tr>
<tr>
<td>Tend to oppose</td>
<td>3%</td>
</tr>
</tbody>
</table>

\textit{Source: NHS Confederation 2015}

\textbf{19.£8 billion is the minimum the NHS will need in additional funding}

The 5YFV settlement sets the ambitious target for productivity improvements, which requires additional funding of around 0.8 per cent each year in real terms, or £8 billion by 2020-21. Without tax increases, this means big cuts across government departments of around 6.1 per cent on average.\textsuperscript{43} We recognise the impact additional funding has on public services. Nonetheless, we’re keen to identify that £8 billion was described in the 5YFV as the minimum needed to meet demand and represents a real terms increase in funding per person. As such, it does account for a growth in the population, although not necessarily an ageing society and wider cost pressures. It is also based on delivering the vision set out in the 5YFV and will not be enough to cover additional commitments made by the Government outside of this document. The 5YFV outlined, for example, the NHS ensuring hospital patients have access to seven day services where this makes a clinical difference to outcomes.

\textsuperscript{42} NHS Confederation (2015), \textit{Annual member survey 2015}

\textsuperscript{43} Institute for Fiscal Studies (2015)
20. Funding is a political choice

The NHS Confederation was consistent throughout the election period that the decision of how much to spend on health is a political choice. It was important to have an open and honest debate about NHS funding and it was one of the top issues during the campaign. This Government has a democratic mandate on which it will make political choices of how much to spend on health. We recognise the £8 billion additional funding as part of this political choice and are not asking for more than this in our representation. This is not because we cannot make a case for the benefits from more resources nor because we think £8 billion would be a secure settlement. Rather, we recognise the mandate on which this political choice is based and the more important duty we have to our members to ensure it is delivered in full.

21. Priority should be made for mental health and commitments need to be delivered

There continues to be concern about the funding of mental health services, which have had a cut in real terms for three years in a row.44 The 2015 Budget looked to address this imbalance with a £1.25 billion commitment over five years for children's mental health services, yet a need remains to restate this commitment.45 Current reports suggest the Department of Health will fall short of the £250 million for this year, by £107 million (43 per cent).46 Ensuring this is delivered, along with other promises, will help deliver the political commitment to ensure mental health is taken as seriously as physical health.47

22. Additional funding should be phased with funding up front

An £8 billion spending commitment by 2020-21 still begs the questions how the additional funding will be phased across the parliament. More than 80 per cent of the additional funding in the last parliament came in the final three financial years, between 2013 and this year. The funding was therefore back-loaded and less resources were available up-front to invest in the NHS. We have forecasted three scenarios of how the £8 billion could be phased over the parliament, which include back-loading (based on phasing in the last parliament), equal-phasing and front-loading (based on reversing phasing in the last parliament). We are keen that additional funding in this parliament be front-loaded, which requires half of the £8 billion be allocated by 2017-18. There are many reasons why this is necessary. Demographic pressures are not back-loaded in this parliament, in fact ONS data estimates greater pressures in the next two years. Furthermore, cost pressures on pay, such as changes to national insurance and pensions, will also be implemented early. In general though, the NHS will need more money up-front to have as much in place early to make the changes needed to make bigger savings towards the back of this parliament. We recognise this may not align with the Government’s intention to make the bulk of savings in public service in the first half of the parliament, yet front-loading funding is a necessity in the short term to deliver benefits in the long term.

44 Mental Health Policy Group (2014), A manifesto for better mental health
45 Mental Health Policy Group (2015), Improving England’s mental health: The first 100 days and beyond
47 Conservative Party (2015), Strong leadership, a clear economic plan, a brighter, more secure future
23. Transformation needs to be resourced

There is strong agreement on the need for the NHS to change how care is delivered, in particular by shifting more care to non-acute settings that are often better suited to dealing with long-term conditions. To do this, investment will be needed in out of hospital care, which in the long-run we would expect to be more cost-effective. Yet, experience indicates it can be difficult to release savings immediately and change therefore is not sustainable by itself in the short-term. Instead, cash-releasing savings, for example in reducing stranded costs like buildings and technology in the traditional model, will only be found once the new model of care is fully up and running. We know the evidence on this is mixed and that inherent in investment in new models is a risk of savings not being delivered. Most investments carry risk and greater risk sits in delivering an increasingly unsustainable model that will creak louder as more people are put in it. Funding needs to be available then for investing in transformation to deliver new models of care, as outlined by the 5YFV.

24. Some of the additional funding needs to be on transformation

The key challenge for the NHS is changing to new models of care at the same time as delivering current services. This has been compared by our members to fixing an engine while the motor is still running. The NHS needs the resources to invest in non-acute care and the time to develop those services so they can effectively reduce the pressures on hospitals – while still delivering the current services on which the public relies. Funding mechanisms have been introduced along these lines in the past, such as the marginal rate for emergency admissions and the overall requirements on CCGs to set aside 2 per cent of their budget for transformation. However, none of these have actually represented new money being...
channelled into the NHS and so do not allow for the ‘double-running’ required as part of investment. We need to see transformation funding bring new money into the NHS explicitly allocated to investing in new models of care and which would allow local health economies to pump-prime funds through a mechanism separate to business as usual.

