A summary of 2016 key documentation as identified by the Nuffield Trust

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Rebecca Jowett and Lisa Burgess

Overview

In 2016 there was Brexit, sustainability and transformation plans (STPs), record provider deficits and the junior doctors' strike. The Nuffield Trust have suggested that in these turbulent times, it's particularly useful to read from a range of viewpoints to help make sense of what has been going on.

The Nuffield Trust have compiled their best six long reads and six short reads of 2016 and these publications and blogs have been summarised by Healthy London Partnership in this document .
For more information, please visit http://www.nuffieldtrust.org.uk/blog/highlights-2016-12-christmas-reads

Literature Reviews

Delivering the benefits of digital health care

Background

Clinically led improvement, enabled by new technology, is transforming the delivery of health care and our management of population health. Yet strategic decisions about clinical transformation and the associated investment in information and digital technology can all too often be a footnote to NHS board discussions. The report '**Delivering the benefits of digital health care'**, published in February 2016, sets out the possibilities to transform health care offered by digital technologies, with important insight about how to grasp those possibilities and benefits.

Seven opportunities to drive improvements in productivity and quality of care:

Seven lessons that all health care organisations embarking on a digital strategy should know:

1. Transformation first
2. Culture change is crucial
3. User-centred design
4. Invest in analytics
5. Multiple iterations and continuous learning
6. Support interoperability
7. Strong information governance

Maximising the benefits from a digital strategy

Acquiring full maturity as a digitally enabled organisation requires:

- engaged leaders who are deeply knowledgeable about the clinical and technological systems in place
- a commitment to maximising the benefits of technology from leaders at board level and below
- an advanced technological infrastructure
- dedication to using data for continuous improvement and learning.

The future

The authors vision of how health care is likely to change in the next 10 years:

- **Patient outcomes will be improved** because technology intelligently supports long-term health management and short-term episodes of illness or injury.
- Clinical professionals and their organisations will be **spending their time on their core competency** – treating patients – rather than wasting time managing processes. They will have access in real time to all the information they need.
- **Computing will be much more ubiquitous, but much less visible.** A lot **less time will be spent by staff on administrative tasks and routine communication**, as automation, voice recognition and natural language processing become more commonplace.
- **New roles and competencies will be added** to the managerial cadre in health care – most importantly that of analytics.
- **Professionals will develop a wider range of consulting and coaching skills**, to account for the increased ways in which they can interact with and empower their patients.
- **Organisational and professional boundaries will be far less visible**, as integrated information and communication systems dissolve many of the current divides between primary, secondary and tertiary care.

Reference: http://www.nuffieldtrust.org.uk/publications/delivering-benefits-digital-health-care

Feeling the crunch: NHS Finances to 2020

Summary

As recognised by the NHS's Five Year Forward View, by 2020 the NHS will need to find savings of around £22 billion in order to balance its books. But there has been no clear articulation of how that gap is expected to be closed. The options for doing so include NHS providers becoming more efficient; NHS commissioners reducing the pace at which NHS activity is increasing each year, either through reducing demand or limiting access to care; more funding for the NHS; or some combination of these.

The **'Feeling the crunch: NHS finances to 2020'** report published in August 2016, examines different scenarios to determine exactly what it would take to close the gap.

''By [2015–16], NHS providers were being paid £925 in cash for the same procedure they would have been paid £1,000 to perform in 2009–10: the equivalent of a real-terms cut of 20% to just £800.''

''By 2019–20, over a third of the STF would be needed to subsidise commissioner costs under the tariff, while the remaining £2 billion or so would be absorbed by provider deficits. No STF would be available for investment in 'service transformation.''

Key Points

The NHS in England will struggle to meet the requirement, set by the Five Year Forward View, **to save £22 billion by 2020**.

• Even if hospitals and other NHS providers made cost savings of 2% a year, year after year, the **funding gap would still stand at around £6 billion** by 2020–21.

