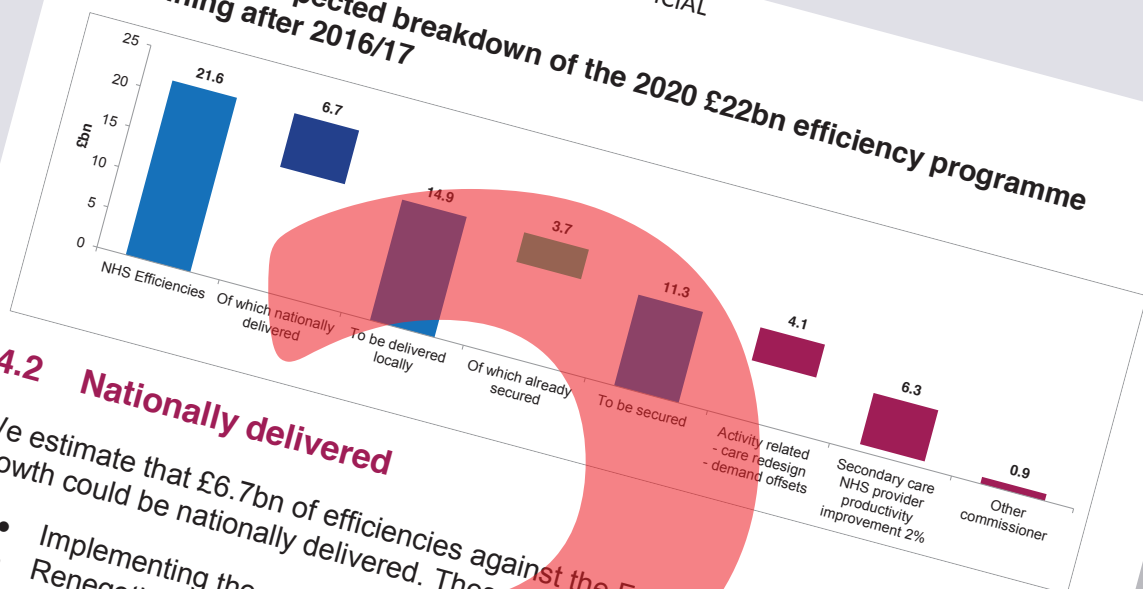


The Five Year Forward View: do the numbers add up?

Chart 4.2 – Expected breakdown of the 2020 £22bn efficiency programme remaining after 2016/17



4.2 Nationally delivered

We estimate that £6.7bn of efficiencies against the Forward View counterfactual cost growth could be nationally delivered. These include:

- Implementing the government's 1% public sector pay cap to 2019/20
- Renegotiating the community pharmacy contract with the pharmacy sector, and a variety of other nationally delivered cost efficiencies
- Implementing income generating activities overseen by the Department of Health as agreed in the SR
- Reducing NHS England central budgets and admin costs

This leaves local health economies needing to find around £15bn in efficiencies.

4.3 Efficiencies to be secured by local health economies

We already have line of sight to £1bn of efficiencies from Non-NHS provider contracts and CCG running cost reductions. Per the SR modelling, this would leave £14bn of efficiencies to find over the period. We expect that these will be delivered through achieving the following:

- **Activity** – Moderating the level of activity growth through care redesign, and interventions such as RightCare and Self Care.
- **NHS secondary care provider productivity** – Achieving 2% productivity improvements each year across NHS secondary care, £8.6bn in savings.
- **Other efficiencies** – including one-off savings from CCG and non-secondary care provider productivity.