25. The 5YFV transformation funding should be increased to £1 billion

The 2014 Autumn Statement created a £200 million transformation fund for 2015-16 to deliver the first year of the 5YFV. We believe this fund needs to bigger and agreed for longer to cover the full period of the parliament. Funding would be allocated as part of the £8 billion investment, with a fund of £1-2 billion in 2016-17. We point to work undertaken by the Health Foundation and King’s Fund on this, which suggests a fund of around £1.5 billion for 2016-17, which was proposed by a similar amount each year and would be on top of over and above the core resource funding of the NHS. Additional funding for a transformation fund can be found by bringing together money already in the system, which is as yet unaligned. Additional funding could also be encouraged on the basis of a clear ‘invest to save’ strategy link to long underused areas of spend, such as property. These aside, we are realistic about the prospect of transformation funding coming from the £8 billion commitment. In which case, we will need to find the right balance between using it to meet the existing funding gap and using it to invest in new models.

26. Clear objectives are needed for spending transformation funding

Money would be provided by HM Treasury to fund local and credible plans to transform services, or else agreed as part of a clear ‘invest to save’ strategy. Strong accountability would need to be in place to ensure investment is spent on transforming care, rather than business as usual, and the focus would remain on achieving outcomes agreed within the plans. When we brought our members together to highlight the top priorities for establishing a transformation fund, below were consistent themes.

<table>
<thead>
<tr>
<th>Must do:</th>
<th>Must not do:</th>
</tr>
</thead>
<tbody>
<tr>
<td>…bring people together</td>
<td>…fund business as usual</td>
</tr>
<tr>
<td>…be bold and innovative</td>
<td>…be focused only on organisations</td>
</tr>
<tr>
<td>…benefit the whole system</td>
<td>…expect short-term gains</td>
</tr>
<tr>
<td>…be spent on genuine transformation</td>
<td>…be implemented without a strategy</td>
</tr>
<tr>
<td>…provide space for the NHS</td>
<td>…be the only source of funding</td>
</tr>
<tr>
<td>…be focused on outcomes</td>
<td>…be centrally-driven</td>
</tr>
<tr>
<td>…have a long-term perspective</td>
<td>…duplicate other programmes</td>
</tr>
<tr>
<td>…be set up to share learning</td>
<td>…be spread too thinly</td>
</tr>
<tr>
<td>…be adaptable to changing environments</td>
<td>…be unnecessarily bureaucratic</td>
</tr>
<tr>
<td>…be accountable for the money spent</td>
<td>…be ongoing without a clear end point</td>
</tr>
</tbody>
</table>

Source: NHS Confederation

48 Health Foundation and King’s Fund (2015), Making change possible: A Transformation Fund for the NHS
27. The NHS should continue to work with their local economy

The NHS is now playing a greater role in the design and delivery of local economies. While it has always been a significant local employer, their role and potential in driving jobs, and growth, has not been widely understood, both by the local leaders of growth but also by many in the service itself. Over the last twelve months the NHS Confederation has helped NHS organisations across England engage with their Local Enterprise Partnerships, ensuring that LEPs have direct and indirect NHS representation as appropriate, and that we are seen as potential investment partners with whom to co-fund local capital and revenue projects. Importantly, many Strategic Economic Plans across England now include a focus on health-related local priority areas, with intentions to work collaboratively to shape next steps. The main priority areas where these relationships are being strengthened are around the commercialisation of R&D; skills and employment; and social inclusion – bringing the NHS closer to the sectors of education, social care, housing, transport, planning and private sector-led inward investment. Working with LEPs has highlighted the scale of opportunities for the NHS and for the wider local economy in co-financing community assets, whether infrastructure or tailored programmes, and should be used as a model for wider investment going forward.

28. Social care is under pressure and it is hitting the NHS

Our members continue to tell us about the impact reductions in social care funding are having on the NHS and two-thirds of NHS leaders have previously highlighted that shortfalls in local authority spending have affected their services.\textsuperscript{49} An example of this is where patients experience delays in being transferred from NHS services to the right social care setting. This has a financial cost, calculated at approximately £200 million per year, and also a human cost, in distressed patients whose conditions will often get worse.\textsuperscript{50} It is the long-established position of the NHS Confederation that health and social care services need to be better joined-up to provide the right care for people. Evidence shows that care delivered out of hospital, whether that be in primary, community or social care services, can reduce the pressure on emergency admissions at the front door of acute care and provide alternatives to ease the flow of acute discharges at the back door.\textsuperscript{51} Further studies show that investment in services such as stroke or rehabilitation care can significantly improve quality and reduce the costs of care overall.\textsuperscript{52} Furthermore, analysis by Monitor suggests that closer working between the NHS and social care would make a vital contribution to closing the funding gap, although it is important to recognise a current lack of empirical evidence to show it will be more cost effective.\textsuperscript{53} We continue to emphasise the potential of investing in out-of-hospital both to improve care and reduce costs, by alleviating the pressure on acute admissions.