• For the most part, the task of **closing the health service's funding gap will be borne by health care providers making efficiency savings**. From 2011–12 to 2014–15 the target for annual efficiency savings was set at 4% per year. Providers have actually achieved savings closer to 2% over the last three years, resulting in an underlying provider deficit in 2015–16 of £3.7 billion.

• Continuing with **2% annual efficiencies to 2020–21 would not be sufficient to close the funding gap by itself**. Reducing that deficit altogether would require providers to make further efficiencies of 4% in 2017–18 and follow that with efficiencies of 3% in 2018–19. That level of recurrent, sustained efficiency saving **has never been achieved to date and would still require funds to be taken from the Sustainability and Transformation Fund** (STF) to balance provider deficits in the meantime.

• **If most of the STF is used to plug the deficit, there will be little money for the transformative service change** that is required to modernise and reshape NHS services for long-term financial sustainability.

• Activity is growing by an estimated 3.1% per year. Even if NHS providers manage to make the huge additional efficiencies set out above, a **sustainable balance can only be brought into the system by 2020–21 if NHS commissioners also manage to curb the rate at which NHS activity is growing** by a third.

• The NHS is relying on service change and new models of care to curb the growth in activity and treat patients more cheaply. This is highly unlikely without access to the STF for transformation. As such the two tasks of **huge provider efficiencies and successful commissioner investment in reducing demand growth** need to happen in a **timely and coordinated fashion**.

• Providers are in deficit in part because **the rate they have been paid for the procedures and treatments they carry out –** set by the national NHS tariff – does not cover their costs and **has been cut by an average 1.6%** in cash terms a year over the last six years.

• NHS England has agreed to increase the tariff this financial year, easing the pressure on providers slightly, but **pushing commissioners into deficit for the first time by 2018–19**.

• **If commissioners fail** in their attempts **to reduce the rate at which demand is growing**, or if additional funding cannot be secured, the **NHS will face some unpalatable decisions in order to curb the growth in activity** and bring the books into balance. These could include extending waiting times for treatment, raising the threshold at which patients become eligible for treatment, cutting some services altogether, or closing whole sites or hospitals.

• These rationing dilemmas come immediately after the EU referendum, which may have **heightened public expectations that there will be new investment** for the NHS.

References: http://www.nuffieldtrust.org.uk/sites/files/nuffield/feeling_the_crunch_nhs_finances_to_2020_web_correction.pdf

Reshaping the workforce to deliver the care patients need

Background

Recent policy, including the five year forward view, mean there is an emphasis on new care models to meet the needs of a rising population with complex needs. Yet the capacity for NHS staff to deliver these models has often been overlooked, in spite of a growing disparity between patient needs and the skills and knowledge of the workforce that treats them.

The Nuffield Trust was commissioned by NHS Employers to examine how best NHS staffing can be reorganised to support new ways of delivering care to patients. The report **'Reshaping the workforce to deliver the care patients need**', published in May 2016, argues that there is an urgent need to rethink the nature of the NHS workforce if new care models are to succeed in meeting the needs of patients in the future.

Key recommendations

Equipping the *existing non-medical* workforce – NHS nursing, community and support staff – with additional skills is the best way to develop the capacity of the health service workforce.

- **Utilising the support workforce:** This subset of the workforce is large and highly flexible, while short training times mean that numbers can be expanded relatively quickly. Evidence suggests that support workers can provide good-quality, patient-focused care, as well as reduce the workload of more highly qualified staff.
- **Extending the skills of registered healthcare professionals:** such as nurses, pharmacists, physiotherapists and paramedics. This provides opportunities to manage the growing burden of chronic disease more effectively, could release some savings, and could help bridge some of the workforce gaps that are forecast.
- **Advanced practice roles for nurses:** including those that require a further period of study, typically a two year Masters qualification, offer opportunities to fill gaps in the *medical* workforce.