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Executive Summary

1. This report reviews the financial assumptions underlying the efforts of England's 44 Sustainability and Transformation Partnerships (STPs) to implement the aims of the NHS Five Year Forward View (5YFV). A close examination of the evidence suggests that they are not realistic. The report concludes by considering the implications for patients if this proves to be the case.
2. In July 2013 NHS England predicted that to meet the healthcare needs of the population in 2020/21 would cost £30bn more than the government was planning to spend on the NHS in that year. This forecast was based on three assumptions: i) no additional (real terms) NHS funding; ii) no productivity growth in the NHS; and iii) costs rising by just under 3% a year.
3. This funding gap - predicted to reach £30bn in the financial year 2020/21 – has received much public attention. But the gap between what the NHS will need over the seven years from 2014 to 2021, and what the government was planning to spend on it, widens year by year; by 2021 these annual gaps would add up to a total of £90bn (although this would fall to £66bn if the 1% trend productivity is achieved).
4. Whilst individual organisations, such as hospital trusts, can run successive deficits the NHS as a whole cannot, leaving it with two options: i) additional government funding; and ii) savings from higher productivity and efficiency.
5. For its part, the government announced in 2015 that it would provide a real-terms increase in NHS funding for England, starting with an additional £2bn in 2015/16 and reaching £8bn a year by 2020/21. The NHS was left to close the remaining funding gap by achieving a net efficiency gain of 2-3% every year over the years from 2015/16 to 2020/21. The joint effect of the additional funding and assumed efficiency gains in closing the funding gap is illustrated in Figure 2 on page 10.
6. The question addressed in this report is whether this is realistic. The view that the STPs will enable the NHS in England to achieve 2-3% net efficiency savings a year rests on a number of assumptions which have not been extensively tested. The report looks at seven key assumptions and evaluates how realistic they are. The 5YFV assumes that:
 1. There is sufficient capital and recurrent funding available to transform the organisation and operation of NHS services in the ways envisaged
 2. The new organisation of NHS services will lead to a fall in the rate of growth of health care provided by acute hospitals from 2.9% a year to 1.3% a year. This realises cost savings, as according to the 5YFV it is cheaper to treat patients in non-hospital settings.

3. Hospitals will find 2% cost savings each year and yet will also be able to make additional cost savings to clear their cumulative deficit.
 4. NHS pay for permanent staff will continue to grow at no more than 1% a year in line with public sector pay restraint.
 5. The total cost of agency staff will fall by an average of 4% a year.
 6. Investment in public health and education will improve health and enable more patients to 'self-care', reducing the costs of the NHS.
 7. There will be adequate investment in social care to ensure that elderly patients do not need admission to hospitals or remain in hospital beds after they are ready to be moved to non-hospital forms of care.
7. On close examination each of these assumptions appears problematic:
1. £1.8bn out of the £2.1bn of this year's up-front funding earmarked for transforming NHS services has instead been spent on reducing hospital deficits and this is expected to continue in 2017/18 and 2018/19. The extra £425m of investment in STPs and A&Es announced in the Spring Budget is welcome but backlog maintenance on NHS estates needs £5bn alone.
 2. It is unlikely that the growth in health care provided in hospitals will fall from 2.9% a year to 1.3% given that an aging and growing population will require hospital activity to grow at 1.5% a year as a minimum.
 3. Last year hospitals were only able to find recurrent cost savings of 2.8% and yet average targets of 4% and 4.2% have been set for this year and next. NHS Improvement has conceded that targets of 4% in previous years were unrealistic.
 4. A 1% pay cap will be hard to maintain with national average earnings expected to grow by 2.9% a year and inflation at 1.9% a year. A 0.9% real wage cut amidst 6% staff shortages is unlikely to hold.
 5. The largest fall in agency staff spend is expected this year, down from £3.7bn (2015/16) to £2.5bn. However hospitals are now forecasting a spend of £2.9bn this year. Hourly caps dampen down cost growth but recruitment difficulties and staff shortages will prevent large savings being made.
 6. £3bn of the additional £10bn real terms funding being provided to the NHS is coming from a cut to the Department of Health's budget which includes the public health grant to Local Authorities. Cuts to public health spending of 3.9% a year make it unlikely that public health will improve.
 7. Social care is expecting a funding shortfall of £3.5bn by 2020/21. In 2017/18 the shortfall is expected to be £2bn double the additional £1bn available that year from the Spring Budget.

8. But if the assumptions are not valid then the needed 2-3% efficiency savings will not fully materialise and the NHS funding gap will not be closed. Unless additional funds are made available local NHS organisations will be forced to take more drastic measures to reduce costs. Rationing non-emergency care, the withdrawal of services, and/or reducing cost by reducing quality will be the only options. Commissioners will be forced to limit the number of non-emergency operations, or the kinds of operations, that they will pay for, or the kinds of patients who can have them (tougher thresholds of need). Instead of the intended improvement in care there will be a decline in quality and access and a growing risk that some services will collapse.