\textsuperscript{49} NHS Confederation (2012), Member survey
\textsuperscript{50} NHS Confederation (2012), Papering over the cracks: The impact of social care funding on the NHS
\textsuperscript{51} NHS Confederation (2013), Transforming local care: community healthcare rises to the challenge
\textsuperscript{53} Monitor (2013), Closing the NHS funding gap: how to get better value healthcare for patients
NHS leaders describing “what impact cuts to social care funding have had on your organisation and services for patients”

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased time that an individual remains in hospital</td>
<td>79%</td>
</tr>
<tr>
<td>Increased demand for community services</td>
<td>69%</td>
</tr>
<tr>
<td>Increased numbers of individuals attending hospital</td>
<td>67%</td>
</tr>
<tr>
<td>Increased numbers of individuals being admitted to hospital</td>
<td>66%</td>
</tr>
<tr>
<td>Increased demand for mental health services</td>
<td>61%</td>
</tr>
<tr>
<td>Increased A&amp;E attendances</td>
<td>61%</td>
</tr>
<tr>
<td>Increased emergency re-admissions</td>
<td>59%</td>
</tr>
</tbody>
</table>

Source: NHS Confederation 2015

29. The BCF demonstrates the enthusiasm to work together locally

The previous funding settlement transferred an extra £2 billion from the NHS to social care up to 2015, which was a necessary ‘sticking plaster’ in the short term but a longer term solution was clearly needed. Therefore, when the Government announced a pooled health and social care budget beyond 2015 we were receptive to its intentions, while insisting NHS organisations obtain strong assurances that money spent on social care would do the job it is meant to.\(^54\) We support the principles behind the BCF and agree with its current focus on reducing emergency admissions because it provides a catalyst for bringing health and social care leaders together to decide the best place to put shared resources. The BCF is a worthwhile attempt to boost the scale and pace of local integration and while its aims are not new, what is new is the growing need to use integration to deliver the long-term financial sustainability of health and care services. The fact that resources committed in some places go beyond the original £3.8 billion shows the appetite locally for integration and recognition of the potential benefits from redirecting resources to it. Evidence so far suggests that the BCF has been an important catalyst for some local commissioners and system leaders to start having open and honest conversations about the need for system transformation.

\(^{54}\) NHS Confederation (2013), “NHS Confederation and NHS Employers comment on the CSR”
30. The next phase needs to be clearer and more focused

There is clearly more work to be done to ensure that projected savings are based on robust evidence though and have the support of local commissioners and providers. In particular, we would be keen to see local areas actively working to address concerns about the lack of provider engagement in some plans. Changing health and care services to make them more integrated relies heavily on building good relationships across those two areas and there may be cases where the BCF has disrupted discussions that were already taking place. The imperative to agree plans in a short space of time has most relationships have been formed between local authorities and CCGs, but implementation now needs a stronger role for providers. BCF plans will be most effective where the whole system has come together to share resources and where providers in the NHS, as well as commissioners, are engaged in implementing the plans. We need to be realistic about what integration can achieve on its own, especially in the short-term. Even where plans are ambitious and successful, they are unlikely to turn around the financial fortunes of areas where the health economy has been in severe difficulties for many years. Without additional resources, the BCF could have dangerous consequences and simply provides a one-way approach to integrating health and social care. The BCF enables money to flow to the kind of services we want to see investment in, but at the risk in the short-term of destabilising acute providers incapable of reducing emergency admissions and stranded costs.

31. Health funding should be evidence-based

To support a secure deal for NHS funding in this parliament, we are keen to also explore establishing an independent body to advise on health spending, something previously put forward by the King’s Fund. This would see an independent body, the “Office for Budgetary Responsibility in Health” (OBRH), produce evidence-based forecasts on different health spending scenarios. In particular, the OBRH would be relied upon to give an expert assessment of realistic efficiencies, likely costs pressures and additional money from economic growth. An Office for Budgetary Responsibility in Health (OBRH) would establish a stronger evidence base to spending decisions and support the political choices made. Our proposals are an ambitious approach to dealing with funding in the NHS and it challenges policymakers to outline how they will support long-term financial planning without a ten-year spending settlement. Fixed-term parliaments do now give the Government a unique opportunity to set budgets over a longer term than could have been the case and we would encourage any new Government to consider how much further it could go with its commitments. An OBRH would act much like the OBR currently does and provide forecasts on which to make political choices. If political parties are serious about stopping the NHS being used as a political football then putting NHS funding on a more stable footing, backed up by evidence on the costs and the money available is a good place to start.

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55 The King’s Fund (2007), *Our Future Health Secured?*