The risks

There is evidence that without careful role and service redesign, new and extended roles can:

- increase demand
- supplement rather then substitute for other staff
- cost rather than save
- threaten the quality of care
- fragment care

Ten important lessons for local leaders

For organisations seeking to redesign their workforce, local leaders must:

1. Be realistic about the time and capacity needed to support change
2. Create a receptive culture to change
3. Support to workforce development and change transformation with strong communications and change management strategy
4. Build roles on a detailed understanding of the work, staff skills and patient needs
5. Invest in the team, not just the role
6. Ensure robust triage mechanisms
7. Develop and invest in a training capability
8. Build sustainability for new and extended roles
9. Evaluate change
10. Adopt a systematic approach

Reference: http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/reshaping_the_workforce_web_0.pdf

Is bigger better? Lessons for large-scale general practice

Summary

Traditional general practice is changing; three-quarters of practices are now working collaboratively in larger-scale organisations. Policy-makers and practitioners have high hopes for these organisations and their potential to transform services. There is a risk that these organisations will become overwhelmed by opportunities available to them; they will need time to develop the necessary skills, knowledge and working relationships, as well as excellent leadership and organisational development support if they are to undertake the work needed to establish and build capacity to deliver new services.

The '**Is bigger better? Lessons for large-scale general practice'** study, published in July 2016, examines the factors affecting the evolution and impact of large-scale general practice on staff, patients, the wider health economy and the quality of care.

Practical insights for emerging groups

- **Clarity about goals and values.** Agreed core values; goals were refined and developed over time. Three broad goals included:
  - sustaining and improving core general practice services
  - delivering extended services in community settings
  - leading whole-system change as a multi-speciality community provider.
- **Governance**. Should support organisational goals and values; an important difference between the case study sites was whether member practices or the central organisation held the contracts for core services.
- **Leadership**. Inspiring clinical leaders played an essential part in engaging staff and supporting them to change. Emerging organisations should develop a broad leadership group to avoid dependence on 'heroic' leaders.
- **Models of change**. Directive model of change used where the central organisation held member practices' GMS / PMS contracts. Where practices retained their core contracts, a model of 'concertive' change was used.
- **Economies of scale.** Added value from implementing initiatives at scale that could be extended into weaker practices, allowing investment in staff, technology and support.
- **Workforce**. New opportunities to strengthen and diversify the workforce. However, senior staff support for initiatives such as investment in training, skills and peer support was at times 'heroic' and staff burnout was described.

Key findings

- **Rate of formation**. Nearly three-quarters of general practices are collaborations with other practices, half formed during 2014/15. Common reasons for forming were to 'achieve efficiencies' and 'offer extended services in primary care'.
- **Sustainability**. Larger scale can help to improve sustainability in core general practice through operational efficiency and standardised processes, maximising income, enhancing the workforce and deploying technology. However, the resources required are significant.
- **Quality of care and patient satisfaction**. No single large-scale organisation consistently outperformed or underperformed the others on all indicators.
- **Patient involvement and experience**. Practices need to find ways to harness the benefits of larger scale while preserving the localism and 'expert generalism' of general practice.
- **Staff experience**. Staff were broadly positive about working in a large-scale organisation, administrators and receptionists reported the highest satisfaction scores and salaried GPs reported the lowest.
- **Extending the range of services offered in general practice**. Case studies had established high-quality community specialist services popular with patients. However, they were mainly small scale and none had redesigned care delivery across a whole speciality or operated at the scale envisaged for new models of care.
- **Working with the local health economy**. The quality of relationships with commissioners and specialists shaped the ability of large-scale general practice organisations to extend services.
- **Realistic expectations**. National and local policy-makers and commissioners need to have realistic expectations of large-scale primary care organisations; newer groups may struggle to establish the systems needed to deliver efficient, high-quality services if too much is asked of them too quickly.

Reference: http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/large_scale_general_practice_web_update_for_lit_review.pdf

Improving care for older people - Using data to identify good-quality care for older people

Background

There is a large amount of variation in the quality of care delivered to older people across England. Numerous initiatives by various bodies have been set up with the aim of improving care, but much of the evidence of their effectiveness remains anecdotal. Furthermore, when multiple health or care improvement activities are in place in one area, it is not always clear which parts improve outcomes and which do not.