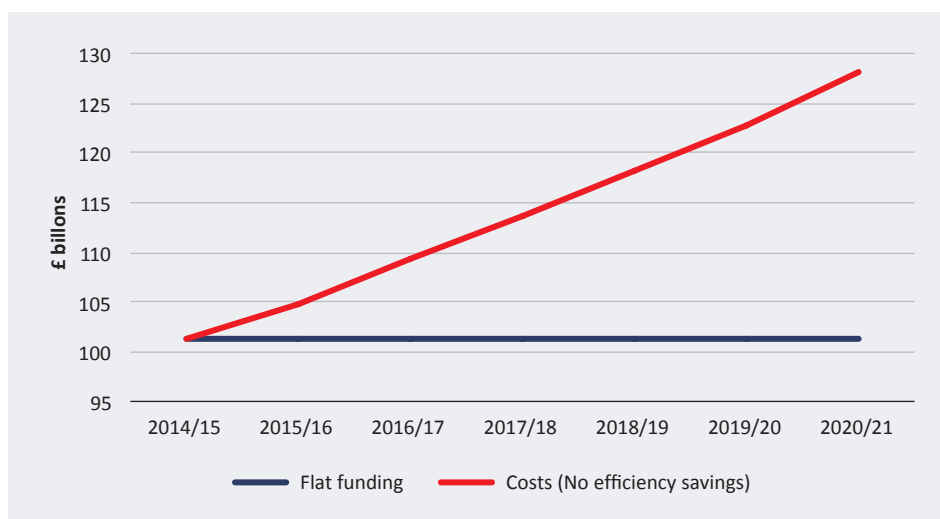
Introduction

1. Across England 44 ‘Sustainability and Transformation Partnerships’ are working to reshape the provision of NHS services in their localities, in line with the vision of the *Five Year Forward View* (5YFV) published by NHS England in October 2014. These teams are charged with transferring many services from hospitals to non-hospital or community settings, and integrating them with primary and social care. The 5YFV maintains that this will provide better services for patients. But it is also proposed as a means of enabling the NHS to survive unprecedented levels of underfunding. The Sustainability and Transformation Plans (STPs) produced by the 44 Partnerships thus have to try to achieve the intended benefits for patients while also saving money (known as ‘closing the funding gap’).
2. This paper asks whether the planning teams or partnerships have been set a feasible task: are the financial assumptions which they have been required to make realistic? A close examination of the evidence for these assumptions suggests that they are not. We conclude by considering the implications for patients if this proves to be the case.

Part 1: The ‘funding gap’

3. In July 2013 NHS England estimated that to meet the healthcare needs of the population in 2020/21 would cost £30bn more than the government was planning to spend on the NHS in that year (see Figure 1): this was the funding ‘gap’.¹ A previous analysis by the Nuffield Trust, and a further one by Monitor, have both arrived at the same projected shortfall.^{2,3} The forecast was based on three assumptions.

Figure 1. The forecast NHS spending gap from 2014/15 to 2020/21 in real terms (2015/16 prices)



Sources: NHS Spending Review⁴, The Health Foundation⁵ⁱ

4. The first assumption was that the need for healthcare, and so its cost, would continue to increase by just under 3% a year, up to and including 2020/21. This assumption reflected a predicted increase in the UK’s population of 500,000 a year, an ageing population, health cost inflation (which tends to exceed general inflation), technological innovations, and rising expectations on the part of patients.⁶ The second assumption was that the NHS would not make any savings at all from productivity growthⁱⁱ (this was in line with the average public sector productivity growth between 1997 and 2010 of zero per cent, although below the long-run average productivity growth in the health sector of one per cent).⁷ The third assumption was that the government’s spending plans, as part of its drive to cut public spending as a share of national income, would remain unchanged. The ‘funding gap’ was a gap between needs and what the government had allocated to the NHS as part of its controversial austerity drive.

5. It is important to note that the forecast predicted a funding gap in every year from 2014/15 onwards, rising to an annual figure of £30bn for the year 2020/21. There has been a lot of focus on the funding gap of £30bn in the financial year 2020/21, but the gap between what the NHS gets and what it has needed and will need over the whole seven years from 2014 to 2021 widens year by year and these annual gaps total £90bn.ⁱⁱⁱ While individual organisations such as NHS hospital trusts can run cumulative deficits, the NHS as a whole will not be allowed to overspend. Instead there is a risk that the gaps will be

i The original cash terms forecast of current spending by NHS England can be consulted on the CHPI website, together with a cash terms estimate of the forecast shortfall in capital funds. The link is: <https://chpi.org.uk/publications/analyses/stps-and-the-5yfv-appendix/>

ii Productivity is the rate at which inputs (e.g. labour, equipment, medical supplies) are converted into outputs (e.g. operations, consultations) and outcomes (e.g. improved health). Productivity focuses on the number and mix of inputs used to deliver a volume of output.

iii This falls to £66bn when a trend productivity growth of 1% a year is included.

closed by not providing needed care or withdrawing services: restricting access to non-emergency services, leaving patients to be cared for by their families at home, and by letting waiting lists grow. NHS England's recent abandonment of the 18-week elective treatment referral target over the next two years is a good example of what seems bound to happen.⁸

6. These are very large annual shortfalls, which the government and NHS England propose to deal with by a mix of additional funding and savings by NHS organisations.

