



HFMA evidence to the House of Lords' Select Committee on the long-term sustainability of the NHS

23 September 2016

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff in healthcare. For more than 60 years, it has provided independent and objective advice to its members and the wider healthcare community. It is a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through its local and national networks.

The association also analyses and responds to national policy and aims to exert influence in shaping the wider healthcare agenda. It has a particular interest in promoting the highest professional standards in financial management and governance and is keen to work with other organisations to promote approaches that really are 'fit for purpose' and effective.

Introduction

This submission is based on the views of the HFMA and its members and draws on HFMA publications and research. We have focused on the areas where we have most knowledge and expertise. Consequently we have not answered all the questions set out in the call for evidence and instead have focused on the first three sections.

We welcome this inquiry and are hopeful that it will lead to changes that support the long-term sustainability of the NHS and a debate about the level of resources the government devotes to the NHS and whether it is sufficient to meet demand now and in the future.

Our responses to the questions asked by the House of Lords Select Committee on the long term sustainability of the NHS are set out below.

The future healthcare system

Taking into account medical innovation, demographic changes and changes in the frequency of long-term conditions, how must the health and care systems change to cope by 2030?

1. To ensure the long-term sustainability of the NHS, greater emphasis needs to be placed on preventing ill-health and improving public health. Individuals need to be better educated about the impact of their lifestyle choices and take more responsibility for managing their own health, well-being and care. In our opinion this will have the single biggest impact on long-term sustainability of the NHS, or indeed any healthcare system. We believe that investment now in public health with a clear strategy supported and driven forward by all parties will pay dividends later. Part of this is about the NHS not being viewed in isolation from the other determinants of public health, including social care, education, employment, housing and transport.
2. There needs to a continued focus on breaking down the barriers between different types of care, including primary, secondary and acute care, health and social care. These should become more integrated with a focus on the patient and their care pathway and a move away from managing the NHS through organisational silos which prohibit this integration. The current organisational architecture of the English NHS may not enable care integration at the pace required. Work underway to develop sustainability and transformation plans (STPs) is a positive move and may lead to a more sustainable integrated health service. However these plans do not have a statutory basis and several individual statutory organisations are involved in each plan. To resolve the debate about whether there is sufficient NHS money there may be a need to re-organise the NHS, perhaps via a governance and organisational model centred on the STPs, as opposed to the current statutory organisations.
3. A culture of embracing and exploiting technological advances needs to be in place across the NHS. It will enable different ways of working, including care being provided in different settings and facilitating patients managing their own conditions. Health appears to be one of the few sectors where technology has not been fully exploited to reduce costs, improve quality and radically change the way in which services are provided.
4. Unwarranted clinical variation and how this can be narrowed needs to be a key part of any health policy going forward, both to improve clinical care and to ensure the efficient use of NHS resources. The work of the Right Care programme needs to be fully embedded within the NHS.
5. Payment mechanisms are complex and in many instances do not incentivise improvements in clinical behaviour. In our opinion doctors do not generally take into account the payment mechanism when making clinical decisions. Improvements to how services are delivered must be clinically-driven and focus

on what is best for patients. Payment systems need to be redesigned to reward this and not act as a barrier to such improvements. They must also reflect the reality of what happens clinically rather than attempt to apply a theoretical approach to a real situation.

6. Patients make decisions based on ease and speed and so for example will go to accident and emergency departments, which are open in the evenings and weekends, as opposed to waiting longer to see a GP. It is essential that patients access healthcare at the right point of entry. This requires investment in an effective and accessible primary care sector, and a concerted campaign to ensure that patients make an informed and appropriate decision to access healthcare, for example, pharmacy, GP and 111, rather than ringing 999 and visiting their local accident and emergency department.
7. There is no 'one size fits all' and different places have geographic and demographic constraints that cannot be met through adopting the same approach across the country. STPs need to recognise and reflect the divergent needs of these populations and ensure that the payment mechanisms do more to recognise them.
8. Tackling many of the above factors form part out NHS England's Five year forward view, which is a sensible plan for the short to medium term. It effectively sets out the broad direction of travel for health services and was supported by our members. However, finance directors do question how achievable the financial aspects of the *Forward view* are and the speed at which significant, transformational change can be delivered.

Resource issues, including funding, productivity, demand management and resource use

To what extent is the current funding envelope for the NHS realistic?

9. The current financial performance of NHS organisations show that the NHS is currently in the midst of a financial crisis. Many organisations, across all NHS sectors and in all parts of the country, do not have the funding they require to deliver their services. At the end of 2015/16 NHS trusts and foundation trusts reported a combined deficit for the year of £2,447million. The deficit would have been larger had it not been for some non-recurrent measures that were taken to reduce the overspend including a number within the commissioning sector. The 2015/16 deficit was three times larger than the deficit reported at the end of 2014/15 and marked a sharp decline in the state of NHS provider finances.
10. Three months into the 2016/17 financial year the overall deficit was £461m, £5m better than planned. This is an improvement from the quarter 1 position in 2015/16 of a £930 million deficit. However, this was only achieved with support from the sustainability and transformation fund (£1.8 billion for the full financial year), so in reality the underlying financial position facing providers is similar to that in 2015/16. NHS finance directors have made it clear in HFMA's regular

*NHS financial temperature check*¹ surveys that this cannot be allowed to continue. Providers are clearly living beyond their means in terms of the funding envelope being made available to them for the services they are required to provide.