The Pilot

The report **'Using data to identify good-quality care for older people'** published in November 2016, describes the results of a pilot analysis of the effectiveness of using routine health care data to determine areas that have made quality improvements in the care of frail and older people over time.

The pilot focuses on a few indicators that were mainly derived from acute emergency hospital use and applies statistical analyses to them at the local authority area level. Follow-up interviews and document reviews were then conducted in an attempt to ascertain whether the identified changes could be attributed to local initiatives to improve quality of care, and therefore whether these statistical methods were relevant signals of quality improvement.

Conclusion

This study shows that there is scope for using more sophisticated analytical methods for identifying improvements in care quality, and that they have advantages in improving specificity and as continuous monitoring tools. If used for local monitoring, any issues of inadequate risk adjustment are less of a problem.

During the engagements with local areas, the authors had problems attributing cause and effect, but this may partly be a consequence of using retrospective findings and the complexity of care. There are likely to be greater advantages in using these methods for prospective monitoring and evaluation, but only once clarity has been achieved regarding the benefits that a new initiative is expected to show.

Key points

- It is possible to use routine data to identify significant changes over time that may relate to improvements in quality of care.
- There is not always a straightforward link between improvements in reported outcomes and changes in the way services are being delivered. These links may exist, but they are not necessarily easy to find.
- In local areas there can be numerous innovations for changing service provision that run concurrently. How these interact may have a more important impact on outcomes than any one activity on its own.
- Much can be gained if local areas are able to make more use of time series (a series of data points indexed, listed or graphed in time order) to monitor changes against their own past history, particularly for the prospective evaluation of new initiatives for improving care.

Reference: http://www.nuffieldtrust.org.uk/publications/using-data-identify-good-quality-care-older-people

The future of child health services: new models of care

Background

The future of child health services: new models of care briefing, published February 2016, describes the current state of child health and quality of care in the UK and how the emerging models are responding to these issues. It is based on a 2015 Nuffield Trust workshop that brought together frontline clinicians, service users, commissioners, representatives from new care models and a range of other stakeholders.

Summary

- Children and young people's (CYP) health services are still heavily weighted towards reactive hospital services rather than prevention, in spite of a shift away from infectious illness towards chronic long-term conditions.
- The report describes the current state of child health and quality of care in the UK, including problems around increasing use of hospitals to treat conditions that could be dealt with in other settings; capacity issues in primary care; and the often disjointed care provided between hospitals and the community.
- New models of child health services have been emerging both within the Vanguard scheme and inspired by it to respond to these issues. Common features include: having a focus on understanding the needs of different sections of the child population and their families, and organising care to meet these needs; strengthening early and easy access to appropriate expert paediatric assessment in the community; understanding how children and their families use the health system, helping them use it more effectively, and actively working with them to design and improve the quality of services; making more of the range of community settings in which health care and wellbeing can be provided; encouraging early, proactive intervention; improving communication between primary and secondary care services; and addressing the wider needs of children and their families by working in multidisciplinary teams and joining up health records.

Key principles of the ideal model/system

Participants at the workshop identified principles of an ideal system.

Understand children, young people and their families' specific needs (including broader determinants). The system needs to be flexible enough to respond rapidly to CYP needs in the appropriate setting. Segmenting the population allows us to understand CYP's general and specific needs, including the broader determinants of their health, so that these together with their expectations can be met, and resources targeted more efficiently.

Health outcomes Enable access to high-quality paediatric/child health expertise in the community. Solutions include:

- Direct access for the GP to a named paediatrician/specialist nurse.
- Multidisciplinary case discussion meetings
- Primary care paediatric clinics
- Actively engaged senior care lead with appropriate training
- Community care under one roof (physical or virtual)
- Workforce and training.

Link up information, data, communication and care (horizontal and vertical) . It is essential to have up-to-date communication and good information/data flow with the child/young person and their family, not only across the different health professionals and professionals in other sectors in the community, but also with secondary and tertiary care.