How is the funding gap meant to be closed?

7. The gap is expected to be closed with a mix of additional funding and improved productivity or efficiency gains.

Additional government funding

8. The original funding gap calculation excluded any additional (real-terms) government funding. In the 2015 Spending Review, however, the government announced that it would provide a real-terms increase in NHS funding for England, starting in the financial year 2014/15 and reaching £8bn a year by 2020/21.^{4 iv} These additional funds would be 'front-loaded' – i.e. instead of being increased by the same additional amount each year, £4bn a year (around half of the final annual total of £8bn) would already be provided by 2016/17. This was an important point: 'front-loading' the additional money was intended to enable the NHS to be re-organised early in the five-year period, on the lines set out in the *Five Year Forward View* (5YFV). As already noted, the re-organisation involves above all shifting a large proportion of the care now given in hospitals to new forms of non-hospital or 'community-based' care, and integrating them with primary and social care. This is expected to allow the NHS to make much greater savings than it has in the past.⁹ Front-loading the additional funds was to provide the resources needed to make these changes.

Productivity and efficiency savings

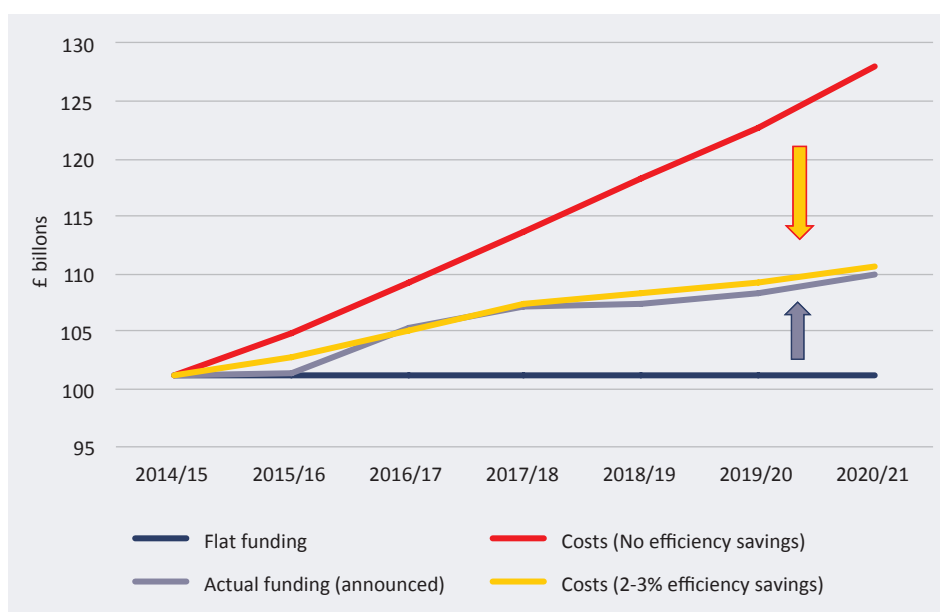
9. The original calculation of the funding gap assumed that there would be no further improvement in the NHS's productivity. But to close the funding gap that will still remain after the additional funding has been taken into account requires the NHS to achieve a net efficiency gain of 2-3% every year from 2015/16 to 2020/21. The 5YFV recognised that achieving this would be a much greater annual gain than the NHS had achieved in the past (over the long run it has achieved just 1%),¹⁰ and greater than the past gains made both by the UK economy as a whole and by

iv The announcement was of additional funding reaching £10bn a year however when measured in 2015/16 prices this actually only equals an extra £8bn a year. For more information see the following post from the Nuffield Trust by Sally Gainsbury and Mark Dayan: <https://www.nuffieldtrust.org.uk/resource/behind-the-numbers-nhs-finances>

other countries' health systems.¹¹ But this was the target required by the limited additional funding the government had agreed to make available.