11. Looking further ahead, NHS finance directors have strong reservations about whether the estimated efficiency requirement set out in the NHS five year forward view is realistic and whether the STPs currently being developed will deliver what is expected of them. Finance directors are positive about STPs being the right way to achieve the objectives of the Forward view, but are under no illusions about the scale of the challenge and are sceptical about whether the £22 billion of savings identified in the Forward view is achievable. While STPs are generally supported they are unlikely to solve all the issues, but providers and commissioners recognise working together to solve some of the issues on a wider basis than the traditional organisation focus is a positive step.
12. At the end of 2015 the HFMA asked finance directors to rank possible actions that would enable the NHS to return to financial stability while maintaining the current range of services and the required quality standards. The majority of finance directors in our sample (66%) ranked more government funding for health and social care, beyond that already promised as most important. The least palatable option for finance directors was the NHS ceasing to provide universal care regardless of ability to pay, for example by the introduction of increased forms of co-payments. If no extra government funding over that outlined in the Forward View is made available, finance directors were clear that the NHS would have to provide fewer, high quality services that are affordable within the resources available rather than continuing to live beyond its means, which it is currently doing.
13. The HFMA is of the opinion that now is the time for an open and honest public debate to identify whether there is an appetite for higher taxes to pay for the NHS and if not, what level and range of universal care should be provided. Currently the NHS is struggling to meet the demands being placed on it and local NHS organisations are struggling to balance their books. If demand for NHS services continues to increase, the pressure will continue to build. Already our members – and other healthcare managers - find themselves with the seemingly impossible task of cutting costs while activity increases. This position is not sustainable.
14. To inform a debate about the level to which the NHS should be funded and what level of access should be provided, it would be helpful to consider the percentage of GDP spent on health in the UK compared to other developed nations. The Organisation for Economic Cooperation and Development (OECD) health data for 2015 shows that during 2013, the United Kingdom spent 8.5% of

¹ Healthcare Financial Management Association, *NHS financial temperature check: finance directors' views on the financial challenges facing the English NHS*, July 2016

gross domestic product (GDP) on health². This compared with an average across the 30 OECD countries of 8.9%. The share of the economy allocated to health spending is similar to Finland and Italy, but well below the levels of France and Germany (10.9% and 11.0% respectively). According to the OECD, per capita spending on health in the UK in 2013 was below the level in 2009, when adjusted for inflation. In our view it would be helpful for the government to commit to a fixed percentage of GDP to fund the NHS during a spending review period.

15. Finance directors are not saying that there is no scope for improving efficiency in the NHS. The Carter report identifies that there is room for improved efficiency in the way services are provided. We would also welcome its roll out to mental health providers as soon as possible, as the focus to date has been on acute hospitals. However, there need to be realistic expectations as to what extent improved efficiency will solve the funding needs of the NHS over the medium to long term. In our opinion, efficiency requirements, particularly on NHS providers have been set at too high and unrealistic levels over recent years.
16. Clarity around social care costs and who should be paying for what is required. A recent study by the King's Fund and the Nuffield Trust³ revealed that social care funding and reductions in the number of people being able to access social care have reduced by 25% and 26% respectively. Finance directors have reported to us that this reduction in both the amount of social care funding and the range of social care services being offered has had a direct knock on effect on the NHS due to increasing numbers of delayed discharges. This occurs where a patient is deemed to no longer require inpatient healthcare, but cannot leave the hospital until an appropriate care package is in place. This is particularly an issue for areas of the country with an elderly population. Cost pressures on NHS budgets have also arisen from increases in activity due to patients being admitted to hospitals when inadequate out of hospital services are available.

Workforce

What are the requirements of the future workforce going to be, and how can the supply of key groups of healthcare workers such as doctors, nurses, and other healthcare professionals and staff, be optimised for the long-term needs of the NHS?

How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?

17. Analysis of the current NHS provider overspend shows that one of the major cost pressures they face is due to an undersupply of appropriately qualified staff

² OECD, *How does health spending in the United Kingdom compare?: OECD health statistics 2015*, July 2015

³ The King's Fund and Nuffield Trust, *Social care for older people: home truths*, September 2016

which has led to high level of vacancies and an increase in the agency bill at premium and excess rates of pay.

18. Our members have stated that workforce costs could be lowered through a better recruitment model and through the operation of an oversupply of workforce model.
19. A review is needed on how doctors are educated and trained in the UK, how this is funded and what can be done to prevent newly qualified doctors moving to work abroad or in the private sector. Some of our members have suggested that consideration should be given to a wider loans based system paying for medical student training. These loans could then be eroded after a period of time spent working within the UK healthcare system. This would avoid the current problem of doctors being trained at significant expense to the UK taxpayer, only to see them go on to work outside of the NHS.
20. Service models, particularly out of hours services, need to be fundamentally reviewed to determine whether they are operationally sustainable from a workforce point of view. If not, options for changing the way these services are provided needs to be explored, such as the consolidation of services over a wider geographic footprint. This may mean that fewer services are provided locally, because it is not clinically and operationally sustainable to do so.
21. Finally, there needs to be an exploration of the make-up of the workforce in terms of specialists versus general lists who can operate across a number of different care settings. Getting this balance right will be essential in ensuring that the NHS develops a workforce with the necessary skills and ability to be adaptable to meet current and future needs.

Submitted by the Healthcare Financial Management Association. For further information please contact:

Paul Briddock
Director of Policy and Technical
Healthcare Financial Management Association
1 Temple Way
Bristol
BS2 0BU

Email: paul.briddock@hfma.org.uk