Health literacy and education. It is essential that CYP and their families, as well as professionals, know where to get information and advice and to have a 'shared language'. Important aspects of health literacy and education are:

- Educate and engage parents.
- Educate staff about the roles and responsibilities of other staff in the system
- Use the currently under-used and under-supported school system.

Reference: http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/child_health_briefing_web.pdf

How are STPs coming together?

In August and November 2016, Nigel Edwards outlined in a series of blogs what we know about STPs, their assumptions about efficiency savings and whether they would be likely to succeed. Summarising in his most recent blog in the series published in November, Nigel says: **"The NHS will go into next year with no plan B and, in some cases, with plan A far from complete."**

It is getting harder to cut costs

There are 44 STPs which must lay out plans to achieve £15 billion of the £22 billion in productivity savings needed across England by 2020-21. We are starting to see what England's 44 new sustainability and transformation plans (STPs) might entail. Much of the process has been conducted behind closed doors, and when this blog was published only Birmingham and Solihull had published their full STP. All STPs have now been published and are available online at this link.

Around half the savings are to come from annual efficiency targets, squeezing down trusts' costs by reducing the tariff of prices. The rest of the savings need to come from STPs and plans have set out lists of measures to achieve savings, with many aimed at reducing the use of hospitals and managing the rising tide of demand. The STPs are very wide in scope, from work on prevention to care at the end of life, and their willingness to tackle the wider determinants of health outside the usual interest of the NHS.

Plans to reduce admissions to hospital, length of stay, emergency department attendances, and outpatient visits, generally by double-digit percentages, are common. There is a focus on patients in hospital who could be cared for in other settings, with ambitious targets for reducing numbers of these patients. Much hope is pinned on investment in primary care and community services, in particular the creation of various flavours of integrated care systems modelled on the accountable care organisation experiments in the United States or Spain's Valencia region.

More radical plans:

Some areas have more radical plans for the rationalisation of hospitals, the closure of beds in community hospitals, downgrades of emergency departments, and other controversial measures. South West London's plan involves fully closing one of its five acute care sites. Often these changes are driven by workforce pressure and a view, not always very well evidenced, that centralisation improves outcomes.

Some ideas are appropriate and based on evidence. Others are on less certain ground. There is little detail to explain by what method some of the more ambitious changes in care will be achieved.

The sheer number of change programmes planned raises questions about whether enough resources or hours in the day exist to do them in the time available. Experience in developing accountable care indicates that success requires several years and a substantial investment that may initially return a loss. Some plans require major capital investment to facilitate new models of care or hospital rationalisation. The NHS capital budget has been repeatedly raided, by £1.2 billion this year, and these plans will struggle to be delivered. Again, the time and managerial effort required to invest well is also an issue.

A last factor is how quickly these plans have had to be put together. Involvement of clinicians, local politicians and others with a stake in local services is often lacking, creating a very significant risk.

We do not yet have enough detail to know whether these plans can close the financial gap, but certainly some have levels of savings that look somewhat optimistic.

There are reasons to be concerned, given the extent to which many of the plans are based on some bold and sometimes experimental assumptions, the time available for change, and the scale of the task.

Reference: http://www.nuffieldtrust.org.uk/blog/tag/stps

The facts on Brexit

Summary

The consequences of Brexit for the NHS remain far from resolved. Two blogs by Mark Dayan published in May and June 2016 ahead of the EU referendum examined what leaving the EU might mean for the health service; there is still much uncertainty about the position of EU immigrants residing in the UK, which is a real concern given that 4% of UK nurses and 10% of doctors are EU immigrants and analysis found that leaving the EU was unlikely to relieve pressure on the service, since the impact of immigrants' use of the NHS is minimal compared to other factors such as ageing and rising costs.