10. Some of the cost savings are to be achieved by the Department of Health and NHS England at a national level, by such measures as imposing a 1% a year cap on increases in public sector workers' pay, renegotiating the contract with community pharmacies, cutting administrative costs at NHS England, and saving £1bn a year in NHS procurements from non-NHS suppliers.¹² The remaining annual funding gap – after taking into account the extra government funding and the cost savings just described – has to be tackled at the local level by hospitals, GP surgeries, and other NHS care providers (the task set for the 44 Sustainability and Transformation Partnerships in England).^v The yellow line in Figure 2 shows how both national and local level cost savings reduce the forecast cost of the NHS over the seven years 2014-2021, while the grey line shows the contribution of the increased government funding to closing the gap. The relatively low level of funding provided by the government leaves almost two-thirds of the annual gaps^{vi} still to be closed, forcing the NHS to aim for efficiency savings of 2-3%.^{vii}

Figure 2. How NHS England proposes to close the 'funding gap' in real terms (2015/16 prices)^{viii}



Sources: NHS Spending Review⁴, The Health Foundation⁵

v The term Sustainability and Transformation 'Partnerships' (in place of 'Plans') was introduced in NHS England's *Next steps on the NHS Five Year Forward View*, 31 March 2017.

vi After additional funding £57bn of the total of the annual gaps of £90bn is left.

vii Whilst both productivity and efficiency focus on the number and mix of inputs used, efficiency also includes the cost of inputs used. In recent years reducing the cost of providing each piece of healthcare treatment in hospitals has been the preferred method of improving efficiencies, along with increasing workforce productivity (partly achieved by pay restraint).

viii The 'Actual funding' figure includes Sustainability and Transformation Funding (see paragraph 14). The 'Costs' lines do not include the actual underlying hospital provider deficit of £3.7bn.

11. With the additional NHS funding (shown in the grey curve) and 2-3% efficiency savings reducing costs (the yellow curve) the gap is almost entirely closed. However, much concern has been raised about how realistic the expectation of 2-3% efficiency savings is, and about what it will imply for the NHS and for patients if it proves unrealistic.

Part 2: Is the expectation of 2-3% NHS efficiency savings realistic?

12. The plan to achieve 2-3% efficiency savings rests on some key assumptions which, as the National Audit Office has pointed out, have not been extensively tested.¹³ Yet if they prove to be invalid some of the funding shortfall will remain. In that case there must either be an increase in funding or costs will be reduced by withdrawing some services or seriously lowering their quality, or both.
13. The plans assume that:^{ix}
1. There is sufficient capital and recurrent funding available to transform the organisation and operation of NHS services so as to achieve the aims of the NHS Five Year Forward View (5YFV).
 2. The new organisation of NHS services will lead to a fall in the rate of growth of health care provided by acute hospitals from 2.9% a year to 1.3% a year. This realises cost savings, as according to the 5YFV it is cheaper to treat patients in non-hospital settings.
 3. Hospitals will find 2% cost savings each year and yet also be able to make additional cost savings to clear their cumulative deficit.
 4. NHS pay for permanent staff will continue to grow at no more than 1% a year in line with public sector pay restraint.
 5. The total cost of agency staff will fall by an average of 4% a year.
 6. Investment in public health and education will improve health and enable more patients to 'self-care', reducing the costs of the NHS.
 7. There will be adequate investment in social care to ensure that elderly patients do not need admission to hospitals or remain in hospital beds after they are ready to be moved to non-hospital forms of care.

ix These assumptions are often implicit in the plans. They have been drawn from work by the National Audit Office and from the NHS Five Year Forward View (5YFV) and its technical notes.

Assumption 1. *There will be sufficient funding for transforming service delivery.*