The facts: EU immigration and pressure on the NHS

- EU citizens moving into and through the UK change both sides of the NHS's financial equation; they affect the number of people who must be treated, but by paying taxes or transferring money under schemes such as the European Health Insurance Card (EHIC), they also affect how much money the health service has to spend.
- It is estimated that in 2014, migration from the EU added £160 million in additional costs to the NHS across the UK.
- Whilst this is a significant figure, it is small compared to the £1.4 billion in additional costs; the biggest contributor to this was the growing and ageing native population with around £1.6 billion from new technologies and the financial implications of improving standards of care, and £2.8 billion from inflation and rising wages.
- Two studies have been carried out on immigrants living in the UK between 1995 and 2011 – one by academics at UCL and another by the campaign group Migration Watch. Both studies agree that immigrants from the European Economic Area (EEA) made a more positive contribution than UK natives and immigrants from outside the EEA. However, over this period the UK as a whole ran a budget deficit and in this context the studies disagree on whether EEA migrants contributed enough to actually be net contributors overall. UCL figures say the EEA migrants net effect was to add £4.4 billion to public coffers, whereas Migration Watch find that the overall impact was a loss of £13.6 billion.
- The UK paid £647 million to EEA countries for treating their citizens on the NHS, while receiving just £49 million in return. Government studies suggest that the NHS is recouping only a fraction of what should be around £340m from other countries.

Fact Check: Migration and NHS staff

- 55,000 out of the 1.2 million staff in the English NHS are citizens of other EU countries.
- Academics have singled out the UK as relying on importing doctors trained abroad. Most come from outside Europe, but more than one in ten of those registered to practice as a doctor is an EU immigrant.
- EU immigrant nursing numbers have risen at a time when the numbers of British-trained nurses has actually fallen.
- Leaving the EU would allow the UK to restrict the flow of immigrants from Europe and campaigners in favour of Britain remaining in the EU have argued that this could cause an NHS staffing crisis, directly through new restrictions preventing EU-born NHS staff from working in Britain, or indirectly, because EU-born staff will leave the UK pre-emptively due to the 'uncertainty' created when migration restriction becomes possible.
- One imprecise precedent is the substantial tightening of rules for non-EU immigrants around 2010 at the same time as migration for most categories of worker who did hold a job offer was capped.
- Over the years following 2010, it does appear that the package of restrictions had a subtle but clear impact on NHS recruitment.
- There was no evidence of a collapse in the numbers of non-EU nurses to suggest a general flight motivated by uncertainty – same for doctors.

References: http://www.nuffieldtrust.org.uk/blog/tag/eu-ref

Weren't new models of care supposed to solve the NHS crisis?

Paul Corrigan is a former special adviser to two new Labour Secretaries of State and Tony Blair. He gave his views on how NHS England's Five Year Forward View has had very little impact on how leaders in the NHS actually do their job. This Nuffield Trust guest blog was published in May 2016.

Current Leadership

The Five Year Forward View argues that developing new models of care in the NHS holds the answer to the triple crises of quality, health and resources.

There is agreement on the cause of the crisis but current leadership actions suggest that to address the crisis, the current model of care should be stabilised first. Leaders seem to have adopted a two-stage process:

1. **First, let's stabilise the current model of care to get rid of the problems...**

2. **...And then let's turn to transformation.**

New models of care

The Five Year Forward View was based upon the belief that the crisis is caused by the way in which the current models of care fail to meet new and increasing demand. So, stabilising the current system of fragmented care will do nothing to enable services to meet these new demands and may lead the system into further crisis.

According to Simon Stevens's blueprint***, 'the new' is being developed to come to the aid of the crisis in the NHS right now.***

The new models of care need to fill in the three gaps of health, quality and resources, and provide better care, cheaper per patient, than the current old models of care.

The ***'new care model'*** should create a model that can be followed by others. This replicable model means that all the different Vanguards have to shave some very local aspect of what they are doing in their locality into something that can be applied everywhere.

The crisis of increased demand is here now. Rather than striving to stabilise a system that cannot solve these problems, we need to pay much closer attention to exactly how the new can come to the aid of the old and move the problems on.

Reference: www.nuffieldtrust.org.uk/blog/werent-new-care-models-supposed-solve-nhs-crisis

Can we afford the NHS in the long term?

Background

The NHS is going through a decade of austerity, but demand for health care continues to rise. There is clearly widespread anxiety about the future of the service, with much speculation that we will need to find new ways to fund the service. Chief Economist John Appleby published a blog in September 2016 to assess new spending projections from the Office for Budget Responsibility, which estimate a rise in public spending to 8.8% of GDP in 15 years and argues that it will be possible to fully fund the NHS in the future.

Key Points:

- NHS providers are set to end the year in financial deficit, and many have warned of the unbridgeable gap between what we need to deliver and the money available to pay for it.
- NHS spending has risen in real terms by around 4% each year since its inception. Historical trends suggest public spending on health as a share of GDP will double by 2065. The question of whether this trend can continue is the subject of a current House of Lords inquiry, with a committee looking into the sustainability of the health service up to 2030.
- New projections from the Office for Budget Responsibility (OBR) provide valuable insight into how spending on health will evolve in the future; a key change in the OBR's assumptions about future spending is the inclusion of a factor for 'other cost pressures'. These are in essence the extra growth in costs over and above demographic change and any effects of growing national income.
- The OBR's new 'cost pressures' growth projections suggest that public spending on health care in the UK could rise from 7.4% of GDP in 2015/16 to between 8.8%-8.9% by 2030/31.
- The OBR's projection implies an annual real growth of 3.5% to 2030, in line with history and slightly lower than the long-term growth in spending.
- From an international perspective, a national public spend of 8.8% by 2030 would take the UK to the levels of public spending for France, the Netherlands, Denmark, Sweden, Germany and Japan in 2015. The Organisation for Economic Co-operation and Development (OECD) projections suggest that all countries' spending is likely to increase, leaving the UK's relative rank on public spending on health essentially unchanged between 2010-30.
- *If* the OBR's cost pressures projection became the *chosen* spending path, this would have policy implications; funding would be provided through a combination of extra taxation and/or shifting government spending away from some areas and towards health.
- It is important to bear in mind that a big chunk of the £100 billion increase implied by the OBR projection arises because the economy is also projected to increase; even if the health spend share remained unchanged at its current rate of 7.4%, the NHS would grow by nearly £60 billion in real terms. This would leave around £40 billion (an extra £2.7 billion each year) to be funded through some combination of increased tax and reprioritisation of government spending.
- The full impact of the Brexit decision on GDP remains unknown, but most projections indicate a reduction in the rate of growth of GDP into the future. This will clearly limit the choices available to future governments in terms of their tax and spend decisions.
- There are grounds to be optimistic that we *can*. A funding increase in line with OBR projections of 8.8% by 2030 is both possible and affordable, but will require some difficult spending decisions, and there is an immediate financial challenge to be dealt with first.

Reference: http://www.nuffieldtrust.org.uk/blog/nhs-financially-sustainable

Where is the public pressure for social care reform?

Social care for older people: home truths report

This report, a collaboration between Nuffield Trusts and the Kings Fund published in September 2016, looks at the current state of social care services for older people in England, through a combination of national data and interviews with local authorities, NHS and private providers, Healthwatch and other groups. It considers the impact of cuts in local authority spending on social care providers and on older people, their families and carers.

Key findings of the report

- **Social care for older people is under massive pressure**; increasing numbers of people are not receiving the help they need, which in turn puts a strain on carers.
- **Access to care** depends increasingly on what people can afford and where they live.
- **Under-investment in primary and community NHS services** is undermining the policy objective of keeping people independent. Local authorities have little room to make further savings, and most will soon be unable to meet basic statutory duties.

Policy implications:

It is recommended that policy-makers need to address three major challenges in shaping the development of social care over the next five years, focusing on how to:

- **achieve more with fewer resources** – e.g. through better commissioning and integrated care.
- **establish a more explicit policy framework**, which makes it clear that primary responsibility for funding care sits with individuals and families.
- **reform the long-term funding of social care** because reliance on additional private funding is unlikely to be sufficient or equitable.