14. The redesign of local NHS services is expected to achieve a large part of the needed savings, and an up-front fund to pay for this has been provided in the shape of a Sustainability and Transformation Fund (STF). For the financial year 2016/17 the STF is worth £2.1bn, £1.8bn of it devoted to clearing the previous year's hospital trust deficits, and £0.3bn for transforming services.¹⁴ However, in 2015/16 the combined deficits of all NHS hospital trusts totalled £2.45bn, £650m more than the £1.8bn funding available.^x This means that most of the 2016/17 STF is being spent on reducing this accumulated deficit, leaving less available for the intended re-design of services.¹³
15. To reduce the total hospital sector's deficit financial targets ('control totals') were set for all hospital trusts in 2016/17, such that their total deficit (including STF funding) for 2016/17 would only be £580m. But even if this target is met (and this is increasingly unlikely¹⁵) NHS England predicts that most of the STF in 2017/18 and 2018/19 – £1.8bn in each of these two years – will be used to cover continuing hospital deficits and not for transforming services.¹⁶ This raises the question of where the money required to bring about the planned transformation will come from.
16. With respect to capital spending (i.e. on land, equipment and buildings), hospital trusts planned to spend £4.3bn in 2016/17, but only £2.7bn is available in the NHS budget.¹⁷ One local team working on plans to implement the 5YFV has already been told that the level of capital spending they had counted on for achieving the required productivity savings from reconfiguring services will not be available.¹⁸
17. If there is any money left over, in the STF or in local NHS organisations, each year, it can be spent on transforming services, but if NHS hospital deficits persist there is a strong risk that there will be insufficient funding left in the STF to invest in service re-design, making the expected savings less likely to be achieved. The announcement in the 2017 Spring Budget of an additional £425m of investment in STPs and A&E departments recognises the problem but falls far short of the sums needed to 're-provide' outside hospitals the services that will no longer be provided in them.^{19 xi} The backlog maintenance for NHS estates has been conservatively estimated at £5bn alone.²⁰

x The reported £2.45bn deficit shows the hospital trusts' surplus/deficit after taking into account additional sustainability and transformation funding and accounting adjustments. These act to reduce the size of the reported deficit. Before the extra funding and accounting adjustments the 'underlying' financial deficit was £3.7bn, which reflects the real scale of the financial difficulties faced.

xi A breakdown of the capital budget (CDEL) by year, including the additional funding announced, can be consulted on the CHPI website at: <https://chpi.org.uk/publications/analyses/stps-and-the-5yfv-appendix/>

Assumption 2. The growth in healthcare provided in acute hospitals will decline.

18. NHS England's original projection of the funding gap envisaged activity in acute hospitals – i.e. the amount of treatment provided – rising by 2.9% a year until 2020/21, in line with the annual growth of 2.8% in A&E admissions from 2013/14 to 2014/15. The hoped-for closing of the funding gap, however, depends on the assumption that the rate of growth in care provided by acute hospitals will fall from 2.9% a year to 1.3% a year.¹³ This would reduce costs by avoiding the need to open many more hospital beds, and by closing some existing hospital departments. But such a large reduction in the growth of hospital activity is unlikely. The number of hospital beds per 1,000 people in the UK is already one of the lowest in Europe.²¹ An analysis by the Nuffield Trust suggests that activity in acute hospitals will need to grow by 1.5% a year just to keep pace with an ageing and growing population, before taking into account changes in technology, patient expectations, and improving access to care.²²
19. Positively, early results from fifty 'vanguard' areas in England where integrated primary, acute, and community services have been trialled have seen lower growth in emergency hospital admissions at under 2% compared to 3.2% for the rest of England.⁸ Whilst this shows that progress can be made it remains to be seen whether these successes can be scaled up across all of England. The vanguard areas have been running for 18-24 months with additional funding to help them re-organise, whilst the STP plans have more stretched funding and will need faster results in order to close the financial gap over the five years. Furthermore, the National Audit Office has found no compelling evidence that integrating health and social care will provide sustainable financial savings or lead to reduced acute hospital activity.²³ Therefore while the shift of care out of hospitals may improve patient outcomes, the funding shortfall is unlikely to be offset by the decline in hospital activity assumed by NHS England.

Assumption 3. Hospitals will make 2% cost savings every year.

20. The savings that the 5YFV needs NHS hospitals to make are expected to be achieved by efficiencies of 2% a year, but to reduce the 2015/16 hospital deficit of £2.5bn a much higher annual level of savings will actually be needed. For 2016-17 hospital trusts were in fact asked to achieve an additional 2% of recurrent cost savings, making a total for the year of 4%,²² and this level of cost savings would need to continue in 2017/18 for there to be any significant money left in the Sustainability and Transformation Fund for investment in transforming NHS services, which is central to the 5YFV vision. NHS Improvement, the regulator of NHS hospital Trusts and Foundation Trusts, has acknowledged that targets of 4% in earlier years were unrealistic and yet 4% was still asked for in 2016/17, and a proposed average 4.2% for 2017/18.^{24 25}

21. Last year trusts achieved recurrent cost savings of 2.8% against a plan of 3.7%.²⁶ In 2015/16 hospitals managed to reduce costs by 3.6% (£2.9bn), but only 78% (£2.3bn) of these savings were recurrent (i.e. savings that would be repeated in all the following years), whereas 92% of the savings were supposed to be recurrent.²⁷ In the past hospitals have achieved recurrent savings by pay restraint (wages and salaries account for 70% of their costs), by reducing bed numbers (and hence the staff numbers required), and by reducing the cost of providing services. Non-recurrent savings have been achieved by sales of land and buildings, and by leaving posts temporarily vacant. However, it is very unlikely that these kinds of cost savings can be repeated annually over the next five years.
22. A further £5bn of savings are expected from the changes proposed by Lord Carter's review into the variation of resource use across acute non-specialised hospitals. The review's recommendations focused on savings from better use of the clinical workforce, medicines, diagnostic services, procurement, estates and facilities management and back office costs.²⁸ These savings were predicated on trusts whose performance is below average being able to 'catch-up' with better-performing trusts. However the fact that less productive trusts have not caught up with more productive trusts over time, and that there has been little movement in the variation in efficiency between trusts, suggests that there could be fundamental differences in the circumstances which account for these 'unwarranted variations'.^{29 30} Along with the declining levels of recurrent cost savings made by hospitals this suggests that we may have reached close to the limits of the productivity gains obtainable by the NHS in its current (post-2012 Health and Social Care Act) form.
23. A further problem is that as services are moved out of hospitals their growth in income from patients will fall, so that without sufficient cost savings hospital deficits will continue to rise. As things stand, money to cover these deficits will continue to come out of the total NHS budget, leaving ever less money for investment in transformation.

Assumption 4. NHS pay restraint for permanent staff will continue.

24. Cost savings are expected to be made by continuing to limit public sector pay increases to a maximum of 1% a year until 2020/21.^{xii} In 2014, however, the 5YFV acknowledged that if pay restraint continued while the economy, and hence private sector wages, improved, the NHS would not be able to recruit or retain frontline staff.¹¹ National average earnings are now expected to grow by 2.9% a year and inflation is expected to be 1.9% a year from 2015 to 2021.³¹ A 1% wage cap for NHS staff will become increasingly hard to maintain if it means an annual 0.9% real wage cut.

xii This refers to the basic pay settlement. Overall pay includes other elements (such as pensions) and so the overall increase will be slightly higher each year.

Assumption 5. *The total cost of agency staff will fall by 4% a year.*

25. The total cost of agency staff is assumed to fall by on average 4% a year with the biggest fall predicted for 2016/17 when it is expected to fall to £2.5bn, down from £3.7bn in 2015/16. However by December 2016 the hospital trust sector was expecting to spend a total of £2.9bn on agency and contract staff in 2016-17.¹⁵ NHS England's review of the next steps for the 5YFV chastised locums for 'placing an unacceptable burden on the NHS' and proposed a further clamp down on the use of temporary staff through further caps on hourly rates and requiring chief executives approve shifts costing more than national rates.⁸
26. Whilst reducing excessive hourly rates makes sense it can distract attention from the underlying issues of staff shortages, poor workforce planning, and what is causing difficulties in retaining staff. Analysis by the National Audit Office found that three-quarters of the rise in spending on temporary nurses from 2012/13 to 2014/15 was due to increased numbers of nurses employed rather than higher hourly rates. Poor workforce planning and training by government is partly responsible with a staffing shortfall of 5.9% in 2014, equivalent to 50,000 clinical staff, and accounting for 61% of the requests made to appoint temporary staff.³² With increased difficulties in recruiting staff from overseas due to immigration controls and uncertainty over EU citizens' rights the focus should be on retaining existing staff. The number of nurses leaving the NHS increased from 6.8% in 2010/11 to 9.2% in 2014/15, most of them leaving before retirement age.³² Meanwhile only 52% of last year's medical graduates chose to stay in the health service - the lowest percentage ever recorded.³³
27. NHS staff are already overworked and stressed: the staff sickness rate of 27% is higher than in any other public sector organizations, and 39% of cases cite stress and overwork as the causes.³⁴ Measures such as hourly pay caps may help lower the spend on agency staff but increasing training places, improved flexibility and better working conditions for existing staff are the only viable medium-term solution – and this is before considering the impact of implementing '7-day NHS' services. To achieve financial sustainability the agency spend needs to start falling immediately, but many of the practicable solutions will take years to have a full impact.