Authors comment

What a family or an older person experiences is highly variable. It depends on levels of wealth, but more than this it depends on local variations: variations in the supply of care homes, the financial health of the local authority, the availability of care workers, and the availability of NHS services 'in the community'.

Once a family is confronted by the irreversible, failing health of a loved one, they are caught up in a maelstrom of assessments, referrals, applications for benefits and equipment, uncertainty about where to turn, whether you have enough money, who is in charge of what, whether you can trust the care home down the road or the carers who come in to your house. And when it is over – and for some people this can last a long, long time – mostly people feel quietly relieved and pick up the threads of their own lives.

A shadow minister for health commented: “what really puzzles me is that this system is so broken and so manifestly poor, and yet my mailbag is not full of outraged constituents about this subject: they just don't write!”

These are silent, private crises happening in hundreds of thousands of homes across the country. It takes extraordinary energy to tell your story and demand change. **So what will make this system change? Will there ever be overwhelming public pressure for social care reform?**

Reference: http://www.nuffieldtrust.org.uk/blog/where-public-pressure-social-care-reform

Our Buzzfeed: Arm yourself with NHS know-how for 2017

Background

The NHS is under considerable financial pressure; and yet some of the reports and headlines contain numbers that are contradictory or just plain wrong. The Nuffield Trust compiled a Buzzfeed explainer in October 2016 that tells you everything you need to know about money in the NHS. In summary, the NHS funding gap is possibly a bit smaller than originally thought; however, the extra money will be less than you were led to believe; last year's financial hole is even bigger than it looks, as is next year's; and the Brexit bonus is cancelled.

Breakdown of the most common numbers about NHS finances

1. The funding gap: £30 billion
Since the figure was first calculated back in 2013, the government has pledged to increase NHS spending by an 'extra £8 billion' over the next five years (although this figure is also misleading, see below). This reduces the £30 billion gap to around £22 billion.

2. The 'extra money': £8 billion (or £10 billion)
Both figures refer to the 'extra' funding the government claims it will increase NHS spending in England by, above inflation, over the next five years. But the figure of £10 billion includes money given to the NHS in 2015 and the £8 billion figure is based on a redefinition of what counts as 'the NHS'. Without this recycled money, the real increase for the health service for the next five years is just over half what the government claims, at £4.5 billion. With NHS-specific inflation factored in, the remaining £4.5 billion of new money for the NHS reduces to £800 million.

3. Last year's overspend: £2.45 billion
This is the amount that NHS hospitals and other service providers reportedly overspent on their budgets last year; and is a significant understatement - the real figure is likely to be nearer to £3.7 billion. The NHS is starting from a position of not having enough, making it very hard for the NHS to recover, even with additional money.

4. This year's overspend: £580 million
This is the deficit NHS hospitals are predicted to be in by the end of next March, compared to last year's £3.7 billion, however, providers received an extra £1.8 billion this year to bail them out and without that, the underlying deficit for the year would actually be £2.4 billion. This can only be achieved if providers can cut their costs by around £3 billion in just one year, which equates to savings of about twice what experts have previously told the government is possible. The money being used to bail out hospitals is being taken from a pot of money intended for investing in setting up new services focussed on out of hospital care and prevention.

5. The Brexit money: £350 million
The claim from the EU referendum's Leave campaign implied that by leaving the EU we could free up additional funds for the NHS. Whilst the UK does pay £19 billion a year to the EU (or £350 million a week), it received over £4 billion in 2014 as a 'rebate'. Many now talk about a much smaller boost of £100 million a week (£5 billion a year) for the NHS; whilst this is feasible, the predicted economic shock of Brexit could potentially wipe out as much as £40 billion from the public finances.

Reference: https://www.buzzfeed.com/nuffieldtrust/they-said-theyd-give-the-nhs-more-moneyguess-w-141sp?utm_term=.iq46EjoOm3#.iizyMYO9pD