Assumption 6. *Investments in public health and prevention will help to cut costs.*

28. Significant savings are expected to come from reductions in the need for health care through public health measures to prevent specific illnesses such as cancer and heart disease, and through helping patients to take more responsibility for their own health ('self-care'). But £3bn of the £8bn additional real-terms funding being provided to the NHS by 2020/21 is coming from cuts to other areas of Department of Health spending, and one of the areas planned to

be affected is the grant the Department makes to local authorities for public health.^{xiii} Local authorities have warned that this will mean cuts to front-line health services such as smoking cessation groups, sexual health clinics, and health visits.³⁵ These cuts to public health spending (averaging 3.9% a year until 2020/21) make it very unlikely that the costs to the NHS arising from obesity, smoking, drug abuse and similar causes will be significantly reduced.³⁶ The STPs' reliance on a reduction in the growth of need from improved public health seems incompatible with these public health spending cuts. Moreover even with sufficient funding the positive outcomes from public health interventions are likely to materialise many years later, not in the time frame covered by the STPs.

Assumption 7. The provision of social care will prevent patients being unnecessarily admitted to and kept in hospital.

29. Finally, as acknowledged in the 5YFV, the expected hospital efficiency savings are reliant on adequate social care funding, so that vulnerable patients do not become so ill as to need hospital care, and those who are admitted to hospital can be discharged into social care when they are ready to leave. The underfunding of social care is expected to persist over the coming years, reaching a shortfall of £3.5bn by 2020/21.³⁷ The 2017 spring budget announcement of an extra £2bn of social care funding in England, spread over the next three years (2017/18 to 2019/20), will only partly offset this.¹⁹ In 2017/18 alone the shortfall is estimated to be £2bn, double the additional £1bn to be made available for that year. The rise in the National Living Wage will also add £900m to the cost of social care provision next year.³⁸ This underfunding of social care is already leading to an increase in A&E attendances and to hospital beds being occupied by patients who need social care, not hospital care, but for whom no social care is available. Simon Stevens has acknowledged that NHS England's plans have not taken into account the scale of the underfunding of social care, and has cited estimates that 'a pound out of social care equals another 35p to 50p of pressure on the NHS'.³⁹

xiii A breakdown of the additional government funding provided can be consulted on the CHPI website at: <https://chpi.org.uk/publications/analyses/stps-and-the-5yfv-appendix/>

Part 3: What are the implications for the NHS and patients if the assumptions on closing the financial gap are wrong?

30. The aims of the 5YFV are to deliver a better healthcare service at better value. Many of the proposals in the 5YFV, while largely untested, could improve patient care and outcomes. However, better care and outcomes don't necessarily lead to cost savings. Often in the short-term a change in healthcare provision requires the double-running of services, and whereas hospital care benefits from economies of scale, community care is generally more labour-intensive.
31. A large proportion of the cost savings is expected to come from hospitals cutting the growth in their costs, but in recent years it has been increasingly hard to make sustainable cost savings of the magnitude needed. The NHS hospital sector has delivered an impressive level of cost efficiencies, managing to absorb an average real cut of 20% in what they were paid in 2015/16 compared with what they received for the same work in 2009/10.²²
32. If the assumptions on which the proposed measures to close the funding gap prove unrealistic, rationing non-emergency care, the withdrawal of services, and/or reducing cost by reducing quality will be the only options; or as Mr Hopson, chief executive of NHS Providers, put it: 'more draconian rationing of access to care; formally relaxing performance targets; shutting services; extending and increasing charges; cutting the number of priorities the NHS is trying to deliver; or more explicitly controlling the size of the NHS workforce'.⁴⁰ In practical terms this means commissioners having to limit the number of non-emergency operations, or the kinds of operations, that they will pay for, or the kinds of patients who can have them (tougher thresholds of need).⁴¹ There is a risk that over the coming years the NHS will degrade into two services: a more or less adequately funded urgent and emergency health service, and an underprovided non-emergency service.
33. The situation will be aggravated if the reorganisation of services is itself insufficiently funded or poorly implemented. As noted above, sufficient capital funding to implement the radical transformation of services called for by the 5YFV is unlikely to be forthcoming from the Sustainability and Transformation Fund even in 2018-19.

Conclusion

34. The 44 teams charged with producing plans to implement the 5YFV – the STPs – have to assume that the overall calculations made by NHS England within which they are operating are realistic – that the numbers add up. If this is not the case the plans will not work. Instead of the intended improvement in care there will be a decline in quality and access and a growing risk that services will collapse. Our analysis suggests that the numbers do not add up.

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